Question 1: *How have systems thinking approaches and tools been incorporated in activities to improve health equity? Were these approaches useful in achieving health equity goals? If so, what are the pathways by which these approaches helped to address the root causes of inequity?*

Health Systems Thinking to Fulfil Unmet Need for Long-Acting Reversible Contraception in Northern Nigeria

Ibrahim Kabo,[1] Marta Levitt,[1] Jaiyeola Oyetunji,[1] Jumoke Azogu,[1] Nadia Carvalho,[2] Usman Al-Rashid,[1] Akingbemisilu Tosin,[1] Audrey Donohue,[3] Abubakar Panti,[4] Shafa'atu Abache,[5] Mairo Sheriff [6]

[1] USAID Integrated Health Program; [2] Avenir Health; [3] Palladium; [4] Society of Gynecology and Obstetrics of Nigeria; [5] Global Health Supply Chain – Procurement and Supply Chain; [6] Sokoto State Ministry of Health

HEALTH SYSTEMS STRENGTHENING ACCELERATOR

Context

Modern contraceptive method use among married women of reproductive age (15–49) varies across Nigeria. It is reported to be as low as 2% in Sokoto State (in the north) and as high as 29% in Lagos State (in the south). The United States Agency for International Development (USAID) Integrated Health Program (IHP) supports health systems strengthening (HSS) and reproductive, maternal, newborn, and child health plus malaria and nutrition (RMNCH+MN) services in the three northern states of Sokoto, Kebbi, and Bauchi, where the usage rates of modern contraception methods are 2.2%, 3.5%, and 6.5%, respectively, all of which fall below the national average of 12% (Nigeria Demographic and Health Survey 2018).

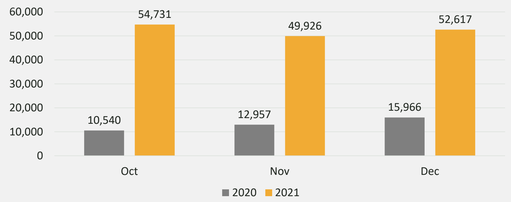
Total demand for family planning (FP) among married women has continued to rise across the country from 27% in 1990 to 36% in 2018. The proportion of demand satisfied by modern methods has increased from 14% to 34%. Total unmet need nationally is 20%. In IHP-supported states, unmet need is 13% (Sokoto), 12% (Kebbi), and 21% (Bauchi). The unmet need in these states is fueled by weak and under-resourced health systems; poorly staffed and trained health workers; and the underlying equity gap linked to the sociocultural and religious prohibitions that limit women's decision-making power, which is positively associated with desirable health outcomes, including contraceptive use (Nigeria Demographic and Health Survey 2018).

With an interest in meeting the demand for FP, the Federal Government of Nigeria (FGON), through the Federal Ministry of Health (FMOH), set a modern contraceptive prevalence rate target of 27% by 2020. Part of the plan to achieve this target included the establishment of a national task-shifting/task-sharing (TS/TS) policy. Adopted in 2014, the policy aimed to address the shortage of professionally trained health providers at primary healthcare centers (PHCs), where over 70% of healthcare, including FP, is provided.

The FMOH reviewed and began implementation of TS/TS in 2018, allowing community health extension workers (CHEWs) and community health officers (CHOs) to receive training to provide FP services—services that typically require credentials. Though TS/TS was in place, CHEWs and CHOs (or community health workers (CHWs)) were struggling. They were often thrust into roles for which they lacked the clinical skills and confidence to be effective, including the provision of long-acting reversible contraception (LARC) and comprehensive FP. Further, systems issues—commodity shortfalls, infrastructural challenges, and lack of resources—further limited the effect that conventional trainings could have on changing the tide.

In 2019, USAID tasked the IHP with partnering with the governments of the Sokoto, Kebbi, and Bauchi states to improve the accessibility and quality of integrated primary healthcare services, including FP, and strengthen the capacity of health systems (public and private). The IHP implemented a systematic cross-sectional approach focused on generating synergies within the FMOH and its agencies and other stakeholders at a national and subnational level, providing tailored interventions to increase informed choice and provision of modern contraceptives by implementing the TS/TS policy and introducing new skills to primary healthcare providers in the provision of LARC. These interventions resulted in improved availability, quality, accessibility, and utilization of modern methods by women in the three states by an average of 56% across methods by 2022. Across all IHP-supported states and the Federal Capital Territory districts, there was a dramatic increase in CYPs pre- and post-training as demonstrated below.

FP CYPs per Month in IHP-Supported States, 2020 vs. 2021
CYPs Pre-Training in 2020 and Post-Training in 2021



Activity Description

To address the equity gap in service capacity for CHWs and access to quality FP services for women in the north, the IHP worked at all levels of the system, prioritizing service improvements at PHCs.

