Community-Based Family Planning
Breaking Barriers to Access and Increasing Choices for Women and Families

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Introduction

The US Agency for International Development (USAID)-funded Maternal and Child Survival Program (MCSP) advocates for **health promotion, prevention, and curative service delivery in and with communities** across the reproductive, maternal, newborn, and child health (RMNCH) spectrum of interventions. MCSP promotes the **institutionalization of community health** as a central component of country **health systems**, ensuring that citizens' health priorities and concerns are addressed and that services are equitable and delivered with cultural expectations and within available resources.

Community-based family planning offers:

- FP services closer to clients
- Services in communities, not health facilities
- Accessibility through community health workers and other cadres
- Increased access to and greater choice of contraceptives
- Opportunity to introduce new methods

Community-based family planning (CBFP) brings family planning (FP) information and methods to women and men in the communities where they live, rather than requiring them to visit health facilities to access services. The goal of CBFP programs is to increase access to and choice of contraceptive methods in underserved areas. This goal is achieved through a variety of channels, including community health workers (CHWs) and other trained health cadres, community depots, drug shops, mobile services (including mobile clinics), outreach events, and the private sector. While traditional CBFP includes the provision of condoms, pills, and sometimes CycleBeads or lactational amenorrhea method (LAM) counseling by CHWs, increasing availability of other methods (injectables and implants) at the community level offers clients greater opportunity to choose the method best suited for their preferences and fertility intentions.

An important aspect of community health platforms, including CBFP, are CHWs. CHWs are an important component of the provision of RMNCH services because they help break down barriers to service coverage, including distance, access, and social or cultural barriers; they can also play a critical role in expanded access to and equity for high-quality FP and reproductive health services. Ensuring they have a well-defined but manageable workload and that they can afford to spend the time on their CHW duties is critical.

MCSP's Approaches for Supporting CBFP Globally

Over the last several years, MCSP has focused on optimizing an integrated platform of RMNCH interventions at the community level to strengthen community-level health systems and community- and facility-level linkages. According to *Moving Toward Viable, Integrated Community Health Platforms to Institutionalize Community Health in National Strategies to End Preventable Child and Maternal Deaths*, "The term integrated

platform entails a community health system capable of adapting and progressively providing services in the full continuum of care, from households to community, and bridging the gap to health facilities."[1]

Although CBFP goes beyond the work of CHWs, MCSP worked closely with governments, ministries, and other stakeholders to strengthen the role and skills of CHWs to provide CBFP in many countries. MCSP's legacy includes improved access to and use of FP for women living in hard-to-reach locations through strengthening and use of community-based programs and platforms in 12 countries (Democratic Republic of the Congo [DRC], Egypt, Ethiopia, Guinea, Haiti, Kenya, Malawi, Mali, Mozambique, Rwanda, Tanzania, and Togo).

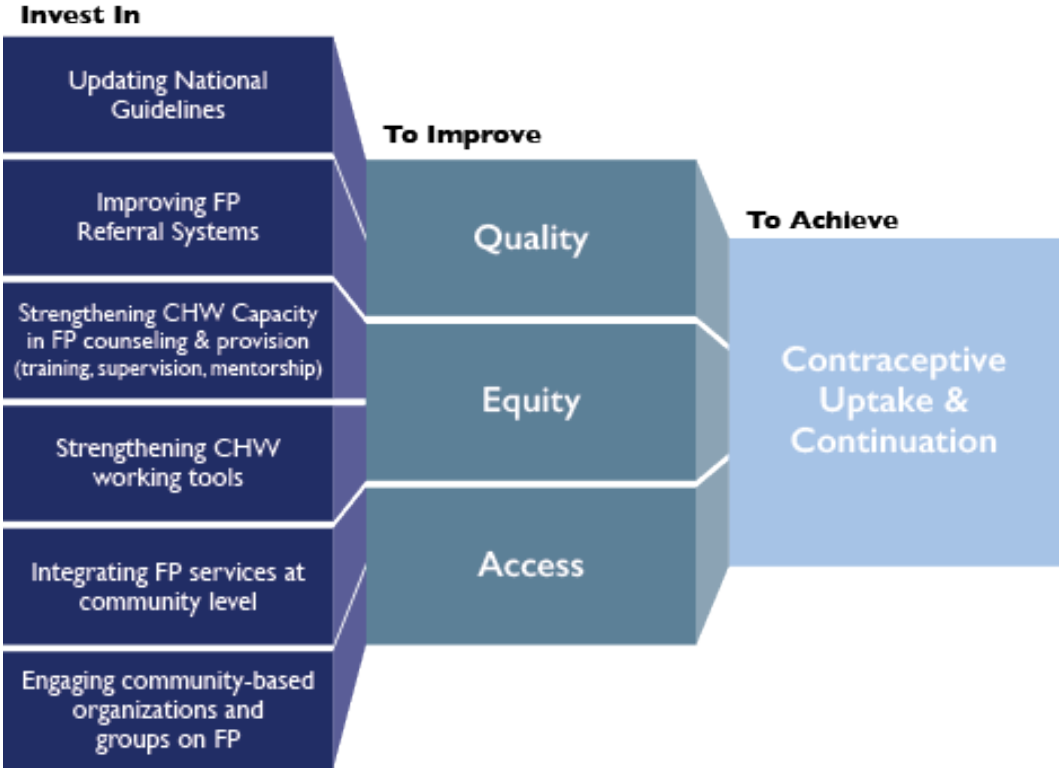
Some MCSP achievements to strengthen CBFP and overall community health, services, and systems include:

- Updated and revised **national guidelines** to advocate for a greater role for CHWs in FP counseling and/or provision in three countries (DRC, Rwanda, and Egypt) and CHW training guidelines in Mali.
- Systematically **improved referral systems** and tracking use of services across the continuum of care and levels of the health system in six countries (DRC, Ethiopia, Malawi, Mozambique, Kenya, and Tanzania).
- **Strengthened CHW capacity** through different models of support in eight countries, including training or supervision to ensure better FP counseling and service provision at the household level (distribution of pills, condoms, and intramuscular depot medroxyprogesterone acetate, and/or counseling on LAM and return to fertility) in six countries (DRC, Haiti, Mali, Rwanda, Egypt, and Tanzania); supportive supervision and monitoring of previously trained CHWs (Guinea); and training and support for CHWs to conduct couples communication activities to promote gender equity and joint household decision-making for FP (Togo).
- Strengthened **community-based health promotion and availability of FP services at the community level** through **developing and applying job aids and resources** targeted specifically to community-based providers in six countries, including new job descriptions, training curricula, and strategies for CHWs in Egypt; new tools that reflect the updated World Health Organization (WHO) medical eligibility criteria for *agents de santé communautaire polyvalents* (polyvalent CHWs) in Haiti, job aids for health surveillance assistants to use in outreach in Malawi, integrated FP and nutrition counseling and support in Tanzania, adapting and revising the health post integrated maternal health cards and tally sheets to nudge discussion of postpartum FP (PPFP) and pregnancy risk in the extended postpartum in Ethiopia, and male engagement counseling cards in Togo. (Note that in other countries, CHW tools and job aids may have already existed; in these cases, MCSP may have simply reproduced and distributed them within the project.)
- Reorganized existing activities (in health posts or during outreach) to allow for integrations of FP and immunization services, and to reach postpartum women with information about health timing and spacing of services in three countries (Malawi, Ethiopia, and Tanzania).
- Engagement of community groups, such as community leaders (Malawi and Tanzania), area development committees (Malawi), and other civil society groups (Tanzania), and radio programs (Tanzania, Togo, and DRC, for promotion of open-door clinic days). In Haiti and DRC, MCSP activities also employed traditional communication channels, or *crieurs de rue* (street criers), to announce mobile outreach events in Haiti and drum beat or "tam-tam" in DRC for clinic open-door days.

These components highlight MCSP's targeted investments to promote improved quality, equity, and access to FP services to improve contraceptive uptake and continuation, as represented in Figure 1.

[1] MCSP. 2015. *Moving Toward Viable, Integrated Community Health Platforms to Institutionalize Community Health in National Strategies to End Preventable Child and Maternal Deaths*. Washington, DC: MCSP.

Figure 1. MCSP community-based family planning interventions to improve contraceptive uptake and continuation



Selected Country Achievements and Results

The *WHO guideline on health policy and system support to optimize community health worker programmes* emphasizes the important role CHWs have in our health systems, in relation to other health cadres. If programs adhere to proper selection processes and training programs, and equip CHWs with resources, WHO maintains that CHWs are effective in the delivery of a range of preventive, promotive, and curative health services, and can contribute to reducing inequalities in access to care.

Several MCSP programs worked in areas that address CHW roles in quality, access, and equity for RMNCH, including through CBFP programs to improve the quality of services. MCSP defines equity as "both the improvement of a health outcome of a disadvantaged group and a narrowing of the difference of this health outcome between advantaged and disadvantaged groups—without losing the gains already achieved for the groups with the highest coverage." MCSP worked to identify a few programs and implementation research studies where the project could test the Equity Tool as a way to assess whether efforts were adequately reaching those they were designed to serve.

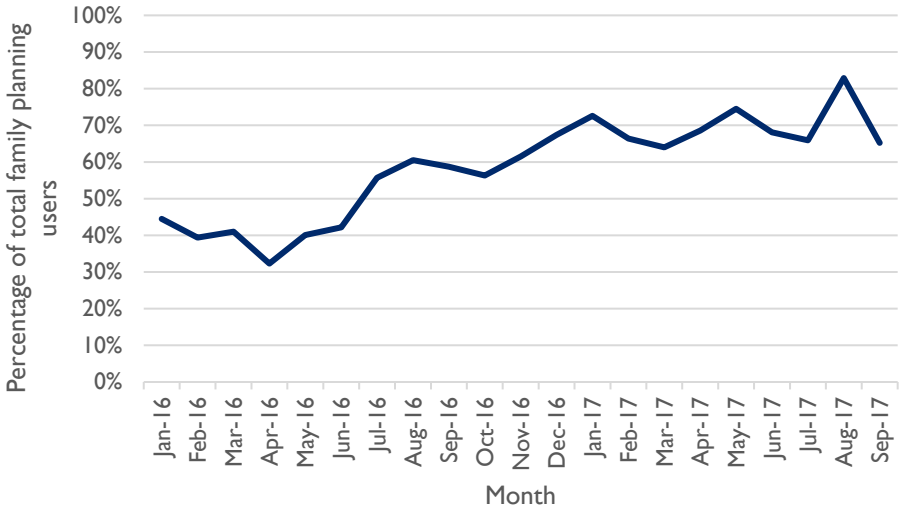
The Equity Tool, developed by Metrics for Management, is available for selected countries as a subset of shortened questions, drawn from that country's demographic and health survey, and tested for their predictive value in relating to national wealth distributions. The site also offers support for analyzing results.

