Community-based Family Planning Model for Faith-based Health Networks

Experience with the Christian Health Association of Kenya (CHAK)

Institute for Reproductive Health, Georgetown University
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Introduction

This document summarizes the methodology, objectives, and activities of a capacity building strategy for community-based family planning provision in church-based health networks like Christian Health Associations (CHA). The strategy was designed by Georgetown University's Institute for Reproductive Health (IRH) in collaboration with the Christian Health Association of Kenya (CHAK). Five components have been identified as critical to implementing a successful community-based family planning program within African CHAs (**FIGURE A**). These five components are described in detail and include lessons learned from an experience implementing the project in Kenya.

Equipping community health workers (CHWs) to provide family planning is an evidence-based and effective approach to improving the health of women, children, and communities. CHAs in Africa are interested in revitalizing family planning efforts and connecting the communities they serve with family planning information and services. CHAs also maintain a unique relationship with pastors who are community leaders and can influence health-related behaviors and create a supportive environment for family planning. Pastors tend not to be involved in or informed about health programs in their communities, but with accurate family planning information, they could assist the community in understanding and requesting family planning services.

Furthermore, many CHAs have existing community health programs but are not currently offering family planning methods at the community level due to lack of funding and capacity. Therefore, support is needed in integrating family planning into the services already being provided by CHWs. This capacity building strategy aims to provide that support through an approach grounded in practical experience, resulting in an essential cadre of health workers who are able to provide their community with four family planning methods (pills, condoms, SDM, and LAM) and referrals to the facility for others.

Case Study: Christian Health Association of Kenya

This pilot project, funded by the World Bank, targeted the training of CHWs in CHAK's network to provide women of reproductive age in their community with four family planning methods (pills, condoms, SDM, and LAM) and referrals to CHAK facilities for others. Facility-based providers were equipped to support CHWs through supervision activities. In addition to building the capacity of CHAK health providers, the project sought to increase the commitment of religious and community leaders to mobilize demand for family planning and strengthen linkages between CHAK and the national family planning program.

67 CHWs, both men and women, from the community health programs at Maua Methodist Hospital and Chogoria Presbyterian Hospital in Eastern region were chosen to participate in this pilot project. These facilities were selected based on the strength of their community health programs. Over the course of one year, CHWs were trained and supported through monthly supervision visits to add family planning provision to their existing responsibilities in the community. Project monitoring data and service statistics indicate that the training equipped CHWs to distribute and accurately counsel clients on the use of pills, condoms, SDM, and LAM.

