

FAMILY HEALTH RESEARCH

South Africa



A forum for putting knowledge into practice

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IMPROVING ACCESS TO FAMILY PLANNING

The theme of the second issue of our quarterly newsletter is the community-based distribution of injectable contraceptives.

In this issue, we consider the potential for reducing barriers to sustained use of contraception by training community-based health workers to provide injectable methods.

The progestin-only injectables depot-medroxyprogesterone acetate (DMPA) and norethindrone enanthate (NET-EN) are increasingly popular contraceptive methods in South Africa. More than 56 percent of South African women of reproductive age have used an injectable contraceptive, and one out of three women ages 15 to 49 are current users.

South Africa's reproductive health programs are not considering community-based distribution because most women are able to access injectable contraceptives through clinical services. Those services, however, face many of the same challenges described in the articles about community-based provision of DMPA on pages 2 and 6. These include ensuring a consistent supply of contraceptives and improving the quality of counseling.

Missed opportunities due to insufficient integration of family planning and HIV services pose another challenge for South Africa. We are pleased to share information about a nationwide effort to promote such integration in an article on page 8, and we invite readers to send their comments to familyhealthresearch@fhi.org.



Sonja Pilusa
Country Director
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KEYPOINTS

- Community health workers can safely and effectively provide injectable contraceptives.
- Adding injectable contraceptives to an established CBD program can be relatively inexpensive.
- Strong logistical systems are needed to ensure consistent supplies.

PROVIDING INJECTABLE CONTRACEPTIVES IN COMMUNITIES

More programs consider community-based distribution.

Evidence from a safety and feasibility study in Uganda, along with the increasing availability of safer injection equipment, is generating new interest in improving access to injectable contraceptives through community-based distribution (CBD) programs.

Although community health workers in a number of Asian and Latin American countries have been providing injectable contraceptives to their clients for years, community-based distribution (CBD) of these popular methods is rare in sub-Saharan Africa. That is beginning to change, however, as health programs learn about the encouraging results from Uganda (see article, page 5).

Improving access

Community-based distribution of contraception clearly has the potential to increase family planning access and convenience, particularly in countries with large rural populations, low contraceptive prevalence, high unmet need for contraception, and critical shortages of trained clinic personnel. CBD programs can increase contraceptive use by making family planning services convenient and by involving trusted community members. Injectable contraceptives, however, are usually provided in clinics. Experience from Asia, Latin America, and now sub-Saharan Africa, shows that the CBD of injectable methods can be safe and effective.

Ensuring effectiveness

Injectable contraceptives are among the most effective contraceptive methods as long as women receive their injections on time. CBD workers must be trained to keep accurate records for scheduled reinjections. Some projects have developed a simple system that helps CBD workers track which clients need reinjections by filing client information cards in the chronological order that the injections were given.

As with any contraceptive method, the consistent availability of DMPA is critical to ensuring its effectiveness. CBD workers usually obtain their supplies from local clinics, so strong relationships between CBD workers and clinic staff are an important link in the contraceptive supply chain.

Adding injectables to CBD programs

The cost of including injectables in a mature CBD program with well-trained, highly motivated workers will be relatively low compared with the cost of adding them to a weaker CBD program, which may have to be strengthened before it can provide injectable contraceptives. Adding injectables may also make CBD programs more cost-effective, because workers may recruit many more new clients by providing local women's preferred method.

A quality-assurance system is essential to ensure that CBD workers use proper screening,

continues on page 3 ...

EXPERIENCES WITH THE CBD OF DMPA

Bangladesh. A CBD program in three subdistricts more than doubled their region's contraceptive use and increased the percentage of contraceptive users choosing injectable methods from 0.1 percent to 25 percent.

Guatemala. A CBD program that provided DMPA to 750 women in four districts achieved a contraceptive continuation rate of 90 percent. Now all community-based promoters in 22 districts are trained to provide injectable contraceptives.

Afghanistan. The success of a pilot project to test the CBD of injectable contraceptives led to a change in national policy allowing community health workers to administer injectable methods.

SAFETY OF THE CBD OF INJECTABLES

Experience from sub-Saharan Africa, Asia, and Latin America shows that properly trained paramedical personnel can safely provide injectable contraceptives in community-based programs. Guidance based on this experience can help community-based family planning workers meet the basic requirements for safe administration of injectables such as depot-medroxyprogesterone acetate (DMPA), including proper client screening, counseling, injection technique, and waste disposal.

