



Population Council Knowledge Commons

Reproductive Health

Social and Behavioral Science Research (SBSR)


2015

Delivering contraceptive vaginal rings—Task sharing policies and practices in the delivery of family planning services: Experiences from Nigeria

Godwin Unumeri
Population Council

Salisu Mohammed Ishaku
Population Council

Follow this and additional works at: https://knowledgecommons.popcouncil.org/departments_sbsr-rh

 Part of the [Demography, Population, and Ecology Commons](#), [Family, Life Course, and Society Commons](#), [International Public Health Commons](#), and the [Women's Health Commons](#)

Recommended Citation

Unumeri, Godwin and Salisu Mohammed Ishaku. 2015. "Delivering contraceptive vaginal rings—Task sharing policies and practices in the delivery of family planning services: Experiences from Nigeria." Abuja: Population Council.

This Report is brought to you for free and open access by the Population Council.

DELIVERING
CONTRACEPTIVE
VAGINAL RINGS

Task sharing policies
and practices in the
delivery of family
planning services:
Experiences from
Nigeria

Godwin Unumeri
Salisu Ishaku





The Population Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives. Through biomedical, social science, and public health research in 50 countries, we work with our partners to deliver solutions that lead to more effective policies, programs, and technologies that improve lives around the world. Established in 1952 and headquartered in New York, the Council is a nongovernmental, nonprofit organization governed by an international board of trustees.

Population Council
House 4, No. 16, Mafemi Crescent
Off Solomon Lar Way
Federal Capital Territory
Abuja
Nigeria
Tel: +234 09 291 4878
Fax: +234 806 778 7750
www.popcouncil.org

Suggested citation: Unumeri, G., S. Ishaku. 2014. *Delivering Contraceptive Vaginal Rings—Task Sharing Policies and Practices: Experiences in Nigeria*. Abuja: Population Council.

Table of Contents

Acknowledgments	iv
List of Abbreviations	v
Executive Summary	vi
Introduction	1
Need for Task Sharing	5
Provision of PCVR in the Context of Local Task Sharing Policies	5
Successful Task Sharing Activities	6
Opportunities and Challenges Within Local Policy Framework.....	9
Conclusion	12
References	13

Acknowledgments

We acknowledge the contribution of the officials of the Federal Ministry of Health who availed themselves to us for consultations in the course of writing this document. We also acknowledge the support we received from staff members of various local and international non-for-profit organizations, too numerous to mention, for their time and effort in providing clarification on some important facts contained in this document.

List of Abbreviations

ARFH	Association for Reproductive Health and Family Health
CHEWs	Community Health Extension Workers
CHOs	Community Health Officers
CPR	Contraceptive Prevalence Rate
FHI360	Family Health International 360
FI	Fertility Intention
FMoH	Federal Ministry of Health
FP	Family Planning
GDP	Gross Domestic Product
HRH	Human Resource for Health
IHV	Institute of Human Virology
IUCDs	Intra-uterine Contraceptive Devices
MDCN	Medical and Dental Council of Nigeria
MSH	Management Science for Health
MSI	Marie Stopes International
NCH	National Council of Health
NDHS	National Demographic and Health Survey
NES/EE CVR	Nestorone® /Ethinyl Estradiol contraceptive vaginal ring
NMCN	Nursing and Midwifery Council of Nigeria
NSHDP	National Strategic Health Development Plan
PCVR	Progesterone contraceptive vaginal ring
PMVs	Patent Medicine Vendors
PRB	Population Reference Bureau
RH	Reproductive Health
SSA	Sub-Saharan Africa
TBAs	Traditional Birth Attendants
USAID	United States Agency for International Development
WCG	WomanCare Global
WHO	World Health Organization

Executive Summary

Despite the tremendous progress made over the past decades in family planning and fertility reduction, especially in middle-income countries, more than 220 million women have an unmet need for contraception globally. This daunting reality triggered a series of international responses culminating in the London Summit (2012) where a commitment was made to provide modern contraceptives to an additional 120 million women in developing countries by 2020. There was a concomitant pledge by the Government of Nigeria to provide an additional \$8.3 million to procure contraceptive commodities for distribution in the public sector, a major outlet for the rural poor. This is in addition to the \$3 million annual budgetary commitment starting from 2011 through 2015 for the same purpose - all with the objective of increasing the contraceptive prevalence rate (CPR) that has stalled at 10% for almost 2 decades.

