Translating Evidence into Policy Change: Advocacy for Community-Based Distribution of Injectable Contraceptives in Zambia

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Abstract

Background Community-based distribution (CBD) of injectable contraceptives has increased access to family planning for millions of women in rural areas in resource-limited settings. Despite the evidence of the success of this contraceptive delivery method, many nations have yet to integrate CBD into their family planning policies. The aim of this paper to describe the process through which PATH spearheaded efforts to successfully advocate for policy change to authorize non-clinical personnel in Zambia to provide injectable contraceptives.

Methods We describe a four-part framework for policy advocacy: (a) evidence building and technical assistance, (b) stakeholder engagement, (c) government engagement, and (d) knowledge dissemination.

Results Advocacy for policy change to allow CBD of injectable contraceptives was long and iterative. Evidence to support advocacy efforts was built through a Zambian delegates' study tour to Rwanda to witness Rwanda's robust CBD program and a rapid assessment of Zambian pilot sites where non-clinical personnel were administering injectable contraceptives. Advocacy was led by PATH in partnership with key stakeholders from the Zambia Family Planning Technical Working Group (FPWTG), key government officials, and a special task force of stakeholders focused on advocating for CBD of injectable contraceptives. This task force used evidence from the study tour and rapid site assessment in national and international forums to demonstrate the beneficial effects of allowing non-clinical personnel to administer injectable contraceptives. The Zambian government authorized the policy change in 2016.

Conclusion The policy advocacy efforts of PATH, FPWTG, and the special task force demonstrate the need for an ample evidence base and sustained engagement of government and stakeholder groups.

Keywords Advocacy · Policy · Community-based distribution · Family planning · Injectable contraceptives

Use of modern contraceptives has led to global reductions in maternal mortality, unintended pregnancies, unsafe abortions, and newborn deaths (Ahmed et al. 2012; Singh et al. 2009). In Zambia, government efforts to improve maternal and child health have led to significant improvements in the availability and prevalence of contraceptives. The proportion of Zambian women using any form of modern contraception rose from 15% in 1992 to 45% in 2014 (Central Statistical Office [CSO], Ministry of Health, and ICF International 2014). Despite significant improvements in contraceptive prevalence, a sizeable unmet need remains for family planning services. Overall, 21% of Zambians report an unmet need for limiting and spacing their children (CSO et al. 2014). However, significant disparities exist with higher rates of unmet need found among women with lower education, lower income, younger age, and those residing in rural areas (CSO et al. 2014).

Access to contraceptives is a significant barrier, especially for those living in remote parts of the country. The majority of women access family planning services from government clinics (CSO et al. 2014) which are limited in rural areas and

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face persistent issues, including staff shortages, stock-outs of contraceptives, and limited hours (Ministry of Community Development Maternal and Child Health [MCDMCH] 2013). Beyond access, women face challenges related to gender-role norms and misconceptions about contraceptives. Married women face limited decision-making power when adopting a contraceptive method (Belohlav and Karra 2013). Until 2005, Zambian law prohibited a married woman from obtaining contraception without her husband's permission, leading some women to opt for covert methods of family planning (Belohlav and Karra 2013). Further, despite generally high levels of awareness across the nation regarding various contraceptive methods (CSO et al. 2014), progress in this area is still hampered by some persistent harmful myths, particularly about long-term contraception (MCDMCH 2013; Solo et al. 2005).

Injectable contraceptives can play an important role in expanding choice of contraceptive method and addressing unmet need. Depot medroxyprogesterone acetate (DMPA) is a progesterone-only injectable contraceptive that is safe, discreet, long acting, and highly effective at preventing pregnancy. DMPA is given as an intramuscular injection every 3 months (Petta et al. 1998). Injectable contraceptives are the most commonly used modern family planning method in Zambia (19%; CSO et al. 2014) and across Sub-Saharan Africa (10%; United Nations 2015). Additionally, injectable contraceptives are the main preferred method for future use (47%; CSO et al. 2014).

