Building Family Planning Services in DRC
A Community-Based Approach

January 2019 www.mcsprogram.org

Introduction

In the Democratic Republic of Congo (DRC) an estimated 70% of the population of 81 million have little or no access to healthcare. DRC has the third highest fertility rate globally at 6.6 children per woman, a national maternal mortality rate of 846 per 100,000 live births and an adolescent birth rate of 138 per 1,000 teenage mothers. Family planning (FP) can support reductions in maternal mortality by 30-40%, but in 2013, the contraceptive prevalence in the DRC was just 8% (2014 Demographic Health Survey [DHS]).

DRC's high rate (28%) of unmet FP need is attributed to: (i) poor integration of FP within the package of services offered at the health facility level; (ii) stockouts of contraceptive commodities or supplies needed for service delivery; (iii) limited availability of health services that specifically target adolescents and young adults; and (iv) inadequate recruitment, deployment and geographic distribution of *agents Distributeurs à Base Communautaire* (DBC) (Community-Based Distributors) to achieve population coverage of services outside the catchment areas of fixed health facilities.

At the national level, the Ministry of Health (MOH) is committed to implementing the 2014-2020 Family Planning Strategic Plan that aims to increase the use of modern contraceptives from 6.5% to 19% and reach 21 million new FP acceptors by 2020. The Government of DRC added FP supplies to the national budget for the first time in 2015 and increased its commitment to $3,000,000 in 2018.

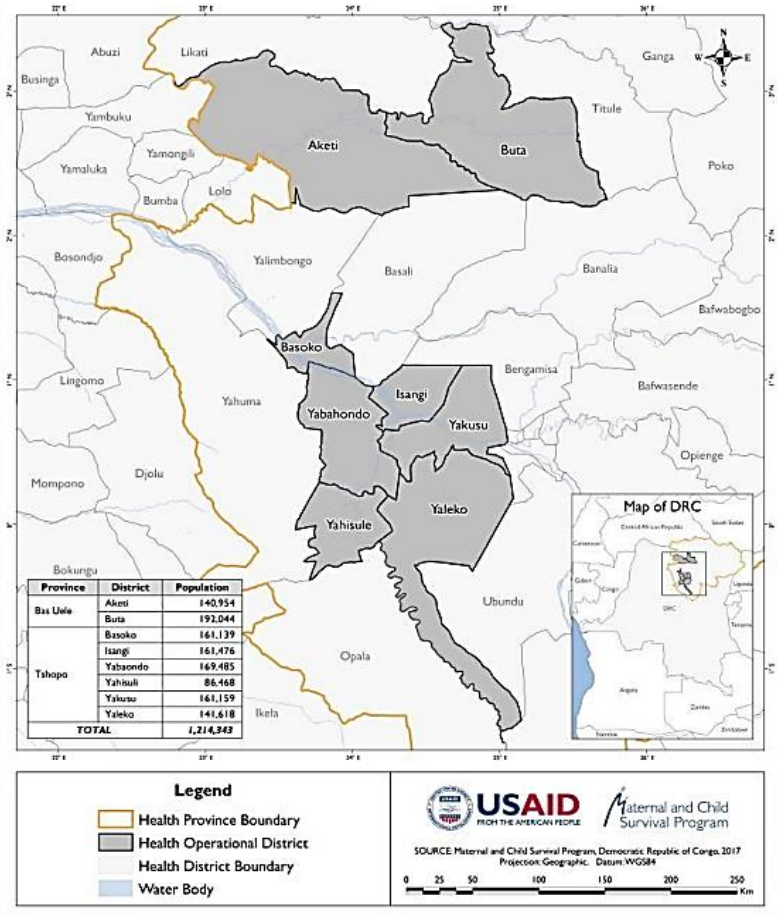


Figure 1: Map highlighting MCSP's areas of intervention in Bas-Uélé and Tshopo in North-Western DRC

The MOH collaborates at the national and provincial levels with a network of partners, including USAID's flagship Maternal and Child Survival Program (MCSP) through multi-stakeholder technical working groups to improve access to voluntary FP and postpartum family planning (PPFP) services.

