HEART
HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Access to family planning and safe abortion

Date: 13 July 2016

Query: What evidence is available for how to increase access to family planning and safe abortion services in Africa, include the need to shift from clinical/hospital based services to increased outreach to reach young people and marginalised populations. What is the evidence of how to increase access to medical abortion, self-injecting contraception and other 'home based' care for increasing CYP, additional users?

Content

1. Overview

Evidence on increasing access to family planning

A WHO systematic review looking at the evidence on sexual and reproductive health among adolescents in developing countries finds quality evidence to be lacking in many areas (WHO, 2012). The report includes the following:

- No evidence was found on the efforts to influence laws and policies though this is recognised as important for increasing access.
- Efforts at increasing access to contraceptives directed at community leaders is acknowledged as useful but no evidence was eligible. Attribution is particularly difficult in this area. Potential harms of community interventions are noted.
- Some evidence was found to suggest that health service improvements can improve access. There are no harms in these areas and the panel recommends health service improvement for improving access.
- Low quality evidence was found to suggest that over-the-counter hormonal contraception improves access. There can be problems with misinformation and lack of follow-up with this type of provision.

Chandra-Mouli et al (2014) review the evidence on contraception for adolescents in low- and middle-income families. They conclude that adolescent friendly health services must be made friendly and welcoming, have adequate stocks of a range of contraceptives, and get competent support for making the best choice. They recommend contraceptive education, counselling and provision be integrated into other health services used by adolescents. They recommend that contraception for adolescents should be made available through a variety of outlets to reach all adolescents. This should include: venues where adolescents socialise, pharmacies, and community-level services with assured confidentiality.

Outreach/out-of-facility services and self-injectable contraceptives

Janowitz et al (2012) review task sharing in family planning finding that pills and injectable contraceptives can be safely provided at the community level by community health workers (CHWs) and through the retail sector. Community-based injectables have been more common in Latin America and Asia than in Africa. Provision of injectables by CHWs has been delivered to as high a standard as provision by nurses and midwives in Uganda (Stanback et al 2007). Technical experts have endorsed safety of the practice also (WHO, USAID, and Family Health International, 2010). Research on the provision of injections in pharmacies suggests practices are often unsafe (Stanback et al, 2011). A study that explored perceptions of home-use of injectable contraceptive in Ethiopia found it to be well received (Keith et al, 2014). A review of the use of performance-based incentives which offer community distributors financial payment to recruit more users of family planning found mixed results from programmes in Africa, Asia and Latin America (Bellows et al, 2015).

Safe abortion

The WHO review (WHO, 2012) also reports on evidence for increasing access to safe abortion. No evidence was found on efforts to increase access to abortion according to existing laws through community or policy leaders. The panel observed that intervention studies were unlikely to address the formulation, enforcement and impact of laws and policies to enable safe abortion services for adolescents. Evidence on reducing barriers to unsafe abortion was not found but recognised as important from both rights-based and public health perspectives.

Evidence on increasing access to safe abortion includes:

- A successful programme in Ethiopia has reduced unsafe abortion cases by deploying health extension workers to provide services (Prata et al, 2011). Health centres and hospitals have increased services also. The project ensured involvement of women and community leaders. Reportedly, physicians are pleased as they can see the reduction in abortion mortality and morbidity and health workers take pride in their work.
- Efforts to increase availability of safe abortion at the University Teaching Hospital, Lusaka, Zambia was found to increase uptake (Macha et al, 2014). Doctors tend to repeat practices they see where they receive their training so it is promising for the future to increase these practices in teaching hospitals.
- A study was identified looking at the feasibility of introducing medication abortion in KwaZulu Natal, South Africa (Blanchard et al, 2015).
- Introduction of medical abortion introduction was found to be successful with low and acceptable rates of adverse events. Provision of safe abortion services was successfully increased with the 'Reducing Maternal Mortality and Morbidity' (R3M) in Ghana. A consortium of organisations provided a basket of services to providers, communities and facilities, such as training in abortion techniques and contraceptive services, sensitising the community and health care providers to client needs, and providing equipment and products to facilities.

2. Evidence on increasing access to family planning

WHO: Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries: what the evidence says
WHO. (2012). Geneva: WHO
http://www.who.int/maternal_child_adolescent/documents/preventing_early_pregnancy/en/

The expert panel considered a selection of questions on increasing the use of contraception by adolescents at risk of unintended pregnancy:

Is there evidence that efforts directed at political leaders/planners, including those at the community level, have resulted in the formulation of laws and policies that increase access to contraceptive information and services for adolescents? And, is there evidence that efforts directed at political leaders/planners, including those at the community level, have resulted in the formulation of laws and policies that increase access to emergency contraception for adolescents?

The systematic review process did not find evidence that was eligible for grading. The panel remarked that efforts to influence laws and policies are rarely subject to evaluations of the type included in this review. The panel observed that limitations to access that are stipulated in laws and policies most often relate to marital status and age. Therefore, it noted that the existence of laws and policies that mandate adolescent access to contraceptive information and services irrespective of their age or marital status can improve contraceptive use by adolescents. The panel agreed that contraceptive information and services can prevent unwanted pregnancies among all women including adolescents. There are no significant harms foreseen. The panel agreed that the formulation of laws and policies to improve adolescents' access to contraceptive information and services is important from both rights-based and public health perspectives. It noted that the provision of contraceptive information and services to adolescents can be controversial as it challenges existing norms. It also recognised that this sensitivity is an important consideration for the design of interventions to influence laws and policies. The costs associated with efforts to influence the formulation of laws and policies were not assessed. The panel concluded that the existence of laws and policies that improve adolescents' access to contraceptive information and services, irrespective of marital status and age, can contribute to preventing unwanted pregnancies among this group.

Is there evidence that efforts directed at community members and leaders are effective in increasing access to contraceptives for adolescents?

