

## Introducing the Community-Based Distribution of Injectable Contraceptives in Uganda

### Summary

#### The Problem:

Research has shown that properly trained paramedical personnel can safely provide injectable contraceptives, yet the community-based distribution (CBD) of injectables remains controversial in many parts of Africa.

#### The Intervention:

Save the Children USA, Family Health International (FHI), and the Uganda Ministry of Health collaborated to introduce the CBD of the injectable depot-medroxyprogesterone acetate (DMPA) in Uganda. The intervention included a safety and feasibility study in the district of Nakasongola, scale-up in additional districts, and advocacy efforts.

#### The Impact:

The intervention confirmed that CBD workers in Uganda can safely and effectively provide DMPA. Contraceptive prevalence increased by an estimated two to three percentage points in Nakasongola, and a follow-on evaluation of the project in three districts showed high continuation rates for women who received DMPA from CBD workers. Scale-up continues in additional districts and with new service-delivery organizations.

The community-based distribution (CBD) of injectable contraceptives is routine in some countries in Asia and Latin America. Yet many authorities in Africa still believe that the CBD of injectables is unsafe—that paramedical personnel cannot provide safe injections or safely dispose of used needles. Therefore, nearly all African women who wish to use injectables such as depot-medroxyprogesterone acetate (DMPA) must obtain their injections at clinics, which can burden clinic staff and reduce access to this popular contraceptive, especially among rural women.

Save the Children USA and FHI identified this as an opportunity to change the policy and service delivery environment in Africa. The timing, they concluded, was right to launch a major research project on the safety, quality, and feasibility of introducing the CBD of injectables.

In Uganda, DMPA accounts for more than 40 percent of the contraceptive method mix. And in the rural district of Nakasongola, CBD workers had already been providing free condoms, oral contraceptive pills, and referrals for DMPA under the supervision of Save the Children. Nakasongola therefore provided an excellent setting for the pilot research, which specifically evaluated the impact of adding DMPA to well-established CBD programs.

In 2004, FHI and Save the Children partnered with the Uganda Ministry of Health (MOH) to initiate this pilot research. However, this was just the beginning of a much larger effort that has involved scale-up and advocacy for the CBD of DMPA in multiple districts in Uganda.

### Facilitating change

#### Gaining stakeholder support

Save the Children and FHI identified a primary stakeholder from the Uganda MOH's Division of Reproductive Health who was supportive of the CBD of DMPA and wanted to be

involved in the intervention from its inception. After discussing the benefits of the CBD of DMPA, this national "champion," or advocate, helped mobilize other key stakeholders, including district health officials.

#### Conducting pilot research

Save the Children, FHI, and district health officials developed a program to train 20 volunteer community reproductive health workers from Nakasongola on DMPA provision. The training included a week of intensive classroom instruction followed by two weeks of supervised clinical instruction. Infection prevention and safe waste disposal were major components of the training, as the CBD workers used only nonreusable syringes and had special containers for their disposal.

The scientists then enrolled 945 first-time DMPA users in a study that compared the experiences of women who received DMPA from the trained CBD workers with those of women who received DMPA from clinic-based nurses. Results showed that injections from CBD workers and clinic-based nurses were equally safe, that clients from both groups were satisfied with their services, and that about 88 percent of women from each group received a second injection of DMPA.

#### Scaling up the practice

Encouraging results in Nakasongola led Save the Children (with technical assistance from FHI) to introduce the CBD of DMPA into two additional districts. In December 2007, 30 volunteer community workers from the districts of Luwero and Nakaseke were trained to provide injectables, and systems for supervising the workers were established. Preliminary results from these two districts showed that 96 percent of the women who received injections from the trained CBD workers received a second injection.

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### Advocating in the community

To engage stakeholders and increase support for this evidence-based practice, FHI (with support from Save the Children) also designed an advocacy campaign to coincide with the scale-up in Uganda. Many models of advocacy exist, but this particular campaign used a “public interest” approach in which professionals launched the campaign to raise understanding and support at the policy level.

FHI and Save the Children are also collaborating with the MOH to gain more support for the CBD of DMPA in Nakasongola, Luwero, and Nakaseke. Local champions are using radio shows and community meetings to spread important messages about the benefits of family planning and the CBD of DMPA. As of March 2008, these messages had reached at least 206 district and subcounty leaders, 662 community members, and 30 health workers.

The partners are also encouraging the MOH and other donors to allocate more resources to introduce the CBD of DMPA in additional districts in Uganda.

### Changing policies

Save the Children and FHI are also working with the Uganda MOH to review national policies and guidelines to include the provision of DMPA by trained paraprofessionals. No changes have been made yet, but the MOH is in full support of the practice, has expanded it into its own programs, and has pledged financial support to train additional CBD workers in districts supported by Save the Children.

### Documenting changes

After the pilot research project, contraceptive prevalence increased by an estimated two to three percentage points in Nakasongola. Preliminary results from a more recent evaluation found that about 47 percent of the women in the CBD group were still using DMPA three to four years later. This is an encouraging result, given that one-year continuation rates in the developing world are not always much higher.

### Promoting further use

The full impact of the project is not yet known, but the original goal of introducing the CBD of DMPA into two districts where Save the Children was working has been surpassed. Workers from MOH-run CBD programs in two additional districts have been trained on DMPA provision, and two nongovernmental service-delivery groups are also implementing the practice.

Another portion of the advocacy campaign is targeting other countries in Africa, such as Kenya, where a parallel effort to introduce and scale up the CBD of DMPA is planned (see the case study titled *Expanding the Community-Based Distribution of Injectables in Africa*). The project's ultimate goal is to increase access to a broad range of contraceptive methods, by encouraging more countries to find local champions and establish the infrastructure necessary to launch their own efforts to introduce the CBD of DMPA.

### Resource

Stanback J, Mbonye A, Bekiita M. Contraceptive injections by community health workers in Uganda: a nonrandomized community trial. *Bull World Health Organ* 2007; 85(10):768–73.



This work is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID). The contents are the responsibility of Family Health International and do not necessarily reflect the views of USAID or the United States Government. Financial assistance was provided by USAID under the terms of Cooperative Agreement GPO-A-00-05-00022-0, the Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) Program.

### The Evidence Base

Research from the developing world shows that properly trained paramedical personnel can safely provide injectable contraceptives, such as DMPA, in community-based programs. For example, in one study from the late 1990s, CBD workers in Nepal easily identified medical conditions that contraindicate DMPA use. In a project conducted in the 1970s in the Matlab district of Bangladesh, infections after injections by CBD workers were rare—about three per 10,000 injections. No infections were reported in a similar, but more recent, program in Afghanistan.

Additional studies from Guatemala, Peru, Mexico, and Bolivia have also contributed to the global body of knowledge on the safety and feasibility of introducing this evidence-based practice.

To learn more about this topic, see <http://www.fhi.org/en/Topics/CBD+of+DMPA.htm>.