Community-based distribution (CBD) of contraceptives has long been implemented across Asia, Latin America, and Africa as a means of improving rural residents' access to family planning services (Prata et al. 2005). Typically, CBD programs enlist community health workers who are trained in the delivery of family services but lack medical credentials (Hoke et al. 2012a). The World Health Organization, the U.S. Agency for International Development (USAID), and FHI 360 (an international nonprofit human development organization; formerly Family Health International) convened a meeting of a technical working group in 2009 to examine the evidence pertaining to efficacy and safety of providing injectable contraceptives through CBD programs. The meeting concluded that community health workers could safely counsel and provide DMPA to clients, and sufficient evidence was available to support including CBD of DMPA in national family planning policies (Stanback, Spieler, Shah, Finger, and Expanding Access Technical Consultation 2010) (Table 1). Research conducted in Uganda, Nigeria, Madagascar, and Kenya has shown that CBD of injectable contraceptives is feasible, satisfactory, and a means of expanding access to contraceptives among hard-to-reach clients (Abdul-hadi et al. 2013; Hoke et al. 2012b; Krueger et al. 2011; Malarcher et al. 2011; Prata et al. 2011).

Table 1 Abbreviations

CBD—Community-based distribution
CSO—Central Statistical Office (Zambia)
DMPA—Depot medroxyprogesterone acetate (brand name Depo-Provera)
FPWTG—Family Planning Technical Working Group (Zambia)
MCDMCH—Ministry of Community Development Maternal and Child Health (Zambia)
MoH—Ministry of Health (Zambia)
NGO—Non-governmental organization
USAID—U.S. Agency for International Development

In 2009, the Zambian Ministry of Health approved a pilot study of CBD provision of DMPA. Key findings from the study showed that (a) DMPA was the most commonly chosen method among new contraceptive users; (b) very few adverse events were reported; (c) clients were highly satisfied with the injections they received from community health workers; and (d) in the pilot site districts, community health workers provided a significant proportion of the DMPA injections (Chin-Quee et al. 2013). These findings provided strong initial evidence that CBD of DMPA in Zambia was effective, safe, and successful in reaching the underserved (Chin-Quee et al. 2013). However, despite the promising results from the pilot study, moving from research to policy change remained a significant challenge. Zambia had no policies in place to support training and authorizing of non-clinical personnel, such as community health workers, to administer injectable contraceptives.

As nations prepare to integrate CBD of DMPA into their family planning agenda, guidance is needed regarding effective strategies for engaging governments to change national policies. This article describes the process through which policy advocacy facilitated Zambia's national policy, National Guidelines on Provision of Injectable Depo-Provera, which authorized community health workers to provide injectable contraceptives (Chanda 2016). Depo-Provera is a brand name of DMPA. First, we describe a comprehensive policy advocacy framework. Next, we provide a case study that describes the ways in which policy advocacy led to policy change in Zambia. Last, we conclude by discussing policy and practice implications that might be instructive for other nations.

Policy Advocacy Framework

The policy advocacy framework was developed to guide the efforts of policy makers and reproductive health advocates seeking to change national policies to include CBD of DMPA. The framework draws on PATH's extensive

experience advocating for policy change; PATH is an international non-profit organization and leader in global health innovation. The framework also draws on a synthesis of the processes used in other Sub-Saharan African nations to enact changes in national family planning guidelines (Hoke et al. 2012a; PATH n.d.). Figure 1 illustrates the policy advocacy framework that consists of four components: (a) evidence-building assistance, (b) government engagement, (c) stakeholder engagement and capacity building, and (d) knowledge dissemination.

This framework recognizes that advocacy for policy change is an iterative non-linear process. During that process, components of the framework might need to be revisited several times based on where the government is in their decision-making process about the policy change. For example, if the government's decision-making process becomes stalled, then those working for change might need to engage new stakeholders or gather additional evidence to move the process forward. Depicting the framework as a circle illustrates the continuous, iterative nature of policy advocacy. The following section details the framework components and their key elements.