At this crucial moment, the Population Council, in partnership with WomanCare Global (WCG), received a grant from the United States Agency for International Development (USAID) to facilitate the registration, introduction and scaling up of promising, relatively newer contraceptive ring in sub-Saharan African (SSA) countries of Kenya, Nigeria and Senegal. This is the Progesterone Contraceptive Vaginal Ring (PCVR) designed particularly for breastfeeding women in order to prolong their lactational amenorrhea, prevent ovulation and provide contraceptive effect. Because of the simplicity of inserting and removing the rings, they are suitable even in settings without sophisticated health infrastructure, including shortage of skilled manpower. In Nigeria, restrictive policies regarding the matching of health care cadres (based on presumed skill sets) with carefully selected maternal and child health interventions have previously hindered widespread availability of essential commodities to rural areas where providers' skills were deemed marginal. This included most hormonal contraceptives such as the injectables and implants. With the adoption of the national task sharing policy, which enables lower cadre and community-level providers to deliver essential Reproductive Health (RH) services in hard-to-reach terrains, this document weighs the feasibility of the PCVR to leverage the existing task sharing platform in order to achieve large-scale rural uptake, expand the methods mix for postpartum contraception and contribute to increasing the CPR in this country.

Introduction

Nigeria, the most populous country in Africa, has a population of more than 173 million with a rate of natural increase of 2.8% (PRB, 2013). It is divided into six geo-political zones and the Federal Capital Territory in Abuja. It is the largest economy in the continent with a Gross Domestic Product (GDP) estimated at \$405 billion (Business day, 2013), demonstrating increased capacity for out-of-pocket spending among its rapidly growing population. However, the country lags behind in most health indices. Rates of maternal and child mortality, after showing a slight decline in the past years, are now rising, and currently stand at 576/100,000 and 128/1,000 respectively (NDHS, 2013), and the total fertility rate (TFR) is 5.5 (NDHS, 2013). Unmet need for contraception is 16% and this is even larger during postpartum period. For example, while the total need for modern contraception among postpartum women at between 9 to 12 months is approximately 80%, the actual met need is only 15% resulting in unmet need of 65% (Borda & Winfrey, 2010). This indicates a need for more contraceptive options to serve the needs of women in the postpartum period.

COUNTRY SNAPSHOT

Population size: **173 million**

Total fertility rate: **5.5**

Rate of natural increase: **2.8%**

Contraceptive prevalence rate: **10%**

Unmet need for FP: **16%**

Maternal mortality ratio: **576/100,000**

Infant mortality rate: **128/1,000**

One factor contributing to this challenge is the distribution of Human Resource for Health (HRH), which is not adequate and equitable, with most of the scarce, high-skilled providers residing in major cities leaving little for rural areas where health care challenges are widespread. In 2009, there were 39 doctors and 92 nurses for every 100,000 population respectively, but with huge regional variation. For example, according to the Nigeria Health Workers Profile (2013), there were 50.5 doctors per 100,000 inhabitants in the federal capital territory Abuja, but only 1.9 doctors per 100,000 inhabitants in Yobe State. This is a sharp contrast to the averages in developed countries of 311 doctors and 737 nurses per 100,000 inhabitants, respectively (Pariyo, 2011).

In order to address the effects of shortages in the number of skilled health care providers for improved health care delivery in the short term, local and international voices have been advocating for task sharing for specific life-saving maternal and child health interventions. According to the World Health Organization, task shifting is defined as the process of enabling additional cadres of health care providers to provide a specific health intervention, especially where they were hitherto prohibited from discharging the duties being task-shifted due to their initial professional training and qualification (WHO, 2013). This approach is already at the center of the renewed commitments by the Federal Ministry of Health (FMoH) of Nigeria to deploy essential maternal and child health services to the rural populace where highly qualified health personnel are not readily available. This policy document has just been approved at the National Council of Health meeting (October, 2014) as the 'Task-Shifting and Task-Sharing Policy for Essential Health Care Services in Nigeria'.

The Population Council is conducting research and landscaping activities as a prelude to the introduction of the PCVR in sub-Saharan Africa, including Nigeria. One of the goals is to widen the contraceptive options for disadvantaged families in need of reliable methods that satisfy their expectations during the postpartum period in urban and rural communities (within both the public and private sectors). The extent to which underserved communities will be reached relies on the stage of implementation of task shifting policies in this country that would ensure wider access to contraceptive information and services.

