Provision of Injectable Contraception Services through Community-Based Distribution

Implementation Handbook

By Benjamin Weil, Kirsten Krueger, John Stanback, and Theresa Hatzell Hoke

Family Health International




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By Benjamin Weil, Kirsten Krueger, John Stanback, and Theresa Hatzell Hoke

This handbook is dedicated to the women and men who participated in the pilot and scale-up projects in Uganda and Madagascar.

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Acknowledgments

The collaborators of this handbook—Family Health International and Save the Children USA—have a wealth of experience assisting the people of the developing world to plan healthy families and to improve their reproductive health. By sharing their knowledge of community health programs in this handbook, both organizations hope to increase access to family planning by providing injectable contraception to people in need.

Many people were involved in the preparation of this handbook and we thank them all. Benjamin Weil, an independent consultant, undertook the major task of compiling the initial manuscript. We are grateful for his ability to synthesize information based on concepts developed by the other coauthors and to incorporate the comments of reviewers rapidly and effectively.

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About This Handbook

This handbook describes how to introduce injectable contraceptives to the suite of family planning services offered in an *existing* community-based distribution (CBD) program. The approach is based on the experiences of two recent pilot projects in Uganda and Madagascar. These countries were chosen because of a dire need for family planning services, the existence of established CBD programs, and the willingness of their governments to adopt this method of providing injectable contraceptives.

The project in Uganda began in the Nakasongola district in 2004 and continues to this day. Its achievements have encouraged the addition of injectable contraceptives to CBD programs in other districts. The program was sponsored by Family Health International (FHI), Uganda's Reproductive Health Division of the Ministry of Health, and Save the Children.

The pilot project in Madagascar began in 2006 in the regions of Anosy and Alaotra Mangoro. The project was sponsored by FHI and Madagascar's Ministry of Health and Family Planning, in collaboration with SantéNet, Population Services International (PSI), the Adventist Development Relief Association (ADRA), and Action Santé Organisation Secours (ASOS).

There is a great demand for the CBD of injectable contraceptives in these two countries and in a number of neighboring countries. Ultimately, this handbook exists to meet this demand. Program managers, policy-makers, and others who are interested in expanding access to family planning will learn much from the lessons offered here. Readers will be able to visualize the nine steps needed to prepare, initiate, and maintain the CBD of injectable contraception.

Although this handbook focuses on adding injectable contraceptives to an existing CBD program, it contains information that might be useful to those who wish to start a CBD program where one does not already exist. However, it should not be considered as a stand-alone guide to starting a CBD program.

The appendices contain a collection of tools—questionnaires, forms, and other resources—that can help you to add injectable contraceptives to an existing CBD program. You are welcome to adapt and improve these tools to suit your circumstances.

We are eager to hear your suggestions on ways that we might improve all parts of this handbook. Please direct your comments to:

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Introduction

According to the World Health Organization (WHO), 36 of 46 African countries currently face critical shortages of doctors, nurses, and midwives. This deficit comes at a time when there is a growing demand for family planning services throughout sub-Saharan Africa. This is especially true in rural areas, where modern contraceptive methods are scarce, and few trained personnel can provide these services.

One way to meet this demand is by providing injectable contraceptives to women through community-based distribution (CBD) programs. "Injectables" are a popular choice for many women because they are safe, effective, and convenient, and they can be used discreetly, without a partner's knowledge. Although there are several kinds of injectable contraceptives, depot-medroxyprogesterone acetate (DMPA or Depo-Provera) is the most commonly used.

A Note on Terminology

The conventional term "community-based distribution" (CBD) is used throughout this handbook for the sake of consistency. However, the concept of distributing commodities to individuals in communities is gradually being replaced by that of delivering not only commodities, but also services. Thus, the term "community-based services" (CBS), which embraces activities carried out through such vehicles as agricultural extension programs, drug shops, pharmacies, and literacy programs, is increasingly used. Likewise, alternative terms—such as community health workers (CHWs), community reproductive health workers (CRHWs), community health officers (CHOs), or village health workers (VHWs)—have been used to describe more specific categories of community-based paraprofessionals.

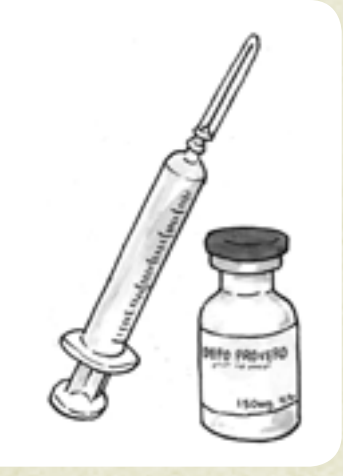
Community-based distributors (also called "CBD agents" or "CBD workers") are usually trusted members of the community who are trained to provide family planning services and information about reproductive health in a private and confidential setting. Distributors often work closely with community health facilities, district health offices, national ministries of health, and nongovernmental organizations (NGOs). The CBD of family planning may take the form of visits to the client's home, visits to the distributor's home, or visits to a community health post. Without these distributors, women often travel long distances to reach proper medical clinics, or they may simply do without family planning services. Although CBD programs are traditionally implemented in rural areas, this approach may also be used in regions where there are large disparities in the use of health services.

