The Jagged Road to a Policy Change: Increasing Access to Family Planning using Community Health Nurses

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INTRODUCTION

Contraception offers promising opportunities for addressing the high and growing demand to limit births, space children, avoid unintended pregnancies and prevent unsafe abortions.[1] However, the provision of contraceptives – particularly implants – to expand family planning options remains restricted in sub-Saharan Africa.[2] Nearly 1 in 3 women in the sub-Saharan African region has an unmet need for family planning, the highest proportion worldwide. [1]

A key requirement for improving access to contraceptive service delivery is sufficient health workforce availability and distribution within countries.[3] In sub-Saharan Africa, expanding access to family planning services is further compounded by acute shortages in human resources for health, especially in rural areas where access to modern contraceptive methods is already limited.[4] To mitigate these acute shortages, the World Health Organization (WHO) recommends task sharing or task-shifting, a process that optimizes health worker roles by "train[ing] cadres who do not normally have competencies for specific tasks to deliver them and thereby increas[ing] levels of health care access".[5] Specifically, WHO recommends the use of auxiliary nurses to deliver insertion and removal of contraceptive implants with targeted monitoring and evaluation.[6]

This article chronicles the phases that led to a policy change allowing auxiliary nurses in Ghana to share the task of providing implant services with midwives. First, we briefly describe the socio-medical context in Ghana, with emphasis on reproductive health indicators and national benchmarks; we then highlight the consequences of medical staff shortages on provision of family planning services and argue the need for task-sharing in Ghana; third, we outline the succession of donor-funded projects and related research studies that generated the evidence needed to influence decision-makers to enact a change in policy; relevant to the latter is an explicit account of the role of the Population Council, a health research organization, in facilitating the policy change process; lastly, we describe the level and type of advocacy required to implement and operationalize the policy change.

THE NEED FOR TASK-SHARING IN GHANA

Over the past two decades, Ghana has made significant progress in key reproductive health indicators. With a total fertility rate (TFR) declining from 6.4 births per woman in 1988 to 4.2 in 2014, current contraceptive prevalence rate among married women stands at 27 percent while unmet need for married women has decreased from 37 percent to 30 percent. [7] This notwithstanding, figures from the Ghana Multiple Indicator Cluster Survey 2011 and other surveys show increased uptake in contraceptive implants among clients preferring long-acting reversible family planning methods. Specifically, the use of implants significantly increased between 2008 and 2012: acceptors for implants in Ghana Health Service (GHS) facilities increased from 25,603 in 2008 to 65,119 in 2012 and the percentage contribution to acceptor increased from 1.4 percent to 3.7 percent in the same period.[8-9]

It is estimated that meeting the unmet need for family planning could reduce maternal deaths in Ghana by almost a third and contribute towards achieving the country's MDG 5 target of 185 per 100,000 live births.[10] However, the strength of the Ghanaian health-sector workforce possessing professional qualification to expand access to family planning services falls short of WHO's recommended minimum of 20 doctors per 100,000 people.[11] The current ratio stands at 10 doctors per 100,000 people and the distribution is skewed towards urban areas, substantially impeding access to health care in rural areas and leaving women and couples in underserved areas in great need of family planning services.[12] Therefore, having a sufficiently trained health workforce for scaling up implant service delivery is critical. To increase access to and improve equity of family planning services, task sharing has been touted as a strategy for optimizing health worker roles.[13] Founded on a policy of training and retraining the health workforce, task sharing allows for a more effective use of existing human resources, where tasks are usually delegated to less specialized, but trained health-care workers.[14]

To address these acute shortage challenges, Ghana has instituted the Community-based Health Planning and Services (CHPS), a national health policy and strategy adapted by the Ministry of Health to improve physical, geographical and financial access to primary health care at the community level.[21] Since the inception of the CHPS model in Navrongo in 1994, CHPS has evolved in a number of components, including the establishment of community-based service delivery points as well as improved partnership with community leaders and social groups in all districts of the country. [21, 23]

A HIDDEN RESOURCE IN PLAIN SIGHT

In Ghana, community health nurses (CHNs) represent the largest cadre of auxiliary nurses and frontline health workers, providing communities with basic preventive health care and health promotion services. CHNs are embedded within the CHPS model and their tasks typically include the provision of quality health information, minor curative services, counseling on all contraceptive methods, provision of pills, injectables and condoms and referrals for IUDs, implants and sterilization.[22] The use of trained CHNs to operate within CHPS and the concept of community engagement has been the backbone of the model and has contributed to its nationwide success.