One forum for this collaboration is the national and provincial *Comité Technique Multisectoriel Permanent* (CTMP) (Standing Multi-Sectorial Technical Committees), which MCSP worked to establish in the provinces of Tshopo and Bas-Uélé.

The 2014 DHS reported low rates of modern contraceptive use among women of reproductive age (15-49 years) in both North-Western provinces of Tshopo and Bas-Uélé provinces (8.1% and 4.2% respectively). Despite elevated levels of unmet need for FP (33.5% in Tshopo and 20.4% in Bas-Uélé), until MCSP initiated activities in 2017, minimal FP or PPFP services were available in Bas-Uélé, and the services that were available in Tshopo were geographically limited.

In the DRC, 89% of women receive antenatal care from a qualified provider, 82% of women give birth in a health facility, and 91% of children receive at least one vaccine in their first year. These high coverage rates for other maternal and child health services highlight opportunities for voluntary PPFP counseling and service delivery within antenatal, postpartum, postnatal and well-baby care during the first year of life.

Goal

MCSP partnered with the MOH's *Divisions Provinciales de la Santé* (DPS) (Provincial Health Divisions), in Tshopo and Bas-Uélé, to improve access to FP/PPFP services and increase voluntary uptake in under-served, rural communities. We did this by providing technical support for both community- and facility-based FP/PPFP interventions to the DPS, its *Zones de Santé* (ZS) (Health Districts) and select health facilities.

With strategic guidance from the MOH's *Programme National pour la Santé de la Reproduction* (PNSR) (National Reproductive Health Program) and USAID/DRC, MCSP and the two DPS worked to:

- Establish quality FP/PPFP services within existing health district infrastructure by providing training, supervision and the distribution of equipment, commodities and tools;
- Garner interest and demand at the community level through interpersonal communication and promotion activities such as radio broadcasts;
- Conduct *Portes Ouvertes,* or Clinic Open Door campaigns, to encourage women and community members to visit facilities and to offer them FP education and provide services free of charge; and
- Develop a formal, national-level FP communication plan for replication at the health zone level that builds on DRC's high facility birth rate (82%) and integrates PPFP into antenatal, delivery and postnatal and extended postpartum care.

MCSP's activities reached eight ZS, general hospitals, 40 health centers, 40 community care sites and 85,000 women of reproductive age (WRA), as described in Table 1.

Table 1: MCSP Coverage and Beneficiaries

Health Zone (Zone de Santé)	Number of MCSP-supported general hospitals	Number of MCSP-supported health centers	Number of MCSP-supported community care sites	Estimated Beneficiaries
Tshopo	6	30	30	60,000
Bas-Uélé	2	10	10	25,000
TOTAL	8	40	40	85,000