The CBD of injectable contraceptives is a relatively new concept for most developing countries. Even so, programs in Africa, Asia, and Latin America have shown that the CBD of injectable contraceptives can be an extremely effective way to provide family planning services. Indeed, community-based distributors have repeatedly demonstrated that they:

- Can provide injections safely
- Know when to refer clients to a clinic
- Can maintain their supplies
- Can safely dispose of needles and syringes
- Can counsel their clients about side effects
- Can administer injectables on a regular schedule

Despite its strong record of safety and effectiveness, the CBD of injectables is still a rare component of CBD programs.

What Are Injectable Contraceptives?



Depo-Provera is an injectable contraceptive that contains a progestin—a synthetic version of the female sex hormone progesterone—called depot-medroxyprogesterone acetate (DMPA). A woman receives an injection of Depo-Provera once every three months to prevent pregnancy. The hormone works by preventing ovulation and thickening the cervical mucus, which makes it difficult for sperm to enter the uterus.

Depo-Provera can be used by women of reproductive age who are not pregnant and who do not have health conditions that may preclude the safe use of injectable hormones. Injectable contraceptives like Depo-Provera are highly effective, reversible, easy to use, and private. Also, they do not interfere with intercourse, and they do not affect breastfeeding.

Depo-Provera has other benefits. Women who use the drug are less likely to have endometrial or ovarian cancer, an ectopic pregnancy, or symptomatic pelvic inflammatory disease. Its use may reduce pain crises in women with sickle cell anemia, and it may prevent epileptic seizures.

Depo-Provera also has some disadvantages. Women often experience a delayed return to fertility—by an average of nine months after the last injection. Also, compared to contraceptive methods such as the condom, Depo-Provera provides no protection against HIV and other sexually transmitted infections. There may also be a few side effects, including prolonged, heavy, or irregular menstrual bleeding (spotting), especially during the first three to six months of use. After the first year, many women develop amenorrhea (the absence of menstrual bleeding). Other side effects may include weight gain, headaches, and nausea.

In the next year or two, the U.S. Agency for International Development (USAID) plans to introduce a new formulation of Depo-Provera called "Depo-subQ Provera 104." Depo-subQ has the same efficacy as the original Depo-Provera, but it contains a lower dose of hormone. The new formulation is administered subcutaneously using a needle that is shorter than the one required by the older, intramuscular formulation of Depo-Provera. More importantly for its use in developing countries, Depo-subQ will be supplied in an easy-to-use, pre-filled, non-reusable Uniject injection device. Depo-subQ received approval from the U.S. Food and Drug Administration (FDA) for use as a contraceptive in 2004.

There is another progestin-only injectable contraceptive, called Noristerat, which must be administered every two months. There are also injectable contraceptives that contain both progestin and estrogen, but they must be administered every month. These combined injectables are less commonly used than progestin-only injectable contraceptives. They also require greater technical skill to administer and are not usually provided by CBD workers. None of the injectable contraceptives causes birth defects or permanent infertility.

THE NINE STEPS

There are nine basic steps needed to establish and manage a community-based program to distribute injectable contraceptives. These steps will help policy-makers and program managers determine whether they can provide the service. It is important to recognize that many of the steps must be considered together, even during the early stages of a pilot project. Each step is addressed in detail in the remaining sections of this handbook.

Step 1:
Determine the feasibility and the need for the community-based distribution of injectable contraceptives.

Step 2:
Evaluate the potential costs of adding injectable contraceptives to a community-based distribution program.

Step 3:
Consider how to incorporate the community-based distribution of injectable contraceptives into national health policy and service delivery guidelines.

Step 4:
Promote the use of injectable contraceptives and sensitize the community.

Step 5:
Set up a logistical system that ensures a steady provision of supplies.

Step 6:
Train the community-based distributors to provide the service.

Step 7:
Install mechanisms that ensure the high quality and the safety of the service.

Step 8:
Plan to document the processes and the outcomes.

Step 9:
Ensure the successful scale-up of the pilot project.