A growing body of evidence from other developing countries demonstrates the feasibility of employing community health nurses to provide family planning services through task-shifting.[15-20,1] The use of auxiliary nurses to augment the provision of implants has occurred in some sub-Saharan African countries, namely Ethiopia, Malawi and Mozambique.[1] The impact of auxiliary nurses providing family planning services including long acting reversible methods has been measured in these countries and the programs have reported expanded access to family planning services, increased uptake of family planning methods and reduced work load in clinics.[1] They have also shown feasibility and effectiveness in the scale up of family planning programs. Similar evidence from Indonesia shows that low cadre health workers are employed to expand family planning access, particularly implants. These successes and several others offer evidence that the role of auxiliary nurses need no longer be limited to the provision of short term family planning methods.[5]

THE JAGGED ROAD TO POLICY CHANGE

Recognizing the limited health human resource, the need to expand options for family planning services, particularly implants, and the possibilities of task shifting or task sharing initiatives to increase access to long term methods, the Population Council supported Ghana Health Service to conduct a pilot study to ascertain the readiness of CHNs in providing implants. We detail here the phases – characterized by funding changes, evidence generation, and effective advocacy – that eventually led to a policy change.

Phase 1: The CHPS-TA Project

In 2004, the USAID Mission in Ghana granted the Community Health Planning and Services/Technical Assistance (CHPS-TA) bi-lateral project to Population Council and its consortium partners: American College of Nurses and Midwives (ACNM), Centre for

Development of People (CEDEP) and EngenderHealth. The aim of this five-year project was to support Ghana Health Service (GHS) to expand CHPS to 30 districts in six selected regions of the country. Implementation of CHPS-TA revealed anecdotal evidence from CHNs whereby clients opting for any long-term methods, particularly implants, had to be referred to facilities where midwives could provide such services. This inconvenience resulted in many clients being discouraged by the distances they would need to travel as well as the transportation costs they would incur. The majority of CHNs expressed dissatisfaction with their inability to provide implant services in their communities and a handful revealed that they had provided counseling for long term family planning methods, a function reserved for mid- or high-level cadres of health providers. Convinced of the important role that CHNs can play in task sharing to improve access and cost-effectiveness in family planning programs, particularly within the CHPS model, the Population Council, through the CHPS-TA Project, supported Ghana Health Service in 2008 to conduct a pilot intervention in which 33 CHNs were trained to provide Jadelle® implant insertion and removal.

Phase 2: The R3M Project

With CHPS-TA funding ending in 2009, Population Council leveraged funds and resources through the Reducing Maternal Mortality and Morbidity (R3M) Program, launched in 2006 and comprising of five consortium partners: EngenderHealth, Ipas, Marie Stopes International, Population Council, and Willows Foundation. Based on their differing strengths and capabilities, it was agreed for EngenderHealth to collaborate with GHS to evaluate the competency levels of the 33 CHNs trained under CHPS-TA. The systematic evaluation conducted by EngenderHealth verified that CHNs safely provided Jadelle®, with 97% of the CHNs performing the entire pre-insertion task correctly, 93% fully performing all the insertion tasks and 87% performing all the post-insertion steps correctly. The evaluation also revealed that knowledge of the contraceptive method was high as were counseling, insertion, and removal skills. More than 75% of the CHNs reported not encountering any complications when providing the implant. The 33 CHNs inserted a combined 1,051 implants during the year preceding the evaluation, with 5 CHNs having inserted more than 40 each. Even so, more than 80% of the CHNs and their managers indicated a need for further training in infection prevention, counseling and management of side effects and complications and over two-thirds requested refresher trainings.