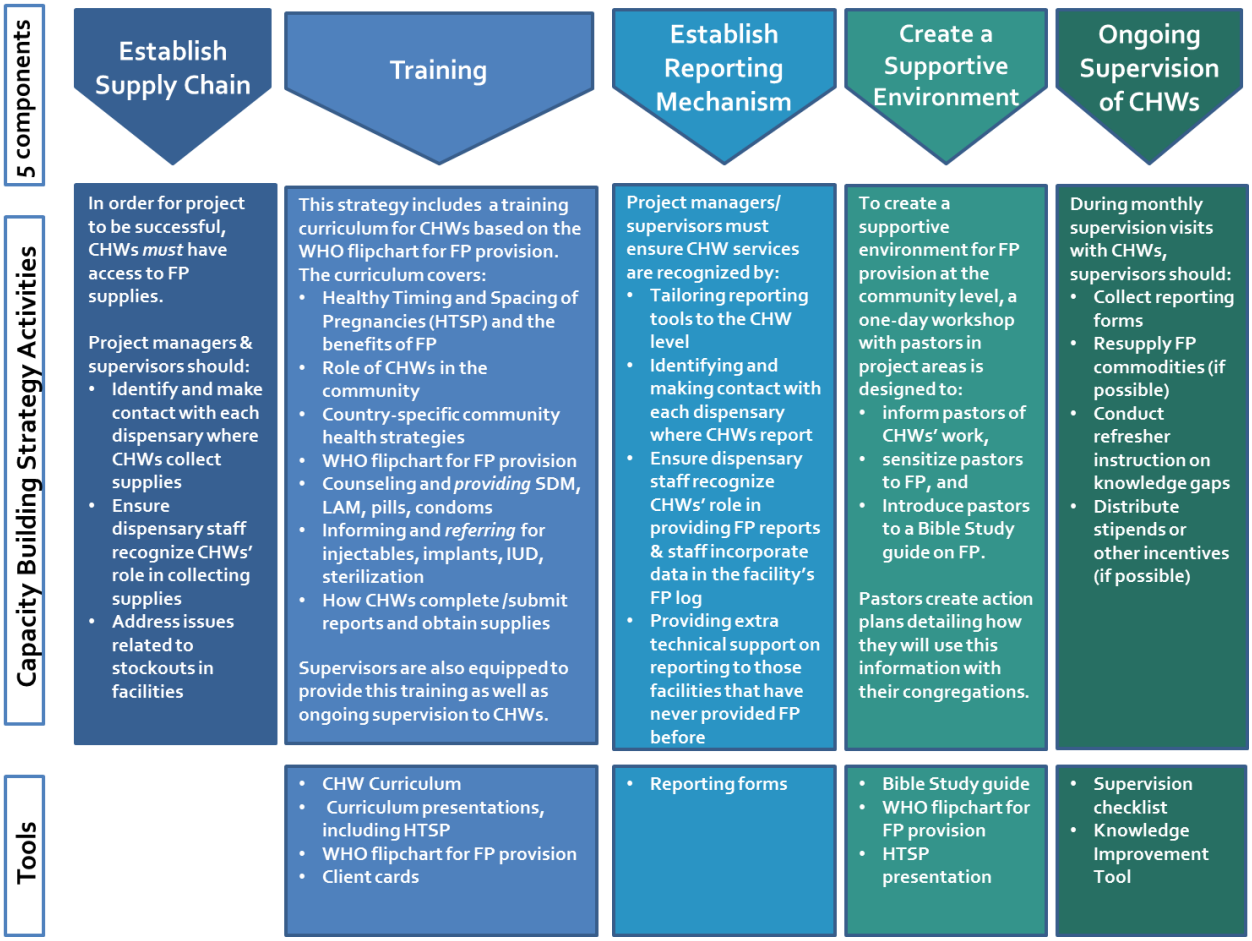
The strategy is intended for use by CHAs who are already operating community health programs in areas of HIV or child survival yet seek to begin for the first time (or revive previous) community-based family planning services. CHAs interested in improving these services can learn from the experience in Kenya where the strategy has been tested through CHAK facilities. The strategy can serve as a guide in designing community-based family planning programs for a particular local context, as each tool is available for adaptation.

Strategy Components

The strategy begins with establishing a functioning supply chain for family planning commodities that reach the community level. Once this is in place, project staff carry out several provider training workshops. The first is tailored to facility-level staff that will be responsible for providing ongoing supportive supervision to CHWs. Once equipped with that knowledge and skills, those supervisors then lead a workshop for CHWs on family planning provision. Before CHWs begin activities in the community, a reporting mechanism must be established so that CHW data are integrated into the existing logistics system and a mechanism is in place to track their work. At the same time, creating a supportive environment is done through sensitization workshops with pastors on the benefits of healthy timing and spacing of pregnancies and the efforts of CHWs to provide family planning in their communities. Finally, the fifth component to the strategy is ongoing supportive supervision of CHWs.

The organizational structure proposed in this community-based program relies heavily on supervisors at the facility level to ensure commodity availability and accurate reporting as well as provide supportive supervision to CHWs. Therefore, stakeholder involvement is a key activity in each component.

FIGURE A: CAPACITY BUILDING STRATEGY



Planning Phase

Before beginning any project activities, CHAs must consider the context in which the family planning activities will be integrated. Successful implementation of the following components relies on a solid understanding of the local situation as well as adaptation of the strategy and tools to fit that context. It is recommended that a situational analysis be conducted of the project facilities. The assessment findings can then be used to guide implementation.

Tools

Situational Analysis: Family Planning Integration at the Community-level

This assessment tool provides a series of questions covering topics important to successful project implementation from service delivery to logistics and procurement. The results collected should be used to design the project and adapt the five components of the model to the local context.

1. Establish Family Planning Supply Chain

What is it?