The following sections review MCSP country efforts to strengthen and address issues around quality, access, and equity in the provision of CBFP services. Readers can also access more information from links to country briefs.

Malawi

In an effort to promote access to services, MCSP supported the Government of Malawi to **systematically integrate FP and immunization services** in all health facilities (n = 43) and associated community-based outreach sites (n = 373) in Ntchisi and Dowa districts over a 15-month period. MCSP conducted a mixed-methods process evaluation that examined factors affecting service provision, use, and experiences of care. Results indicate that integration of FP and immunization services did not negatively affect immunization outcomes. They also show shifts in use of FP services from health facilities to community-based outreach sites, where use increased significantly shortly after the start of the intervention (see Figure 2). **Results suggest many women switched from health facility- to community-based services because the latter were more accessible**.

Figure 2. Percentage of total family planning users who received community-based family planning services during the intervention period (sites with >= 80% reporting)



As part of the evaluation, MCSP conducted focus group discussions with mothers and fathers who described how the service integration affected their experiences of care. Benefits that were frequently cited included time savings and geographic convenience. Some mothers mentioned the proximity of the community outreach clinics to their homes as a motivator for continuing to use both services through the outreach platform. Others indicated that service integration saved them time, as they were able to receive two services in one trip to a health facility or outreach session. Women also indicated they valued the opportunity to receive information about the other service when they sought one of the two services. The intervention appears to have facilitated continued increases in total FP use, accessibility of services, and perceptions regarding quality of care. As shared by one father:

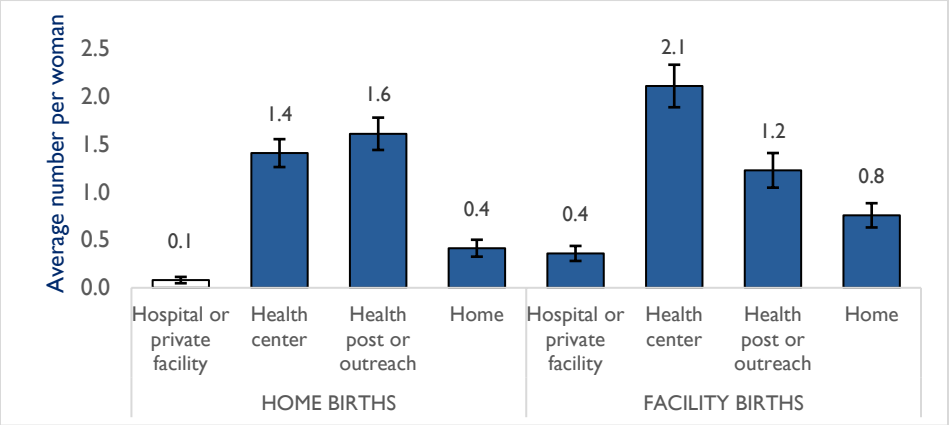
> "This is very good because it has reduced the time the mothers were wasting instead of doing household chores due to coming different days for immunization and FP services. This new program of all this [FP and immunization] happening at one time and place has also helped the families so that it should not be a burden on the mothers that leave other duties and children at home. The health facility is also quite far in this area, about 6 kilometers, so this integration is helping so the mother does not have to walk this distance twice to access the care. The men also escort the women to the hospital for these services, so the integration is also giving us [men] time to do some businesses and going the field to farm." – Father of child < 1 year, Ntchisi

Ethiopia

To assess the role of community actors in improving access to and use of PPFP information and services, MCSP conducted a study in Arsi Zone, Oromia Region, in Ethiopia, on the effect of systematically integrating PPFP discussions into all health system contacts with pregnant and postpartum women**. These contacts included those at the community level** with health extension workers (HEWs) and Women's Development Army (WDA) volunteers. To prompt discussions, existing integrated maternal and child health cards were modified, so HEWs had to document PPFP counseling, method choice, and method adoption during all antenatal care (ANC), postnatal care (PNC), immunization, and growth monitoring contacts, and were nudged to review content of earlier contacts when caring for women and their infants. WDA volunteers used a pictorial tool to share information on PPFP with women, track a woman's PPFP choice and uptake, and discuss and educate about breastfeeding, return of menses, and sexual activity, prompting WDA volunteers to refer postpartum woman at risk of pregnancy for FP and other services, such as immunization.