STEP 1

Determine the Feasibility and the Need for the Community-Based Distribution of Injectable Contraceptives

JOHN STANBACK/FHI

STEP 1

Determine the Feasibility and the Need for the Community-Based Distribution of Injectable Contraceptives

1

Is there a need for this service in your region or your country? Program managers and policy-makers should:

- **Determine whether the government's policies support the CBD of family planning services.** These policies may help or hinder your efforts, depending on whether they foster or discourage CBD.
- **Identify an existing community-based program that might benefit from the addition of injectable contraceptive services.**
- **Determine whether the CBD program is strong enough to add injectable contraceptive services.** You should also consider the relative strengths of the program supervisors and the health facility staff. The questions below may help you determine the relative strengths of the existing program *(also see Appendix 4)*.
  - Is the current CBD program effective? For example, how many "couple-years" of protection does it provide?
  - Does the program currently screen a client's health before providing family planning (such as oral contraceptives)? Or does it only provide condoms?
  - Does the program have a good history of retaining workers?
  - Has the program been successfully keeping records—including the records kept by the distributors?
  - Does the program have access to reliable, consistent supplies from clinics or other sources?
  - Does the program have strong logistical support?
  - Does the program have a sustained presence in the area?
  - What are the qualifications of the distributors? Do they have the basic knowledge and skills needed to learn about injectable contraception?
  - Is there a need for community-based family planning services that existing clinics cannot provide, but which might be provided by distributors?

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Two Models of Community-Based Distribution: Uganda and Madagascar

In Uganda and Madagascar, distributors work closely with local health facilities to obtain supplies for the provision of injectable contraceptives. The distributors in both countries do not receive direct payment for their work, but they did receive a transportation stipend for attending the initial training sessions.

In Uganda, the distributors receive raincoats, galoshes, and bicycles to support their work. Distributors in the Madagascar pilot project do not receive these incentives. Instead, they receive their first 15 doses of Depo-Provera for free, along with an initial supply of syringes, needles, alcohol, and cotton. The distributors must pay 150 Ariary—approximately US$0.08—for each subsequent dose of Depo-Provera, which comes with a syringe and a needle. They sell each injection to clients for 300 Ariary—a profit of 100 percent.

Which model is better? Distributors in Uganda are grateful for the incentives they receive, but they would like to earn some money for their work. In Madagascar, the distributors say they could use incentives such as raincoats, galoshes, and bicycles, especially during the rainy season. They also feel that a profit of 150 Ariary per client is too small.

Some distributors report satisfaction with the opportunity to develop skills, earn the respect of their community, and help others. Personal and professional empowerment can be an important reward for some. Others say the lack of financial or material remuneration is a factor that affects the sustainability of CBD programs. New models to reward distributors are needed.

- Are the CBD workers linked to a health facility? This is crucial for reporting, supervision, supplies, and referrals.
- Will staff members from a health facility, or technical supervisors, be willing to supervise the CBD of injectable contraceptives?
- Would the current program be sustainable if you added injectable contraceptive services?

- **Determine how the distributors are compensated or motivated to do the work.**
  - Do the distributors volunteer? Or, do they receive some type of payment (from sale of DMPA or a salary)?


KELSEY LYND/FHI

- **Conduct a needs assessment.** The need for the CBD of injectable contraception may depend on several factors:
  - The unmet need for family planning.
  - Client demand for the provision of family planning methods in communities without health facilities, including a specific demand for injectable contraception.
  - Women's demands for a family planning method that does not require their husband's or their partner's cooperation.
  - Women's requests for a family planning method that breastfeeding mothers can use.
- **Identify regions that may need injectable contraceptives.**
  - Is there a specific area of the country that demonstrates a particular need for the CBD of injectable contraceptives?
  - Is there a history of community-based services in that area?
  - Does the area have links to community-based services?
  - Is there a way to ensure the sustainability of community-based services in the area?
- **Assess the potential success of injectable contraceptives in your country by comparing the relative popularity of different contraceptive methods now in use.**
- **Determine whether there is a lack of clinic-based personnel trained to deliver injectables.** Could this shortage be filled by providing injectable contraception through community-based services?
  - Are family planning services readily available in the local health facilities?
  - Do local health facilities have enough staff to provide injectable contraception on a continuous basis?
  - How large is the health facility's service area? If the facility is attempting to serve a large area, the clinic's staff may not be able to travel to the outlying communities.
  - Do community members travel great distances to access family planning services at health facilities?

Possible Pitfalls During Step 1

- Assuming that a region will benefit from the CBD of injectable contraception when demand is low and supply is high (at existing health facilities accessible to a majority of the population).
- Deciding to initiate the CBD of injectable contraception in the absence of an established CBD program.

STEP 2

Evaluate the Potential Costs of Adding Injectable Contraceptives to a Community-Based Distribution Program

KELSEY LYND/FHI

STEP 2

Evaluate the Potential Costs of Adding Injectable Contraceptives to a Community-Based Distribution Program

2

A long-standing criticism of CBD programs is that they are simply too expensive. However, this need not be so. The cost of adding injectable contraception to a CBD program can be low if the program is already well resourced and functioning effectively. More often than not, a well-functioning CBD program has already devoted the funds needed to train, supervise, and provide incentives for CBD workers. With these systems in place, the cost of adding injectables to the CBD program can be low. But the payoff can be high in terms of increased effectiveness and a greater number of new clients who accept family planning. Here are some of the factors you must consider before you add injectable contraceptives to a CBD program.