The ring is inserted vaginally which can be done by the client herself with minimal counseling and instruction. It, therefore, has no need for complex health system structure in terms of facilities (equipment and supplies) and human resources. Coupled with its stability at room temperature, the ring is a highly attractive product for distribution by lower health cadres such as Community Health Extension Workers (CHEWs) and lay community workers and even the TBAs in some instances.

This document reviews the state of implementation of task sharing policies in Nigeria, challenges and opportunities, and examines the feasibility of integrating the PCVR in Nigeria's task shifting environment and the potential benefits therein.

RELEVANT BASELINE SITUATION

Childbearing and contraceptive behaviors

Everything being equal, there is a strong relationship between the fertility intention (FI) of men and women and the number of children they bear (NDHS, 2013). The FI is therefore an important determinant of people's decision to use contraception for spacing or terminating childbearing. According to the NDHS (2013), 18% of married women and 12% of married men want no more children, and up to one-third of married women and 40% of men want to wait at least two years before their next birth. Since nearly one-quarter of all children were born less than 2 years after their siblings (NDHS, 2013), this is an indication that there may be a large unmet need for spacing (12%) and limiting (4%) in Nigeria. In order to adequately address this gap, a concerted effort must be made to reach all women, wherever they live, with quality and affordable family planning commodities, especially for spacing between births.

Distribution of Human Resource for Health (HRH)

Although the strength of Nigeria's HRH is only comparable to that of Egypt and South Africa in the continent, the absolute ratio of doctors and nurses to population size is still very low and their distribution is skewed in favor of urban areas. The ratio of 39 doctors per 100,000 and 92 nurses per 100,000, determined from the registers of regulatory bodies such as the Medical and Dental Council of Nigeria (MDCN) and the Nursing and Midwifery Council of Nigeria (NMCN), did not change since 2006 (AHWO, 2008). The influence of the brain drain of qualified professionals to industrialized countries only adds to the challenges. The distribution of HRH, as well as being affected by rural/urban dichotomy, varies with geo-political regions as depicted in Table 1.

Table 1: Regional distribution of health workers, 2007

Health worker cadres	Total number	North-Central (%)	North-East (%)	North-West (%)	South-East (%)	South-South (%)	South-West (%)
Doctors	52,408	9.73	4.06	8.35	19.59	14.37	43.9
Nurses	128,918	16.4	11.65	13.52	15.29	27.75	15.35
Radiographers	840	14.3	3.66	5.97	15	18.3	43
Pharmacist	13,199	19.94	3.8	7.79	11.74	12.39	44
Physiotherapists	1,473	10.8	2.73	8.32	8.58	7.93	62
Med. Lab. Scientists	12,703	6.82	1.72	3.6	35.26	23.89	29
Environment HW	4,280	9.39	11.27	18.94	12.36	15.69	32.08
Health Records Officer	1,187	13.34	4.85	11.6	14.64	29.9	26
Dental Technologists	505	14.08	5.92	5.92	12.96	16.62	44.5
Dental Therapists	1,102	13.19	10.29	21.88	10.19	12.99	31.5
Pharmacy Technician	5,483	6.17	9.12	18	8.58	11.8	46

Source: Professional Regulatory Agencies 2008

From Table 1, it can be seen that the distribution of highly-skilled personnel like doctors is skewed in favor of the southern regions, with about 80% of doctors practicing in the south and only about 20% in the north. In addition, the majority of doctors from the south are distributed mainly in the two cities of Lagos and Ibadan. This is similar to the pattern in the north where more than 90% of doctors practice in major cities. This implies that there are fewer doctors in rural areas to provide skilled services, including family planning services such as implants, intrauterine contraceptive devices and other surgical procedures (tubal ligation and vasectomy). Furthermore, use of contraceptive services is much more restricted in the northern region than in the south, with the regional contraceptive prevalence of approximately 8% and 32% for the north and south respectively (NDHS, 2013).

The seeming inequality in the distribution of skilled personnel between the urban and rural settings on one hand and between the southern and northern parts on the other hand suggests that lower cadre providers in both settings would be required to perform more complex tasks if we are to ensure equity in the distribution of quality maternal and child health services in the country. This may require the expansion of task sharing and/or task shifting in the national health agenda in the coming years. Based upon the challenges with human resources, task shifting and task sharing policies have begun to be implemented.