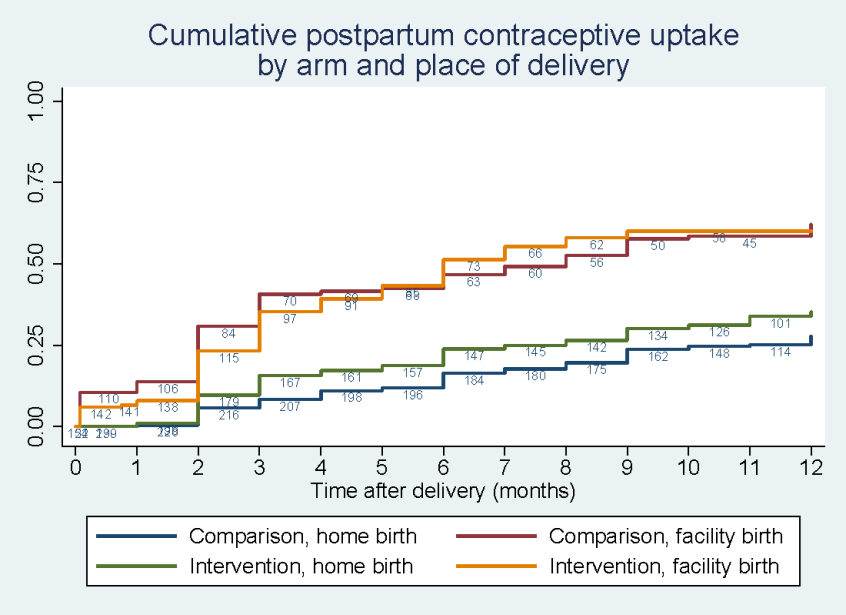
Study results show visits to health posts (staffed by HEWs) and, to a lesser extent, home visits (conducted by HEWs and WDA volunteers) were used to share information on PPFP (see Figure 3). HEWs also provided many women with contraception; 35% of postpartum women who delivered at home in areas where the study involved HEWs accepted PPFP (as opposed to 28% in areas where HEWs were not involved). Women who deliver in facilities are not as impacted by HEWs, but they represented fewer than 50% of the study population. Furthermore, 34% of contraceptive users in this study obtained their method from an HEW, compared to 27% nationally.

Figure 3. Average number of antenatal care, delivery, and child immunization visits where woman received information on family planning in the intervention area (N = 706 women enrolled in pregnancy and followed through 12 months postpartum)



Overall findings showed that integrating PPFP into maternal, newborn, and child health (MNCH) services offered at the community level for pregnant and postpartum women and their infants improved PPFP adoption. The intervention benefited women who delivered at home, with 45% greater adoption of PPFP among women who delivered at home in areas where PPFP was integrated via community-level intervention over areas where PPFP was integrated with services at the health center only (see Figure 4). This analysis controlled for demographic variables of woman's age, education, marital status, religion, household wealth status, and number of living children, with the household wealth status measured using the Equity Tool. Increasing PPFP uptake among women who deliver at home is critical to increasing contraceptive prevalence in a country like Ethiopia, where only 48% of women deliver in facilities.

Figure 4. Multivariate Cox proportional hazards regression modeling of cumulative postpartum contraceptive uptake by study area where health extension workers were engaged in postpartum family planning (intervention) and comparison areas, by place of delivery



Access to PPFP was equitable in the study intervention area across wealth strata. Household wealth status was not associated with PPFP adoption, likely because the public sector provides free contraception. Muslim participants were less likely to use contraception than Christian participants, but few cited religious objection as a reason for nonuse. Instead, PPFP may have been less accessible in harder-to-reach parts of the study area, where a greater proportion of Muslim women lived. Muslim women may also have experienced more discrimination in the health system, though it was not studied.

Tanzania

MCSP conducted a study in Mara and Kagera regions of Tanzania focused on understanding and testing new approaches for **improving integrated maternal, infant, and young child nutrition (MIYCN) and PPFP practices**. The implementation approach focused on improving both the quality and equity of services by increasing access through community engagement and "opt-in" CHW home visits. It included onsite capacity-building and supportive supervision for facility service providers and CHWs, a LAM song aired on local radio, engagement of community leaders, introduction of tools for women to self-track LAM use, and cues for timely transition to other modern FP methods and for CHWs to monitor women's adherence and need for transition. Routine program data included client exit interviews with clients with children under 1 year old seeking RMNCH services at intervention health facilities (n = 193). These facilities are the same areas where the community interventions were also implemented. Facility exit interviews used the Equity Tool to determine the relative socioeconomic status of interviewees to determine the reach of intervention activities across different levels of household wealth measured in wealth quintiles, with quintile 1 (Q1) representing the lowest and Q5 representing the highest socioeconomic status. Those clients' wealth quintile distributions generally matched those of the respective regions, although women in Q2 and Q4 were slightly overrepresented in Mara, compared to Q1 and Q5, and Q4 was overrepresented in relation to Q3 in Kagera Region. Among the sample, women in lower-income quintiles reported follow-up from CHWs more so than women in higher-income quintiles, suggesting that CHWs may have targeted follow-up to women in these groups. Regionally, CHW follow-up among poorer respondents was higher in Kagera compared to Mara, despite Mara being a relatively poorer region.