Screening. Medical conditions that contraindicate DMPA initiation are rare in potential users and were easily identified by community-based distribution (CBD) workers in a study conducted in Nepal. To help CBD workers screen potential DMPA users for such conditions, FHI has developed and extensively field-tested a checklist containing 13 simple “yes” or “no” questions. It is available, along with a checklist to help providers rule out pregnancy, at: <http://www.fhi.org/en/rh/pubs/servdelivery/checklists/index.htm>.

Counseling. Side effects, such as menstrual changes, headaches, and weight gain, are the primary reason that women stop using DMPA. Studies have shown that providing full and intensive counseling can significantly increase continuation rates for DMPA. CBD workers can be trained to counsel women on changes to expect when they begin using DMPA and to refer them to other levels of care when necessary.

Giving injections. CBD workers have demonstrated that they can safely give intramuscular injections. In a project in the Matlab subdistrict of Bangladesh, infections after injections by CBD workers were extremely rare — about three per 10,000 injections. No infections were reported after more than 1,000 injections in a similar program in Afghanistan. Meanwhile, scientists have developed a subcutaneous DMPA formulation, depo-subQ provera 104 or DMPA-SC, that is less painful to receive and easier to administer than the current intramuscular formulation because it can be injected under the skin with a shorter needle.

Disposing of needles and syringes. Concerns that needles and syringes be disposed of properly and not reused have been reduced by the availability of disposable injection devices that become automatically disabled after a single use. Such devices can be burned, but proper waste disposal requires careful planning and follow-up to ensure public safety. Training should emphasize safe use and disposal of needles and syringes to prevent the risk of infections such as HIV or hepatitis B through accidental needle sticks. The advent of nonreusable injection devices has greatly reduced the risk of such accidents.

The SoloShot FX, which becomes automatically disabled after a single use, is packaged with all DMPA shipments supplied by the U.S. Agency for International Development.



Program Dispatch continues ...

counseling, and injection procedures. In some programs, supervisors evaluate trainees' performance three to six months after training.

CBD programs also must develop or strengthen logistical systems for predicting demand and delivering supplies to ensure uninterrupted availability of DMPA, needles, and syringes. In Uganda, for example, the Ministry of Health is

working with a logistics advisor hired by the United Nations Population Fund to address persistent stock-outs of DMPA. John Snow, Inc.'s DELIVER Project will conduct a diagnostic study to identify gaps in the contraceptive supply chain, and FHI is training health workers in the three districts that are implementing CBD of DMPA to strengthen their ability to monitor and order supplies.

MADAGASCAR TESTS THE CBD OF DMPA

KEYPOINTS

- Over 60 well-trained CBD workers are providing DMPA in remote rural communities.
- Support from district health officials is key to the program's success.
- CBD workers receive refresher training and support during monthly supervisory visits.

Initial success spurs plans for expansion.

Harimanana Ambohidray, a community-based family planning worker in Madagascar's Moramanga district, learned to give injections by practicing on papayas. She was one of 63 community-based distribution (CBD) workers trained in November 2006 to provide the injectable contraceptive depot-medroxyprogesterone acetate (DMPA) in rural Malagasy communities.

After the initial three-day training session, the CBD workers returned to their local health centers several times to administer their first six DMPA injections to clients, under the supervision of center staff. By the end of 2006, Ambohidray had completed the six injections and was certified to provide DMPA in her community. Just three months later, she had 31 DMPA clients.

Ambohidray and her fellow CBD workers are part of an introductory trial of CBD of DMPA in Madagascar. This pilot project is a collaborative effort by FHI, the Madagascar Ministry of Health and Family Planning (MOHFP), a health project called SantéNet that is funded by the U.S. Agency for International Development, the Adventist Development Relief Association (ADRA), and Action Socio-sanitaire Organisation Secours (ASOS).

It is estimated that 23 percent of Malagasy women of reproductive age who do not want to become pregnant are not using a modern method of contraception. Madagascar's high total fertility rate (an average of more than five children per family) and annual population growth rate of over three percent also point to the need for innovative ways to increase contraceptive prevalence.

