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The Integrated Health Project Plus (IHPplus) was implemented in the Democratic Republic of Congo (DRC) from June 2015 to June 2018 by Management Sciences for Health (MSH) and Overseas Strategic Consulting, Ltd. (OSC), under a subcontract via Pathfinder/Evidence to Action. This USAID-funded project was designed to avoid a gap in services in USAID-supported health zones upon completion of the USAID Health Office's five-year flagship Integrated Health Project (IHP) in 2015. The two major project components were direct support for service delivery and health systems strengthening activities. The service component included increased use of high impact family planning, maternal, newborn, and child health (FP/MNCH), nutrition, malaria, tuberculosis (TB), HIV and AIDS, water, sanitation, and hygiene services (WASH), and adoption of healthy practices in targeted health zones. The health systems strengthening component included improved implementation of selected policies, program advocacy, and decision-making, particularly at the provincial levels. Ultimately, the project was designed to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices for more than 31 million people in nine provinces of the DRC with 168 target health zones (an increase from the 78 health zones supported by IHP).

Reach Every Household with Family Planning Door-to-Door Mini-Campaigns to Promote Contraceptive Methods

Background

The fertility rate among women in the DRC is high, at 6.6 births per woman, at least partly explained by the low use of modern contraceptive methods (8%). Nearly 28% of women of reproductive age have unmet needs for modern contraception, yet DRC faces a significant challenge in ensuring access to family planning (FP) services.¹ Geographic disparities across a vast territory, coupled with the fragile context, poor infrastructure (including roads), and low knowledge or misinformation about FP make it difficult for women to access health facilities and to ensure continuity of services, especially when availability and quality are also often limited.² In addition, although women may wish to space or limit the births of their children, inequitable gender norms create social barriers for women to access services, and more active involvement and support of men is needed.

The DRC National Strategic Plan 2014-2020 outlines a multi-sectoral vision that aims to increase the modern contraceptive prevalence to 19% and provide access to and use of modern contraceptive methods to at least 2.1 million women by 2020. To rapidly increase access to and information about FP services, the Ministry of Health

¹ DRC Ministry of Planning, DRC Demographic and Health Survey, 2013-2014.

² Mpunga D, et al. Availability and Quality of Family Planning Services in the Democratic Republic of the Congo: High Potential for Improvement. *Global Health: Science and Practice* 2017 Jun 27; 5(2): 274–285.

(MOH) introduced an approach that engages at least three community-based distributors (CBDs) of FP methods per health area. CBDs, according to national policy, are authorized to provide oral contraceptive pills and condoms. CBDs offered Implanon NXT through an MOH-supported pilot intervention. Sayana Press is currently being scaled up, and policy change for provision of this method by

CBDs is under way. Even in health areas with at least three CBDs, with an average of only one CBD per 700 women of reproductive age, coverage is low. Despite the potential for CBDs to improve access to FP, the limited numbers of CBDs per population, coupled with their low motivation, prevent the full potential of this approach from being achieved.

The Approach: Reach Every Household with FP

Given the large unmet need and low contraceptive use, the USAID-funded Integrated Health Project Plus (IHPplus) sought to identify innovative means to reach more households with FP services. The DRC MOH has successfully used vaccination campaigns for polio and measles to reach target populations, leading to increased immunization coverage and a reduction in vaccine-preventable diseases.³ DRC's approach to providing immunization outreach services is rooted in the Reach Every District approach, which has three strategies—fixed, advanced, and mobile—for ensuring population coverage. The latter two are used for reaching populations with difficult geographic access or social barriers as well as those with no access to services and inspired the FP mini-campaigns.

IHPplus thus adapted DRC's field-tested approach to vaccination campaigns to FP. Three-day mini-campaigns were designed to mobilize communities around FP, provide door-to-door services for FP, and link women and men to CBDs while supporting and motivating the CBDs. The strategy was also aimed at enabling CBDs to talk with couples and engage men in counseling and awareness sessions. Previously, large campaigns to provide FP had been organized, but provided only same-day services; in addition, the campaigns called interested users to a specific outreach site without assurance of linkages and continuity for short-term methods, and they were not as targeted to specific geographies as vaccination campaigns had been.