Phase 3: Advocacy for Policy Change

(1) Presenting Evidence

In October 2011, the R3M Program convened a dissemination seminar for selected decision-makers and stakeholders of the Ministry of Health and GHS. The main objectives of the meeting were: first, to present the results from the training of 33 CHNs under the CHPS-TA Project as well as the follow-up evaluation under R3M as a demonstration of the feasibility of and safety for CHNs to undertake insertion and removal of implants; second, to use the results as a platform to recommend the review of existing reproductive health service delivery standards to emphasize task-sharing and allow CHNs in Ghana to insert and remove implants.

(2) Encountering Resistance & Identifying Policy Champions

Despite the encouraging outcomes from the results presented, decision-makers and stakeholders at the October 2011 dissemination seminar identified weaknesses in the methodological approaches of both the CHPS-TA-based study and the follow up evaluation, concluding that both sets of findings did not provide enough evidence for policy change. The stakeholders insisted on additional and stronger evidence. Additionally, they raised concerns about the medical and legal implications of allowing CHNs to inserts implants. With CHNs having not completely undergone competency-based training in implants insertion and removal, the potential for medical complications from the procedure carried out by CHNs was higher and opened up opportunities for legal suits.

Although some decision makers were reluctant to support this initiative due to a lack of strong evidence as well as medical and legal concerns, other decision makers enthusiastically welcomed the findings and notion of task-sharing for CHNs in Ghana. For instance, a number of providers from some regions and districts spoke up about the reality on the ground and attributed some of the challenges faced by midwives in providing implants to the workload at the facility. Thus, the need to share tasks was germane and a solution to the persistent problem. One regional manager's observation aptly captures the opinion echoed by these health professionals: "*for access to FP services and for FP coverage to improve, national policy on FP implants service delivery should be revised to include CHNs as part of the cadre delivering these services. Training on FP implants should be incorporated in their school curriculum*."

Identifying these policy champions was a critical step in maintaining momentum, given the charge to generate additional evidence, and for Population Council to continue advocacy at the national level.

(3) Generating additional evidence

Heeding to the call for additional evidence to convince decision makers towards policy change, it was agreed that a broader study would be conducted, designed to address the previous studies' methodological shortcomings and to generate more reliable findings. The Ghana Health Service called a meeting with other stakeholders where discussions were held to shape the way forward. At this meeting, the study design was developed based on the group discussions and a strategy to encourage the policy change process was outlined. The decision makers concluded that the R3M program would fund the evidence-based study that would form the bedrock for the call to change policy on implants insertion and removal by CHNs. Regrettably, despite IRB approval of the study, R3M retrenched its funding on the basis that a body of literature provided ample evidence on task-sharing for CHNs to provide implants. With proposed study now halted, Population Council conducted a systematic review of the literature with a focus on studies using randomized control designs to investigate the potential benefits and harms of task sharing as well case studies of large-scale programs measuring the acceptability and feasibility of task sharing services to patients, health workers and others.

(4) Stronger Case Leads to Policy Change

Population Council convened a second stakeholder meeting on February 14, 2013, during which results from the systematic review and case studies were shared. This meeting brought together a larger cluster of reproductive health stakeholders (see Figure 1). The systematic reviews revealed a number of task-sharing interventions carried out within the health sector in Africa, with results pointing to the benefits of task-sharing. Moreover, a study from Ethiopia found that implants provision by Community Health Workers had increased use from 5% to 25%. In addition to the studies, Population Council presented the WHO guidelines that had been released a few months prior. The guidelines were timely as they defined health worker roles for maternal and newborn health and made recommendations for task sharing among various cadres of health care providers to address the critical human resource shortages. The WHO recommendations served as a key advocacy tool and placed the proposal to remove policy restrictions and allow CHNs in Ghana to provide implants within a global discourse.

Also present at this meeting were the 33 CHNs who underwent the training on implant insertion and removal. They shared their experiences with the stakeholders, validated the anecdotes offered by the Regional Directors' about the reality in the field, and concretely supported the proposal to change the policy. A combination of the evidence provided through systematic review of rigorous studies, the WHO recommendations, and testimonies from CHNs about their positive experiences with implant provision all played a critical role in influencing the stakeholders to accept the recommendations and make the

pivotal decision to allow CHNs to insert and remove implants. An official memorandum announcing the policy change was drafted at the meeting, to be issued and distributed with immediate effect to all regional health directorates and throughout the public health system.