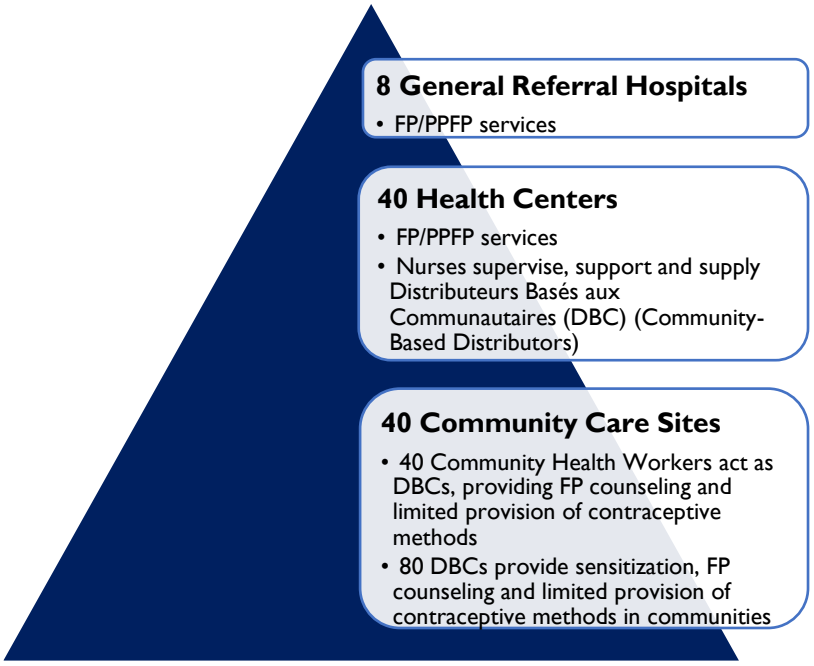
Program Approach

At the national level, MCSP worked in close collaboration with the MOH's PNSR to review and update national FP policies and guidelines, review FP indicators and revise the national registers and Health Management Information System (HMIS) indicators and forms. MCSP worked in coordination with the CTMP to integrate PPFP into existing maternal (antenatal, intrapartum, and postpartum) and FP services and training modules and tools. MCSP supported the development of a guideline document for the national postpartum strategy and provided support to develop a national FP communication plan.

The Yelenge health center FP team in Tshopo Province.
From left to right: Dr. Marie-Thérèse (DPS), Dr. Jimmy Anzolo (MCSP), Vimilia Vimi and Elysée Bayaelo (DBCs), and Ilombe Lomia (Nurse).

At the provincial level, in July 2016, MCSP and the MOH completed a rapid FP situational analysis in Tshopo and Bas-Uélé to understand the health system and cultural context of the provinces and inform the program's design. The analysis explored current FP perceptions and practices, service delivery processes, and factors facilitating and hindering FP uptake. Twenty-three focus groups and 39 interviews were conducted. The results revealed that almost all women knew at least one FP method; care providers and community leaders had favorable attitudes toward FP; and the majority of women were giving birth in health facilities, offering promising opportunities for the introduction of PPFP services in health facilities and their voluntary adoption by the population. Provincial-level stakeholders reviewed the results and worked with MCSP to develop the program's strategies and action plans. MCSP then worked with the DPS to establish quality FP/PPFP services at the 48 health centers and general hospitals in Tshopo and Bas-Uélé, before developing community-level capacity to increase local knowledge and use of modern contraceptives.

Figure 2: MCSP's provincial level FP/PPFP interventions from hospital to community level



As described in Figure 2, MCSP's community-based approach relied upon the community-based distributors or DBCs to facilitate access to information and services, improve awareness, generate demand and provide a limited number of short-term FP methods. At the same time, MCSP worked to expand the range of FP/PPFP services provided by facility-based health care providers to meet clients' varying needs and choices. This included focused work to expand the package of long-acting reversible contraceptives available from the health facilities and to ensure that health care providers were trained and ready to provide them.