Evidence Building

The foundation of the policy advocacy process is the development of an ample evidence base. For CBD of DMPA, an effective method of building the evidence base is to conduct pilot studies with rapid assessment of the study findings. Conducting rigorous studies to assess the acceptability, feasibility, and cost-effectiveness of including DMPA in CBD programs can provide support for national-level programs. Sub-Saharan African nations that have successfully integrated injectable contraceptives into their existing CBD programs began with small-scale evaluations conducted by collaborations between national governments and local and international non-governmental organizations (NGOs; Hoke et al. 2012a). Pilot studies were conducted in rural districts with low contraceptive prevalence and where community health workers were already providing contraceptives (Jacinto et al. 2016; Prata et al. 2011; Stanback et al. 2007). Moreover, if pilot study results are promising, scale-up studies in additional settings can provide additional information for governments to consider. Scale-up of the CBD of DMPA has been successfully implemented across SSA and Asia (Curry et al. 2013). In scale-up sites in Uganda, new DMPA initiators and continuing users were more likely to seek injections from CHWs as compared to clinics (Krueger et al. 2011), demonstrating the effectiveness of the modality

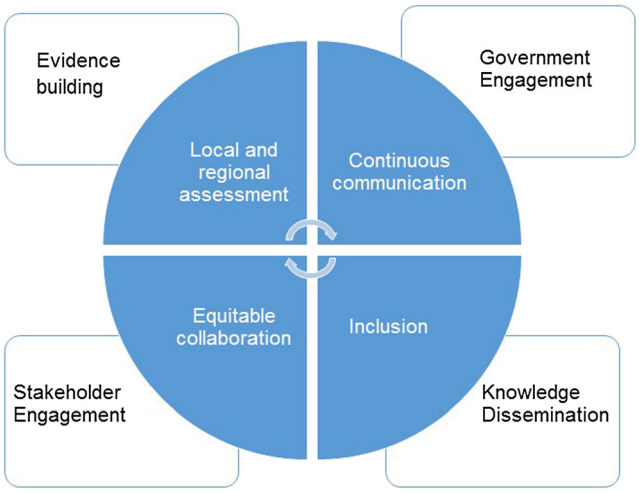

Fig. 1 Four-part framework for policy advocacy

Government Engagement

To ensure government buy-in for policy change, partnerships with government officials must be strategic and ongoing. Government leaders should be kept abreast of any new developments about CBD of DMPA through regular meetings and reports. An element of critical importance is identifying and leveraging champions of maternal and child health at the local, district, and national levels and involving those champions from the initiation of the advocacy process and forward. Having prominent leaders who are advocates of CBD of DMPA can ensure that the policy change remains on the national agenda. Further, situating the policy change within national priorities can increase government ownership. For example, aligning with country goals to reduce maternal mortality, or international commitments such as the Sustainable Development Goals, may increase the urgency for the policy.

Stakeholder Engagement and Capacity Building

Stakeholders play a significant role in supporting the policy advocacy process. As such, cultivating relationships with a wide range of organizations committed to increasing peoples' access to family planning can increase the likelihood of successful policy change. For CBD of DMPA, stakeholder groups should span the public and private sectors, including medical professional organizations, community health workers, donors, implementing partners, and both international and local NGOs.

Collaboration between stakeholders must be equitable. Efforts must be made to ensure that all stakeholder voices, particularly those of marginalized groups, are heard. One strategy to increase equity between stakeholders is capacity building. Capacity building is the process of developing or building the skills of an organization or community. Providing specialized training to stakeholders can ensure that they have equal footing and instill a sense of collective ownership (MacQueen et al. 2012).

Knowledge Dissemination

Dissemination of findings to a wide range of stakeholders can have a significant influence on decision makers. Dissemination must be timely and appropriate for each stakeholder group. Written materials such as reports and policy briefs should be tailored and accessible to various audiences. Further findings should be presented in a variety of formats at different forums, both locally and internationally.