The systematic review process did not find studies that were eligible for grading. The panel noted ungraded evidence from several developing countries that demonstrated increased use of contraceptives resulting from interventions that included efforts directed at community members and leaders. These interventions ranged from community-wide mass media education to sensitisation of individual parents in communities. The panel recognised the difficulties in attributing observed outcomes to those intervention components that specifically targeted community members and leaders. It also observed that the majority of these studies reported pregnancy as a secondary outcome. The panel acknowledged that communicating the rationale for adolescent contraceptive provision to the community could facilitate access to and use of contraceptives by adolescents. Panel members noted that a potential harm of this intervention is that a negative response by the community can adversely affect adolescent health programmes including contraceptive provision. The panel recognised that these interventions would encounter resistance in some communities because they challenge existing norms. Panel members agreed that acceptance of contraceptive provision by the community is important. They also agreed that interventions to understand and respond to a community's concerns about the health and development of adolescents should be implemented. No significant harms were foreseen. The costs of these interventions were not assessed. Despite limited evidence, the panel recommended interventions to influence community members to support access to contraceptives by adolescents.

Is there evidence that efforts to improve health services are effective in increasing access to contraceptive information and services (including emergency contraception) for adolescents?

The panel considered a number of graded studies to inform its recommendation. Very low quality evidence from a graded systematic review reported an increase in subsequent contraceptive use as a result of multiple postnatal visits with health workers. The panel noted that although this review included studies from both developed and developing countries the majority were implemented in developed countries. Moderate quality evidence from another graded study reported increased use of contraceptives as a result of a package of

interventions that included improvements in health service delivery to adolescents. Very low quality evidence from a third graded study reported an increase in the use of condoms at last sexual contact as a result of a voucher system to facilitate access to contraceptive information and services. The panel noted that these interventions collectively resulted in increased knowledge about contraceptives and improved use of contraceptive services by adolescents. The panel also noted ungraded evidence from several low- and middle-income countries that demonstrated increase in knowledge about contraceptives and increased demand for and use of contraceptives among adolescents resulting from improvements to health services. Panel members noted the importance of access to health services as an important component of adolescent health. The panel recognised that there are endeavours in many countries to improve adolescents' access to health services, including training health workers to influence their attitudes about the provision of contraceptives to adolescents. The panel concluded that, with adequate training, health workers would overcome their reticence and acknowledge the potential health benefits of providing contraceptive information and services to adolescents. The panel also agreed that health services for adolescents should be reoriented to improve access by overcoming the adolescent-specific barriers to their access and use. There are no ascertainable harms or burdens foreseen. The cost implications of these interventions were not assessed. After examining the existing evidence, the panel made a strong recommendation to implement interventions to improve health service delivery to adolescents.

Is there evidence that efforts to make hormonal contraceptive methods, including emergency contraception, available over-the-counter are effective in increasing the access to contraceptives by adolescents?

The panel considered low quality evidence from a graded systematic review that included studies assessing unlimited emergency contraceptive provision or pharmacy provision of contraceptives. The panel noted that, although this review included studies from both developed and developing countries, the majority were implemented in developed countries. The panel observed the many instances in which over-the-counter provision of condoms had improved access compared to static health service provision. However, the panel expressed concerns regarding the accuracy and thoroughness of information provided to adolescents about hormonal contraceptives (including emergency contraceptives) when delivered over-the-counter. The panel also recognised that misuse of contraceptives by adolescents due to inaccurate or incomplete information or lack of follow-up was a potential harm for this intervention. The panel agreed that there could be bias or ambiguity among pharmacists or vendors regarding the acceptability of providing contraceptives in light of policies or community norms related to adolescent sexual activity. However, the reluctance of providers may be overcome by training or by appealing to their commercial interests. Based on the limited research, the panel decided not to recommend a specific intervention but concluded that further research is required to identify interventions that improve contraceptive accessibility.

The following questions were considered by the expert panel looking at reducing unsafe abortion among adolescents:

Is there evidence that efforts directed at policy leaders/planners and community leaders are effective in improving access to safe abortion for adolescents according to existing laws?

The systematic review process did not identify any evidence that addressed this question. The panel observed that intervention studies were unlikely to address the formulation, enforcement and impact of laws and policies to enable safe abortion services for adolescents. Panel members noted that unsafe abortions contribute substantially to maternal mortality in adolescent and adult women. Further, restrictive legislation increases the likelihood of pregnant women and adolescents having unsafe abortions. The panel concluded that it is likely that the existence of laws and policies that enable adolescents to obtain safe abortion services could reduce unsafe abortion if their formulation is combined with efforts to

apply them. Panel members noted that in some communities there may be a conflict of values regarding the legalisation of abortion. The panel recommended the formulation of such laws and policies from both rights-based and public health perspectives.

Is there evidence that efforts to inform adolescents and other stakeholders about the conditions under which abortions are legal are effective in reducing unsafe abortions among adolescents?
The systematic review process did not identify any evidence that addressed this question. The panel noted that informing adolescents and other stakeholders about what abortion services are available, and where and under what circumstances they could be obtained legally could reduce unsafe abortion if there are complementary efforts to ensure their provision. In some settings, some segments of the population could protest the provision of such information. The panel concluded that such efforts to inform adolescents about abortion services (where legal) are important from both rights-based and public health perspectives.

Is there evidence that efforts to reduce barriers are effective in increasing access to and use of safe abortion services among adolescents according to existing laws?
The systematic review process did not identify any evidence that addressed this question. The panel noted that where safe abortion services are legally available, identifying and overcoming barriers to their provision and use by adolescents could reduce unsafe abortions. This is because adolescent girls face barriers to obtaining these services even where they are legal and safe. The panel concluded that efforts to identify and overcome these barriers are important from both rights-based and public health perspectives.

Is there evidence that efforts to increase the availability of post-abortion services are effective in reducing post-abortion mortality and morbidity among adolescents?
The systematic review process did not identify any evidence that addressed this question. The panel noted that ensuring access to post-abortion care services for adolescents could reduce maternal mortality. It also recognized that such efforts are important from both rights-based and public health perspectives. Despite the lack of evidence, the panel concluded that interventions to ensure access to post-abortion care by adolescents should be implemented.