No Product, No Program—at the most basic level, project success relies on access to family planning supplies. Since community-based provision of family planning is a new program for most CHAs, a continuous supply of family planning commodities must be established. When implementing a new community-based family planning program, it's preferable to choose project areas where facilities already receive supplies of pills, condoms, and Cyclebeads—either from the Ministry of Health (MOH) or private entities. Project staff can then extend this supply chain to the community level. Some CHAs may already receive health commodities (i.e. oral rehydration packets, vitamins, water purification tablets) which are distributed at the community-level. In these cases, integrating family planning commodities into existing logistics systems will be easier and more sustainable.

Must Haves

- **Pills, condoms, and CycleBeads at the community level:** A logistics system must be established to regularly supply CHWs with family planning commodities.
- **Stakeholder involvement:** From hospital administrators to dispensary staff, stakeholders must support CHWs' role in providing family planning commodities.

Project staff should keep in mind the challenges of supply stock outs. Although some stock outs are due to factors outside the project's control, it is possible to prevent unnecessary stock outs by keeping open lines of communication with the MOH and ensuring that CHW service statistics are included in facility reports. This way, demand for family planning is captured accurately and facilities receive the ne cessary amount of supplies to meet the need. MOH officials as well as facility-based staff are important stakeholders to involve. It is the responsibility of project staff to confirm that these stakeholders understand the benefits of community-based family planning provision and their role in collecting CHW reports and replenishing supplies.

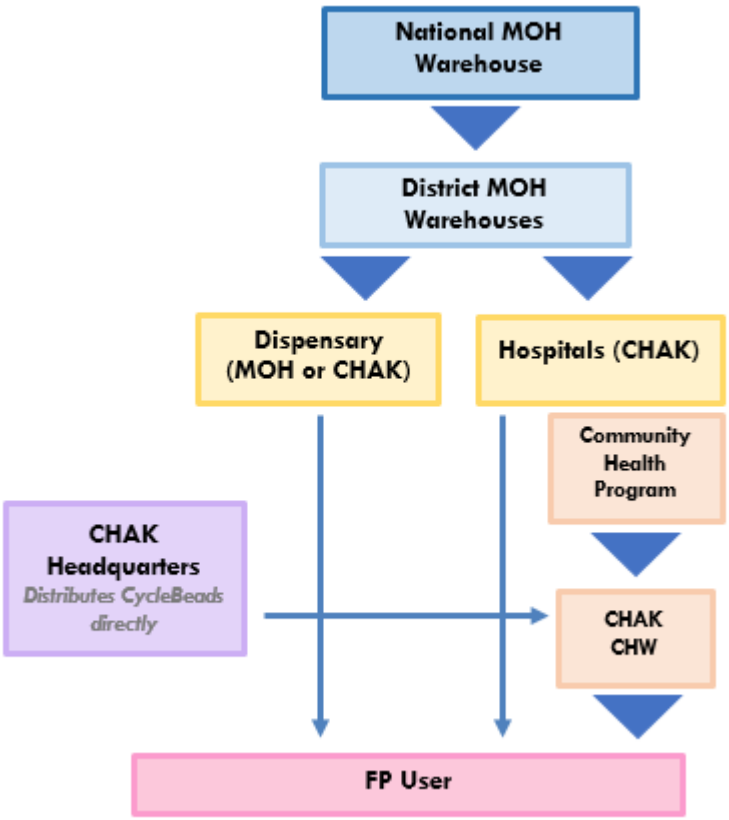
How was it implemented?

In Kenya, CHAK facilities receive family planning supplies free of charge from the MOH. However, the number of supplies facilities receive is based on the number of services they report from the previous months. Since CHWs in CHAK's network had not previously been providing family planning, CHAK expected a large increase in demand which could have resulted in stock outs for the facilities. Therefore, CHAK informed the MOH of the project before activities began and asked that additional commodities be provided to select facilities.

In Chogoria, CHWs were given resupplies of pills, condoms, and CycleBeads during monthly supervision meetings. In Maua, CHWs picked up resupplies of pills and condoms at dispensaries located closest to their village but received CycleBeads at monthly supervision meetings. CHWs in Maua encountered

barriers picking up pills and condoms because some dispensaries, although geographically closest to their catchment area, were public facilities, not CHAK-affiliated facilities. Some dispensary staff in the public facilities did not recognize CHWs as credible health workers and turned them away.