Interventions

Training

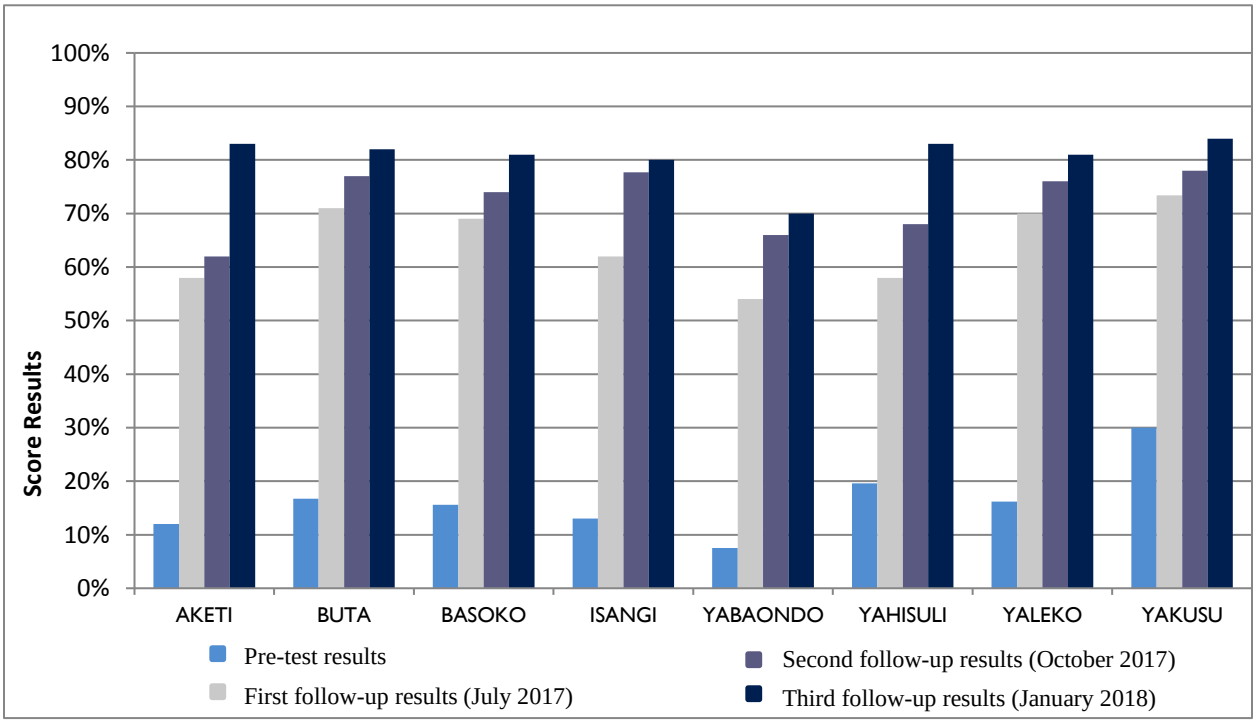
In December 2016, the MOH reviewed and validated the MCSP-designed national FP/PPFP training tools that MCSP subsequently used in the following:

- **Training of Provincial Trainers**: MCSP, the PNSR and DPS organized FP/PPFP training of trainers (TOT) workshops in Tshopo and Bas-Uélé in April 2017, establishing a local cadre of 32 provincial trainers (22 from Tshopo and 10 from Bas-Uélé).

- **Training FP Providers in Health Facilities**: Provincial trainers trained 96 healthcare providers from the 48 MCSP-supported health facilities in April 2017, successfully increasing the average health workers' FP/PPFP knowledge scores from 16% to 80%. The competency-based training emphasized knowledge and skills in delivering the different FP methods, FP counseling, behavior change communication (BCC), PPFP, prevention of sexually-transmitted infections, management of side effects and client rights.

- **Post-Training Follow-Up at the Health Facilities:** MCSP supported the PNSR and DPS to develop follow-up tools and then to conduct three rounds of post-training follow-up visits of the 96 providers trained in July 2017, October 2017 and January 2018. The follow-up provided a refresher on key concepts and the opportunity to demonstrate and provide coaching on key FP skills using anatomical models. Consultations with patients - including counseling, initiation and follow-up of an FP method - were observed and providers were evaluated on their knowledge, performance and skills in delivering effective, client-centered counseling. As described in Figure 3, by the third follow-up, seven out of the eight facilities had achieved scores of 80% or higher, which is the MOH's performance standard. By supporting the PNSR and DPS to conduct such follow-up training activities, MCSP reinforced the supervisory and mentorship skills of the zonal officials who will continue providing technical support and mentorship after the close of the MCSP program.