Cadres of Providers and Roles in Contraceptive Service Delivery

As in other countries, Nigeria has a number of cadres providing health care services, including skilled, semi-skilled and unskilled providers. For example, medical officers, nurses/midwives and CHEWs are considered trained health professionals, although at varying degrees. While doctors, nurses and midwives work across both the secondary and tertiary levels, the CHEWs traditionally work at the lowest level of health care structure – the PHCs. The Patent Medicine Vendors (PMVs) and community health advocates and Traditional Birth Attendants (TBAs) are relatively unskilled but are crucial actors in health care service delivery, live within the communities they serve, and are dominant gatekeepers in rural area. The PMVs, despite their categorization as unskilled providers, are often the first point of

contact in rural and semi-rural areas when the need to seek for health care services arises, and potentially represent a window of opportunity upon which to build a workable referral system.

While this categorization is not an exact fit with the WHO classification of health workforce cadres (WHO, 2013), they approximate reasonably well. For illustration purpose, Table 2 lists the common health care cadres and their roles in providing FP services in Nigeria.

Table 2: Cadres of Providers and Roles

PROCEDURES	Doctors	Nurse/ Midwives	CHEWs	PMVs	TBAs or community workers
Initiation of oral pills	Yes	Yes	Yes	No	No
Maintenance of oral pills	Yes	Yes	Yes	Yes	No
Initiation of injectables	Yes	Yes	Yes	No	No
Maintenance of injectables	Yes	Yes	Yes	No	No
Insertion & Removal of IUDs	Yes	Yes	No	No	No
Insertion & Removal of implants	Yes	Yes	No	No	No
Provide male & female condoms	Yes	Yes	Yes	Yes	Yes
Tubal ligation	Yes	No	No	No	No
Vasectomy	Yes	No	No	No	No
Promotion of uptake of FP & RH services	Yes	Yes	Yes	Yes	Yes

Since CHEWs and PMVs are easily accessible to the rural populace and can be found in hard-to-reach communities, there are increasing calls to enable these cadres to provide more services and undertake additional tasks. There is an ongoing pilot study in northern Nigeria to determine the feasibility of CHEWs to provide implants, and the Population Council is assessing and strengthening the roles of PMVs in the provision of injectable contraceptives in three states of Abia, Nassarawa and Oyo. This is with a view of scaling up the use of injectables across the country. At present, only the health workforce cadres in Nigeria can play a key role in distributing the PCVR when it is registered and eventually introduced.

Need for Task Sharing

The WHO guidelines recommend task sharing in family planning as a cost-saving approach, and as an innovative solution to ameliorate the crisis of human resources for health in developing countries. The guideline describes task shifting as an inexpensive and cost-effective intervention given the health workforce shortages and restrictive policies on the roles of mid- and lower-level cadres in the provision of effective contraceptive methods in many settings. The guideline stresses that expanding the roles of other lower cadre health care staff to provide contraceptive services can significantly improve access to contraception for all individuals and couples (World Health Organization, 2013).

Task sharing represents the core principles of health services: accessibility, equity and quality. It provides a framework for extending health services to people in an effective and sustainable manner. It also provides an efficient and cost-effective way to provide multiple services, achieve client satisfaction, reduce congestion, and give clinicians more time to manage patients. For healthcare workers, it has the potential to reduce burnout, increase the knowledge, skill base, and capacity of all providers, and expand the pool of workers (World Health Organization, 2013). This clearly supports the need for task sharing in the provision of health care services, particularly the family planning services.

Accordingly, the Federal Ministry of Health of Nigeria, in collaboration with local and international development organizations, has finalized a national policy document for rapid adoption and implementation of task sharing in Nigeria's health sector in line with the WHO recommendations. Under the emerging policy consideration are arrays of life-saving interventions to be task-shifted to CHEWs, including specific family planning interventions, such as providing IUDs and implants.