Contraception for adolescents in low and middle income countries: needs, barriers, and access
Chandra-Mouli V, McCarraher DR, Phillips SJ, Williamson NE, & Hainsworth G. (2014). Reprod Health, 11(1).
https://reproductive-health-journal.biomedcentral.com/articles/10.1186/1742-4755-11-1

In 2011, WHO issued Guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries. The interventions discussed below are drawn from WHO's Guidelines.

Overcoming restrictive laws and policies
In many countries, laws and policies restrict the provision of contraception to unmarried adolescents or those below a certain age. Policymakers must intervene to reform these laws and policies to ensure that adolescents are able to obtain contraceptive information, counselling and services. Policymakers should also consider providing adolescents contraception at no or reduced cost.

Making social and group norms supportive
In many societies premarital sexual activity is not considered acceptable, and there is considerable resistance to the provision of contraceptive information and services to unmarried adolescents. To overcome this barrier, it is important to improve the understanding of influential community leaders and of the community at large on adolescent's needs for information and contraception, and the risks to their wellbeing of not responding to these needs.

In many places, social and group norms hinder discussion between couples about contraception. In addition, knowledge gaps and misconceptions prevent use or proper use of contraceptive methods. Mass media (radio and television programmes), peer-education, and inter-personal communication and information education communication materials (such as posters and leaflets) have been used successfully to communicate health information to adolescents, and to influence their norms. In recent years, the ways adolescents communicate have changed radically. Mobile phone technology, the Internet and social media are increasingly being used even in LMICs. These technologies are potentially valuable for communicating contraceptive information and options to adolescents conveniently and discretely.

Improving knowledge and understanding
The evidence of the benefits of curriculum-based comprehensive sexuality education is strong. The most successful sexuality education programmes provide accurate and age-appropriate information and in addition, develop life skills and provide support to deal with thoughts, feelings and experiences that accompany sexual maturity (e.g. falling in love and refusing unwanted sex). They are also linked to contraceptive provision and services.

Although policies requiring sexuality education for adolescents are in place in many countries, they are poorly implemented, if at all. Health and education policymakers and managers must ensure that curriculum-based sexuality education is widely and effectively implemented. Complementary efforts are needed to reach the many adolescents who are not in school. Because many adolescents have knowledge gaps and misconceptions about contraception and their side effects, they must be provided accurate information and given opportunities to ask questions and discuss their concerns. They must also be told where they could get contraception.

Improving access to contraception
This means making a wide range of contraceptive methods available and accessible to adolescents, and supporting them to choose a methods that meet their special needs through counselling. In line with WHO's eligibility criteria on contraceptive provision, a range of methods are appropriate for adolescents as age alone is not a contraindication for any method (apart from sterilisation). Long acting reversible methods such as intrauterine devices or implants can also be good choices for adolescents depending on their needs and preferences.

Adolescents in many places are unwilling to visit facilities providing contraception because they view them as unfriendly. There is growing evidence of the value of making health services adolescent friendly. WHO's Guidelines on adolescent pregnancy call for making health services adolescent friendly to make it easier for adolescents to obtain the contraceptive methods they need.

What are Adolescent Friendly Health Services?
To be considered adolescent-friendly, health services should be accessible, acceptable, equitable, appropriate and effective, as outlined below:

- Accessible. Adolescents are able to obtain the health services that are available.
- Acceptable. Adolescents are willing to obtain the health services that are available.

- Equitable. All adolescents, not just some groups of adolescents, are able to obtain the health services that are available.
- Appropriate. The right health services (i.e. the ones they need) are provided to them.
- Effective. The right health services are provided in the right way, and make a positive contribution to their health.

To improve access to contraception, health facilities must be made easy to get to and welcoming, they must have adequate stocks of a range of contraceptive methods, and adolescents must be supported to choose the ones that meet their needs and preferences by empathetic and competent health workers.

Contraceptive education, counselling and provision could be integrated into other health services used by adolescents – including STI management, HIV counselling and testing, comprehensive abortion care services and postpartum care. For many adolescents, contact with these services may be their first opportunity to have a face-to-face discussion about contraception with a competent person. Integration into postpartum services offers the opportunity to reach first-time mothers with information on birth spacing so they can delay a second pregnancy.

In making health services adolescent friendly, it is important to build on what already exists - modifying general health facilities and building the competencies and attitudes of existing health-service providers, rather than setting up new facilities and assigning some health-service providers exclusively for adolescents. Having said this, dedicated health facilities could be useful to reach marginalised groups of adolescents (such as sex workers) who may be reluctant to use a service-delivery point open to all.

Even if health facilities are adolescent-friendly, they are unlikely to attract all adolescents. Therefore, contraception should be provided through a variety of outlets. Outreach to adolescents in venues where they socialise can improve their access to contraceptive information and services – on the spot or through referral. Making pharmacies and shops adolescent-friendly could greatly expand ready access to over-the-counter contraceptive methods. Some countries have begun to task-shift contraceptive services to community-level providers in response to shortages of qualified medical personnel. Adolescents could benefit from these efforts if confidentiality can be assured.

In summary, there is fairly good evidence - from research studies and small-scale and time limited projects – on effective ways of increasing access and use of contraception by adolescents. They include favourable laws and policies; multifaceted communication programmes directed at community leaders and members, and at adolescents – that inform, educate and create supportive norms for the provision and use of contraception; accurate and age-appropriate curriculum based sexuality education; and the provision of a wide range of contraceptive methods through different adolescent-friendly outlets. The challenge is to build on these small-scale and time-limited initiatives to build large scale and sustained programmes.

WHO: Making health services adolescent friendly. Developing national quality standards for adolescent friendly health services
WHO (2012). Geneva: WHO
http://www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en/

There is growing evidence for the effectiveness of some of these initiatives in improving the way health services are provided, and in increasing their use by adolescents.