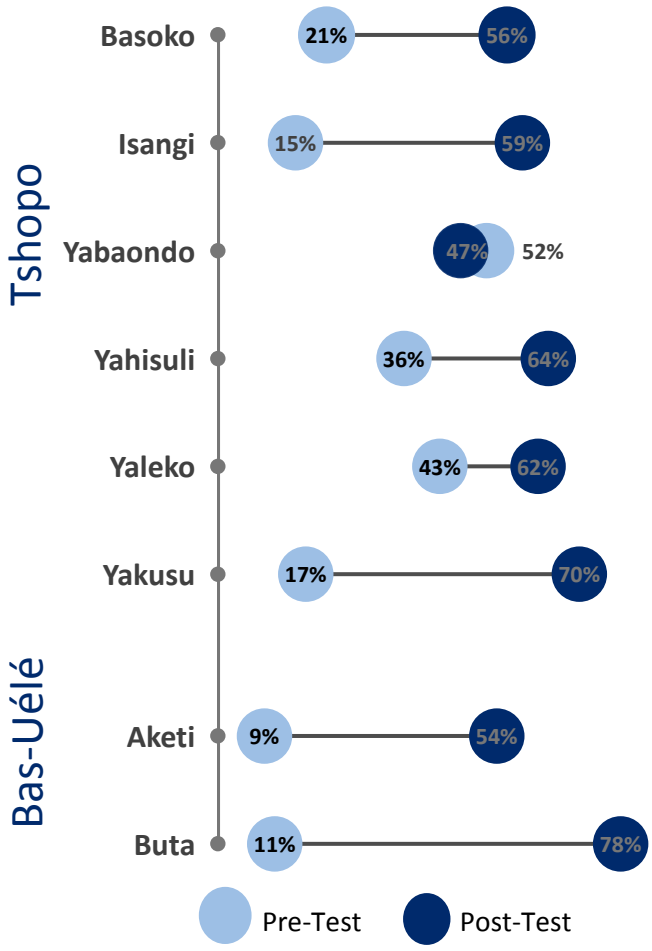
Figure 3: Pre- and Post-Training Test Scores in MCSP-Supported Facilities in 8 Health Zones



- **Training DBCs**: MCSP and the PNSR supported the provincial trainers to train 120 DBCs in eight MCSP-supported health zones in Tshopo (November 2017) and Bas-Uélé (April 2018). The training focused on FP counseling and the community-based distribution of contraceptive methods, and included practical lessons, role-playing, and onsite practice in the community. The training activities made use of materials and supplies designed and distributed by MCSP to build DBC capacity on demand creation and behavior change communication (BCC), including visual job aids, posters, and other reporting and management tools. As of December 2018, each of the 40 MCSP-supported community care sites had three DBCs in place.

- **Post-Training Follow-up in the Communities:** MCSP and the DPS conducted post-training follow-up visits with the DBCs in June 2018 (Tshopo) and August 2018 (Bas-Uélé). The objectives were to ensure the effectiveness of the DBCs in their communities, provide mentorship on FP promotion and counselling, and build the capacity of the DPS and health zone staff to effectively supervise the DBCs in the future. The DBCs were assessed on their theoretical knowledge and contraceptive technology and counseling competencies. The results show significant improvements from baseline, with the exception of Yabaondo, where DBC baseline scores were higher than the rest (Figure 4). In Yabaondo, five out the 15 trained DBCs left the village due to personal reason, and the DBCs hired to replace were only trained during the first follow-up visit.

Figure 4: DBC Follow-Up Test Scores in Tshopo and Bas-Uélé



Supervision

MCSP worked with the DPS to carry out quarterly joint supervision visits to 36 sites in Tshopo and Bas-Uélé. The results informed action plans at the facility level as well as revisions to supervision tools to ensure that subsequent visits focus on specific areas for improvement.

Where possible, 'Star FP providers' -- nurses and community-based providers recognized by the health zone for exceptional services -- participated in the supportive supervision, to motivate their peers and promote FP quality improvement.

Distribution of FP/PPFP Equipment and Supplies

MCSP received an initial donation of oral contraceptives, male and female condoms, cycle beads, intrauterine devices (IUD), injectables (Depo-Provera), contraceptive pills and implants (Implanon and Jadelle) from USAID in September 2016. MCSP quantified, procured and distributed FP/PPFP commodities and reporting tools, registers, and consumable materials beginning with the eight general hospitals and 40 health facilities in April 2017. In addition, the DBCs received job aids, contraceptives, posters, and reporting and management tools to support their roles in the communities.

MCSP provided technical and financial support to train 36 DPS staff, health zone representatives and partners, on the quantification of FP commodities during a two-day workshop. The workshop equipped participants to

forecast FP commodity needs for the next five years by teaching participants how to calculate needs based on the target population of women of childbearing age, contraceptive prevalence and number of users. It was the first time the DPS had participated in this type of FP quantification exercise.