During January to March 2018, IHPplus, working with the National Reproductive Health Program (NRHP) and provincial and zonal health staff, organized FP mini-campaigns in 66 targeted sites across 6 provinces.

Preparations for the mini-campaigns

- **Targeting geographic areas:** Similar to vaccination campaigns, IHPplus aimed to reach communities with limited or no access to FP services. Using data from the national health information system, 66 health areas where CBDs were already present were selected based on low use of FP services (less than 5%) or less than 200 new FP users in the past 3 months.
- **Training for providers:** Five to eight CBDs in each area had received training previously, as well as two nurses for each area to supervise the CBDs. Short refresher briefings were conducted before each campaign. All training was conducted by the provincial health departments.
- **Mobilizing the community:** One week before the activity, communities were notified via different channels about the upcoming mini-campaign and the benefits of FP. The messages were developed and pretested in local languages by the NRHP coordination team in collaboration with health zone and community members. Community mobilizers or “criers”—typically well known in the community—had the task of identifying the villages and locations to cover during the campaign. The mobilizers also collected phone numbers, which the community facilitator then used to send SMS messages. Information was disseminated on community radio and through posters placed in strategic parts of the community.
- **Putting in place tools and supplies:** CBDs were provided with service provision kits and reporting tools following the training. Each kit included a T-shirt, vest, cap, backpack, boots, umbrella, calculator, plastic bucket for storage, and picture boxes. At least two weeks before the campaign, each site was provided with the commodities required, including contraceptive methods and other important supplies for service provision. FP methods provided included pills, injectables (intramuscular and subcutaneous), implants, intrauterine devices (IUDs), and cycle beads.

³ DRC Ministry of Health, Expanded Program on Immunization Annual Reports, 2015 and 2016

Conducting the mini-campaigns

During the campaign, the criers passed through the streets and high traffic areas, such as markets, to announce the imminent arrival of the CBDs and spread FP messages. The CBDs visited each house in their respective catchment areas during the three-day campaigns to offer the following:

- Educational sessions and the range of available methods
- Counseling sessions for interested clients/couples
- Short-term methods (pills, subcutaneous DMPA, cycle beads, male and female condoms, and Lactational Amenorrhea Method [LAM])
- Referrals for clients interested in other methods (intramuscular DMPA, implants, IUDs, fertility awareness methods) to either a health center or a fixed site set up in the community and staffed by a nurse; community sites were selected on the basis of proximity to the population, standards for maintaining confidentiality, and an aseptic environment

Supervisors assigned to each health area used checklists to ensure quality, provide clarifications to the CBDs or clients as needed, and monitor availability of commodities and tools. Daily sessions were held to assess the successes and challenges and plan for the following day.

Follow-up to the mini-campaigns

Following the mini-campaigns, data on service provision were systematically entered into the DHIS 2. Additionally, during the following month, the CBDs used their registers to identify and revisit all clients in their catchment area. Clients could discuss any method side effects or needs for switching methods; obtain counseling; and strengthen their relationship with the CBDs.

Methods

IHPplus implemented the mini-campaigns in 66 health areas selected from 16 health zones in 6 provinces (Sud Kivu, Kasai Oriental, Kasai Central, Lualaba, Sankuru, and Lomami). These sites were purposely selected on the basis of indicators of access and utilization of FP. The selected health areas had an average population of 14,883; the populations in the sites ranged from 4,914 (Cimpuka in Kamiji) to 44,877 (Mpala in Fungurume). Campaign data were collected by the CBDs and providers at community sites and reported to the national health information system (NHIS) by national government staff. Ongoing, routine FP service provision data are also entered into the system at health facilities. To evaluate the approach, data were extracted from the national HIS and used to determine the number of new FP users, calculate couple years of protection (CYP), and determine the method mix. Data from the campaign were compared with data from the same three-month period in 2017.