Before ending the meeting, the decision makers also devised strategies to ensure the efficient implementation and operationalization of the revised policy, including an action plan, a consensus on the content of the policy change, an agreement on a selected group of technical reviewers (10-12 experts from relevant departments of the Ministry of Health and GHS), and a draft working plan for these technical reviewers. These decisions ushered in the next phase of the policy change process. Fulfilling the activities outlined in the action plan necessitated a concerted effort to secure funding support from various donors. We elaborate on these activities below.

Phase 4: Ensuring policy change take-off

Activity 1: Support Ghana Health Service in the revision of the Sub-dermal Contraceptive Implant training manual

In April 2013, Population Council secured funding support from USAID's Community Health Workers Project to assist GHS to initiate a process of revision and printing of 1,000 copies of its 'Sub-dermal Contraceptive Implant' training and monitoring manual for trainees (midwives and CHNs) and trainers. Updating the widely used manual would guarantee that specific guidelines for provision of three common and nationally available contraceptive implants (Jadelle®, Implanon and Zarin) would be incorporated.

- **Activity 2: Support Ghana Health Service in the revision of the *National Reproductive Health Service Policy and Standards* document**

The *National Reproductive Health Service Policy and Standards* document was developed in 2003 and required an update to align it with new or revised national policies. Under the USAID-sponsored Evidence Project, the Population Council provided technical assistance to the technical reviewers in developing and revising the components related to CHNs to explicit detail their expanded portfolio. The technical reviewers held five meetings in the course of the projected six months to draft the revisions for vetting by a larger group of reviewers and stakeholders, consisting of approximately 25 GHS and MoH department heads and administrators who met twice over the course of the project.

The third edition of the *National Reproductive Health Service Policy and Standards* was fully revised in November 2014, with 500 initial copies printed with support from the Evidence

Project for GHS. Discussions with GHS point to a phased regional dissemination strategy, scheduled for in the last quarter of 2015.

- **Activity 3: Support to the Nursing and Midwifery Council to review the pre-service curricula**

Also under the Evidence Project, Population Council has supported the Nursing and Midwifery Council (NMC) to review its pre-service training curricula, last updated in 2007, and ensure that the CHN curriculum includes training modules on implant insertion and removal. The process also required the revision of certification by NMC to ensure that auxiliary nurses graduate with the capacity to provide implant services.

The NMC identified a national taskforce to lead a seven-phase review process, which began in February 2014. This group comprised appropriate Ghana Health Service personnel, nurse educators, nurse clinicians from public, private and Christian Health Association of Ghana (CHAG) facilities, private health facilities (both schools and hospitals), representatives from health partners, midwifery educators, midwifery clinicians and lecturers from the universities that offer nursing and or midwifery programs. The national taskforce reviewed the processes for all the identified areas and updated the pre-service curriculum. It also vetted the draft document with GHS and other stakeholders. Several key institutions and stakeholders such as the pre-service schools, the preceptor/certification agencies, GHS and MOH at central, regional and districts levels were also the involved process. The review process is set to be completed by the fourth quarter of 2015.