The IHP worked with relevant stakeholders to develop a modular low-dose high-frequency (LDHF) capacity-building approach that included:

- Training of a health facility **team** of health workers
- **On-site** (at place of work) training with little interruption of services
- Modular sessions of **3–4 hours over a series of days**
- **Competency-based and hands-on** training using anatomical models, role playing, and supervised clinical practices with a proficient coach that included documentation of services

The IHP implemented the LDHF capacity-building approach via competitively vetted local partners including:

- The Muslim Aid Initiative of Nigeria
- The Society of Obstetrics and Gynecology of Nigeria
- Women, Children's Health and Community Development
- The Association of Reproductive and Family Health

Activity Description (continued)

Between January and December 2021, these local partners provided significant scale to clinical training and mentoring across 792 PHCs, training 4,474 primary healthcare workers (71% of whom were CHWs) on-site in all aspects of FP (including LARC). This approach kept human resources for health teams together and on-site while exposing them to small doses of training, and practical competent training with observation allowed for course correction. Training doses of other topics were intentionally spaced out two to three weeks apart to allow participants to digest, practice, and absorb new skills. Documentation of services into DHIS2 offered a lens of impact and means for additional monitoring.

The IHP knew that training in the vacuum of systems challenges was unlikely to produce durable change. For example, over the three weeks of the on-site training, the supply of LARC commodities to the PHCs could not keep up with the demand. Within three weeks of the bimonthly commodity supply to the health facilities, they were stocked-out. The trainers created a waiting list of women with an unmet need for modern methods. The IHP addressed this challenge with the following actions:

- Applied the Lives Saved Tool (LiST) to estimate averted numbers of unintended pregnancies and maternal and child deaths and cost-savings scenarios in health expenditure to advocate with state governments for additional health financing for FP commodities, particularly LARC, for PHCs
- Partnered with the Global Health Supply Chain – Procurement and Supply Chain (GHSC-PSM) to adopt the mix-methods approach of using historical consumption data and waiting list data per PHC to determine a resupply plan and delivery of LARC to health facilities
- Facilitated private sector donation of hormonal intrauterine devices (IUDs) from Rotary and Bayer Germany through the International Contraceptive Access (ICA) Foundation, which were shipped to Nigeria and distributed to PHCs with waiting lists
- Developed a commodity tracker providing real-time visibility of stock-out reporting by health facilities that can also be used to validate the data reported by health facilities to the national dashboard

Simultaneously, the IHP supported state governments in addressing access to commodities, infrastructure, and financing constraints (highlighting commodities gaps for the FGON, partners, and USAID) while addressing increasing revenues allocated to PHCs through bottom-up budgeting cycles. For **longer-term sustainability** and **access to equitable health services**, the IHP has worked with a coalition of civil society organizations in Bauchi to develop the first Bauchi State Universal Health Coverage (UHC) scorecard. The scorecard serves as an advocacy tool for engagement of relevant stakeholders and decision makers to improve funding of the health sector. Additionally, the IHP is supporting efforts to increase enrolment in state health insurance plans.

Activity Impact

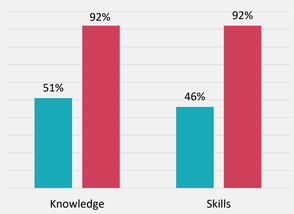
Our initial assessment of human resources for health before roll-out of the training revealed profoundly inequitable distribution of health workers. However, advocacy to governments resulted in redistribution of staff from facilities with larger teams to facilities with smaller teams and made the latter facilities eligible for on-site training.

Training participants completed 10 FP learning modules on Balanced Counselling Strategy Plus, Copper-T and hormonal IUDs, one-rod and two-rod contraceptive implants, DMPA-SC, postpartum FP, and infection prevention and waste management. Within two years of the training, these newly trained healthcare workers (71% of who were CHEWs and CHOs) at PHCs and private health facilities provided 1,310,108 clients with modern contraceptive methods in the three states.

Following this intervention, the three states saw a 19.3% increase in monthly provision of injectables, a 46.5% increase in IUD provision, and a 49.2% increase in implant insertions monthly.

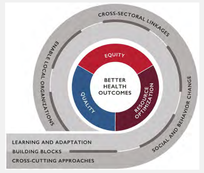
At the frontline level, provider pre- and post-test assessments demonstrated an unprecedented skills competence increase.

FP and Reproductive Health LDHF Training Pre- and Post-Test Assessment Results



These gains have continued to increase over time. In two years, on-site training resulted in the provision of quality FP services, particularly LARC (average of 55.6% increase in two years across methods), while overall coverage of FP increased by 96.5% in two years.