Data were analyzed using STATA version 14.2. The project performed a series of t-tests to check if the number of new acceptors (number of new acceptors, new acceptors in postpartum category, new acceptors in the post-abortion category, and new acceptors less than 20 years of age) in Q1 2018 was similar to Q1 2017. We also tested whether on

average the CYP delivered in health areas and the method mix changed across the two quarters. Regression analysis was also conducted with the number of new acceptors as a response variable or the dependent variable, and the post period as a predictor or independent variable. Province fixed-effects were also added to the model. Reports from project implementation were reviewed to identify challenges and lessons learned from implementation of the mini-campaigns.

There were a number of limitations to this analysis, and these preliminary findings should be considered to drive further testing and analysis of the approach. Limitations to the analysis include the quality of the routine data (e.g., missing data), the type of data available for trend analysis (aggregate FP service statistics), and the limited number of performance indicators examined. The analysis contained no comparison areas, so causal conclusions could not be drawn. Given these limitations, the validity and generalizability of our results would require further study to validate. However, the findings are useful to inform further testing and analysis of the approach.

Context

The mini-campaigns were organized in the regions of Kasai, Katanga, and Eastern Congo, where the total fertility rates are among the highest in the country at 8.2, 7.8, and 7.7, respectively. In the Kasai Region, the provinces of Kasai Central, Sankuru, Lomami, and Kasai Oriental were included; Lualaba in the Katanga Region and Sud Kivu in the Eastern Congo Region were also included (table I). In the selected provinces in the Kasai, poverty is widespread, with half of the population classified in the two poorest quintiles and more than a third of the population having no education at

all (31.5%).⁴ Modern contraceptive prevalence is 5% in Kasai; conversely, in Lualaba, half the population is classified in the richest quintile, but the modern contraceptive prevalence is among the lowest in the country at 3.9%. Some 25% of the population has had no education at all, and there are a number of religious sects that are resistant to modern medicine. In Sud Kivu, the rate for modern contraception is slightly better at 7.9%, and the wealth distribution appears to be more even, while about 20% have never had any education.

Table I. Rates of modern contraception

Province	Total fertility rate	CPR* (modern methods)	Number of health areas that held mini-campaigns	Total population of areas covered
Kasai Central	8.2	5%	15	186,353
Kasai Oriental	8.2	5%	4	36,847
Sankuru	8.2	5%	10	102,467
Lomami	8.2	5%	12	134,054
Lualaba	7.8	3.9%	17	307,348
Sud Kivu	7.7	7.9%	20	302,804