In Kenya, pills and condoms are available from the MOH, but CycleBeads had not yet been integrated into the method mix of available family planning supplies. Since SDM is included in Kenya's national family planning guidelines and CHAK had expressed interest in expanding the family planning options available to women—especially at the community level—CHAK received an initial donated supply of CycleBeads for the project. CHAK was responsible for distributing the CycleBeads to CHWs during monthly supervision meetings. Therefore, even though CHWs experienced occasional challenges with commodity stock outs of pills and condoms, they always had access to a supply of CycleBeads throughout the life of the project. Once the Kenyan government procures CycleBeads, CHAK will need to advocate with the MOH to receive CycleBeads supplies in the project areas so that they can meet client needs where demand has already been generated.



2. Training Providers

What is it?

The family planning training for both CHWs and their supervisors was designed using the World Health Organization's (WHO) counseling tool, *A guide to family planning for community health workers and their clients*. This tool is based on the WHO Medical Eligibility Criteria and provides essential family planning information in a simple and concise manner through a flipchart.

Must Haves

- **Work with existing cadre of CHWs:** The training is designed to build the family planning capacity of supervisors and CHWs who already have a presence in their communities and report to a local community health program.
- **Carefully selected participants for supervisor workshop:** Participants invited to the supervisor workshop should be from facilities interfacing with the CHWs trained in family planning provision. These participants will liaise frequently with CHWs through monthly supervision meetings, report collection or supply distribution. Key stakeholders, such as facility administrators or MOH officials, could also be invited to the workshop to encourage local buy-in.

Supervisor Workshop

Before CHWs are trained in family planning provision, project staff can identify supervisors and other stakeholders in each project site and equip them with the knowledge and skills to carry out the trainings. Therefore, project staff uses the same curriculum with supervisors as they do with the CHWs, simply with some modifications. Emphasis is given to learning how to translate high-level family planning concepts into messages acceptable at the community level.

In the workshop, participants are oriented to all of the available tools: the WHO counseling guide, reporting forms, the Knowledge Improvement Tool (KIT) and supervision checklist. The approach used in the training workshop for supervisors is one of demonstration. Participants are asked to "wear the hat" of a CHW during the training. Facilitators then demonstrate use of the WHO counseling guide and reporting forms. Consequently, supervisors are able to focus on understanding the materials from the perspective of a CHW and later deliver the training themselves in a confident, well-equipped manner.

CHW Workshop

The training is designed to equip CHWs to add family planning provision to their current responsibilities. Therefore, participants should be selected from a cadre of CHWs who already have experience in areas such as home-based care for HIV/AIDS, child survival, or pre-natal care. Family planning services at the community level includes providing information on all family planning methods, distributing methods approved for delivery by CHWs, and referring clients to the facility for all other methods or health concerns. Using the WHO tool as a foundation, the training builds CHW capacity in family planning provision, reporting, and supply management. The training also gives attention to the value of ongoing meetings among CHWs and their supervisors for problem-solving, experience sharing, and refresher training.

Knowledge Improvement Tool

The KIT is an instrument developed by IRH to assess family planning providers' competency immediately after receiving training in a specific topic or to assess quality of service delivery over time across different levels of providers. This application allows supervisors to quickly identify gaps in knowledge of providers, permitting them to provide targeted, effective support during routine supervisory visits. A provider is observed by a trained data collector or supervisor during a simulated counseling interaction and the person applying the KIT records whether or not the provider covered all the key counseling points required for that method. At the end, the supervisor reinforces any messages that were missed, incomplete, or incorrect.

How was it implemented?

A workshop for CHAK trainers and community health directors was conducted which included a Contraceptive Technology Update (CTU) on all available family planning methods in Kenya. This CTU was based on the WHO counseling guide to be used by CHWs, and participants had an opportunity to practice organizing and delivering the family planning training for CHWs which was also based on the WHO guide. Participants drafted action plans for their own facilities detailing how they would inform their colleagues of the project and initiate integration of family planning provision into CHW responsibilities.