PROVISION OF PCVR IN THE CONTEXT OF LOCAL TASK SHARING POLICIES

Task sharing has been proposed for the delivery of family planning services as well. Specifically, the NCH has granted permission for CHEWs to administer injectable contraceptives and encouraged all the State Ministries of Health (SMoH) to scale up this practice (ARFH, 2012). In the same vein, the National Strategic Health Development Plan (NSHDP, 2012-2015) affirmed that geographical equity in access to health services will be pursued through task sharing and also aims to develop and institutionalize a gender-responsive human resources policy framework for task sharing that encourages public-private participation. Implicit in this arrangement will be ensuring sufficient gender balance in the training and recruitment of the health care workforce in the country. These governmental actions indicate commitments to task sharing as a concept, and are firmly grounded in its policies to address the challenges in the HRH situation.

Nevertheless, not all health care interventions are suitable for task sharing. Some maternal and child health interventions are not implementable at primary and community levels of care due to their inherent complexities requiring the attention of higher-level care with appropriate human and material resources. Fortunately, many of the high-impact

interventions are amenable to task sharing with reasonably anticipated gains in maternal and child wellbeing and survival, as shown by evidence. The WHO document on optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting made far-reaching recommendations for task sharing life-saving maternal and child health interventions to lower-level health care providers (World Health Organization, 2013). In Nigeria, lower cadre providers include the Community Health Extension Workers, the Community Health Officers (CHOs), and in some cases, nurses, midwives and Traditional Birth Attendants (TBAs). The recommended interventions to be task-shifted, according to WHO (2013), are tasks within family planning and reproductive health fields.

It has been described elsewhere in this document what type of family planning service a particular cadre of health care provider could provide under the task sharing arrangement in Nigeria. Tasks specific to FP include provision of:

- Initiation and maintenance of injectable contraceptives
- Insertion and removal of intrauterine devices
- Insertion and removal of contraceptive implants
- Tubal ligation, and
- Vasectomy

In the last two years, the FMoH of Nigeria and development partners have scaled up activities to ensure that task sharing is an integral part of the country's approach as the 2015 Millennium Development Goals (MDGs) deadline draws near. Consequently, a dedicated national task sharing policy for essential maternal and child health interventions is now finalized and approved. Starting from the London Summit (2012) with the pledge to train frontline health workers to deliver a range of contraceptives (including long-acting methods) and the formal approval of task sharing policy at the National Council of Health (NCH) meeting (2012), activities in support of task sharing are gradually gaining traction.

SUCCESSFUL TASK SHARING ACTIVITIES IN NIGERIA

Since the emergence of national interest on task sharing, it has been increasingly acknowledged, adopted and promoted by federal and state-levels policy-makers, local and international development agencies working on a broad spectrum of health issues in Nigeria. This has resulted in increased capacity of nurses/midwives, CHEWs and other health care cadres to perform tasks that were, hitherto, outside their jurisdiction. Within the past two years, several organizations have implemented successful task sharing projects particularly to improve access to and uptake of contraceptives and reproductive health services. The following are examples of successfully implemented task sharing and task shifting projects in Nigeria:

- A. Building on the evidence from a pilot project in Nigeria and on evidence from the World Health Organization and other global communities, the National Council of Health approved a policy to allow CHEWs to provide injectable contraceptives in communities and encouraged the Nigeria state ministries of health to scale-up this practice. The Nigerian pilot project was conducted in Gombe state, located in a region

with one of the highest maternal mortality and total fertility rates, and lowest contraceptive prevalence rates in the country. According to a policy document from the FMOH and its partners (FHI360, 2013), a total of 30 female CHEWs were selected by authorities from 2 local government areas to serve as volunteers in the pilot project. CHEWs were trained on family planning methods, informed choice counseling, injection safety waste disposal, and record keeping. The project provided kits to the CHEWs to carry and safely store a range of contraceptives, including depot medroxyprogesterone acetate (DMPA- depo provera). After months of supervising and mentoring, findings suggest improved uptake of injectable contraceptives in the two communities. This evidence has been translated into policy action across the country, and CHEWs are now allowed to provide injections and dispose of waste.