Case Study

Moving from Evidence to Policy: Advocating for CBD of DMPA in Zambia

The following case study outlines the process through which policy change was brought about in Zambia to allow for CBD of DMPA. Advocacy for this policy change began at a time when the Zambian government was in the midst of initiatives to improve family planning access. In July 2012, the government made a commitment at the London Summit on Family Planning to increase the country's family planning budget and meet family planning targets. These commitments, referred to as the Family Planning 2020 Commitment (Government of Zambia 2018), led to the development of the Integrated Family Planning Scale-up Plan 2013–2020. The Scale-up Plan aimed to accomplish the following goals: increase demand of contraception through behavior change communication, target and serve the reproductive health needs of adolescents and youth, increase access to family planning in rural and underserved areas, improve the distribution and supply of contraceptives, and improve coordination for family planning services at different levels of government (MCDMCH 2013). Although the development of the Scale-up Plan included discussions of the potential utility of community health workers administering injectable contraceptives to improve task shifting and increase family planning access in rural areas, this role for community health workers was not yet national policy. To move the policy change forward would require evidence building, engagement with government and key stakeholders, as well as strategic knowledge dissemination activities that would lead to policy change.

Building Evidence for CBD of DMPA

Following the launch of the Family Planning 2020 Commitment (Government of Zambia 2018), a study tour was organized for a delegation of Zambian officials to visit Rwanda in September 2012 and observe that country's robust community-based family planning program. The study tour was hosted by FHI 360 implementing partners, professional bodies, and donors in collaboration with the Zambian Ministry of Health (MoH) and MCDMCH. The tour enabled the Zambian delegates not only to engage with stakeholders on operational, regulatory, and policy issues but also to draw lessons for moving forward with CBD provision of DMPA in Zambia. The study tour also provided key decision-makers with a successful model from a similar setting.

Despite the success of the study tour, government officials still needed additional local evidence beyond the initial pilot results (Chin-Quee et al. 2013). In 2014, the MCDMCH permanent secretary requested a rapid assessment to support the government in considering policy change. PATH commissioned a rapid assessment of the Zambia pilot and scale-up sites (three districts) where community health workers administered DMPA from 2011 to 2013. The study examined the number of community health workers providing injectable Depo-Provera, new acceptors, continuation rates, supervision, and the number of referrals to clinics for adverse events. The rapid assessment found that across the three districts during a 2-year period, 110 community health workers had administered nearly 12,000 DMPA injections, with no adverse events reported. The study concluded that leveraging community health workers to serve rural populations can be an effective way to provide services to women and recommended that the ministries undertake policy changes to allow national scale-up, including addressing CBD regulatory and supervisory issues.

Stakeholder Engagement: Building a Consortium of Key Players in Family Planning

Harnessing the findings from the pilot study and study tour, PATH spearheaded a policy advocacy agenda through partnerships with the Family Planning Technical Working Group (FPTWG). The FPTWG is composed of FHI 360, ChildFund Zambia, Scaling Up Family Planning, the United Nations Population Fund, USAID, MCDMCH, MoH, and key government officials. The FPTWG is a government-led collaborative that meets monthly to discuss issues related to family planning research, policy, and programming. The group devised and implemented a strategic advocacy agenda to pursue policy change to allow non-clinical personnel to administer DMPA. The FPTWG stakeholders developed a policy advocacy agenda with two objectives: (a) to increase interest in DMPA provision by community health workers and foster renewed program ownership among MoH/MCDMCH and (b) to generate support among professional associations that had expressed concern about regulation and supervision of CBD programs.

Recognizing the need for more focused advocacy efforts, the FPTWG developed a CBD Task Force. Task force members shared evidence from their respective organizations, strengthened partnerships, and worked to develop shared policy priorities. Task force activities included educational

initiatives, evidence generating, consultation with stakeholder groups, and within-task force strategizing on ways of harnessing Zambia's Family Planning 2020 Commitments (Government of Zambia 2018) to promote policy change for CBD of DMPA. PATH provided task force members with training in policy advocacy strategies, including how to best package evidence for various decision-makers and how to identify key events at which they could advocate for CBD of DMPA. Additionally, the task force formed an internal safety subcommittee to respond to concerns raised by the medical community about the safety of allowing community health workers to provide DMPA injections. The role of the Safety Committee was to maintain reports on any adverse events or safety issues related to CBD of DMPA.