*CPR, contraceptive prevalence rate

Results

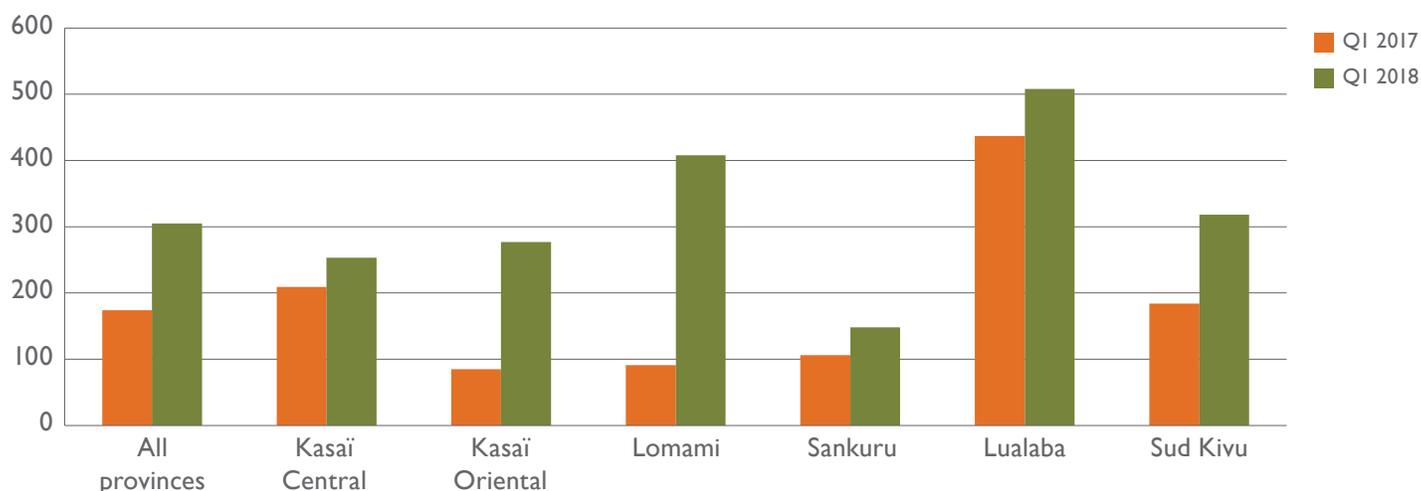


Figure I. Average number of new FP acceptors per health area

During the period of the mini-campaigns in Q1 2018, the number of new acceptors per health area that held an FP mini-campaign was, on average, 305, a significant increase when compared with 174 in Q1 2017 (95% CI, $p = 0.0002$). Similarly, the number of new postpartum FP acceptors per health area doubled after the FP mini-campaigns (from 18 to 36) (95% CI, $p = 0.0142$). However, there were no statistically significant

differences between the two quarters in terms of the average number of new acceptors in the post-abortion category or new acceptors less than 20 years of age. The average number of new users under 20 was very small in both time periods (less than two). In the regression model, the increase across the two periods was statistically highly significant.

⁴ Ministry of Planning and Ministry of Health. DRC Demographic and Health Survey 2013-2014, Rockville, Maryland, USA: MPSMRM, MSP and ICF International.

To better understand the role of context and how this might influence the effectiveness of the intervention, variations across the sites and across the health zones were examined. The increase in the number of new acceptors (average of 23) only remained significant in the areas where there were between 50 and 150 new acceptors ($p = 0.0113$). In those areas where new acceptors were less than 50 or more than 150, the significance of the change vanished. Across the provinces, three showed significant changes in new acceptors between 2017 and 2018. Lomami showed the highest increase with 316 new acceptors on average, followed by Kasai Oriental (192) and Sud Kivu (134). Lualaba, Kasai Central, and Sankuru saw mean increases of 70, 43, and 42, respectively, but none of these were statistically significant (figure 1). Kasai Oriental showed a large and significant increase despite the fact that the mini-campaigns only covered a population of about 37,000.