There were also regional differences in the rates of FP uptake among women of different socioeconomic status. In Mara, women in wealthier quintiles reported higher rates of FP uptake compared to women in

lower quintiles; however, in Kagera, FP uptake was higher among women in lower wealth quintiles. Other programs were active in Kagera, including a results-based financing scheme that included FP indicators. While the exit interviews only represent a portion of the women potentially reached through the interventions, **the results show that CHW follow-up generally reached women of lower socioeconomic status compared to those of higher status.** Overall interventions, as designed, provided MIYCN counseling and encouraged uptake of FP methods across all quintiles, including among poorer women.

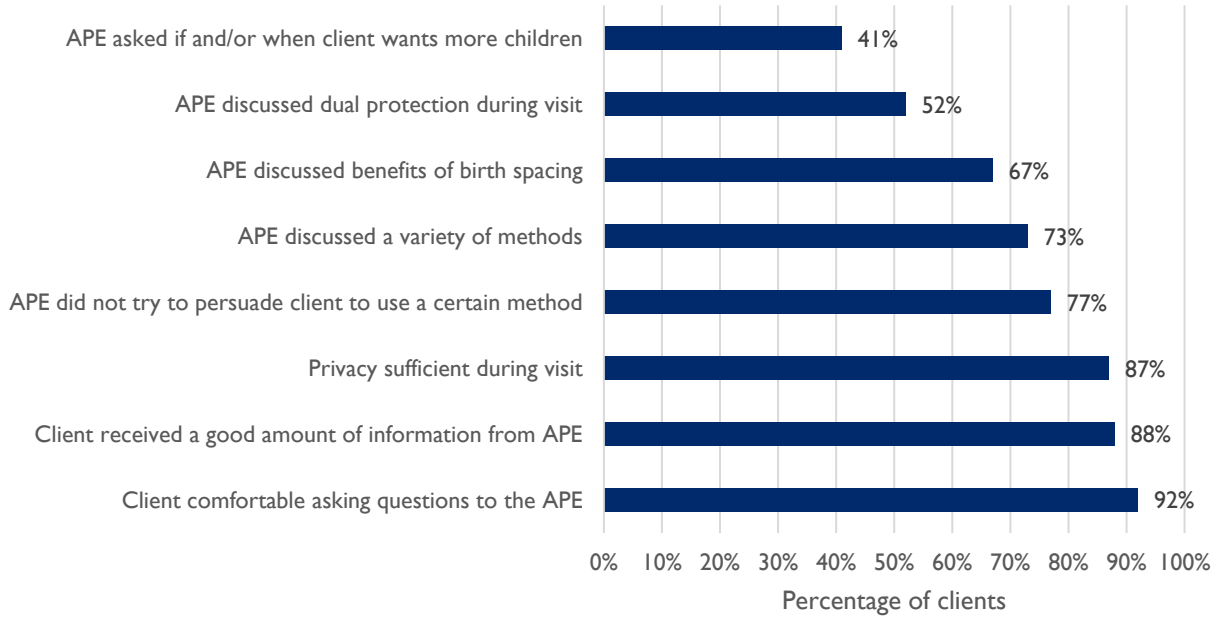
Preliminary intervention results revealed that initiation of breastfeeding within an hour of birth increased in both regions, with a 61% increase in Kagera and 126% increase in Mara, comparing the intervention period to the same period of the previous year. Total modern FP use (inclusive of LAM) also increased in both regions, with a 37% increase in Kagera and 11% in Mara, as did use of a modern FP method within 6 weeks postpartum, by 123% in Kagera and 101% in Mara. Results demonstrate the feasibility of a multichannel, integrated approach to improve MIYCN and voluntary FP outcomes in Tanzania and point to areas where adjustments could further strengthen outcomes, including remaining gaps around perceived risk of pregnancy and timeliness of postpartum contraceptive uptake after childbirth.

Additional MCSP work in Tanzania included engaging civil society organizations to facilitate community scorecard (CSC) processes in 26 wards of Mara and Kagera regions in Lake Zone. CSC processes brought together service users, health care providers, and community leaders to examine barriers to utilization of RMNCH services and adoption of related barriers, and to develop action plans for improving quality, access, and utilization of health care and linkages between the community and different levels of the health system. Action plans commonly included items related to FP, among other tasks. Lessons learned through implementation included that it is critical for civil society organization facilitators to be equipped with skills to address technical questions that arise during these sessions, such as around providing accurate information on contraceptive side effects. Facilitators found that CSC action plan items related to promoting facility deliveries and earlier ANC1, establishing emergency transport systems, and ensuring services available 24/7 were easier to achieve than items like promoting acceptance of FP by men. The latter requires a change in social norms for which a single intervention, such as the use of CSC, is unlikely to suffice. In summary, CSCs are useful tools for promoting use of MNCH services and for sustaining quality of CBFP, and show promise to improve quality, but they alone are not sufficient to address larger social norms issues.

