SUMMARY

A 2004 study conducted in the Nakasongola district of Uganda demonstrated the safety, quality, and feasibility of community-based distribution (CBD) of depot-medroxyprogesterone acetate (DMPA or Depo-Provera) by community reproductive health workers (CRHWs). CBD of DMPA appeared to be as safe as provision by clinic-based nurses. Women who received DMPA from community reproductive health workers were as satisfied as women who received DMPA from clinics and, in fact, seemed to prefer CBD to clinic-based provision, as indicated by difficulty recruiting clinic-based clients for the study.

Background

Nakasongola, a rural district two hours north of Uganda's capital, Kampala, has a total fertility rate (average number of children per woman) of 7, which is similar to Uganda's overall rate of 6.9, but a contraceptive prevalence rate of only 3 to 5 percent, which is much lower than Uganda's overall rate of 17 percent.

Since the late 1990s, almost 100 community reproductive health workers (CRHWs) have been providing free contraceptive services and products (condoms and pills) to the women of Nakasongola district, under the supervision of 15 Save the Children field supervisors.

In 2004, Family Health International (FHI) and Save the Children, in collaboration with the Ugandan Ministry of Health, conducted a study to assess the safety, quality, and feasibility of CBD of DMPA in Nakasongola, comparing DMPA clients of CRHWs with those of clinic-based providers. Four outcomes were assessed: 1) continuation rates at three months (i.e., acceptance of a second DMPA injection), 2) user satisfaction, 3) client knowledge of key information about DMPA (a proxy for the quality of counseling received), and 4) reported incidence of injection-site morbidities.

A total of 945 clients (562 CRHW; 383 clinic) were enrolled in the study, 82 percent of whom were reached for follow-up by local Ministry of Health health assistants. The community reproductive health workers' clients had less education, had husbands who were less supportive of family planning, and were more likely to have been first-time users of DMPA. These differences between the CRHW and clinic clients may be due to the fact that CRHWs were recruiting women who had less access to clinics or were not typical clinic users.

Prior to initiation of the study, CRHWs underwent intensive classroom training as well as a two-stage clinic practicum, which included supervised patient screenings and provision of injectable contraceptives. To ensure safety, CRHWs used only auto-disable (nonreusable) syringes and were trained in the proper use and disposal of sharps containers.

During the study, all CRHWs were supervised by staff from Save the Children and also maintained contact with staff from nearby health centers. District health officials further ensured quality control by making periodic visits to the CRHWs.

KEY POINTS

- **DMPA is a strongly preferred contraceptive method in Uganda, accounting for more than 40 percent of the contraceptive method mix.**
- **In a Ugandan study, community reproductive health workers were trained to safely provide DMPA to their clients, who were as satisfied with their method choice and service as were clients who received DMPA at clinics.**
- **The Nakasongola project demonstrated that fears that paramedical personnel cannot safely provide DMPA were unfounded.**

Findings

DMPA clients of CRHWs were as satisfied with the quality of care they received and with their method as clients of clinic-based providers. Clients of CRHWs also continued use of DMPA as long as their clinic-going counterparts did (i.e., received a second injection), and received care that was, in most respects, comparable in quality in terms of client satisfaction and recall of counseling messages. Most importantly, low incidence of client-reported injection site morbidities and the absence of any reported accidental needle pricks demonstrated the safety of DMPA provision by CRHWs. These findings reinforce the successful experiences of CBD of DMPA from other regions and confirm that well-trained community health workers can safely provide injectable contraception in Africa.

Researchers concluded that, given the popularity of DMPA in sub-Saharan Africa, community-based family planning programs in Uganda and other sub-Saharan African countries should consider making programmatic and policy changes that would allow provision of injectable contraception by appropriately trained paramedical personnel. Furthermore, Ministries of Health and donors should ensure that trained CRHWs receive a continuous, routine supply of both DMPA and auto-disable syringes.

Reference

Stanback J, Mbonye A, LeMelle J, et al. *Final Report: Safety and Feasibility of Community-Based Distribution of Depo Provera in Nakasongola, Uganda.* Research Triangle Park, NC: Family Health International, 2005.

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For more information or additional copies, please contact:

Head, Reproductive Health Division, Ministry of Health Uganda
Plot 6 Lourdel Rd, Wandegeya
P.O. Box 7272 Kampala Uganda
Tel: 256-41-340884 Fax: 256-41-340887
E-mail: info@health.go.ug
or
Project Director, Family Health International
Plot 35, John Babiiha (Acacia) Avenue
P.O. Box 4553 Kampala, Uganda
Tel: 256-312-244-730
E-mail: publications@fhi.org

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