Method mix

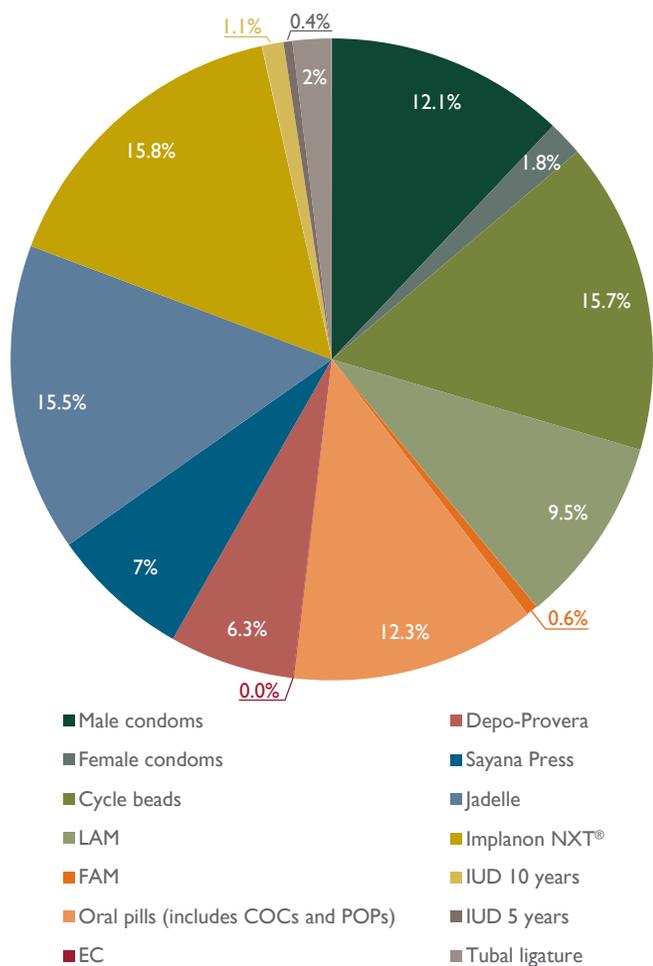


Figure 2. Method mix by CYPs generated in Q1 2018 (FAM = fertility awareness methods; EC = emergency contraception)

The contraceptive method mix has been evolving as seen in comparing the results of the Demographic and Health Survey in 2013-14 and PMA2020 (round 6) in 2017. Although condoms remain a dominant method within the mix, the use of implants has increased to become a preferred method. Injectables have gained traction as well, notably with the pilot introduction of Sayana Press (figure 2).

When looking at the method mix, there were statistically significant increases in average uptake of certain methods. These included the following by delivery system:

- CBD: Sayana Press, progestin-only oral pills (POPs), combined oral contraceptives (COCs), female condoms, and male condoms
- Health facilities: Sayana Press, Jadelle, Implanon NXT®

Conversely, adoption of 5-year IUDs on average decreased by 2 per health area in Q1 of 2018 (figure 2) compared to Q1 of 2017; uptake of 10-year IUDs also declined, on average, but this decrease was not significant. Some other nonsignificant declines were seen in health facility services, but these may reflect a shift from facility- to community-based delivery, as most showed parallel increases in CBD delivery on average. No other significant differences between the two time periods were found.

When the health facility- and CBD-delivered methods are combined, statistically significant increases are found only in Sayana Press (increase of 32, $p = 0.0000$), Implanon NXT® (increase of 5, $p = 0.0092$), and female condoms (increase of 167, $p = 0.0454$).

Couple years of protection

We tested if, on average, the CYP delivered in the health areas statistically changed across the two quarters. In the first quarter of 2017, the average CYP per health area was 177, but it was only 136 in the same period in 2018. However, this decline is not statistically significant ($p = 0.3098$) and could potentially be attributed to the observed declines in some long-acting, reversible contraception, such as 5- and 10-year IUDs, which provides more CYP.

Discussion and Lessons Learned

These results, while preliminary, illustrate that FP mini-campaigns may be a promising strategy for improving access to and use of FP services, particularly to attract new users to FP. Notably, it did not appear to be as effective at reaching adolescents, for whom use is low to begin with, and different strategies—such as more targeted events at places where adolescents meet—are likely needed for this population. Of concern is that IUD acceptors decreased, and more information is needed to understand why this might have occurred. Nonetheless, the average number of new users at both time periods was quite low for IUDs and implants, indicating a need for more promotion of long-acting, reversible methods. This may explain why there was no significant increase in the CYP, despite the increased number of acceptors. Sayana Press, which was available during the campaigns, appeared to be quite popular and did not seem to displace Depo-Provera use.

There was large variation across the six provinces, with some showing significant increases in new acceptors, while in others, declines were observed. Because there were no

comparison sites, we cannot say whether these observed variations of increased or decreased FP uptake were due to the intervention or other external factors. In some areas, such as Sankuru, the presence of strong cultural norms that oppose modern medicine and low education levels were likely important factors, and more work beyond the campaigns as well as repeated campaigns may be required to bring about a social shift. In Lualaba, the number of new acceptors on average per health area was already much higher than the others, and analysis showed that those in the higher range were less likely to see significant change.