Some of the Community Health Extension Workers trained to administer injectables in Gombe State.
Photo credit: FHI 360/Nigeria

- B. Population Council Nigeria experimented with task shifting in Kano State by mentoring CHEWs in selected Primary Health Care (PHC) centers to correctly diagnose pre-eclampsia and eclampsia among presenting women and administer the loading dose of MgSo₄ to women before making a referral. This pilot intervention demonstrated the feasibility of working with CHEWs, which paved the way for a policy change nationally. Currently, CHEWs, working at all levels of health care services, can administer the loading dose of MgSo₄ before embarking on further referral. This process also required a 'call for action' from Kano State government in collaboration with Population Council at the National Council of Health in 2012. This policy change has gained much traction nationally, including revising the pre-service curriculum of schools of health technology nationwide. Schools of health technologies are responsible for the training of CHEWs and CHOs. For example, up to 70 of these schools have been trained and mentored to include and teach pre-eclampsia/eclampsia and the use of MgSo₄ in their teaching curricula. All schools have restructured their curriculum, and pre-eclampsia/eclampsia and MgSo₄ are now topics for CHEWs and CHOs during their pre-service training.

C. *Task Shifting in Medical Laboratories:* As in clinical settings, there is a dearth of skilled personnel in medical laboratories, so efforts are underway to address the human resource shortage in the clinical areas, and commitments are being made to improve the quality and turn-around time in medical laboratories across the country. A typical example is that of Garkida General Hospital Laboratory in Adamawa State. This was accomplished through the 'ProAct', a project supported by the Management Science for Health (MSH) for the treatment of HIV/AIDS patients (MSH, 2012). According to MSH, the greatest challenge the project faced was the acute shortage of manpower to do the laboratory work such that one or two laboratory staff members did all the work in the laboratory, including chemistry, hematology, immunology, malaria and tuberculosis microscopy. The average daily patient/staff ratio was 40:1. The project opted for task shifting as a human resources solution to the workforce shortage. Students from Adamawa State College of Health Technology were deployed to take over some aspects of the laboratory work following a skilled-based training and mentorship. The students were found to be very effective in providing basic laboratory support, allowing time and space for regular staff to perform more complex assignments.



Garkida General Hospital Laboratory
Photo credit: MSH

OPPORTUNITIES AND CHALLENGES WITHIN LOCAL POLICY FRAMEWORK

The adoption of task shifting at the NCH meeting in 2012 and the subsequent evolution of intervention programs to address human resource shortages are major steps in the right direction. There is a growing consensus among public health practitioners to extend task shifting to include other commonly available family planning commodities such as implants and injectables due to the dearth of qualified personnel to administer these contraceptives in rural areas where the need is highest. These two additional contraceptive commodities are now included in the new task shifting document that was recently approved by the FMOH. This represents a window of opportunity to integrate the PCVR, especially given that both injectables and implants deliver progestogens, derivatives of natural progesterone which the PCVR is made of. However, this may require specific training for providers on peculiarities of the PCVR which can be challenging as not all states and local government authorities pay attention to the training of their providers. While the UNFPA may provide training support of this type, they only work in selected locations as their priority intervention states.

As already noted, CHEWs are providing injectable contraceptives throughout the country and Marie Stopes International (MSI), in collaboration with Population Council, is preparing a pilot to examine the feasibility of CHEWs to administer implants in two states in northern Nigeria. Monitoring and evaluation of these interventions will be necessary to inform future efforts. In the event of positive outcomes, they will serve as platforms for the PCVR to achieve a large-scale distribution in the country. But as in the case of injectables, this lack of structure for continuous quality monitoring must be surmounted in order to be sure that the intended benefits of PCVR introduction are being derived.

Similarly, the PMVs are being strengthened to play active roles in counseling and referring women to increase access to injectable contraceptives. Within this national task shifting framework lies a huge prospect for the PCVR. Wherever the CHEWs practice, they can carry along with them the PCVR as part of the methods available for their clients. In this way, access to a new method that is appropriate for breastfeeding women in the first year postpartum could be made available to women who live in the underserved localities, with marginal health care infrastructure, dearth of skilled personnel and absence of refrigeration system for commodities that cannot be stored at room temperature. Since PMVs live in the communities serving their clients and are easily accessible 24 hours per day and 7 days per week, their involvement in counseling and referral for hormonal contraceptives will augur well for the PCVR. PMVs can store and dispense the commodity directly to consumers due to its simplicity of use. Since the PCVR is woman-initiated, this device is likely to be the only source for a long-acting hormonal method for rural women. However, PMVs are heterogeneous group of providers ranging from those with no formal education to those with nursing or midwifery background. Therefore, there must be an oversight process in place with the view to determining the right PMVs for the distribution of this device.