Tools

2.1 WHO tool, *A guide to family planning for community health workers and their clients*

The CHW training was based on a new tool developed by WHO titled "A guide to family planning for community health workers and their clients." This tool is based on the WHO Medical Eligibility Criteria, and it is able to provide the essential family planning information in a simple and concise manner through a flipchart. The tool is accessible to providers at all levels—from master trainers to community health workers to clients. It helps providers convey key messages to clients such as the benefits of family planning, the importance of informed choice, and what changes to expect with method use.

The evidence-based information assists providers in counseling clients on choosing the most appropriate method based on the client's fertility intentions, physical health and other socio-cultural conditions.

Based on feedback from the workshop, IRH and CHAK finalized a CHW training and supervision packet to be used with the selected community health programs of Maua Methodist Hospital and Chogoria Presbyterian Hospital. A total of 67 CHWs were trained to integrate family planning into their existing responsibilities by providing four methods (pills, condoms, CycleBeads, LAM) and referring clients to facilities for others. The trainings lasted two days and were conducted at the project facilities where CHWs would be convening on a monthly basis for their supervision meetings.

Tools

2.2 Knowledge Improvement Tool (KIT)

The KIT is a checklist of essential counseling messages which is applied to determine the effectiveness of a training approach in preparing service providers to offer a family planning method. For this purpose, it is applied within 2-3 months of the training event. The KIT can also be used to assess quality of service delivery over time across different levels of providers.

The data collected from the KIT is used to improve family planning programs since it is a simple, easy way to monitor the quality of training and identify the need for review of content learned in the initial training. In service delivery, KIT application can assist with providing high quality, uniform service delivery and supplement supportive supervision with corrective feedback.

Following the training, CHW skills were assessed using the KIT [see box 2.2]. The tool was implemented during a supervision meeting several months after the training took place. 20% of CHWs were randomly selected to participate. Supervisors asked selected CHWs to join in a simulated client counseling session and recorded the key messages mentioned by CHWs for each method. Supervisors provided immediate feedback to individuals when necessary and also analyzed the data from all KIT assessments to understand knowledge gaps across CHWs. The findings were then used to determine topics for review in subsequent supervision meetings.

3. Establish Reporting Mechanisms

What is it?

Since the goal of the strategy is to include the efforts of CHWs in existing health management information and procurement systems that will continue after the pilot program has ended, it is important to create or adapt reporting tools that are compatible with existing systems (i.e. Christian Health network and Ministry of Health). Ensure, first, that the country-specific guidelines permit CHWs to distribute family planning methods, and then sensitize facility staff on the role of CHW service provision and reporting. Since CHWs are expected to submit reporting forms regularly to the health facility where they receive their supplies, it is critical that staff at these facilities are aware of their role and accept the legitimacy of these reports. Facility staff will be expected to transfer data from the CHW reports into the facility reports which are submitted to the district level MOH. Designing the reporting forms in a manner that allows for easy transfer of CHW data to facility reports will encourage facility providers to include this data in their reports. If CHW data is not recognized by facilities and incorporated into their reports, the contribution of CHWs will not be reflected in the national family planning statistics.

Must Haves

- **Tested reporting forms:** When creating reporting forms for CHWs, adapt them to the local context and test them before implementing widely.
- **Facility staff understands their role:** All facility staff where CHWs collect supplies and submit reports should be informed of their role in linking CHW service data to district level data. This includes orienting them to CHW reports and how to transfer data to facility log books.
- **MOH buy-in:** Family planning service provision by CHWs will likely be a new service in the project areas, and CHWs may interface with MOH facilities. Therefore, the MOH—at all levels—must be informed of the project.

The reporting mechanism begins with well-tested reporting forms appropriate for use at the community level. Project managers should consider literacy levels and language when designing these forms and consider using images to convey reporting concepts when possible. If other reporting forms exist in the community health program, it is recommended that the family planning forms be designed in a similar format or that family planning indicators are integrated into the existing forms. Finally, CHWs must be thoroughly trained on how to fill out the forms and submit them.