- **Determine the costs of introducing and sustaining the CBD of injectable contraceptives.**
  - Do women have access to clinic-based family planning? There is little value to adding injectables to a CBD program if women have access to a clinic where they can receive the service.
  - Training the providers is one of the greatest expenses associated with introducing injectable contraceptives. In Uganda, midwives underwent intensive training to provide injectable contraception. In addition to the trainer's costs, there are expenses associated with travel, meals, supplies, and the rental of audiovisual equipment. Using trainers connected with the ministry of health can help to forge ties between local health officials and the CBD program.
  - Supervision can also be very costly. Frequent supervision is the key to a strong program, and all programs should have frequent visits from supervisors to ensure that clients are being served in a timely manner with adequate counseling. Frequent supervisory visits will result in higher costs for transportation and daily expenses. In a well-resourced CBD program, supervisory visits are likely to be adequate. Therefore, there may be little or no additional cost for supervision when adding injectables to the method mix. Although a greater number of supervisory visits may be needed in an under-resourced CBD program, they


BUDGET

Item	USD
Participants - Location 1	
Accommodation	3,500
Full Board Meals	5,250
Transport refund	333
Facility Rental	583
Facilitators	
Accommodation	1,533
Transport refund	2,300
Facilitation allowance	2,300
Participants - Location 2	
Accommodation	1,056
Full Board Meals	1,042
Transport refund	244
Facilitators allowance	250
Training materials	
Stationery and Photocopying	56
Soap, cotton wool	56
Hand wash basin/stand	56
Depo-Provera, needles and syringes and safety boxes (to be donated)	0
TOTAL	18,559

Funding the CBD of Injectable Contraception in Uganda and Madagascar

The programs in Uganda and Madagascar both benefited from support provided by their respective ministries of health. Family Health International (with support from USAID) and Save the Children helped to sponsor the Uganda program. With support from USAID, FHI also worked with partners such as SantéNet, PSI, ADRA, and ASOS to provide technical assistance to the program in Madagascar.

may not actually be conducted because of the lack of funds. In this case, funds will be needed to meet the cost of increasing the number of supervisory visits.

- **Determine the costs of scaling up the program.**
  - Although training is costly, planners may decide that less intensive training is possible during scale-up, so the costs per person may be lower. This would occur if more participants are included in each training session or if the duration of the training is shorter. If the scale-up can take advantage of in-house trainers, then the costs can be met by redeploying these trainers. However, if the scale-up requires a large number of additional trainings, it may be necessary to hire or contract for additional trainers, and the financial costs will then increase.
  - What kind of incentives or motivation will you provide to the distributors, given the greater responsibilities and increased workload?
- **Assess the effectiveness of introducing and sustaining the CBD of injectable contraception relative to its costs.**
  - Under the right conditions, adding the CBD of injectable contraception can be very cost-effective. If a program is strong, injectable contraception can be added to the existing methods at a reasonably low cost. Research shows that increasing the range of contraceptive options available to women increases contraceptive use and prevalence.
- **Find funding to add injectable contraceptives to community-based services.**
  - Will the ministry of health (alone or in collaboration with international partners) support the provision of injectables in an existing CBD program?
  - Is the program feasible without financial support from the ministry of health? In the absence of government financial support, it is important to have a commitment from a long-term donor.

Possible Pitfalls During Step 2

- Introducing a program for the CBD of injectable contraception and assuming (without evaluation) that the national health program or donors will pay for contraceptives.
- Assuming (without evaluation) that clients are willing and able to pay for injectable contraceptives.
- Neglecting to calculate the cost of training (including retraining on technical updates for all contraceptives, including injectables).

STEP 3

Consider How to Incorporate the Community-Based Distribution of Injectable Contraceptives into National Health Policy and Service Delivery Guidelines

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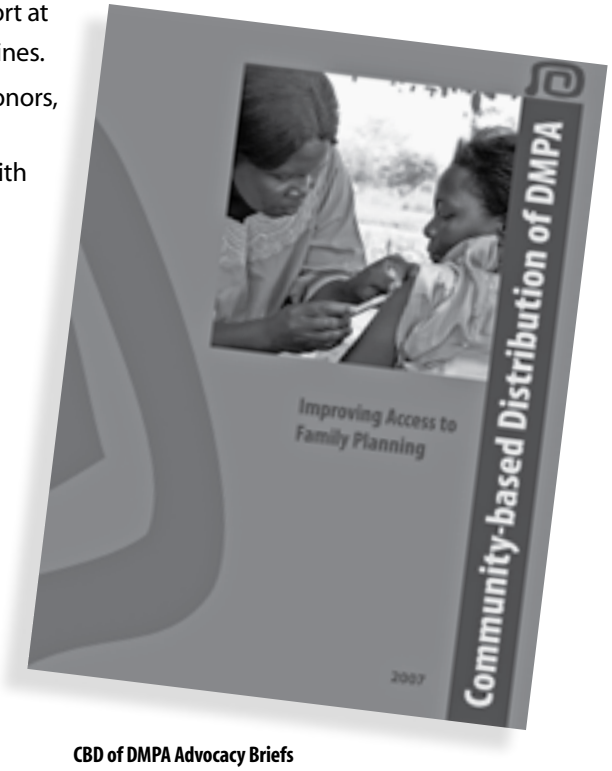
STEP 3