Mozambique

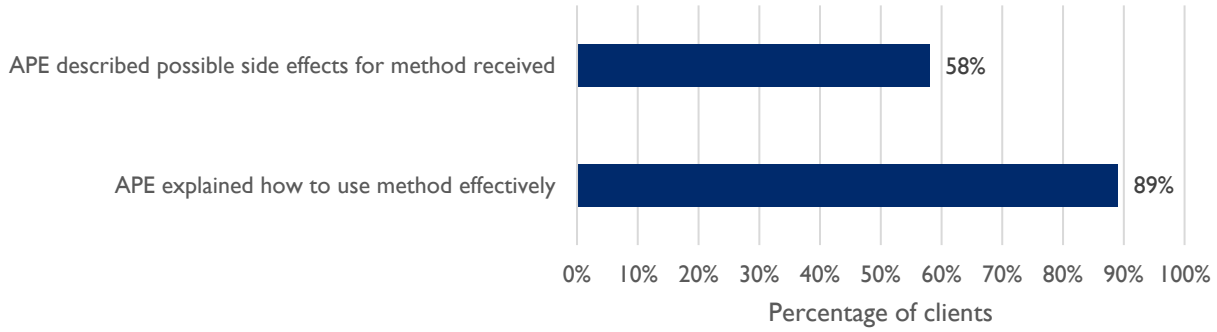
In Mozambique, MCSP supported the Ministry of Public Health to improve a broad range of services in two provinces, Nampula and Sofala, across the continuum of care and from the household to hospital levels. As part of program monitoring, MCSP conducted a rapid assessment of the **quality of FP counseling** provided by CHWs (*agentes polivalentes elementares*, or APEs, a Mozambican CHW cadre) by interviewing 171 APE clients in 11 MCSP districts (eight in Nampula and three in Sofala). These interviews were conducted in 2017 with clients who received FP services from an APE in the prior 6 months. MCSP found the quality of CBFP counseling provided by APEs in MCSP-supported areas to be generally good, with some areas flagged for improvement (see Figure 5). The majority of clients reported being comfortable asking questions, receiving what they perceived to be a good amount of information, and feeling that their privacy was respected. The majority also reported that the APE supported informed and voluntary choice by discussing a variety of methods and not persuading clients to use a certain method, though additional work may be necessary to ensure all clients feel they can freely choose the method they want, given that 23% suggested APEs tried to persuade them to use a certain method and 24% said that APEs had not discussed a variety of methods. Less than half of clients reported that APEs discussed if or when the client wanted more children, but most clients also reported they sought out APEs for the purpose of obtaining an FP method, so APEs may not have felt it was necessary to discuss fertility intentions or the benefits of spacing.

Figure 5. Quality of community family planning counseling reported by clients (N = 171)



Among those clients who actually received a contraceptive method from an APE, the majority reported the APE explained how to use the method, but only about half reported the APE described possible side effects the client may experience (see Figure 6).

Figure 6. Information given to clients receiving a method from *agentes polivalentes elementares* (APEs) (N = 166)



To expand access to FP services and improve the quality of FP counseling, MCSP provided supportive supervision to 266 APEs. From October 2016 to September 2018, the MCSP-supported APEs provided FP methods to 156,539 new FP users and 48,906 continuing FP users through community visits and mobile brigades. In addition, MCSP-supported APEs and traditional birth attendants referred 186,266 women for FP services in facilities.

DRC

In DRC, MCSP worked to improve the quality of CBFP services by strengthening the capacity of supervisors and health officials to provide support and supervision to community-based distributors (CBDs) and use data reviews to identify gaps in services. To increase FP access and coverage, MCSP and the National Program for Reproductive Health supported the training of 22 trainers and recruited 120 CHWs (40 health post agents, or

recosites, and 80 CBDs) on FP counseling and community-based distribution in the eight MCSP-supported health zones in Tshopo and Bas-Uélé. Community-based distribution accounted for a substantial proportion of new FP clients. MCSP reached 13,442 new FP users, including 10,662 at facilities and 2,780 by CHWs. Before MCSP's work, 62% of women accessed FP at hospitals, whereas MCSP improved access in health centers and at community level. In the final quarter of the program, 61% of FP new users received services at the health center level (from 40 sites), and 29% received their methods from 80 CBDs linked those sites (just 10% obtained their methods from hospitals). The rate of acceptance of PPFP rose to an average of 18% in Year 4 compared with 5.9% in Year 2.[2]

As part of this work, MCSP developed supervision tools and supported the National Program for Reproductive Health and prefectoral health departments to carry out several rounds of post-training follow-up on FP with trained CBDs. In addition to building capacity of local supervisors, the visits generally found that agents were welcomed in the communities they served, as these communities had no prior access to FP before MCSP intervened. They also uncovered a few gaps, such as reluctance of CBD agents to mention possible side effects to expect for pills, as well as some difficulties with completing reporting forms accurately. The latter then had an effect on available restocking of those agents. Follow-up and supervision are essential to addressing performance gaps. This was highlighted in the process of MCSP's work and then in handover of project activities to the local government.

Egypt

MCSP supported the Egyptian Ministry of Health and Population to revitalize a decades-old *Raedat Refiat* program of CHWs who provide **preventive care and referrals for maternal and child health and for pregnancy spacing at the community level.** MCSP helped the Ministry of Health and Population develop a new strategy and subsequently strengthened the national training system for this cadre.[3] Implementing the work in 23 governorates and with the updated CHW curriculum and the new national CHW strategy in place, MCSP embarked upon a rigorous training program benefiting CHWs from the governorates, including 216 districts and 4,839 primary health care units. MCSP trained 63 master trainers and 132 lead trainers. The trainers then cascaded the training to 1,280 CHW supervisors with MCSP's coaching and mentoring support. The CHW supervisors then built the capacity of 10,183 CHWs using the hands-on, interactive, low-dose, high-frequency approach, with a focus on workplace-based learning and practice.