Accountability of service and commodities increased through use of documentation. The IHP facilitated data quality strengthening as participants learned to document services in Nigeria Health Management Information System registers completely and accurately for monthly reporting in the DHIS2. As a result, the FGON could see service delivery utilization and prioritize which PHCs should receive greater training and/or resources. The commodities tracker revealed stock-outs (days from delivery), enabling the FGON and donors to identify gaps in commodity use not revealed through historical use projections. The findings also supported advocacy for states to include FP commodities in the Drug Revolving Fund (DRF) to ensure steady and sustained availability of FP commodities. Additionally, these findings are supporting efforts to include FP commodities in the state health insurance scheme for formal, informal, and vulnerable groups, which include millions of people who are traditionally underserved.

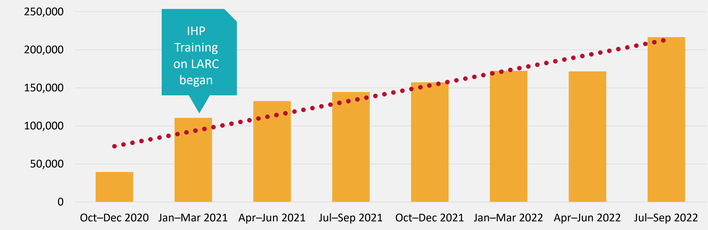


Evidence

The spectrum model of demographic projections, LiST, and USAID couple-year of protection (CYP) calculation tools were deployed to measure the impact of LARC availability on fulfilling unmet needs. The outcome was presented to the Sokoto State Ministry of Health to secure additional LARC for PHCs in primary healthcare facilities. The GHSC-PSM also reassessed its LARC quantification for PHCs.

In FY 2021, across all IHP-supported states and Federal Capital Territory, the fourth quarter reached 144,567 CYPs, up from 132,839 in the third quarter. Over the entire year (FY 2021), CYPs reached 427,171. The monthly CYPs that year demonstrated an increasing trend, with a 4.5-time increase from October 2020 (10,540 CYPs) to September 2021 (48,045 CYPs). The year also saw a significant increase in LARC provision, with Implanon NXT and Jadelle accounting for 74% of all CYPs, followed by Injectable contraceptives at 11.6% and IUDs at 9.6%. The newly introduced hormonal IUDs led to over 8,000 CYPs, of which 4,125 CYPs, more than half of the total, were contributed by the 1,255 hormonal IUDs donated to IHP through Bayer (1,155) and Rotary (100). Bauchi, Kebbi, and Ebonyi had the highest number of CYPs among the IHP-supported states. As demonstrated in the chart below, CYPs continued to increase through 2022.

CYPs Generated per Quarter in IHP-Supported States
Total CYPs Per Quarter in all IHP-Supported States



Facilitators

- The TS/TS policy provided a legal environment in which CHWs could be trained to competency to provide quality FP services.
- The presence of local and indigenous nonprofit, nongovernmental organizations and their support enabled the roll-out of LDHF training at scale to operationalize the TS/TS policy.
- The FP LDHF training package developed by Jhpiego enabled adaptation and implementation at an unprecedented scale.
- The Training and Service Delivery Technical Working Group, which comprised government stakeholders and implementing partners (Breakthrough Action Nigeria (BA-N), GHSC-PSM, Health Workforce Management (HWM) Project, IHP, Plan International, United Nations Children's Fund (UNICEF), and World Health Organization (WHO)), enabled coordination and collaboration, progress reviews, advocacy and informed decision making.
- Local partners helped the IHP to scale the LDFH cost effectively (while leaving behind a cadre of capable grantees who can provide clinical competencies) and supported accountability through development of the first state UHC scorecard.

Lessons Learned and Challenges

- The IHP faced a shortage and inequitable distribution of healthcare workers in the selected health facilities. At least four eligible healthcare workers should be available and participating per facility for the LDHF on-site training approach to remain cost-effective. The IHP, in collaboration with the ministries of health and the primary healthcare development agencies (PHCDAs), therefore conducted a pre-intervention assessment of human resources for health, presented the findings, and advocated for redistribution of CHWs to make the selected health facilities eligible for the training.
- Stock-out of FP commodities due to global shortages, poor quantification, and increased demands followed the capacity building and mobilization. The IHP worked with the FMOH, state PHCDAs, drug management and medical consumables agencies (DMMAs), and GHSC-PSM to improve quantification and documentation, development, and roll-out of a commodity stock-out tracking tool to provide real-time information of stock-outs for immediate action. The IHP worked with ministries of health and other relevant stakeholders to roll out the DRF to include FP commodities to ensure steady and sustained availability of FP commodities. The IHP also advocated for the use of rollover memorandum of understanding basket funds to procure FP commodities via the DRF and include FP commodities in the state health insurance scheme for formal, informal, and vulnerable groups.

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