Consider How to Incorporate the Community-Based Distribution of Injectable Contraceptives into National Health Policy and Service Delivery Guidelines

3

- **Determine whether national health policy or service delivery guidelines already support such activities, and whether paramedical personnel are allowed to administer injections.** If nonmedical personnel occasionally give other injections (e.g., during vaccination campaigns), it may help convince policy-makers that the CBD of injectable contraceptives is acceptable.
  - In some countries, official national policy is not essential to start a program for the CBD of injectable contraceptives, but it will help. In one country, national health policy did not officially sanction the practice of distributors giving injections, but key members of the ministry of health approved starting a program.
  - The new *Standards and Procedures* of Madagascar's Ministry of Health and Family Planning was finalized just before the pilot project began, and it now includes the CBD of injectable contraception. The change in policy was the culmination of continuous advocacy to the Ministry of Health and to donors that was led at the national level by a dedicated physician.
  - Some countries may wish to develop pilot programs before they make policy decisions. In Uganda, Dr. Anthony K. Mbonye, the head of the Ministry of Health's Reproductive Health Division, has said, "regarding CBD of DMPA, we felt we had to get the experience before changing the policy. After testing it in Nakasongola, Nakaseke, and Luwero, we should have enough experience to change the policy."
  - Malawi is revising its guidelines in anticipation of a program to provide injectables by CBD.
- **Advocate the CBD of injectable contraceptives if a country's national health policy does not already support the service.** Generating support at the national level may influence health policy or service delivery guidelines.
  - Convene meetings with ministry of health officials, relevant NGOs, donors, and other partners to discuss the benefits of the CBD of injectable contraceptives to reach women in rural areas, as well as in settings with limited services, such as urban slums. Key benefits include:
    - Expanding access to contraception in areas with unmet need
    - Providing greater choice to women, especially those who prefer a highly effective, discreet, and convenient method
    - Reducing unplanned pregnancy, unsafe abortion, and related maternal morbidity and mortality
    - Promoting better child survival through greater child-spacing
  - Use the example of Uganda to demonstrate the effectiveness of a project featuring the CBD of injectable contraceptives.
  - Use material from the *Advocacy Briefs* available from FHI (*see Appendix 1*) to demonstrate how the project would operate, the injection's safety, the desirability of CBD of injectable contraception, and other factors.



CBD of DMPA Advocacy Briefs

- **If official guidelines cannot be changed before your pilot project begins, obtain support from the ministry of health to help you move forward with your project.** A letter supporting the project, which is sent to district health offices, should suffice.
- **Engage key stakeholders at the national level to secure their support for the service.**
  - In Uganda, Save the Children and FHI held stakeholder meetings with Ministry of Health officials and NGO representatives, as well as the USAID Mission. Uganda also formed a core team—including the Ministry of Health, FHI, and Save the Children—to coordinate and implement the project. Other important stakeholders were consulted, including:
    - Uganda Medical Association
    - Uganda Private Midwives Association
    - Association of Obstetricians and Gynecologists of Uganda
    - Uganda National Expanded Program for Immunization
  - In Madagascar, the USAID/FHI Best Practices Team met with officials from the Ministry of Health and Family Planning to discuss incorporating reproductive health best practices, including the CBD of injectable contraceptives, into family planning programs. Afterwards, the Ministry formed a steering committee comprised of the following key players:
    - Steering committee coordinator from the Ministry of Health and Family Planning
    - Project coinvestigators from the Ministry of Health and Family Planning

Engaging Key National Stakeholders: Advocacy in Action

"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 the process that FHI and its partners used to persuade national decision-makers to promote the CBD of DMPA in his country. "The first person to be concerned in the Ministry is the program manager—and that is me," he explained.

Once he became convinced of the potential benefits of the approach, Dr. Mbonye played an important role in advancing Uganda's pilot project on the CBD of DMPA. He submitted the study protocol to the National Council of Science and Technology, and campaigned for its acceptance. Then he ensured that the necessary logistics, supplies, and supervision were in place. He also helped to organize regular meetings among Ministry of Health officials, Save the Children representatives, and local health officials and community leaders in Nakasangola.

When the results of the pilot project became available, Dr. Mbonye helped disseminate them to scientists and other professional colleagues. "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."