In 2006, WHO published a systematic review of the effectiveness of interventions to improve the use of health services by adolescents in developing countries.[1] This review identified twelve initiatives, including one randomised controlled trial (Nigeria), six quasi-experimental studies (Bangladesh, China, Madagascar, Mongolia, Uganda and Zimbabwe), two national programmes (Mozambique and South Africa), and three projects (Ghana, Rwanda and Zimbabwe), which demonstrated that actions to make health services user friendly and appealing had led to increases – sometimes substantial – in the use of health services by adolescents.

These conclusions were reiterated in another review published in 2008, which concluded that: "*Enough is known that a priority for the future is to ensure that each country, state and locality has a policy and support to encourage provision of innovative and well-assessed youth-friendly health services*."[2]

A multi-sectoral approach to providing reproductive health information and services to young people in western Kenya: Kenya adolescent reproductive health project
Askew I, Chege J, Njue C, & Radeny S. (2004). Washington, DC. FRONTIERS Final Report.
http://pdf.usaid.gov/pdf_docs/Pnada289.pdf

Successful results were found from this study but unable to distinguish between the effect of improved access or the information campaign.

Making the case for investing in adolescent reproductive health. A Review of Evidence and PopPov Research Contributions
Merrick TW. (2014). Population and Poverty Research Initiative and Population Reference Bureau
http://www.prb.org/pdf16/poppov-report-adolescent-srh.pdf

A study in Zimbabwe found a significant increase in reported contraceptive-seeking behaviour and a reduction in reported pregnancies as a result of an intervention to improve access and quality of reproductive health services for adolescents.[3] Integrating services into school settings can be an important way of making them friendly to young people.

Youth-friendly services have proven effective in some settings but the impact has been mixed in others. Most programmes attempt to make their services more youth-friendly through a combination of interventions, including training providers, educating consumers, and improving the accessibility of services. Researchers need to focus evaluations on the specific approaches used to make services more youth friendly and on how they are implemented, particularly in reducing barriers that keep young people from using services.

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1 Dick B, Ferguson J, Chandra-Mouli V, Brabin L et al. A review of the evidence for interventions to increase young people's use of health services in developing countries in Ross D, Dick B, J Ferguson (Eds.). Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries. Geneva, World Health Organization, 2006.
2 Tylee A, Haller DM, Graham T, Churchill R et al Youth-friendly primary-care services: how are we doing and what more needs to be done. The Lancet, 2007, 369.
3 F. M. Cowan et al., "The Regai Dzive Shiri Project: A Cluster Randomised Controlled Trial to Determine the Effectiveness of a Multi-Component Community-Based HIV Prevention Intervention for Rural Youth in Zimbabwe—Study Design and Baseline Results," Tropical Medicine International Health 13, no. 10 (2008): 1235-44.

3. Outreach/out-of facility services and self-injectable contraceptives

Task sharing in family planning
Janowitz B, Stanback J, Boyer B. (2012) Studies in Family Planning, 41 (1), 57-62.
http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2012.00302.x/abstract

Pills and injectable contraceptives can be safely provided at the community level by CHWs and through the retail sector. Although this provision has been common for years in some Latin American and Asian countries, community-based access to injectables has only recently begun in Africa and remains limited in scope. A study conducted in Uganda in 2005 showed that CHWs provided injectables with quality and safety at least equal to that of nurses and midwives (Stanback, Mbonye, and Bekiita, 2007).[4] The practice has been introduced in Ethiopia, Madagascar, Malawi, and Nigeria, with pilots ongoing in Rwanda, Senegal, and Zambia. Even more African countries are likely to adopt community-based access to injectables. In June 2009, a group of technical experts convened by FHI, USAID, and WHO concluded that "community-based provision of progestin-only injectable contraceptives by appropriately trained CHWs is safe, effective, and acceptable. Such services should be part of a family planning program offering a range of contraceptive methods".[5] This conclusion has since been endorsed by the International Confederation of Midwives, the International Council of Nurses, the International Federation of Gynaecologists and Obstetricians, International Planned Parenthood Federation, Marie Stopes International, UNFPA, and the World Bank.

If women in rural areas do not practice contraception because of low motivation or poor access to services, CHWs can help fill this gap. Recent research in Afghanistan and prior research from Mali and Bangladesh indicate that the introduction of community-based distributors increased demand for and access to contraceptives and led to significant gains in contraceptive use. In the case of Bangladesh, however, the long-term value of the outreach approach is questionable. Whereas Hossain and Phillips (1996; Phillips, Hossain, and Arends-Kuenning, 1996)[6] contend that the outreach programme sustained use of contraceptives by maintaining women's contact with and support from outreach workers, Schuler, Hashemi, and Jenkins (1995)[7] suggest that the programme might reinforce women's isolation and powerlessness by accommodating existing gender norms. Although contraceptive use did increase in Bangladesh, recent research suggests that the need for the community-based distribution (CBD) programme has diminished over time. For example, in both urban and rural areas, use of combined oral contraceptives (COCs) has continued to increase, whereas household provision has declined. In urban areas, women shifted their source of contraceptives to pharmacies, whereas women in rural areas made use of "cluster spots," which are service sites "operated on a monthly basis at fixed households in the community and which serve a cluster of 40–50 surrounding households" (Routh et al., 2001: 84).[8]

4 Stanback, J., Mbonye, A. K., & Bekiita, M. (2007). Contraceptive injections by community health workers in Uganda: a nonrandomized community trial. Bulletin of the World Health Organization, 85(10), 768-773.
5 http://www.who.int/reproductivehealth/publications/family_planning/WHO_CBD_brief.pdf
6 Phillips, J. F., Hossain, M. B., & Arends-Kuenning, M. (1996). The long-term demographic role of community-based family planning in rural Bangladesh. Studies in family planning, 204-219.
7 Schuler, S. R., Hashemi, S. M., & Jenkins, A. H. (1995). Bangladesh's family planning success story: a gender perspective. International Family Planning Perspectives, 132-166.
8 Routh, S., Ashraf, A., Stoeckel, J., & Barkat-e-Khuda. (2001). Consequences of the shift from domiciliary distribution to site-based family planning services in Bangladesh. International Family Planning Perspectives, 82-89.

