

Expanding the Community-Based Distribution of Injectable Contraceptives in Africa

Summary

The Problem:

Research from Family Health International (FHI), Save the Children USA, and the Uganda Ministry of Health had shown that the community-based distribution (CBD) of injectable contraceptives is safe and feasible in Africa. However, fears about safety and feasibility remained challenges to expanding this promising practice in the region.

The Intervention:

As the CBD of the injectable depot-medroxyprogesterone acetate (DMPA) was being scaled up in Uganda, FHI and its partners launched a broad advocacy campaign to promote the evidence-based practice throughout Africa.

The Impact:

The government of Madagascar independently changed its national reproductive health policy and introduced the CBD of DMPA, while the Kenya Ministry of Health and its partners are preparing to launch the CBD of DMPA in Kenya. At least seven other countries have shown interest in replicating the practice.

Many countries in Africa continue to have a high unmet need for family planning and, among women who use contraception, injectables remain one of the most popular methods. Yet, the community-based distribution (CBD) of injectables has not been introduced on a large scale for several reasons, including concerns about safety and feasibility.

In 2005, research, supported by the U.S. Agency for International Development (USAID), from FHI, Save the Children USA, and the Uganda Ministry of Health (MOH) demonstrated the safety and feasibility of recruiting local members of the community to provide the injectable depot-medroxyprogesterone acetate (DMPA).

Building on this pilot research, FHI and Save the Children began working with other organizations to scale up the practice in Uganda and launched an advocacy campaign to promote the CBD of DMPA there (see the case study titled *Introducing the Community-Based Distribution of Injectable Contraceptives in Uganda*).

However, the advocacy campaign was also designed to promote the successful practice throughout Africa. One of the immediate goals of the broader campaign, which is described here, was to interest other countries in adding DMPA to their existing CBD programs.

Facilitating change

Creating awareness

Upon the successful completion of the pilot project in Uganda, FHI and Save the Children disseminated the results via printed materials, electronic media, and presentations at conferences in Africa. The CBD of DMPA was also included in a package of “best practices” that FHI was promoting to the Madagascar Ministry of Health and Family Planning (MOHFP).

Independently, a local champion in Madagascar was encouraging the MOHFP to include the CBD of DMPA in its national norms

and standards for reproductive health. The results of the pilot project in Uganda were among the evidence the champion presented to the MOHFP. The national policy was quickly updated to include the evidence-based practice, and the MOHFP teamed with FHI and local service delivery partners to conduct a pilot project to assess the feasibility of adding DMPA to the services offered within its community-based family planning program.

Holding a global online forum

In May 2007, FHI and Management Sciences for Health cohosted a week-long online forum to give health professionals an opportunity to share their experiences on the CBD of DMPA. “Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraceptives” was broadcast via the Global Exchange Network for Reproductive Health for nearly 200 participants from 19 countries. Among the participants were members of the Nigeria MOH, whose participation led them to attend a study tour in Uganda and eventually commit to introducing the practice.

Hosting study tours

Despite the Madagascar MOHFP’s immediate interest in the CBD of DMPA, securing support for a practice is typically more challenging, especially when the evidence behind the practice is not generated locally. Study tours are one way to help potential adopters witness the success of a project for themselves.

Study tours to Uganda, where visitors could visit the sites of the pilot research and scale-up, were an important component of the advocacy campaign. In March 2007, the Uganda MOH, FHI, and Save the Children hosted the first three-day educational tour for delegates from Kenya who were interested in introducing the CBD of DMPA. A second three-day tour was held in February

Expanding the Community-Based Distribution of Injectable Contraceptives in Africa

2008 for delegates from Rwanda, Nigeria, Tanzania, and two nongovernmental organizations working in other regions of Uganda.

As a result of these tours, the two nongovernmental organizations in Uganda are replicating the CBD of DMPA in the districts of Kanungu and Mubende, with technical assistance and support from FHI and USAID. The Kenya MOH, in collaboration with FHI and other partners, will soon begin replicating the practice in Kenya. Key decision-makers in Nigeria and Rwanda have also committed to introducing the practice.

Developing advocacy tools

To strengthen the advocacy campaign, FHI collaborated with Save the Children and the Uganda MOH to develop an evidence-based toolkit that decision-makers can use to support programs for the CBD of DMPA. The kit, *Improving Access to Family Planning: Community-Based Distribution of DMPA*, is already in use in Uganda and Kenya (see http://www.fhi.org/en/RH/Pubs/servdelivery/cbd_dmpa/index.htm).

FHI and Save the Children also developed a step-by-step guide for program managers and policy-makers that explains how to begin providing injectables within existing CBD programs. The guide, *Provision of Injectable Contraception through Community-Based Distribution: Implementation Handbook*, is based in part on the successful pilot project in Uganda, as well as on the more recent pilot project in Madagascar (see http://www.fhi.org/en/RH/Pubs/booksReports/CBD_DMP_imp.htm).

Documenting changes

The Madagascar MOHFP, FHI, and their service delivery partners have completed their pilot project, in which more than 60 community-based workers were trained to provide DMPA, and successfully introduced the practice into four districts. Scale-up is ongoing, and more than 70 additional workers have been trained.

Kenya is next in line to replicate the introduction and scale-up of the CBD of DMPA. An advisory committee has been formed to guide the work, which will include training 20 to 30 CBD workers in Tharaka district in Eastern Province to provide DMPA.

Nigeria and Rwanda are each committed to creating an in-country steering committee or identifying a local champion to help develop a national plan for introducing the practice there.

Promoting further use

Momentum for the CBD of DMPA continues in Africa. As the experiences from Uganda, Madagascar, and Kenya become better known and women's demand for contraceptive access increases, more countries may adopt the CBD of DMPA. So far, additional countries that have expressed interest include Ethiopia, Malawi, Mali, Senegal, and Zambia. To continue to support the practice, FHI and its partners are planning a state-of-the-art training workshop in sub-Saharan Africa and will develop a standardized training kit for implementing the CBD of DMPA worldwide.



Research to **Practice**

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.

© 2008 by Family Health International

CS-08-03E

The Evidence Base

Although the CBD of DMPA is routine in some countries in Asia and Latin America, it is still relatively new to Africa. Pilot research on the safety and feasibility of the CBD of DMPA in Africa—conducted by FHI, Save the Children, and the Uganda MOH—has helped pave the way for scale-up in Uganda and replication of the evidence-based practice throughout the region.

In 2004, the partners trained 20 volunteer community health workers from the district of Nakasongola to provide DMPA. Research among 945 first-time DMPA users found that the women who received DMPA from the trained CBD workers were as satisfied and as likely to continue using the method as the women who received their injections from clinic-based nurses. It also confirmed that CBD workers could provide injections as safely as their clinic-based counterparts. After the practice was introduced, contraceptive prevalence increased by an estimated 2 to 3 percent in the district.

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