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- Health-sector partners, including SantéNet and PSI
- NGOs, including ADRA and ASOS
- USAID representative
- FHI representative

- Engage key stakeholders at the district level—including political leaders, community leaders, religious leaders, and service providers. District-level participation is crucial for (1) engaging health facility staff at the community level, (2) project supervision, (3) maintaining supplies, (4) making referrals to clinics, and (5) linking communities to national authorities.
  - Keep in mind that some stakeholders may have reservations about nonmedical personnel giving injections. It may be helpful to cite the example of Uganda, where it was extremely rare to have problems with the injections or injection-related infections.
  - Explain how the CBD of injectable contraceptives may ease the workload of clinic-based providers and help them to increase the availability of contraception, especially to women in remote areas.
  - In Uganda, key stakeholders in the district included the directors of health services, who were able to motivate others, such as the secretaries of health at the district level. In Madagascar, early involvement of district health authorities helped to build support for the project. Project coordinators approached district health offices to request permission to conduct the pilot project. The national steering committee, once established, held regional coordination meetings.

Building District Support for the CBD of Injectable Contraception

Before the Uganda pilot project began, health officials at national and district levels were hesitant about nonmedical personnel giving injections. "The idea of [distributors] giving injections was considered radical. I was really very skeptical about it," said Dr. Godfrey Kasibante, Acting District Health Officer for Nakasongola District. "It was hard to see someone without training in medical ethics or safety giving injections. But then I saw there were no problems. The fact that there were [distributors] successfully giving immunizations helped."

Dr. Kasibante was also swayed by the need to expand health care into remote regions. "We don't have enough health workers to give injections. We have to encourage health-seeking behavior, and bring the services to them rather than them coming to us."

The statistics on health services in the district have further diminished Dr. Kasibante's skepticism: "Save the Children came to Nakasongola in 2001, and are improving family planning indicators. In 2001, the contraceptive prevalence rate [in district-level service statistics] was 9 percent. Now it is 14 percent." This increase comes at a time when there was virtually no growth in the national rate of contraceptive use. The CBD of family planning (including DMPA) is believed to be the primary reason for this increase. In conclusion, he says, "Let us speed up the process of offering DMPA. . . . It would be good to expand it to every part of Uganda."

- **Determine whether local health facilities support the idea of a CBD of injectable contraceptives.**
  - What are the distributors' relationships with the health facilities? When planning your pilot project, try to build on any existing relationships between the distributors and local health facilities. If these relationships do not exist, make sure you approach the health facilities early in the planning phase. Emphasize the need for their expertise and supervision. You should also point out that distributors can help to reduce the facility's workload, and they can reach clients who are unable to access health facilities.
    - In Uganda, project coordinators hold monthly supervisors' meetings to link local health facilities with their communities.
    - In Madagascar and Uganda, distributors turn in monthly reports to community health facilities, which ensures regular contact with the facility's staff and allows the distributors to get more supplies. The clinic staff members also supervise the distributors.
    - In Madagascar and Uganda, distributors acquire their supplies from community health facilities. The clinical officer in the Lwampanga subdistrict, Nakasongola, Uganda, was surprised when he first heard that distributors were giving injections. But he said it now makes his job easier, "The [CBD-agents] are doing good work. We are working hand-in-hand with them."
- **Mobilize community support for the CBD of injectable contraception.**
  - In Madagascar, project coordinators worked to secure the commitment of mayors and other community leaders, as well as the directors of community health facilities. These directors were hesitant in the beginning, but they are now committed to supporting the project. Project coordinators officially presented the project at community health facilities and held community meetings to introduce distributors.
  - In Uganda, the Senior Health Educator, who specializes in advocacy and communication at the Ministry of Health's Reproductive Health Division, was involved in developing an advocacy kit, *Improving Access to Family Planning: Community-based Distribution of DMPA (see Appendix 1)*. She believes the briefs from the kit will help to garner support for further expansion of these services in Uganda. She also said that, "[Local] stakeholders have had a hand in development of materials, not just Save the Children and FHI. This helped allay fears and concerns. Openness in developing materials has been helpful, especially involving community leaders. Their involvement and acceptance help others jump on the bandwagon."

Possible Pitfalls During Step 3

- Assuming that the absence of existing national regulations and service delivery guidelines for the CBD of injectable contraception rules out the possibility of starting a program.

STEP 4

Promote the Use of Injectable Contraceptives and Sensitize the Community

JASON B. SMITH/FHI

STEP 4

Promote the Use of Injectable Contraceptives and Sensitize the Community

4

- **If possible, conduct a mass media campaign.**
  - Mass media campaigns could consist of radio or television spots, which advertise the availability of injectable contraception through CBD in the target area. Be sure to consider what proportion of your target population has access to radio or television before undertaking such a campaign.
    - Radio spots in Madagascar attracted clients to community health facilities, helping distributors to complete their practical training, which included administering six injections.
- **Produce and disseminate printed advocacy materials—such as handbills and posters—about injectable contraception.** Programs can also use or adapt *Improving Access to Family Planning: Community-based Distribution of DMPA (see Appendix 1)*.
  - For literate populations, handbills (distributed at local health facilities, community meetings, and other gathering places) and posters (displayed in health facilities, municipal buildings, marketplaces, etc.) may attract community demand and support for the CBD of injectable contraceptives.
- **Convene and coordinate community meetings for opinion leaders.**
  - In Madagascar, project coordinators convened community meetings with mayors, village chiefs, and other leaders to generate support for the CBD of injectable contraceptives. Coordinators also made an official presentation at community health facilities. Distributors who were newly trained to give injections received an official certificate from the Ministry, and they were introduced to their communities by the mayors, village chiefs, and technical supervisors. Word of mouth among clients has also helped to generate demand.