What is the future of task sharing in family planning? One country, Ethiopia, is training a cadre of CHWs to insert contraceptive implants. Ethiopia's vast rural areas are chronically short of health facilities. To ensure women's access to at least one long-term method, the government has opted to take this bold step. Another bold step—the ultimate in task sharing for injectable contraception—is self-injection (also known as "home injection" if someone else in the household is trained to provide the method). A new formulation of Depo-Provera, designed for subcutaneous injection, may soon be available in a single-use injection device called Uniject®. Earlier studies of contraceptive self-injection have shown that this concept is promising (Prabhakaran, 2008)[9], and the availability of Depo-Provera in a simple, self-contained injector that can be socially marketed may well change the provision of family planning in many countries, particularly Africa, where Depo-Provera is the dominant method.

Contraceptive injections by community health workers in Uganda: A nonrandomized community trial
Stanback J, Mbonye AK, & Bekiita M. (2007). Bulletin of the World Health Organization 85(10): 768–773.
http://www.scielosp.org/pdf/bwho/v85n10/a13v8510.pdf

This research aimed to compare the safety and quality of contraceptive injections by community-based health workers with those of clinic-based nurses in a rural African setting. A non-randomised community trial tested provision of injectable Depo Provera (DMPA) by community reproductive health workers and compared it with routine DPMA provision at health units in Nakasongola District, Uganda. The primary outcome measures were safety, acceptability and continuation rates.

A total of 945 new DMPA users were recruited by community workers, clinic-based nurses and midwives. Researchers successfully followed 777 (82% follow-up): 449 community worker clients and 328 clinic-based clients. Ninety-five percent of community-worker clients were "satisfied" or "highly satisfied" with services, and 85% reported receiving information on side-effects. There were no serious injection site problems in either group. Similarly, there was no significant difference between continuation to second injection (88% among clients of community-based workers, 85% among clinic-going clients), nor were there significant differences in other measures of safety, acceptability and quality.

In conclusion, community-based distribution of injectable contraceptives is now routine in some countries in Asia and Latin America, but is practically unknown in Africa, where arguably the need for this practice is greatest. This research reinforces experience from other regions suggesting that well-trained community health workers can safely provide contraceptive injections.

Injected with controversy: Sales and injections of Depo-Provera® in drug shops in Uganda
Stanback J, Otterness C, Bekiita M, Nakayiza O, & Mbonye AK. (2011). International Perspectives on Sexual and Reproductive Health 37(1): 24–29.
https://www.guttmacher.org/sites/default/files/article_files/3702411.pdf

Informal drug shops are the first line of health care in many poor countries. In Uganda, these facilities commonly sell and administer the injectable contraceptive depot medroxyprogesterone acetate (DMPA), even though they are prohibited by law from selling

9 Prabhakaran, S. (2008). Self-administration of injectable contraceptives. Contraception, 77(5), 315-317.

any injectable drugs. It is important to understand drug shop operators' current practices and their potential to provide DMPA to hard-to-reach populations.

This research was conducted between November 2007 and January 2008. 157 drug shops were identified in three rural districts of Uganda, and the operators of the 124 facilities that sold DMPA were surveyed. Data were analysed with descriptive methods. Only 35% of operators reported that the facility in which they worked was a licensed drug shop and another 9% reported that the facility was a private clinic; all claimed to have some nursing, midwifery, or other health or medical qualification. Ninety-six percent administered DMPA in the shop. Operators gave a mean of 10 injections (including 3 of DMPA) per week. Forty-three percent of those who administered DMPA reported disposing of used syringes in sharps containers; in the previous 12 months, 24% had had a needle-stick injury and 17% had had a patient with an injection-related abscess. Eleven percent said they had never reused a disposable syringe. Overall, contraceptive knowledge was low, and attitudes toward family planning reflected common traditional biases.

In conclusion, provision of DMPA is common in rural drug shops, but needs to be made safer. Absent stronger regulation and accreditation, drug shop operators can be trained as community-based providers to help meet the extensive unmet demand for family planning in rural areas.

Community-based health workers can safely and effectively administer Injectable contraceptives: Conclusions from a technical consultation
WHO, USAID, and Family Health International (FHI). (2010). Research Triangle Park, NC: FHI.
http://www.fhi360.org/sites/default/files/media/documents/community-based-injectables-safe-effective.pdf

In June 2009, a technical consultation held at the WHO in Geneva concluded that evidence supports the introduction, continuation, and scale-up of community-based provision of progestin-only injectable contraceptives. The group of 30 technical and programme experts reviewed scientific and programmatic experience, which largely focused on the progestin-only injectable, DMPA. The experts found that community-based provision of progestin-only injectable contraceptives by appropriately trained CHWs is safe, effective, and acceptable. Such services should be part of a family planning programme offering a range of contraceptive methods.

Perceptions of home and self-injection of Sayana® Press in Ethiopia: a qualitative study
Keith B, Wood S, Chapman C, & Alemu E. (2014). Contraception, 89(5), 379-384.
http://www.sciencedirect.com/science/article/pii/S0010782413007531

Sayana® Press, a new subcutaneous formulation and presentation of a popular injectable contraceptive, has the potential to expand non-clinic access to contraception, including home and self-injection (HSI). This study collected information from potential users and stakeholders on their perceptions and preferences, the feasibility of an HSI of Sayana Press programme and key policy considerations.

PATH conducted 62 interviews and 7 focus groups with family planning users, non-users, physicians, other health care providers and key informants in the Oromia region of Ethiopia. Participants watched a demonstration and tested the device on a model mid-interview. The study did not involve product use in humans.

Women found the product easy to use, liked the simple design and valued the time and expense that could be saved through HSI of Sayana Press (HSI-SP). Of those with inhibitions about their ability to self-inject, most shifted their opinion favourably after demonstration. The majority of other stakeholders also supported HSI-SP and thought it could increase contraceptive use in Ethiopia, and they suggested that any successful programme must include proper training and supervision, particularly regarding product storage and waste management.