An evaluation assessed CHW knowledge and skills before, immediately post-training, and retention of the same after 6 months. The pre-test sample was matched with an identical post-test sample of 2,453 CHWs from 23 governorates. The retention of knowledge test took place 6 months after completion of training, but not all governorates were able to collect the retention tests, so the final representative sample was smaller (N = 1,633), from 15 governorates only. Among test scores assessing CHWs' technical knowledge before the training, the lowest average knowledge score was on the subject of newborn and child health (47%), and the highest average pre-test score was for reproductive health (68%), which was the original focus area of the CHWs' scope of work. Participating in the low-dose, high-frequency sessions led CHWs to consistently demonstrate improvements across technical areas, with an average increase of 30% in thematic knowledge and an average increase of 16% in skills from pre- to post-test immediately after training. Retention of knowledge scores generally showed decreases compared with the immediate post-test results but demonstrated an average retention of 90% across the thematic areas.

Kenya

In Kenya, MCSP supported community HEWs to train community health volunteers (CHVs) from Migori County's hard-to-reach areas on **providing FP commodities (e.g., condoms and refill oral contraceptives), promoting a range of FP methods, conducting referrals for the methods they do not**

[2] More details on MCSP's FP work in DRC are available at https://www.mcsprogram.org/resource/building-family-planning-services-in-drc/?_sfm_resource_country=drc

[3] More details on MCSP's work to develop a new national strategy for CHWs in Egypt: https://www.mcsprogram.org/resource/development-of-egypts-national-community-health-worker-strategy-optimizing-a-historical-program-for-the-future/ and regarding building CHW capacity in Egypt at https://www.mcsprogram.org/resource/building-community-health-worker-capacity-in-egypt/.

provide, and reporting community FP data.[4] Between 2014 and 2016, new FP users increased from 24,236 to 79,769 in Migori and Kisumu counties. Program experiences highlighted that CHVs have understanding of the clients they serve because they are known in the community and come from the same or a similar cultural background, and, as such, can respond to local societal and cultural norms and customs to ensure community acceptance and ownership. CHVs' work leads to promotion of health interventions at the community level and contributes to changes in health-seeking behavior by community members.[5]

Rwanda

In Rwanda, MCSP led the process to develop community mentorship guidelines in three areas, including **integrated community case management; community-based MNCH services, and community-based provision of FP methods (CBP/FP)**.[6] Mentorship increased CHW performance scores over time. Additional highlights of MCSP's work in Rwanda included a 10-day CBP/FP training for new trainers and a 2-day refresher training for existing trainers. MCSP trained new CHWs (*binomes*, or male and female FP-focused CHW teams, and *agents de santé maternelle*, or maternal health CHWs) on CBP/FP knowledge and skills, including PPFP counseling and linking to services. CHWs were instrumental in organizing outreach services for permanent methods, referring potential clients to health centers for counseling, and compiling lists until sufficient numbers justified calling an outreach team. Further, the project coordinated with districts to plan for adjacent health centers to support provision of modern FP methods at health posts that are located within the catchment areas of the faith-based health facilities not providing FP services.

Mali

In Mali, MCSP supported the Ministry of Health (MOH) to build on the previous USAID global Maternal and Child Health Integrated Program and **strengthen the availability of community-based services by supporting the capacity-building of CHWs**. MCSP worked with the MOH to finalize and validate the National Strategic Plan for Essential Community Care (SEC), which enabled the development of regional action plans for the SEC. MCSP also strengthened supportive supervision, monitoring, equipment, supplies, training, and incentive payments to 571 CHWs. Training sessions were organized for 107 new CHWs in Kayes and Sikasso on the SEC package and on data collection and reporting tools. Seventy-five (70%) of the trained CHWs were women. In addition, MCSP provided technical support for a training of CHWs supported by UNICEF and the regional health director in Kayes for 54 replacement CHWs. MCSP provided financial support for an additional 20 CHWs to participate in this training. The CHWs provide support in increasing community awareness of pregnancy spacing and community-based access to modern contraceptives, including injectables and implants. Through these efforts, the percentage of women who think there should be at least 24 months between two consecutive births rose from 50% in 2011 to 66% in 2014 in project zones.