Although the PCVR acts by exerting systemic effects, the ring is inserted in the vagina from where it releases the active ingredient to subsequently prevent ovulation. The simplicity of these rings could allow for much wider deployment in a task shifting manner to enable wide range of providers to dispense in both the public and the private sectors. As the ring is very

easy to insert and remove with minimal coaching, it would enable the country to achieve benefits of task shifting in much larger scale given that Doctors, Nurses, Midwives, CHEWs, PMVs and even Traditional Birth Attendants and the women themselves can be trained to counsel and provide the rings, increasing the chances that these rings could be available to women and families in hard-to-reach localities.

For doctors, nurses and midwives, the issue with ring provision is straightforward as they are already allowed to provide a range of contraceptives, both hormonal and non-hormonal. What is needed is to familiarize them with this newer technology whose route of administration is locally in the vagina. Experiences from the ongoing acceptability study of the PCVR in Nigeria do not suggest that any difficulty would be encountered in orienting doctors, nurses and midwives on how to counsel and dispense the rings. For those doctors, nurses and midwives who are involved with the study, they have fully accepted the technology and are enquiring if they could continue to provide the ring beyond the acceptability study timeline. Their previous doubts and hesitation regarding the size of the ring and the possibility of dislodgement and discomfort to the woman and her partner have all evaporated in the course of the study, as follow-up experience with the clients under the study showed high acceptability. However, achieving this level of acceptance with providers at the study sites cannot be assumed in wider use. Providers' resentment, doubts and bias can resurface when the ring is distributed through the public family planning programs. If this possibility is considered early in the introductory process, any unsupportive attitudes on the part of the providers can be detected and addressed appropriately.

Traditional Birth Attendants will also have a role to play in scaling-up the uptake and utilization of the rings in rural settings. Under the current recommendation by the World Health Organization (World Health Organization, 2002) and reinforced by Nigeria's policy document, the role of Traditional Birth Attendants is limited to provision of support for women during pregnancy and childbirth and as promoters of health facility utilization of essential services, including family planning. As TBAs are often a trusted group of providers whose advice is likely to be taken seriously by the communities, their role in facilitating referral to health facilities cannot be overstated. Presently, up to 63% of deliveries occur at home (NDHS, 2013) and are mainly supervised by the TBAs. We estimated that more than half of all parturients in Nigeria are in direct contact with the TBAs, at one point or the other, along their maternity care pathways. These TBAs can be reliable collaborators in disseminating information about the PCVR and enhancing referral for its uptake. If possible, the TBAs would be given the placebo rings for demonstration to the women during pregnancy and childbirth. As all these women are within the postpartum period and given the fact that breastfeeding is almost universal in Nigeria, the TBAs can be reliable allies in increasing the uptake of postpartum contraceptives in general, and specifically the PCVR, when eventually introduced. But an important challenge with the TBAs is with their predilection to be judgmental, especially around cultural and religious beliefs. Many rural women, including the TBAs, still believe their culture and religion do not support contraception, and so for TBAs to play a significant role in the distribution of the PCVR, these attitudes and beliefs must be addressed in a culturally and religiously sensitive manner.

Looking at the demand side, the PCVR is undoubtedly a welcome addition for women who seek reliable methods to satisfy their contraceptive needs while breastfeeding. As noted

above, the total contraceptive need for women in the postpartum period in Nigeria is about 80% while the actual met need is only 15% yielding a 65 percentage point gap. The introduction of the PCVR will fill a large gap and help women, families and the country to meet their contraceptive targets. The current official commitments and the interest being generated by the ongoing acceptability study of the PCVR are an indication of the potential for the commodity to be included on the essential medicine list in the country – a minimum precondition for public sector purchase and distribution. Should this happen, the commodity will be available free of charge in all public facilities, which are the predominant access points for rural poor. However, public sector financing for family planning in Nigeria is not always guaranteed and commodity procurement, including the PCVR may not be as easy as anticipated. But the recent increase in the country's GDP means increased capacity for out-of-pocket spending for the average Nigerian. Consequently, access through the private sector is feasible, especially as this sector currently provides 60% of Nigerians' contraceptive need.