The data provide findings to stimulate further research and support future planning. They suggest that HSI-SP may meet the needs of many women if key requirements and challenges are met. It may also be necessary to revise policies and guidelines to integrate the approach with national family planning strategies.

An Assessment of the Policy and Programmatic Evolution of the Community-Based Distribution of Family Planning Program in Kenya and Prospects for its Sustainability
Musila RN & Mueni E. (2014). MEASURE Evaluation PRH.
http://www.cpc.unc.edu/measure/resources/publications/wp-14-144/at_download/document

Family planning (FP) has been increasingly acknowledged for its health, economic and environmental benefits. However, about a quarter of married Kenyan women (mostly poor and residing in rural areas) would like to delay the next birth or stop childbearing altogether but are not using any form of contraception. Task-shifting specific services to trained volunteers (CHWs) was initiated in Kenya in the early 1980s as a solution to the health workforce crisis and insufficient number of health facilities. The community-based distribution programme stalled in the late 1990s, affecting FP uptake, but was rejuvenated in the 2000s. The African Institute for Development Policy (AFIDEP) was awarded a small grant from the MEASURE Evaluation PRH project to evaluate these policy and programme changes

Kenya has a conducive policy and legal framework for implementing the CHW programme with the community as the foundation of the national health system. CHWs supply clients with short-term FP methods—pills and condoms. Recently, CHWs trained to administer injectable contraceptives were authorised to do so in marginalised areas only. Since April 2013, the governance structure of the CHW programme has been modified and improved with the establishment of standards and tools to guide recruitment, training and allocation of CHWs; community advocacy and mobilisation for the CHW programme; and data from the community captured in the national health information system. A number of further improvements are underway, including revising the policy framework that guides implementation of the CHW program, developing implementation guidelines for service delivery, and establishing quality of care standards for training and supervision of CHWs.

Notably, programme implementation began after the release of the most recent Kenya Demographic and Health Survey in 2008/09, making it impossible to determine if there is an association between the CHW programme and FP uptake in Kenya. However, a UNICEF/Ministry of Health evaluation in 2010 found that the CHW programme is successful in promoting and improving access and utilisation of FP in Kenya. Despite this, some existing challenges put the sustainability of community-base distribution of FP and the CHW programme at risk, including:

- CHW training on FP is supplementary, not mandatory
- Too much reliance on external support for financial resources, resulting in poor retention of CHWs and sporadic payment-for-performance incentives
- Frequent FP commodity stock-outs due to inaccurate requisitions by CHWs
- Irregular monthly supervisory meetings of CHWs because of long distances to health facilities
- Delivery of community health services by various implementing partners in silos
- Uncertainty if county governments will prioritise delivery of FP services and products.

Review of performance-based incentives in community-based family planning programmes
Bellows NM, Askew I, & Bellows B. (2015). Journal of Family Planning and Reproductive Health Care, 41(2), 146-151.
http://jfprhc.bmj.com/content/early/2014/07/18/jfprhc-2014-100883.full?rss=1

One strategy for improving family planning (FP) uptake at the community level is the use of performance-based incentives (PBIs), which offer community distributors financial incentives to recruit more users of FP. This article examines the use of PBIs in community-based FP programmes via a literature search of the peer-reviewed and grey literature conducted in April 2013.

For this research a total of 28 community-based FP programmes in 21 countries were identified as having used PBIs. The most common approach was a sales commission model where distributors received commission for FP products sold, while a referral payment model for long-term methods was also used extensively. Six evaluations were identified that specifically examined the impact of the PBI in community-based FP programmes. Overall, the results of the evaluations are mixed and more research is needed; however, the findings suggest that easy-to-understand PBIs can be successful in increasing the use of FP at the community level.

The report concludes that for future use of PBIs in community-based FP programmes it is important to consider the ethics of incentivising FP and ensuring that PBIs are non-coercive and choice-enhancing.

A cost-effectiveness evaluation of a home visit program for adolescent mothers
Aracena M, Krause M, Pérez C, Méndez MJ, Salvatierra L, Soto M, Pantoja T, Navarro S, Salinas A, Farah C and Altimir C. (2009). Journal of Health Psychology, 14(7), pp.878-887.
http://hpq.sagepub.com/content/14/7/878.short

A home visit intervention programme for adolescents throughout their pregnancy and during the early stages of motherhood was evaluated. The participants (N = 90) were part of a larger group of adolescents treated in two health centres in a poor neighbourhood in Santiago, Chile. The programme was carried out by volunteer community health monitors and evaluated through an experimental, randomised, controlled clinical trial. Cost-effectiveness was examined in comparison with standard health care. Results show higher scores for the intervention group on the mothers' mental health and nutritional state, as well as on the children's levels of linguistic development.

Reaching youth with Out-of-facility HIV and reproductive health services: a systematic review
Denno D, Chandra-Mouli V & Osman M. (2012). J Adol Health. 51 (2): 106-121.
http://www.sciencedirect.com/science/article/pii/S1054139X12000109

This review looks at both developed and developing countries.

Many young people, particularly those who are marginalised and most at risk for HIV and reproductive health-related problems, cannot or will not seek traditional facility-based health services. Policies and programmes are being implemented to provide them with these health services in the community. We sought to review the effectiveness of such approaches in increasing HIV and reproductive health service use.

A systematic literature review was undertaken to identify policies promoting or programmes delivering HIV or reproductive health services in the community. We reviewed studies that evaluated uptake of services or commodities. Data from studies meeting inclusion criteria were qualitatively analysed.

Twenty studies met inclusion criteria, including 10 containing comparative data (e.g. before and after study or control study design). The studies generally demonstrated positive impact, although results varied across settings and approaches. The most successful approaches included mail-based chlamydia screening in the Netherlands, condom distribution via street outreach in Louisiana, home-based HIV counselling and testing in Malawi, and promotion of over-the-counter access to emergency contraception in various countries.