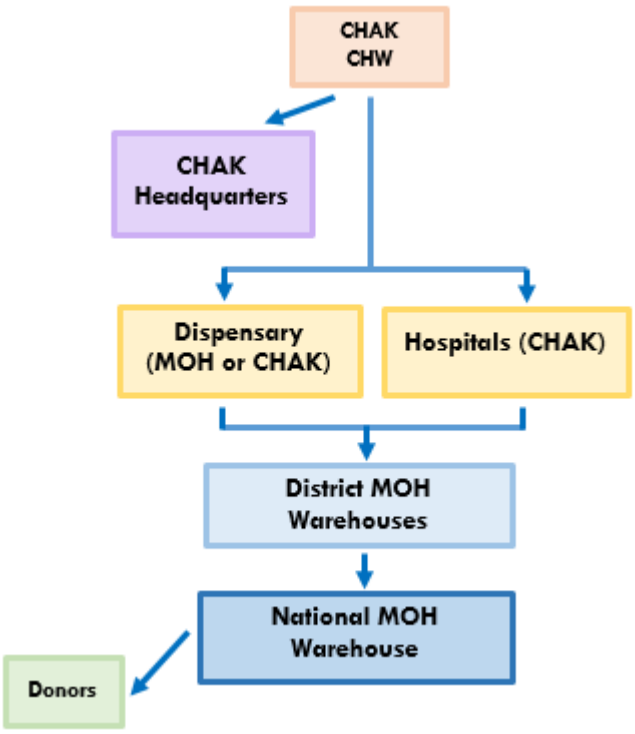
How was it implemented?

The community health programs in Maua and Chogoria did not have a reporting mechanism established for provision of health supplies by CHWs before the project was implemented since CHWs' primary role was information sharing. Therefore, new reporting forms were developed by IRH and CHAK. Since CHWs were not accustomed to filling out reporting forms on a regular basis and their average literacy levels were unknown, the design of the forms emphasized simplicity and use of images.

Challenges with the reporting mechanism arose because initial reporting forms had not been sufficiently vetted with CHWs or supervisors. The supervisor training occurred before the reporting tools were finalized and thus supervisors were not adequately trained on use of the tools. Furthermore, project staff noted after the first few months of service provision that CHWs were not filling out the forms in their entirety. Adjustments were made to the forms which improved their clarity, and time was designated during the next monthly supervision meeting to update both supervisors and CHWs on the use of the forms.

In both Chogoria and Maua, CHWs submitted their reports to supervisors during monthly meetings, and these reports were collected and analyzed by CHAK. However, it was also necessary that CHWs bring their reports to their respective facility so their service data could be translated into facility-level reports. In Chogoria, CHWs were able to submit their reports to their supervisors at their monthly supervision visits. In Maua, some CHWs encountered challenges submitted reports to their local dispensaries. Although CHWs met monthly at Maua Methodist Hospital, a CHAK affiliate, they frequented the local dispensaries in their communities for resupplies and submitting reports. Many of these local dispensaries were public facilities, managed by the MOH not CHAK. Depending on the staff present at the MOH dispensaries, CHWs were not seen as credible family planning service providers and their reports were not accepted. Therefore, CHAK brought this concern to the MOH at the national and district level in order to work out a solution.

4.1 Family planning service data reporting, CHAK



4. Create a Supportive Environment

In order to create a supportive environment for CHWs who are part of Christian health networks, the project should consider involving local religious leaders like pastors. In some cases, cultural or religious customs can discourage family planning use or define it as a "woman's issue." Involving pastors in information-sharing activities like sensitization workshops can inspire debate and foster acceptance of family planning within the community, particularly among men who are often left out of family planning information and service delivery efforts. During sensitization workshops, pastors can be introduced to the project and be informed that CHWs will begin offering family planning in their communities. It is valuable to inform pastors of the benefits of healthy timing and spacing of pregnancies and provide an overview of the available family planning methods, including mechanisms of action. Ample opportunity should be given for pastors to ask questions of health professionals, including the local CHWs, and discuss Christian views toward family planning use. Pastors can develop action plans detailing how they will take the new information back to their congregations. One key resource available to them is a Bible study discussion guide which was designed to encourage Biblically based dialogue among religious leaders and parishioners alike on the topic of family planning [See box 4.1].