Government Engagement: Identifying and Leveraging Family Planning Champions

Since the initiation of the pilot study of CBD of DMPA in 2009, Zambian government officials have been involved in the policy advocacy progress in some capacity. At the outset, government representatives participated in stakeholder meetings and asked for specific measures to be added to the pilot study to assess program impact (Chin-Quee et al. 2013). Moreover, the Zambian government is the official convener of the FPTWG, which meant that there was government representation and participation at all of the work group's meetings.

A few health officials were integral to the policy advocacy process. Both the director of Maternal and Child Health and the Safe Motherhood officer of the MCDMCH were part of the FPTWG's CBD Task Force. These two officials were champions of family planning and made sure that CBD of DMPA remained on the national agenda. In addition, Dr. Christine Kaseba-Sata, the former First Lady of Zambia, was an ardent supporter of maternal and child health and spoke out nationally about women's health and family planning.

Knowledge Dissemination: Sharing Findings from CBD of DMPA Trials

Knowledge dissemination took on many forms during the policy advocacy process. Reports highlighting findings from evidence-building activities were written and distributed, but the bulk of dissemination occurred during in-person meetings. Results from the reports on the pilot study, study tour, and rapid assessment were all shared during special meetings of various stakeholder groups and government officials. The meetings of the FPTWG's CBD Task Force also provided a consistent platform that provided attendees with the opportunity to share and discuss findings from CBD of DMPA trials. In addition to local meetings, evidence from Zambia's implementation of CBD of DMPA were shared at international gatherings. For example, former First Lady Dr. Kaseba-Sata discussed findings from the pilot study of CBD of DMPA at the 2013 Women Deliver Conference held in Kuala Lumpur, Malaysia (http://womendeliver.org/conference/past-conferences/2013-conference/).

Changes in National Policy

The combined effect of dissemination of findings from the pilot study, study tour, and rapid assessment, which were bolstered by regular meetings and advocacy by the CBD Task Force, helped lead to a closed-door meeting in January 2015 among MCDMCH, MoH, and the professional bodies to discuss the way forward. At this meeting, the Zambian government committed to using community health workers in the national provision of injectable contraceptives and agreed to engage professional bodies closely in the review of national guidelines developed by the FPTWG's CBD Task Force. These efforts culminated in the first of many important policy changes. First, in 2015, the Zambian government released its new National Guidelines on Provision of Injectable Depo-Provera by Community-Based Distributors. The following year, the MoH officially changed policy to allow CBD provision of injectable contraceptives. Currently, members of the FPTWG are creating a roadmap for national scale-up to expand CBD provision of DMPA countrywide.

Discussion

The change in Zambia's National Family Planning Guidelines to allow for CBD of DMPA was enacted through persistent advocacy efforts. Assessing this process through the lens of the policy advocacy framework highlighted the key activities and actors that made this process possible. Findings from Zambia's process of integrating DMPA into their CBD programs indicate the importance of having an ample evidence base and sustained commitment from key stakeholders. The policy advocacy process spearheaded by PATH made Zambia one of 12 African nations that have adopted policies that allow for CBD provision of DMPA (FHI 360 2018).

Regional and local data played a crucial role in moving CBD of DMPA from a topic of interest to policy action. At the initiation of policy advocacy, pilot studies provided government decision-makers with limited evidence, but the evidence was insufficient to move the policy change forward. However, results from the rapid assessment gave the MoH and MCDMCH confidence about the effectiveness of the existing distribution program as well as evidence of women's strong demand for injectable contraceptives. Further, the study tour to Rwanda gave Zambian officials insights on how to implement a successful program in their country. Study tours have been an important tool for evidence building in other

African nation's efforts to implement CBD of DMPA: In 2008, USAID and FHI 360 funded delegations from Nigeria, Rwanda, and Tanzania to visit Uganda to learn from their implementation of CBD of DMPA. The study tours provided the delegates with opportunities not only to witness CBD of DMPA in Uganda firsthand but also to share information within the delegations (FHI 360 2008).