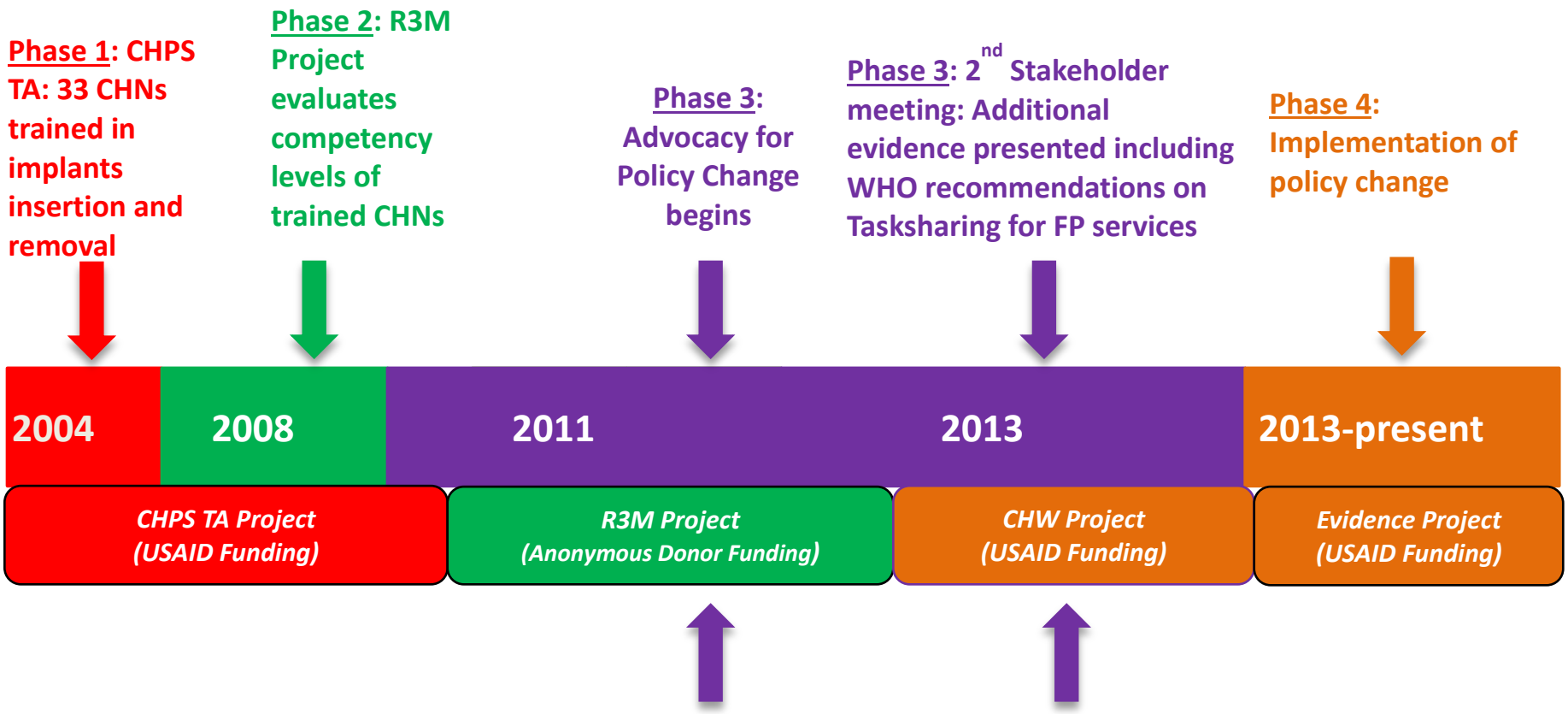
- **Activity 4: The training and certification of up to 4,000 CHNs nationwide by GHS by year 2015 with the support from the Millennium Accelerated Framework (MAF) Fund sponsored by the European Union;**
    - As of June 2015, the Director of the Family Health Division stated that approximately 3,000 CHNs have been trained and certified by the Ghana Health Service with the support of MAF Fund and the EU.

- **Activity 5: A targeted monitoring to assess competency skills of trained CHNs by GHS with the support of Population Council, as recommended by WHO.**
    - The Population Council is helping the Ghana Health Service develop a web-based tool to track and monitor the service delivery performance of CHNs as well as health professionals.

DISCUSSION & CONCLUSION

TBD

The Road to Policy Change



STAKEHOLDERS INVOLVED IN THE POLICY CHANGE PROCESS		
Government	RH Partners	Development Partners
1. Ministry of Health (MoH) 2. Ghana Health Service (GHS)-National Level 3. GHS-Regional Level 4. GHS-Human Resource 5. GHS- Institutional Care Division (ICD) 6. GHS-Family Health Division 7. GHS-Policy Planning, Monitoring and Evaluation Division 8. GHS- Research Development Division 9. GRMA 10. Nursing and Midwifery Council 11. National Population Council	1. Planned Parenthood Association Ghana (PPAG) 2. USAID Focus Region Health Project 3. USAID Deliver Project 4. DKT International 5. EngenderHealth Ghana 6. Ipas Ghana 7. Population Council Ghana 8. Marie Stopes International Ghana 9. Willows Foundation Ghana 10. Health Keepers Network	1. USAID 2. DFID 3. UNFPA 4. WHO

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