Must Haves

Pastors willing to share health information with their congregations: Pastors in the project area are critical stakeholders. Their role as community leaders should be recognized, and they should be updated about project activities and accurate family planning information.

Tools

4.1 Bible Study Discussion Guide: ***Love, Children, and Family Planning: Seven discussion guides for Christian small groups*** is a series of Bible studies on family planning and related topics to be used with Christian audiences to inspire discussion on family planning and provide accurate information about each method. It is currently being used by CHAK with pastors and their congregations to encourage a supportive environment for community-based family planning services. Development of the guide was a cooperative effort of Christian health workers, pastors, church leaders, youth, and members of churches in DR Congo, Kenya, Malawi, Rwanda, Tanzania and the United States.

How was it implemented?

In Kenya, CHAK invited over 50 pastors serving in the project area to attend a day-long sensitization workshop on family planning. The workshop's aim was to inform and involve these community leaders in the integration of a new health service in their communities. Pastors were initially introduced to the concept of healthy timing and spacing of pregnancies and its benefits for the community. CHAK then explained the project activities which would include provision of four family planning methods by CHWs. CHAK provided a simplified contraceptive technology update for pastors using

the WHO counseling guide and introduced the Bible study discussion guide on family planning. Pastors were encouraged to meet the CHWs in their community and refer their followers to these individuals for information and services. Pastors were also encouraged to incorporate family planning discussions into pre-marital counseling sessions.

This workshop marked the first time CHAK formally gathered pastors to include them in health-related activities. CHAK found that pastors were willing to attend such workshops and were supportive of the new family planning activities in their communities. Discussion during the workshop prompted many questions signaling a need for more accurate information about family planning for these leaders, particularly concerning mechanisms of action and side effects. Since the success of this workshop, CHAK has implemented a similar strategy of convening pastors around Kenya for other health topics.

5. Ongoing Supervision of CHWs

What is it?

Supervision is central to any service delivery effort, but it is particularly essential in community-based family planning provision. CHWs may have limited education and minimal training in the technical aspects of their work. They may also require support in reporting and accounting procedures. In many settings, CHWs are working in isolation, with little contact to the health facility. Supervision of CHWs can serve three functions: technical assistance in providing family planning information and services, performance monitoring and evaluation, and motivation and support. While a supervisor needs to monitor CHW performance, s/he should primarily be a supportive problem solver. It is as important to recognize good work as it is to notice and correct inadequate or flawed performance.

Must Haves

- **Stakeholder involvement:** Supervisors, particularly at the facility level, must support CHWs' role in providing family planning commodities. This also requires the buy in of stakeholders at all levels to empower the supervisors in their role.
- **Incentive for CHWs:** CHWs are volunteers, but they must be enabled to carry out their work with the support of travel stipends or materials goods like supply bags, umbrellas, bicycles, or mobile phones.
- **Capable supervisors equipped to support CHWs:** Supervisors selected for the project must have the tools and skills necessary to face the unique challenges of "frontier work" as they are the primary link between CHWs and the facility.

Supervisors should be identified at the facility level, preferably within community health departments, so they can develop sustained relationships with CHWs and provide ongoing supervision. Supervisors typically facilitate monthly meetings in which CHW performance is assessed and supported. They identify challenges or areas of weakness in CHW knowledge and provide instant feedback as needed. A valuable tool to aid supervisors is a supervision checklist. Checklists can provide standard performance measures and guide discussion, but supervisors should remember to remain flexible in their role and address any challenges that arise. Supervisors collect and review reporting forms to ensure CHWs are able to fill them in correctly. If CHWs are reporting directly to the health facility where supervision meetings take place, supervisors can ensure that CHW reports are included in service statistics and are submitted to the district office. They can also resupply CHWs with family planning supplies If, however, CHWs are reporting to and receiving supplies from local dispensaries, supervisors can use monthly meetings to address any challenges.