Togo

In Togo, MCSP collaborated with the Department of Maternal and Child Health and FP to test out three different community-level approaches to **promote male engagement, couple communication, and contraceptive uptake** in the Kloto Health District. The project tested out three approaches, including CHW home visits to provide couples counseling, guided group discussions and video screenings, and working with husbands' schools (*école de maris*) to promote positive male engagement, gender equity, joint household decision-making (including around the use of FP methods), and more. Findings from USAID's Breakthrough RESEARCH project's evaluation of MCSP's work highlighted that couples counseling improved couples' communication by identifying relationship strengths and areas for improvement. Home-based counseling and group discussions provide the opportunity for couples to rethink inequitable gender roles within the household and raise men's awareness of workload-sharing benefits. In addition, couples counseling enhanced

[4] More details on MCSP's FP work in Kenya at https://www.mcsprogram.org/wp-content/uploads/dlm_uploads/2019/03/ProgramBrief-FamilyPlanning.pdf

[5] This MCSP brief highlights broader health contributions by CHWs in Kenya: https://www.mcsprogram.org/wp-content/uploads/dlm_uploads/2019/09/KenyaMCSPCommunityEngagementBrief.pdf

[6] See also MCSP's brief *Mentoring the Community Health Worker in Rwanda*: https://www.mcsprogram.org/resource/mentoring-the-community-health-worker-in-rwanda/

men's awareness, knowledge, and support for their partners' sexual and reproductive health, while also facilitating contraceptive decision-making and agreement. MCSP gathered reports from local health providers that highlighted an increased attendance at health services by male partners.

Key Takeaways and Future Recommendations

Reflecting on MCSP's contributions and the number and scale of programs that have incorporated work in CBFP suggests that many USAID Missions and country-based decision-makers shaping MCSP field programs embraced CBFP as a strategy to improve equitable access to FP, especially for remote or hard-to-reach populations. Future programs should review both MCSP's work and the achievements of USAID's global award for Advancing Partners and Communities to further support country programs in strengthening and scaling up these programs.

A community health worker provides health education in Mozambique. Photo by: Fernando Fidelis/MCSP

As MCSP prepares to close out after 5 years, there remains more work to be done and additional implementation learning to improve access, equity, and quality of FP services, including through promotion of CBFP services. The recommendations listed below mainly target global programs and technical assistance providers similar to MCSP, although other stakeholders may also find them useful:

- A review of MCSP country programs found that all countries with CBFP programming tracked different indicators. Future global awards should review common CBFP indicators and seek to track common indicators across technical areas, working at the community level from the start of a project. Programs may need technical support to improve systems to track common indicators. A short and common set of indicators could also guide the documentation of learning about community health information systems across countries.

- Metrics of CHW performance could include a greater emphasis on continuation, as well as recruitment of new FP users, and evaluate the effectiveness of strategies to reduce the reluctance of CHWs to discuss potential bodily changes or side effects clients may experience from hormonal contraception.

- There is a need to strengthen and ensure linkages between community- and facility-level activities across projects and MOH divisions. This includes strengthening of referral services and exploring/understanding what can make community-based referrals successful. MCSP worked on referral networks and systems in Haiti, Mozambique, and Ethiopia, but the systems prioritized obstetrics and sick newborn emergencies, not FP.[7]

- Further explore and document approaches for improving **quality** of CBFP services, including social accountability approaches for improving change agency role of CHWs.

- Further explore new systems and tools to equip CHWs to explore **comprehensiveness of care and promotion of healthy practices** for mother-baby pairs over the continuum of care, as CHWs often have opportunities to revisit households over time and could potentially contribute to ensure that these pairs receive complete, **integrated** packages of care across maternal, newborn, and reproductive care,

[7] See MCSP brief on Haiti's work here: https://www.mcsprogram.org/resource/establishing-model-referral-networks-in-ha/, report on Mozambique efforts here: https://www.mcsprogram.org/resource/narratives-of-referral-experiences-for-maternal-newborn-and-child-health-complications-in-mozambique-nampula-province/, and report on sick newborn referrals in Ethiopia here: https://www.mcsprogram.org/resource/do-caretakers-of-sick-newborns-with-possible-serious-bacterial-infection-referred-from-health-post-to-health-center-comply-with-the-referral/

inclusive of maternal and infant nutrition counseling and support, healthy spacing and timing of pregnancies, and immunizations.

- Consider ways to advance equity measures within future FP programming by integrating into periodic data collection and using those results to adapt and redesign programming as needed to ensure it reaches its intended audience.
- Explore how CBFP approaches can better reach stigmatized populations and marginalized communities (people living with HIV, sex workers, certain ethnic and religious groups, etc.).
- Explore potential partnerships with community-level actors and organizations to improve community-level data collection and data use for decision-making while not overburdening CHWs (note that this is only tenable when CHWs are compensated, as recommended in the WHO policy).
- Continue to expand the range of FP methods offered through CHWs in community settings, including with newer or women-controlled methods, such as emergency contraceptive pills, progesterone contraceptive vaginal rings, subcutaneous depot medroxyprogesterone acetate (including with self-injection), and one-size-fits-most diaphragms.

Conclusion

MCSP's collaborative work with local MOHs and other stakeholders in CBFP led to important insights. Recruiting, training, supervising, and equipping CHWs to offer FP information, counseling, and services improves access by reducing geographic distances and improving convenience for clients, especially in hard-to-reach areas. Where it has been measured, community actors and outreach strategies have shown that they reduce inequities in access to services. CHWs have demonstrated that they can provide high-quality counseling, though they may be reluctant to share information they may feel uncomfortable with regarding side effects and need to be reassured that continuation, including method switching, is as important as initial uptake. While these are not entirely new insights, the recommendations that emerged from this review provide useful ideas for future investments from global programs.

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