Community Outreach

In addition to stationing trained DBCs in the communities to offer FP/PPFP guidance and counseling and distribute limited FP supplies, MCSP initiated a community outreach campaign to promote awareness and increase demand for FP/PPFP services. The major focus of this effort was three *Portes Ouvertes,* or Clinic Open Door campaigns. The MOH promotes such campaigns as an effective approach to encourage women and community members to visit facilities and to offer them FP education and provide services free of charge, including methods that may not always be available at their usual service delivery points. MCSP worked in close consultation with the PNSR and DPS to donate commodities for use in 24 *Aires de Santé* (areas) adjacent to MCSP-supported health centers during three, three-day Open-Door campaigns in June 2018. MCSP supported trained, qualified FP providers from MCSP-supported sites to travel to the health centers closest to their own health facilities to offer FP counselling and cost-free services to clients during the campaigns. The providers also followed up with clients already using contraceptive methods and completed data collection tools to monitor new acceptors and document the events.

Targeted community radio broadcasts supported the campaign in eight health zones to raise awareness about the importance and benefits of FP and share the details and locations of the Open-Door campaigns. In some cases, the village chief also promoted the event by drumbeat ("tam-tam"), which is the traditional method of communicating important news to the community.

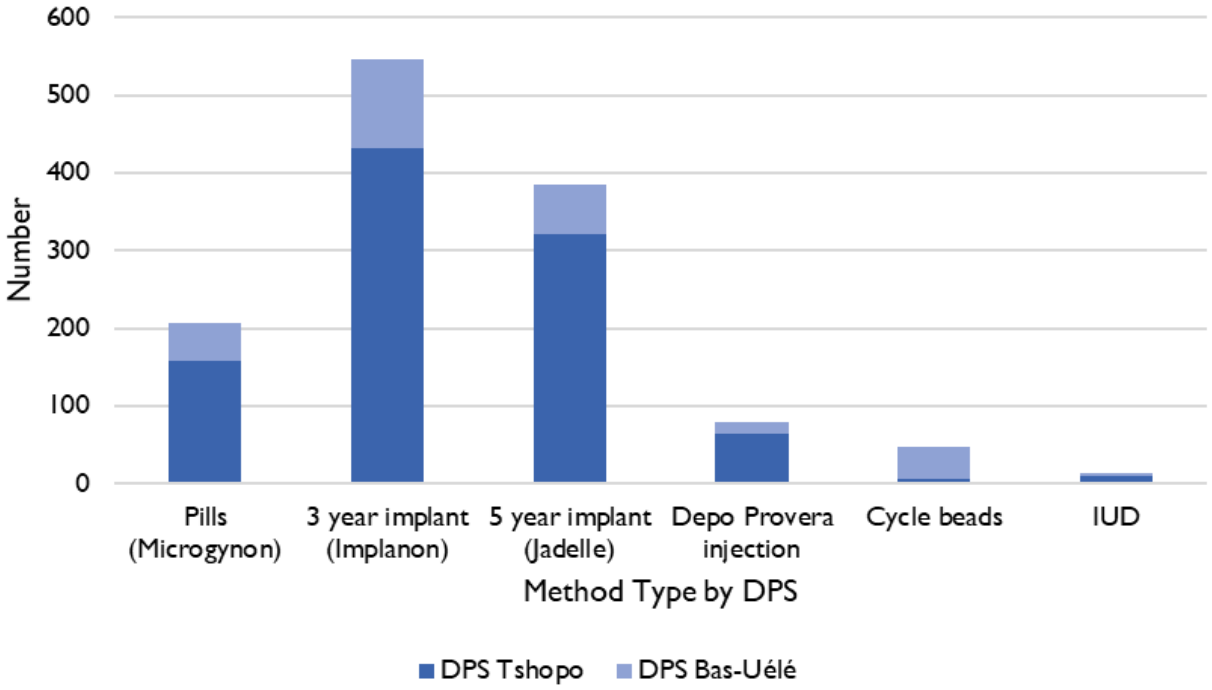
Photo: PNSR/DPS, Buta
Recording the broadcast at Radio Rubi, Buta, promoting the June 2018 Open-Door campaign

Improved Coordination at the Provincial Level

MCSP helped establish provincial CTMP chapters in Tshopo and Bas-Uélé in partnership with the Advance Family Planning project. The CTMP's role is monitoring the implementation of the national FP strategic plan and advocacy to ensure upholding of other national and international FP commitments.