In summary, the prospects for PCVR delivery within Nigeria's task shifting policy environment are numerous, and include: the official recognition of task shifting as a human resource solution to family planning services; the policy change enabling CHEWs to provide a wide range of contraceptive services in rural areas; the increasing realization that the PMVs can be reliable partners for contraceptive distribution nation-wide; the high PCVR acceptance among providers and national stakeholders involved in the ongoing acceptability study; and the recent commitments and willingness of the FMoH to procure contraceptive commodities for free distribution in the public sector. However, the following challenges must be overcome:

- Absence of continuous capacity training for providers
- Lack of a formal structure for quality monitoring
- Heterogeneous nature of the PMVs as a group of providers, especially in rural areas
- Persistence of culturally and religiously held misperceptions about FP in some quarters
- Judgmental attitudes by some FP providers, and
- Over-reliance on donors for family planning funding.

Conclusion

The current effort to introduce and scale-up the uptake of the Progesterone Contraceptive Vaginal Ring (PCVR) in Nigeria comes at a time that is both crucial and strategic. The FMOH objective to raise the CPR for modern methods from its present 10% to 36% by the year 2018 calls for greatly increasing women's access to contraceptive methods, especially in underserved rural areas. If this ring is registered and becomes available in Nigeria in both the public and private sectors, it would be one approach to achieving this commitment. By including the rings among the list of tasks that are being task-shifted, a wider distribution of the rings in both the public and private sectors could be achieved within a relatively short period of time. But this will require continuous partnership with all levels of governance on one hand and the local and international stakeholders on the other hand. A system of continuous training for the providers, dispelling of culturally- and religiously-held misconceptions and bias, continuous providers' validation and a robust financing strategy must be instituted. Any success with the PCVR would provide clues to the likely high acceptability that may accompany the Nestorone®/Ethinyl Estradiol Contraceptive Vaginal Ring (NES®/EE CVR) when it eventually becomes available.

References

1. Population Reference Bureau (2013). World Population Data Sheet 2013. Retrieved June 3rd, 2014 from <http://www.prb.org/publications/datasheets/2013/2013 - world - population - data - sheet.aspx>
2. Business Day Online (2013). Nigeria's Economy Largest in Africa as Rebasing Boots GDP to \$405bn. Retrieved on June 3rd, 2014 from [http://www.businessdayonline/2013/12/nigeria - economy - largest - in - Africa - as - rebasing - boots - gdp - to - \\$405bn/#.U472WCjhCZQ](http://www.businessdayonline/2013/12/nigeria - economy - largest - in - Africa - as - rebasing - boots - gdp - to - $405bn/#.U472WCjhCZQ)
3. National Population Commission [Nigeria] and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Rockville, Maryland, USA: National Population Commission and ICF International.
4. Pariyo, G. W. (2011). *Overview of the Human Resources for Health Crises in Developing Countries – Way Out of the Crises, Implications for Nigeria*. GHWA Presentation at First National Conference on Human Resources for Health, October 31 – November 1, 2011, Abuja, Nigeria.
5. National Population Commission (2009), *Nigeria Demographic and Health Survey, 2008*, Federal Republic of Nigeria, ICF International Calverton, Maryland, USA
6. Africa Health Workforce Observatory (2008), *Human Resources for Health Country Profile*
7. World Health Organisation (2013), *The WHO Optimize MNH guidance*
8. Family Health International, 360 (2013). New Policy Allows Community Health Extension Workers to Provide Injectable Contraceptive in Communities. Retrieved July 15, 2014, from <http://www.fhi360.org/sites/default/files/media/documents/community-based-access-injectables-nigeria.pdf>
9. Federal Ministry of Health (2010). The National Strategic Health Development Plan 2010 – 2015.
10. Management Science for Health (2012). Tackling Workers Shortages with Task-shifting: The Garkida General Hospital Laboratory Experience. Retrieved July 23, 2014, from <https://www.msh.org/blog/2012/01/31/tackling-worker-shortages-with-task-shifting-the-garkida-general-hospital-laboratory>.
11. Borda M., Winfrey W. (2010). Postpartum Fertility and Contraception: An Analysis of Findings from 17 Countries. Retrieved 26 August, 2014 from https://www.k4health.org/sites/default/files/winfrey_borda_17countriesanalysis.pdf
12. World Health Organization, Department of Reproductive Health and Research.
13. Global action for skilled attendants for pregnant women. http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_02_17_/en/. Published 2002.



USAID
FROM THE AMERICAN PEOPLE



**POPULATION
COUNCIL**
Ideas. Evidence. Impact.

Population Council
House 4, No. 16, Mafemi Crescent
Abuja, Nigeria

popcouncil.org