Representatives of FHI and its partners visited health centers and consulted with district health officers to choose 13 sites for the pilot project in two remote regions that had low contraceptive prevalence and limited access

to health facilities. These regions, Anosy and Alaotra Mangory, also had CBD workers who were providing oral contraceptives and condoms and were counseling clients about other forms of contraception available at the health centers, including Madagascar's most popular method, DMPA.

FHI and its partners worked closely with mayors, village chiefs, community health center staff, and district health offices to build support for the community-based distribution of DMPA. A national steering committee led by the MOHFP held regional coordination meetings.

The CBD workers received their first 15 doses of DMPA at no cost from the MOHFP. After exhausting their initial supplies, they began purchasing DMPA from health centers for 150 ariary (about US\$0.08) per dose. They sell injections to clients for 300 ariary per dose, receiving a 100 percent profit.

Resupply visits and monthly reporting to the local clinics ensure regular contact between the CBD workers and health center staff. Technical supervisors from ADRA and ASOS also visit CBD workers monthly to help them with any problems and to monitor their performance.

"We have been thorough in our monitoring visits," said Kelsey Lynd, FHI assistant program officer. "We sit down one-on-one or in small groups with all the CBD workers to find out their weaknesses and give them some refresher training, and also to honor their work."

Before the project began, some MOHFP officials had expressed reservations. "We were afraid that the CBDs [CBD workers] were not capable of giving injections," said Dr. Eugenie Rasamihajamanana, director of the Mother and Child Health Division of the MOHFP, "but already during training we saw that CBDs could do this." Now the MOHFP plans to expand community-based distribution of DMPA to additional sites by 2008. This expansion will be guided by the results of a formal evaluation of the pilot project, which FHI will conduct in the summer of 2007.



A community-based family planning worker prepares to give a practice injection as a trainer supervises during a three-day training session.

THE CBD OF DMPA IN UGANDA

Community-based distribution proves as safe as clinic-based DMPA services.

The results of an intervention study of the community-based distribution (CBD) of depot-medroxyprogesterone acetate (DMPA) in Uganda confirm that well-trained community health workers can safely provide injectable contraceptives.

Conducted by FHI and Save the Children USA in 2004 and 2005, the study assessed the safety, quality, and feasibility of CBD of DMPA by comparing the clients of CBD workers with those of clinic-based providers in Uganda's Nakasongola District.

A rural district, Nakasongola had a contraceptive prevalence rate of 3 to 4 percent in 2000, compared to the national average of 17 percent. Since the late 1990s, almost 100 CBD workers have been providing free family planning services, including condoms and oral contraceptives, to the women of the district.

The study involved 449 clients of CBD workers and 328 clients from local clinics. Differences between the women in the two groups suggest that the CBD workers recruited clients who had limited access to clinics or were not typical clinic users.

Read or download the full study report at: <http://www.fhi.org/en/RH/Pubs/booksReports/DepoCBDinAfrica.htm>.

KEYPOINTS

- The CBD of DMPA appears to be as safe as provision by clinic-based providers.
- Women who receive DMPA from CBD workers are as satisfied as women who receive DMPA at a clinic.
- Fears that paramedical personnel cannot safely provide DMPA are unfounded.

THE INTERVENTION . . .

- CBD workers received a week of intensive classroom training before participating in a two-week clinic practicum including supervised client screenings and DMPA injections.
- To ensure safety, CBD workers used only nonreusable syringes. They were given special containers for disposal of used injection equipment and were trained in the proper use and disposal of these "sharps" containers.
- Save the Children staff continued to supervise all CBD workers, who also maintained regular contact with staff from nearby health centers.

. . . AND ITS EFFECTS ON FAMILY PLANNING SERVICES

- Contraceptive prevalence in Nakasongola increased by about five percentage points after the CBD of DMPA was introduced.
- DMPA clients of CBD workers were as satisfied with their choice of method and the quality of care they received as were clinic-based clients.

- The study had difficulty recruiting clinic-based clients, suggesting that many women prefer the CBD of DMPA to clinic-based provision.
- Women receiving DMPA from CBD workers continued using the method just as long as their clinic-going counterparts did.
- Clients in both groups reported few problems resulting from the DMPA injections and no accidental needle sticks.
- Based on the results of the study, Uganda health officials decided to continue the CBD of DMPA in Nakasongola and expand it to two other districts.

A CBD worker uses a tomato to practice her injection technique at a training session in Uganda's Nakasongola District.