Overall, this review suggests that out-of-facility approaches can be important avenues to reach youth. Continued evaluation is necessary to better understand specific approaches that can successfully deliver health services.

4. Safe abortion

A new hope for women": medical abortion in a low-resource setting in Ethiopia
Prata N, Gessessew A, Campbell M, & Potts M. (2011). Journal of Family Planning and Reproductive Health Care, 37(4), 196-197. Commentary.
http://jfprhc.bmj.com/content/37/4/196.full

The Adigrat Zonal Hospital, Tigray, Ethiopia had a dramatic decline in unsafe abortion cases. This was the outcome of a pilot project testing whether all levels of health providers could be trained to provide medical abortion and to refer appropriately. The Comprehensive Abortion Care (CAC) project was a partnership between the Regional Health Bureau, Venture Strategies Innovations and the Bixby Center for Population, Health and Sustainability at the University of California, Berkeley, USA.

The Ministry of Health has deployed 1,700 female health extension workers (HEWs) who have 18 months' training in the provision of health care. The CAC project is having a rapid impact, and 4354 safe abortions have been provided since the project started in a relatively small area in May 2009. In 20 health posts, the HEWS provided medical safe abortion with misoprostol up to 9 weeks and also treated incomplete abortion with misoprostol. In 9 health centres, nurses and health officers provided manual vacuum aspiration together with medical abortion up to the gestational age of 12 weeks. Four hospitals provided a full range of abortion services to the 28th week of gestation. Misoprostol is more readily available and far less costly than mifepristone. During the first course of management with oral misoprostol there was a failure rate of on average 18%, but when another dose of misoprostol for treatment of incomplete abortion was given the failure rate was only 7%. The HEWs are required to refer all continuing pregnancies from health posts to a higher facility.

The CAC project was careful to involve women and community leaders. While abortion will always draw some controversy, there is unanimity among the health professionals who have seen the reality of unsafe abortion, and CAC has been highly successful. Evaluation showed the women preferred medical abortion to surgical abortion, and they sought help early in pregnancy (the mean gestational age was 9 weeks). Some 22% of abortion cases attending health posts were unmarried, while 57% in health centres and 59% in hospitals were unmarried. Women placed a high value on confidentiality and some did not tell their husbands they had had an abortion.

Increasing access to legal termination of pregnancy and post-abortion contraception at the University Teaching Hospital, Lusaka, Zambia

Macha S, Muyuni M, Nkonde S, & Faúndes A. (2014). International Journal of Gynecology & Obstetrics, 126, S49-S51.
http://www.sciencedirect.com/science/article/pii/S002072921400160X

The Zambian Association of Gynecology and Obstetrics is one of the member societies participating in the International Federation of Gynecology and Obstetrics (FIGO) Initiative for the Prevention of Unsafe Abortion and its Consequences from the East, Central, and Southern Africa region. The main motivation to be part of the initiative was that unsafe abortion remains a challenge in Zambia despite a liberal abortion law dating back to 1972 that permits pregnancy termination when there is a risk to the health of the pregnant woman or when there are claims based on socioeconomic grounds. However, most women and health professionals in Zambia appear to ignore the existence of this law. Safe legal pregnancy terminations were not practiced until recently; consequently, almost all abortions were clandestine and unsafe.

One tragic consequence of the lack of application of a more liberal abortion law is that the maternal mortality ratio in Zambia is estimated at 591 per 100,000 live births, with up to 30% of these deaths resulting from unsafe abortion, at least at the University Teaching Hospital in Lusaka in 2006.

As a result of participating in the initiative, Zambia Association of Gynaecologists & Obstetricians (ZAGO) was encouraged to promote some of the strategies proposed by FIGO aimed at reducing the incidence of unsafe abortion and its consequences. An effort has been made over the past 5 years to make safe legal abortion available and to increase the acceptance of post-abortion contraception, with these initiatives beginning at the University Teaching Hospital, Lusaka.

Until 2007, legal termination of pregnancy was rarely performed at the University Teaching Hospital, as in most of the country. In addition, post-abortion contraception was seldom provided and information on post-abortion family planning was rarely given. Under the stimulus of the FIGO initiative and the objective of contributing toward reducing maternal mortality, staff began to inform patients of the benefits of preventing a further pregnancy and to provide these women with contraceptive methods. At the same time, the hospital staff was given information on the actual legislation governing the practice of abortion in Zambia and encouraged to provide safe, legal terminations of pregnancy as an alternative to combatting the many complications resulting from the practice of unsafe abortion.

A high number of women attend the Teaching Hospital as a result of incomplete abortion, either spontaneous or induced. Since 2009, legal termination of pregnancy is available at the hospital to women who request it and comply with the broad conditions established within the law. This information was made public. Therefore, women requesting an abortion within the law are provided with safe pregnancy termination care.

The intervention implemented at this teaching hospital appears to have been successful. While the overall proportion of legal terminations of pregnancy (approximately 8% in 2011) is not very high, the trend toward an increase in the numbers and rates is promising.

The relevance of introducing these strategies at the University Teaching Hospital in Lusaka relates to the role of this hospital as the principal teaching institute in the city—a place where future generations of health professionals including physicians, nurses, and specialists acquire the knowledge that they will later put into practice. In general, doctors tend to repeat the practices they witnessed at the hospital where they received their training and, in particular, what they themselves did during their clinical practice. In addition, the University Teaching Hospital is considered a model to be copied by doctors in Zambia. ZAGO is working to accelerate this process. The FIGO initiative is currently being expanded to the rest of the country and should be the subject of a detailed evaluation in the near future.

