Community-based Distribution of DMPA: The APROFAM Project, Guatemala

SUMMARY

In 1995, the Guatemalan family planning association Asociación Pro-Bienestar de la Familia de Guatemala (APROFAM), in partnership with the Population Council, conducted operations research comparing acceptance and continuation rates between clinic provision and community-based provision of the injectable contraceptive depot-medroxyprogesterone acetate (DMPA). The project provided community-based provision of DMPA to over 750 women in four districts. At 15 months, the continuation rate for clients of community-based distributors (CBDs) was 90 percent, which was identical to the clinic continuation rate. CBDs also achieved high acceptance and continuation rates among rural Mayan women, an important goal of the program. Follow-up of community-based distributors who had the most clients and who provided the most couple-years of protection noted that these successful CBDs tended to be women over 30 years old who were recognized as community leaders. Among all clients served by CBDs, only three infections were reported. Due to the success of this program, APROFAM expanded community-based distribution of DMPA throughout the country to all of its 22 districts of operation. All community-based promoters in APROFAM's rural development program are trained to provide DMPA services. Furthermore, CBDs now distribute not only progestin-only DMPA, but also the monthly combined (progestin and estrogen) injectable Cyclofem.

KEY POINTS

- **CBD provision of DMPA increased contraceptive uptake.**
- **Continuation rates for CBD and clinic provision of DMPA were virtually identical.**
- **Injection site infections were minimal and comparable for CBD and clinic DMPA provision.**
- **Hard-to-reach populations benefited from CBD of DMPA services.**

Background

APROFAM, the Guatemalan International Planned Parenthood Federation affiliate, is the largest provider of family planning services in Guatemala. In 1995, APROFAM was operating 15 maternal-child health clinics located in urban centers as well as a network of over 4,000 semi-urban and rural distribution posts. The distribution posts are run by trained community volunteers who provide family planning counseling and referral, in addition to provision of oral contraceptives and barrier methods.

In 1995, APROFAM in partnership with the Population Council conducted an operations research project to measure acceptance and continuation rates for the contraceptive injectable depot-medroxyprogesterone acetate (DMPA) when its provision was added to existing community-based family planning services. The study compared DMPA service delivery by APROFAM clinics with DMPA service delivery by community-based distributors (CBD) in four rural districts.

When the project began, CBDs did not give the first injection. Women received the first injection either at the clinic or from an APROFAM educator supervising CBDs. Clients were then offered the option of receiving subsequent injections from the trained CBD closest to their home. However, two problems emerged that limited the number of women who had access to DMPA. First, APROFAM educators made supervision visits to CBDs only once or twice a month, which often meant women were not at the appropriate phase of their menstrual cycle to receive the first injection. Second, clients who came to the clinic initially almost always chose to continue coming to the clinic for subsequent shots. To address these barriers to access, researchers changed the strategy, allowing CBDs certified by clinicians to provide all injections, including the first.

A total of 160 CBDs were trained to provide DMPA, and subsequent acceptance of CBD provision of DMPA was robust. Within four months, more than 600 new DMPA users were receiving DMPA from CBDs. By the end of the 16-month project, 1,189 women were receiving DMPA services: 410 women from clinic providers and 779 women from CBDs. Sixty-five percent of the women who participated in the project had never used a family planning method before. This suggested that rather than merely adding to the method mix, CBD provision increased contraceptive uptake. Furthermore, at 15 months, DMPA continuation rates for CBD provision were high and nearly identical to those for clinic provision: about 90 percent. Suggested reasons for the high continuation rates include convenience, privacy, and cultural perceptions that injected medications are effective; however, researchers noted that reasons for the project's success needed to be explored further.

A key project goal was to provide services to the hard-to-reach, rural Mayan community. Eighty-three percent of the Mayan clients in the study received DMPA services from CBDs and local educators. Overall, Mayan clients had an 89 percent continuation rate, showing that hard-to-reach populations can benefit from CBD.

Choosing the right people: CBD selection criteria

CBDs were selected based on their proximity to APROFAM clinics, basic literacy skills, interest in participating, and previous family planning experience. During training, CBDs learned specifics about DMPA, how to counsel on all available contraceptive methods, technical aspects of injection and infection prevention, side effects management and referral, use of the CBD manual and job aids, and informed choice and consent.

CBDs were required to pass a certification test in DMPA provision before they could provide services in the community. CBDs who provided quality services – as determined by a supervisor – to a minimum of three clients were eligible for certification. Supervisors used a certification checklist to ensure a minimum standard of service.

In follow-up monitoring visits, all CBDs demonstrated accurate knowledge of DMPA and were aware of the importance of counseling clients. Notably, only five DMPA users were documented to have had infections at the injection site. CBDs had injected three of these users and clinic staff had injected two users, attesting to the overall comparability in quality between CBD and clinic DMPA provision.

Acceptance of CBD of DMPA

Educators who supervised community-based distributors said CBDs who had the most DMPA clients tended to be recognized as leaders in the community who already enjoyed the community's confidence and respect. Of the most successful CBDs (those who distributed more than 5 couple-years of contraceptive protection), only two were men, compared to 15 women. (One particularly successful woman distributed 23 couple-years of protection.) Most of these top performers had completed their primary education and were 30 years of age or older.

Three-quarters of 47 women who were still actively using DMPA at follow-up after 15 months chose to have their injections given by the CBD because such provision was accessible, confidential, and private.

Continuation rates for CBD of DMPA

Impact of home visits

The original service strategy for the project called for CBDs to make home visits to provide reminders about upcoming injections as well as provide the injections. Home visits can be important for follow-up and continuation: The continuation rate for those who received home visits was 94 percent compared with 88 percent for those who did not receive home visits. However, home visits may be undesirable to women concerned about privacy. Only 38 percent of DMPA users would permit home visits.

Attention to migrant workers

A unique aspect of the project was finding a way for migrant workers to continue their injections while away from home, since an earlier study had shown that in some communities migration was a principal reason for DMPA discontinuation. The project was not designed to specifically measure acceptance or continuation rates among migrant women who used DMPA. However, a pamphlet was developed to give these users basic messages about DMPA, including injection instructions, so an APROFAM promoter or clinician in the new location could provide the injection. These women were also sold additional doses to take with them when they migrated.

References: Fernandez VH, Montúfar E, Ottolenghi E, et al. Injectable contraceptive service delivery provided by volunteer community promoters. Unpublished paper. Population Council, 1997; Personal e-mail communication with Dr. Montúfar.

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