The monthly supervision meetings are an ideal time for CHWs to share experiences—positive and negative—and brainstorm together how to overcome certain challenges. Supervisors can also use this time to provide CHWs with incentives such as travel stipends, meals or other materials which support their work (i.e. IEC materials, bags, umbrellas, mobile credit, etc.). By using the supervision meetings as

an opportunity to distribute incentives, CHWs are more likely to attend and, therefore, also receive technical updates, collect supplies, and turn in their reports.

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How was it implemented?

A national family planning advisor from CHAK worked closely with two supervisors from select CHAK facilities to maintain high quality training and supervision of CHWs. The supervisors were staff members of CHAK hospitals and were responsible for overseeing the community health units at these facilities. They co-facilitated the CHW trainings and monthly supervision meetings with CHAK project staff.

During the monthly visits, supervisors led a group of 25-35 CHWs in a review of information covered during the initial training in which CHWs demonstrated weakness. They also facilitated solution-seeking discussions about the challenges they faced in their work. Topics covered in the content review varied from meeting to meeting and were decided ahead of time by supervisors (i.e. filling out reporting forms, key messages when counseling on pills, LAM, CycleBeads, and condoms, involving men in family planning discussions, referring clients to the facility, etc.). These meetings were also used to collect reporting forms and distribute supplies.

Tools

5.2 Example Agenda from CHAK Supervision Meetings

1. Opening Prayer
2. Introductions
3. Content Review [i]
4. Challenges experienced by CHWs
5. Supervisor response to the challenges
6. Collection of reporting forms
7. Distribution of supplies
8. Payment of stipends

[i] Topics are identified by supervisors ahead of time using either the supervision checklist or data from the KIT, a training assessment and monitoring tool.

CHWs in the CHAK program received a transportation stipend and meals at the supervision meetings, further motivating CHWs to attend regularly. However, remuneration was a challenge for the project. Stipends barely covered even the round trip transportation to the monthly meetings, and since CHWs were working in a mountainous, rural setting, the lack of sufficient remuneration for travel impeded their work. Feedback received from the CHWs indicated that they understood their positions to be volunteer-based, but sufficient stipends for travel and other incentives which aided their work (i.e. bags to carry supplies, t-shirts to identify them in the community, umbrellas for working in the rain) would greatly improve their moral and ability to visit clients.

Lessons Learned

- **Expanding the mix of methods** provided at the community level can increase overall contraceptive use and bring new users to family planning. Introducing SDM in project sites brought renewed interest to family planning use. Project results showed that use of pills more than tripled as compared to the previous year, and uptake of CycleBeads--which was added to the method mix for the first time--was high. Use of implants and injectables also increased, indicating that the CHWs are referring clients to health facilities for methods they are not able to provide at the community level.

- **Simplify and test your reporting forms** with CHWs *and* facility staff persons who will record the data in their service log books. Service providers are often over-burdened with responsibilities. Strive to streamline the number of indicators being collected and simplify any new tools that need to be designed. Then test these tools in the field to ensure comprehension.

- **LAM criteria are consistently misunderstood**. LAM is not the same as breastfeeding which is a common misconception. LAM requires that three criteria must be met in order for it be be effective: 1) woman has not gotten her period since giving birth, 2) baby is exclusively breastfeed, and 3) baby is less than six months. These criteria need to be emphasized during training and supervision. The LAM client card and job aid can improve comprehension.

- **Select qualified supervisors and build their capacity to offer supportive supervision.** When selecting supervisors for the project, identify individuals who already have CHW supervision responsibilities or individuals who are able to dedicate time on a monthly basis to conduct supervision visits. Often the performance of these supervisors depends on support they receive from management so invite other the stakeholders to the supervisor training workshop, such as the head of the health center, M&E officer, and commodity/procurement officer.

- **Consider the procurement strategy for commodities, especially CycleBeads.** Procurement of family planning commodities is essential to a successful program. Many service delivery outlets will already have an established supply chain for family planning commodities. If this is not the case, consider how commodities will be sourced during the planning stage. This may be through an arrangement with the government, partners, or through donations. In some settings, CycleBeads may not be available while other commodities are. In this case, it's important to plan ahead for procurement by forecasting the number of CycleBeads that will be needed and ordering the supply. This can be done through Cycle Technologies (the manufacturer) and USAID's global health supply chain mechanism (if program is USAID funded).

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