Social Determinants and Access to Induced Abortion in Burkina Faso: From Two Case Studies
Ouédraogo R, & Sundby J. (2014). Obstetrics and Gynecology International, Article ID 402456.
http://www.hindawi.com/journals/ogi/2014/402456/abs/

Unsafe abortion constitutes a major public health problem in Burkina Faso and concerns mainly young women. The legal restriction and social stigma make abortions most often clandestine and risky for women who decide to terminate a pregnancy. However, the exposure to the risk of unsafe induced abortion is not the same for all the women who faced unwanted pregnancy and decide to have an abortion. Drawn from a qualitative study on the issue of abortion in Ouagadougou, Burkina Faso's capital, the contrasting cases of two young women who had abortion allow us to show how the women's personal resources (such as the school level, financial resources, the compliance to social norms, the social network, etc.) may determine the degree of vulnerability of women, the delay to have an abortion, the type of care they are likely to benefit from, and the cost they have to face. This study concludes that the poorest always pay more (cost and consequences), take longer to have an abortion, and have more exposure to the risk of unsafe abortion.

Introducing medication abortion into public sector facilities in KwaZulu-Natal, South Africa: an operations research study
Blanchard K, Lince-Deroche N, Fetters T, Devjee J, de Menezes ID, Trueman K, Moodley, J. (2015). Contraception, 92(4), 330-338. doi:10.1016/j.contraception.2015.07.001
http://www.abortionresearchconsortium.org/reports/BlanchardContra2015.pdf

Objectives: Examine the feasibility of introducing mifepristone–misoprostol medication abortion into existing public sector surgical abortion services in KwaZulu-Natal, South Africa.

Study Design: Cohort study of women offered medication or surgical abortion in a larger medication abortion introduction study. The sample included 1167 women seeking first-trimester abortion at four public sector facilities; 923 women at ≤ 9 weeks' gestation were eligible for medication abortion. Women who chose medication abortion took 200 mg of mifepristone orally at the facility and 800 mcg of misoprostol buccally (or vaginally if they anticipated or experienced problems with buccal administration) 48 h later at home, based on international research and global safe abortion guidelines. Women who chose surgical abortion received 600 mg of misoprostol sublingually or vaginally on the day of their procedure followed by manual vacuum aspiration 4 h later. Main outcome measures included proportion of eligible women who chose each method, proportion with complete abortion and proportion reporting adverse events.

Results: Ninety-four percent of eligible women chose medication abortion. No adverse events were reported by women who chose surgical abortion; 3% of women in the medication abortion group reported adverse events and 0.4% reported a serious adverse event. Seventy-six percent of women received a family planning method at the facility where their received their abortion, with no difference based on procedure type. Medication abortion patients were significantly more likely to report they would choose this method again (94% vs. 78%, p<.001) and recommend the method to a friend (98% vs. 84%, p<.001).

Conclusions: Medication abortion was successfully introduced with low and acceptable rates of adverse events; most women at study facilities chose this option.

Implications: Mifepristone–misoprostol medication abortion was successfully integrated into public sector surgical abortion services in South Africa and was chosen by a large majority of women who were eligible and offered choice of early termination method; access to medication abortion should be expanded in South Africa and other similar settings.

'High profile health facilities can add to your trouble': Women, stigma and un/safe abortion in Kenya
Zugbara CO, Egesa C, Okelo R. (2015). Social Science & Medicine, doi:10.1016/j.socscimed.2015.07.019
http://www.sciencedirect.com/science/article/pii/S0277953615300356

Public health discourses on safe abortion assume the term to be unambiguous. However, qualitative evidence elicited from Kenyan women treated for complications of unsafe abortion contrasted sharply with public health views of abortion safety. For these women, safe abortion implied pregnancy termination procedures and services that concealed their abortions, shielded them from the law, were cheap and identified through dependable social networks. Participants contested the notion that poor quality abortion procedures and providers are inherently dangerous, asserting them as key to women's preservation of a good self, management of stigma, and protection of their reputation, respect, social relationships, and livelihoods. Greater public health attention to the social dimensions of abortion safety is urgent.

The impact of Ghana's R3M programme on the provision of safe abortions and postabortion care
Sundaram, A., Juarez, F., Ahiadeke, C., Bankole, Ak., & Blades, N. (2014). Health Policy and Planning, 2014, 1-15.
http://abortionresearchconsortium.org/reports/SundaramHPP2014.pdf

In 2003, the Ghanaian Government introduced changes in its reproductive health policy, and issued guidelines for the provision of comprehensive abortion care services (CAC), within the limits of the law. To ensure the full implementation of this policy, in 2006, the Ministry of Health, in partnership with a consortium of international health organizations, including Ipas, Engender Health, Marie Stopes International (MSI), the Population Council, and Willows Foundation, launched the programme 'Reducing Maternal Mortality and Morbidity' (R3M). The programme, aimed largely at health care providers, sought to increase access to CAC to reduce morbidity and mortality caused by unsafe abortion, and to widen access to family planning services to reduce the unwanted pregnancies that lead to abortions in the first place. The R3M programme was initiated in three regions—Accra, Ashanti, and Eastern—and within these regions, a total of seven districts were chosen.

The timeframe for the programme's first phase was between 2006 and 2008, which was extended to 2009. Phase II was implemented between January 2010 and December 2011, and two additional districts in each R3M region were added during this time.6 Phase III in all districts in these regions is currently underway.

The consortium provides a mutually reinforcing basket of services to providers, communities and facilities, such as training in abortion techniques and contraceptive services, sensitising the community and health care providers to client needs, and providing equipment and products to facilities. Different organisations provide different types of services. For instance Ipas and the Ghana Ministry of Health have the task of training the providers in CAC in the public health facilities, while MSI focuses on the private health facilities. Engender Health provides training on contraceptive counselling and services, while the Willows Foundation and Population Council focus on educating the communities, and provide guidance to the programme.

This research uses a quasi-experimental approach to determine whether the R3M programme has made a difference in the provision of safe abortion services and post-abortion care (PAC) in facilities.

Findings show that, net of all potentially confounding variables, participation in the R3M programme does have a substantial association with the provision of safe abortion services in all groups, including among those who have clinical knowledge of abortion provision.

5. Additional information

Author

This query response was prepared by **Laura Bolton**