JASON B. SMITH/FHI

Possible Pitfalls During Step 4

- Neglecting to generate support and demand for the CBD of injectable contraception before launching a program.

Advocates at the District Level

In Uganda, family planning is often promoted by people who are widely recognized in their community. In the Luwero District, the local Secretary of Health, Erasmus Musisi Mugerwa, was selected by the community as the family planning advocate. A popular leader and a Catholic, Mugerwa strongly believes in the need to limit family size. According to Mugerwa, "As leaders, we should try to help our people understand the link between their quality of life and the size of their families, and then lobby for support for family planning from the government and donors." As a political leader, Mugerwa is strategically positioned to secure support for the CBD of DMPA initiative in his district. One of his key strategies is to encourage women and other leaders in the community to support the CBD agents and to mobilize women for family planning services.

STEP 5

Set Up a Logistical System that Ensures a Steady Provision of Supplies

KELSEY LYND/FHI

STEP 5

Set Up a Logistical System that Ensures a Steady Provision of Supplies

5

- **Define a specific system that will reliably facilitate the CBD of injectable contraception.** Work within an established system (governmental or nongovernmental, depending on the circumstances) to procure and distribute contraceptives and related supplies. In some programs, it may prove more practical to supply distributors directly through an NGO or other program sponsor, rather than through local government clinics. For example, this could happen if the NGO has access to donated contraceptive commodities. No matter how the distributors are supplied, the links with local health facilities must be strong to facilitate referrals between the distributor and the clinic.
  - Ideally, project coordinators will work within an existing system. Distributors may already be familiar with this system, or coordinators will need to develop a collaboration between the distributors, their supervisors, and the clinic staff. The system may function through the national ministry of health or a different partner.
  - In Uganda and Madagascar, community health facilities (in liaison with district health offices and the ministries of health) are responsible for managing supplies (*see Appendix 12*). In Uganda, these contraceptives are free, whereas the clients in Madagascar must pay for contraception.
- **Identify the people in charge of logistics management.**
  - In most places there are established systems—typically linked with the ministry of health—that provide access to medical supplies. Where these systems do not exist, you will need to identify people at the national level who can coordinate the supply of commodities. You must also determine how these commodities are distributed to health facilities at all levels.

Managing Supplies in Uganda and Madagascar

Distributors in Madagascar began their work with 15 doses of Depo-Provera, 15 syringes, 30 milliliters of alcohol, 50 grams of cotton, two safety boxes, monitoring tools, reporting forms, checklists, guidebooks, and a backpack in which to store and transport the supplies. In Uganda, start-up supplies were similar, but distributors use boiled water instead of alcohol to clean the injection site.

Logistics managers need to consider frequency of visits and quantity of supplies when they resupply the distributors. For example, stockouts have sometimes been a problem in Uganda, so that community health centers are sometimes unable to provide distributors with Depo-Provera. The logistical system in Madagascar has yet to find a sustainable solution to supply alcohol for the distributors; some distributors have had to purchase it themselves when their original supply ran out. Others have started to use boiled water.

- In Uganda, the District Medical Officer is responsible for overall logistics management for the district. Within a community health facility, the officers in charge or the maternity unit dispensary may be responsible for providing supplies to distributors. Other community-level logistics managers may include midwives, clinical officers, and health facility directors.
- In Madagascar, NGOs help monitor and reinforce national logistical systems. If there is a stockout or supply problem, NGOs help to report and resolve the problem.