MCSP trained 42 CTMP members (17 in Bas-Uélé and 25 in Tshopo), including representatives of multiple provincial administrative agencies, the local MOH and partners, on FP advocacy techniques using the Advanced FP-Specific, Measurable, Agreed, Realistic and Time-based (AFP-SMART) Advocacy Tool. Now established, the CTMPs in Tshopo and Bas-Uélé will play an ongoing role in monitoring progress towards achieving national FP targets, including the MOH's commitment to increasing modern contraceptive prevalence from 6.5% to 19% by 2020. MCSP supported the eight health zones to adapt the national FP communication plan to their needs, and each health zone now has a budgeted plan in place. Each plan takes into consideration social factors associated with FP use, available communication channels to mobilize the community, and decision-makers and stakeholders to target for advocacy.

Figure 5: New Clients Initiating Family Planning by Method Type During Clinic Open Door Campaigns

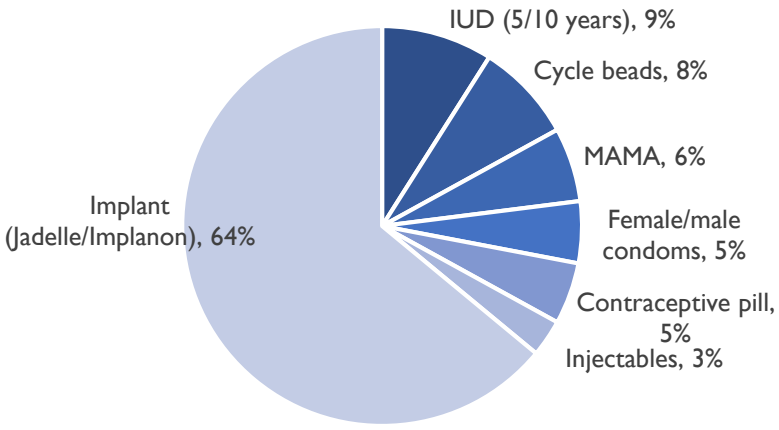


Results Summary

- The local cadre of 34 provincial trainers - 22 from Tshopo and 10 from Bas-Uélé -- trained 96 health care providers on FP/PPFP, increasing the average health provider knowledge and skills scores from 16% to 80%.
- FP/PPFP services were added to services offered in 40 health centers, eight general hospitals and 40 community care sites in Bas-Uélé and Tshopo, reaching an estimated 85,000 WRA who had previously had very limited access to FP and enabling them to take control over their reproductive choices.
- Between January 2017 and September 2018, 13,442 new users accepted FP services at health facilities (10,662) or in the community with trained DBCs (2,780). This included 4,251 in Bas-Uélé and 9,191 in Tshopo.
- The rate of acceptance of voluntary, pre-discharge PPFP among women giving birth in MCSP-supported health facilities rose to an average of 18% in 2018 compared with 10% in 2017. Many women were also counseled about breastfeeding, the return to fecundity and advised to come back for PPFP services in the months subsequent to birth.

- 100% of MCSP-supported health facilities were supplied with updated FP tools (registers/job aids) and guidelines, and at least one provider per facility was trained to use them.
- 36 DPS staff and health zone representatives were trained on the quantification of FP commodities to improve future procurement and other aspects of the FP supply chain management.
- The provincial chapters of the CTMP, set up by MCSP and Tulane University in Tshopo and Bas-Uélé, are monitoring progress and should theoretically ensure the implementation of recommendations from the national FP strategic plan and FP platforms after the end of MCSP.