Engaging government officials throughout the research and advocacy processes was critical to policy advocacy efforts. Because the FPTWG is a government-led group that includes leaders from MCDMCH and MoH, this policy advocacy was not faced with the challenge of keeping the government involved and aware of developments related to CBD of DMPA. Consistent communication was also fostered by the FPTWG meetings, which occurred on regular schedule of monthly meetings. Government officials were involved from the earliest stages of the pilot study in 2009, and this "from the ground up" involvement helped build sustained government interest and ownership.

Moreover, maintaining the momentum of policy advocacy was helped by situating the policy-change effort within Zambia's Family Planning 2020 Commitment and highlighting the utility of CBD of DMPA to increase task shifting and expand access to contraceptives for women in rural areas. Similar to many African nations, Zambia has a shortage of trained medical professionals, especially in the most remote areas (MCDMCH 2013). The FPTWG and its CBD Task Force rallied behind the 2020 Family Planning Commitment and used evidence from the pilot and scale-up sites to show how CBD of DMPA worked in remote pilot sites.

Another strength of the policy advocacy efforts was the engagement of a diverse set of stakeholders. The FPTWG included many of the international and local organizations at the forefront of maternal and child in Zambia. Although these organizations had varying levels of influence on the government, efforts were made to ensure that each stakeholder had an opportunity to voice their concerns. Stakeholders were invited to meetings where points of view were discussed, and all views were considered before joint conclusions were shared. Integrating the perspectives of various actors allowed for the development of a national policy that was inclusive. Moreover, PATH provided policy advocacy training for stakeholder groups to build their capacity to package and communicate results in ways that were appropriate and accessible to different audiences.

PATH, the FPTWG, and the CBD Task Force faced several challenges during policy advocacy. The entire process from the Family Planning Summit to the changing of the national policy took roughly 4 years. Sustaining momentum over this extended period required perseverance on the part of stakeholders. Components of the policy advocacy framework had to be repeated several times. Namely, additional evidence had to be gathered and disseminated at different meetings. Advocates worked relentlessly to make sure that CBD of DMPA remained on the national agenda.

Another challenge encountered during policy advocacy was gaining the support of the medical community. As a group, the professional bodies representing Zambian healthcare providers were reticent to endorse CBD of DMPA. The group's concerns about the safety of allowing non-clinical personnel to provide DMPA posed a potential obstacle to policy change. However, the components of the policy advocacy framework helped the health professional bodies to get on board with policy change. Specifically, these components were the development of the safety subcommittee within the CBD Task Force, the results from the pilot trials, the rapid assessment of pilot data, and the findings of the study tour.

Finally, advocates faced issues finding the right platforms or engagement spaces and the appropriate audiences for disseminating the evidence. Although FPTWG meetings were one forum in which policy advocate could engage with stakeholders and government officials, these meetings were limited to a select group. To overcome these challenges, PATH consulted with stakeholders to understand what options provided the best ways to disseminate knowledge. In addition, PATH took opportunities to discuss CBD of DMPA at any Family Planning 2020 related events and took advantage of family planning champions to disseminate the information at various forums.

Conclusion

Using research evidence to inform policy change is a long process that requires sustained advocacy and persistent effort. Adding DMPA to the family planning methods offered by trained community health workers helped to address unmet need, alleviate the workload of understaffed clinics, and brought Zambia closer to its health and development goals. The potential to enact policy change comes through policy advocacy efforts that are inclusive of various stakeholders as well as the strategic use of evidence. The policy advocacy framework is an instructive tool that those advocating for policy change can use to initiate and sustain advocacy for CBD of DMPA in their own localities.

Compliance with Ethical Standards

Ethical Approval This article does not contain any studies with human participants performed by any of the authors.

Conflict of Interest The authors declare that they have no conflict of interest.

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