KEYPOINTS

- Building on a strong, well-integrated CBD program promotes sustainability.
- Providing injectables in communities increased contraceptive prevalence.
- Advocacy efforts and positive results overcame initial resistance to the approach.

PROGRAM DISPATCH

LEARNING FROM UGANDA'S EXPERIENCE

CBD of DMPA results impress a delegation from Kenya.

In March 2007, a delegation of seven Kenyan policy-makers and health professionals arrived in Kampala to learn about Uganda's experience with the community-based distribution (CBD) of injectable contraceptives. They were a receptive but skeptical audience.

Could volunteer community health workers be trained to provide injectable contraceptives safely to women in their communities? What kind of support would the volunteers need, and how sustainable is such a program? During the next three days, the Kenyan delegation had an opportunity to discuss these and other questions with those who had been involved in a pilot project to test the CBD of the injectable contraceptive depot-medroxyprogesterone acetate (DMPA) in Uganda (see article, page 5).

Representing the Ministry of Health (MOH), various medical associations, and others with a stake in reproductive health care in

Kenya, the visitors met with local leaders and health officials, including family planning program managers. They also discussed the CBD of DMPA with staff members from Save the Children USA and FHI, who provide technical assistance to the Ugandan program, and with the CBD workers (called community reproductive health workers, or CRHWs, in Uganda) who implement it.

Perhaps most important, the Kenyan team visited three of the CBD workers at their homes and met staff from the health centers that support them. They learned that many DMPA clients prefer to receive their injections from a CBD worker and that none had experienced serious side effects or complications from their DMPA injections.

At one house, the visitors witnessed the CBD of DMPA firsthand. "We were very impressed with what we saw and the way the CRHW did her work, especially the [client] counseling and recordkeeping," said Dr. William Obwaka of JHPIEGO, an international health organization affiliated with Johns Hopkins University.

When the Kenyan visitors asked about the sustainability of the CBD of DMPA, their Ugandan hosts emphasized the importance of starting with a strong, stable CBD program that is well integrated into the MOH structure. They acknowledged that sustaining a program that

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Dr. Anthony Mbonye

MOH OFFICIAL CHAMPIONS CBD APPROACH

"It all starts with convincing one key person, who will be the catalyst."

That is how Dr. Anthony Mbonye, head of the Ministry of Health's Reproductive Health Division in Uganda, explains his role in the process that FHI and its partners used to persuade national decision-makers to advocate for the CBD of DMPA in his country.

Once he became convinced of the potential benefits of the approach, Dr. Mbonye was instrumental in advancing Uganda's pilot

project on CBD of DMPA. And when the results of the pilot project became available, he helped disseminate them. "We found that the acceptance rate was high, the continuation rate was high, and injection safety was good," he said.

Dr. Mbonye advises other government officials considering support for the CBD of injectable contraceptives to examine the evidence and consider how the approach could help them achieve their goals. "We have to look at innovative ways of doing things, and involve everybody," he said. "We also need to link the community initiatives to formal health services, including referrals."

Program Dispatch continues ...

relies on unpaid volunteers is challenging, even though the Uganda CBD workers are highly motivated. The support the volunteers receive includes monthly meetings with Save the Children staff to discuss their concerns, work tools such as bicycles and bags for carrying supplies, refresher training, and recognition from their communities.

The Uganda team cautioned the Kenyan delegates that ensuring a continuous contraceptive supply might pose a challenge. Stock-outs of contraceptive commodities are common in Uganda. When the health centers run out of DMPA, clients have to buy it from the local drug shops.

Members of the Kenyan delegation learned that many national and district health officials initially opposed the CBD of DMPA. Advocacy efforts by MOH supporters of the approach and other local advocates played an important role in persuading those officials to agree to a pilot project.

Many were swayed by the need to expand health care into remote regions. “We don’t have enough health workers to give injections,” explained Dr. Godfrey Kasibante, district director of health services in Nakasongola, where the pilot project was conducted. “We have to encourage health-seeking behavior, and bring the services to them rather than them coming to us.”

The district’s MOH trainers taught the CBD workers how to administer injections, which also helped overcome resistance because it increased the local providers’ confidence in the project. Many others changed their minds about the CBD of DMPA when they saw the results of the pilot study (see article, page 5).