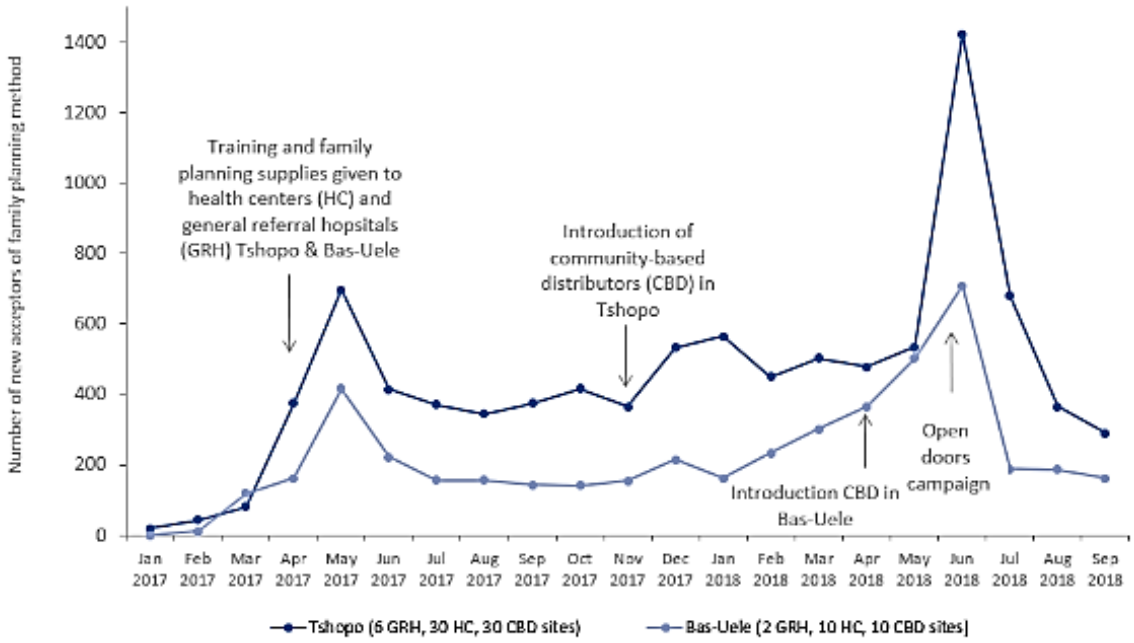
Figure 6: Contribution of FP methods to 13,970 Couple Years Protection over 1 year period (Jul 17-Jun18)



Conclusions and Recommendations

- The increase in new acceptors following the addition of FP/PPFP services at health facility and community sites confirmed the high unmet need and demand for FP in rural communities. The arrival of the DBCs and the open-door campaigns resulted in further increases, as described in Figure 7, highlighting the effectiveness and the importance of the community-based components of the program. To sustain and increase FP coverage in Bas-Uélé and Tshopo provinces, continued support for DPS supervision and periodic open-door campaigns will be required.

Figure 7: New FP Acceptors by Implementation Site



- MCSP has successfully strengthened the capacity of the DPS and zonal health officials to conduct supportive supervision to the newly installed FP/PPFP providers in the eight health zones within Tshopo and Bas-Uélé and ensure that the system is equipped, on a local scale, to sustain USAID's investments in voluntary FP/PPFP services.

- Before MCSP's intervention, the majority of women (62%) accepting FP did so at general reference hospitals, but once services were available at other levels, including within the communities themselves, health centers became the lead provider of FP services. This underlines the importance of better integrating FP/PPFP at the facility level and investing in decentralized and community-level FP/PPFP activities which can be easily accessed by the beneficiary communities.

- USAID procures FP/PPFP commodities for distribution at no cost to the MOH, so program continuation by individual DPS is both feasible and recommended. However, the DPS will require ongoing logistics support if they are to routinely visit the health facilities for supervision and distribution of contraceptives and FP supplies. The provision of vehicles and the means to maintain them are therefore key to future success.

MCSP's activities in Tshopo and Bas-Uélé resulted in compelling evidence that FP/PPFP services are in demand and that unmet need for FP in communities that have had little or no previous FP/PPFP care can be swiftly addressed with a combination of health worker training and supervision at both the community and facility levels, commodity distribution and community outreach. The relatively short duration of MCSP's program in DRC limited the geographic scope of the program reported here, but the design was successful and should be replicated and expanded by partners and, when feasible, the MOH in additional provinces.

This brief is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Program and do not necessarily reflect the views of USAID or the United States Government.