In terms of implementing the approach, immediate feedback from supervisors may have improved the work of CBDs and was probably a key factor in the results. Organizers felt also that preparing the community for the home visits in advance ensured that clients were more likely to be present and available for visits on the days of the mini-campaigns.

Conclusion and the Way Forward

The mini-campaigns incorporate multiple elements that may act as mechanisms for change, both in the immediate and longer term. Communication during the campaigns, combined with home visits, can spark discussions between couples and the community about FP. Immediate and visible supervision by doctors and nurses may have improved the performance of CBDs and reassured the community about their capacity to provide FP. The events mobilized CBDs, enabling them to locate their clients and gather their phone numbers, and likely raised their profile in the community. The engagement of CBDs in the mini-campaigns was aimed at improving the monitoring and continuity of service; however, we were unable to track whether this occurred, and further studies are needed to evaluate the continuity of service for clients

choosing short-term contraceptive methods. The effects of repeated campaigns on increasing use, shifting norms, and reducing social barriers, as well as appropriate frequency, also needs further research.

Our findings hold promise that large-scale implementation could accelerate progress toward achieving the DRC MOH's goal of 2.1 million FP users by 2020 and reducing unmet FP needs among women of childbearing age. The strategy may also be useful in similar contexts with high unmet need and limited access. The approach should be implemented again with stronger evaluation methods to better determine its impact and answer the remaining research questions.

SUCCESS STORY: THEORY AND PRACTICE: A FAMILY PLANNING MINI-CAMPAIGN INSPIRES ALMOST 1,000 COUPLES TO TRY MODERN CONTRACEPTION

Health workers trained in family planning hit the streets to offer counseling and services in an underserved area of DRC



Anna Mujinga, her husband, and youngest child with the doctor who inserted her Implanon NXT®, a new, long-acting contraceptive.

“We chose to use [long-acting contraceptive implant] Implanon so I can recover my health. And with our limited means, it will help us better raise and educate the children we already have.”

—Anna Mujinga

a 38-year-old farmer with 11 children, during the family planning mini-campaign

In the Democratic Republic of Congo (DRC), closely spaced and numerous births contribute to the high mortality rates among mothers and babies. Yet few couples use modern contraception. Recently, the DRC government made family planning a priority with the goals of making services available to 2.1 million more women by 2020 and increasing the contraceptive prevalence rate from 5% to 19%.

The USAID-funded Integrated Health Project Plus (IHPplus) is supporting the Ministry of Health (MOH) in adding new contraceptive methods to the mix offered and making them available through local community health workers (CHWs). New methods include the Sayana Press and Implanon NXT®—long-term implants that can be administered by a CHW.

In June 2016, the MOH provincial office organized a 12-day training with IHPplus support in Lomami, a health zone where reported contraceptive use lagged below 4%. Participants included 50 CHWs and 17 providers from health facilities. A nine-day workshop was held, followed by three days devoted to real-life practice in a mini-campaign in the areas of Kanda Kanda and Mutebwe.

The results? Nearly four times the typical number of new adopters for a three-month period. Of the 1,146 people reached (1,024 women and 122 men), 951 (83%) became new acceptors of modern family planning. (The previous quarter, 337 people had become new adopters in the same areas.) Offered a wide choice of methods, the new adopters collectively signed up for 617 couple years of protection. Two kinds of oral contraceptive pills were the most widely selected; after that, the long-term implants Implanon and Sayana Press. Male and female condoms came at the bottom of the list, after cycle beads.

Anna Mujinga, a 38-year-old farmer with 11 children, attended with her husband. “My health doesn’t permit me to have more children,” she said. “We chose to use Implanon so I can recover my health. And with our limited means, it will help us better raise and educate the children we already have.”