The Kenyans’ visit to Nakasongola was part of a broader initiative by FHI and its partners to promote expanded access to injectables contraceptives through CBD programs in sub-Saharan Africa. FHI has worked with partners in Uganda to develop an advocacy strategy and materials and to identify district-level advocates to help raise awareness about the benefits of family planning and the CBD of

DMPA. FHI’s DMPA checklist, a screening tool, was adapted for use in Uganda, and the MOH is introducing it to CBD workers and other family planning providers through training sessions. And FHI and its partners in Uganda and Madagascar have summarized the practical lessons from their pilot projects into a handbook for family program managers who are interested in starting their own CBD of injectable programs.

At the end of their three-day study tour, the Kenyan delegates concluded that they could give the CBD of DMPA a trial in areas already served by an active CBD program. They recommended starting a pilot project, spearheaded by the MOH, from which Kenya could draw further lessons.

PROFILE

CBD WORKER FAITH MULEKHWA

When the Kenyan delegation visited Faith Mulekhwa in March 2007, five clients were waiting for her under a massive tree in her family’s compound. A community reproductive health worker in the Nakasongola District of Uganda since 2000, Mulekhwa provides family planning services to women at her home.

“I prefer giving services at my house for privacy,” said Mulekhwa, who added DMPA to the contraceptive methods she provides after attending a three-week training workshop conducted by Save the Children USA in 2004. “Most of the men in this area do not support family planning, so the women hide in order to come for an injection.”

Mulekhwa reported that none of her DMPA clients had experienced complications so far. She had recorded 50 DMPA clients in her register and had referred 15 women to the local health center for Norplant and tubal ligation.

Mulekhwa is not paid for this work but is motivated by the opportunity to help other women in her community. “When I see the health of a mother has improved, I feel happy,” she said.



Faith Mulekhwa

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COLLABORATIONS

CHAMPIONING INTEGRATION IN SOUTH AFRICA

Research findings often make their way into practice through the efforts of influential people who dedicate their time and talents to promoting a practice or approach.

In South Africa, where 5.5 million people are living with HIV, the National Department of Health (NDOH) is working with FHI to create a network of advocates for the integration of family planning and HIV services. Integrating these services is an NDOH priority because so many of the country's family planning clients are at risk of HIV and because many clients of HIV services have an unmet need for family planning services.

Family planning providers can help their clients protect themselves from HIV by counseling them on HIV prevention and by providing condoms. They can also offer their clients HIV tests or provide referrals to testing. And HIV service providers can provide family planning services to HIV-positive women who do not want to become pregnant. Preventing unintended pregnancies among HIV-positive women will not only improve the reproductive health of the women, but is also one of the most effective ways to reduce the number of infants born with an HIV infection.

The NDOH chose ten people — one at the national level and one from each of South Africa's nine provinces — to build support for the integration of family planning and HIV services and to strengthen the implementation of integrated services. All of these advocates are strategically placed to do so as members of the Department of Health. They will work with policy-makers, program managers, and service providers to develop and carry out national- and provincial-level activities.

The initiative was launched at a national meeting in December 2006. Since then, the NDOH and FHI have been working with the provincial advocates to bring together people in each province who are working on HIV and reproductive health. Participants at

Resource

Contraception for Women and Couples with HIV, a training module from FHI and EngenderHealth, contains guidance for providers who offer contraception to clients with HIV, including those on antiretroviral therapy. The module includes PowerPoint slides, a narrative, audience handouts, and reprints of key scientific studies and other sources. Available in English and French (electronic version only) at: <http://www.fhi.org/en/RH/Training/trainmat/ARVmodule.htm>.

these meetings include policy-makers, program managers, and service providers.

At each meeting, participants helped the provincial advocate develop an action plan to strengthen the integration of family planning and HIV services in their province. These plans will be carried out by the advocates and staff members of the provincial departments of health, with technical assistance from FHI when needed. Some of the activities outlined in the plans include:

- Reviewing the training curricula for health service providers to ensure that modules on HIV services address family planning.
- Revising daily register forms to enable staff members to track referrals of clients between family planning services and HIV voluntary counseling and testing services.
- Developing communication materials to promote and facilitate service integration.

In March 2007, advocates from five of the provinces began working with FHI staff to assess the integration of HIV and family planning services at the health facilities in their provinces. These assessments will guide their efforts to strengthen service integration and will serve as a benchmark for measuring progress over time.

If you would like to comment on the applicability or experience of such a network of advocates in your own country, please write: familyhealthresearch@fhi.org.