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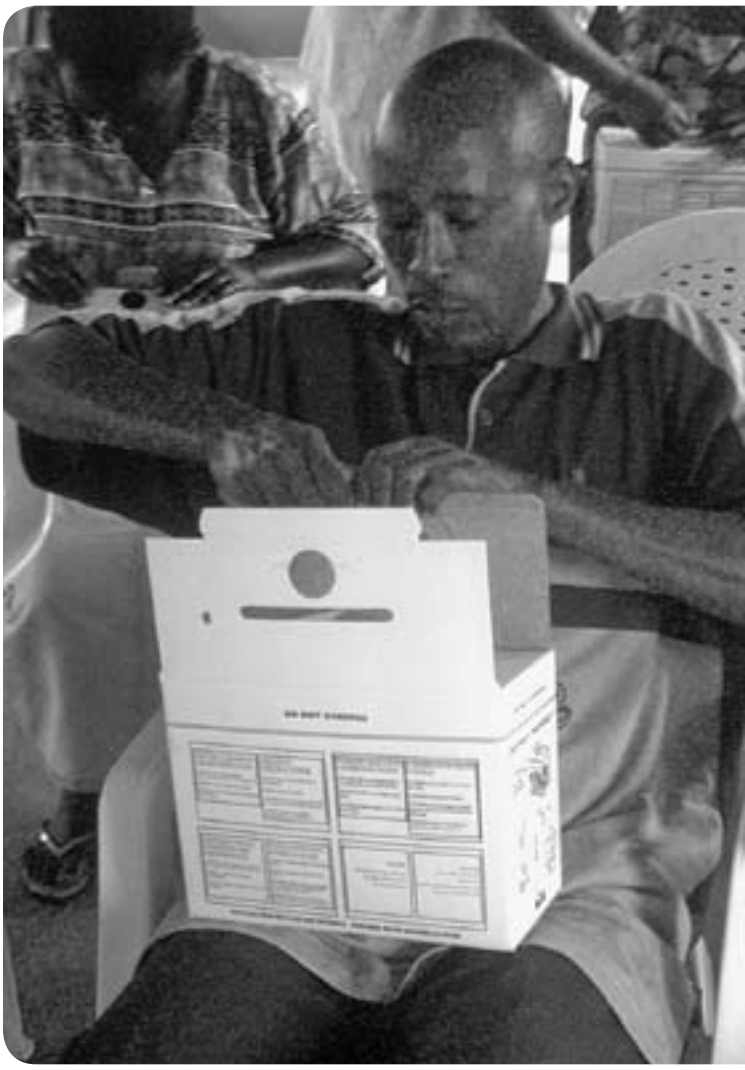
- **Procure sufficient stocks of single-use vials, injection safety boxes, and auto-disable syringes.** As Uniject syringes (which are pre-filled with a single dose and cannot be reused) become more widely available, they will facilitate the provision of injectable contraceptives.
- **Ensure timely submissions of supply orders.**
  - Submitting supply orders at regular intervals (and requesting sufficient supplies) can help avoid stockouts. This can be challenging, because distributors, community health facilities, and district health offices all need to submit their requests in a timely manner. Project coordinators can employ tactics such as:
    - Ordering new supplies when one month of stock is left. Tracking the distribution of stocks and estimating future stock needs is an important part of project monitoring and evaluation (*see Steps 7 and 8*).
    - Following the ministry of health's guidelines for restocking.
  - In Madagascar distributors return to their local health facility each month to submit reports to their supervisors, so they also have the opportunity to reorder and receive new supplies. In Madagascar, distributors must purchase at least five doses of Depo-Provera and five syringes per order.
- **Link community-based health workers to community health facilities for supplies, referrals, and waste management.**
  - Your project should encourage community health facilities and distributors to refer clients.
    - Community health facilities should refer clients to distributors when clients live too far away to access the facility regularly or when the facility does not have time to provide family planning methods.
    - Distributors should refer clients to community health facilities if there is a problem with the injection site, when clients are experiencing serious side effects that warrant medical attention, or when clients need or request a family planning method that the distributors cannot provide (such as an intrauterine device or a contraceptive implant).
  - Waste management should not be a problem if distributors receive proper training about the disposal of sharps and if agreements are made between distributors and community health facilities. Project coordinators should keep in mind that it takes a long time to fill a safety box with used syringes.
  - Project coordinators can convene monthly meetings with health facility staff to discuss supplies, referrals, and waste management.
    - In Madagascar, the distributors are told to return their full containers of sharps to the clinics. It is the clinic's responsibility to properly incinerate the box and its contents.

- **Make sure you can properly store injectable contraceptives such as Depo-Provera.**
  - Depo-Provera should be stored upright, away from direct sunlight, out of reach of children and animals, and at a temperature of 20 to 25 degrees Celsius. It should be used within its five-year shelf life.
  - A sturdy container—made of metal, if possible—protects injectable contraceptives and syringes and keeps them inaccessible to children and animals.
  - To prevent any possible problems with the expiration of the injectable contraceptives, projects can distribute just a few doses at a time to the distributors (e.g., five to ten per visit). The number of doses can be adapted to the number of clients to prevent stockouts.

Possible Pitfalls During Step 5

- Not defining the relationships between the distributors and the local health facilities with respect to the supply of commodities.
- Failing to establish a system for submitting supply orders in a timely fashion; this can result in stockouts. Orders need to be submitted from distributors to local health facilities, from local health facilities to district health offices, and from district health offices to national health programs.



ANGELA AKOL/FHI

STEP 6

Train the Community-Based Distributors to Provide the Service

KELSEY LYND/FHI

STEP 6

Train the Community-Based Distributors to Provide the Service

6

- **Identify competent people who have the potential to be good distributors.** It is important to have clear, written criteria for selecting distributors to provide injectable contraception. Together with stakeholders, project coordinators should:
  - Develop criteria for selecting the distributors, including a way to ensure adequate geographic coverage.
  - Select distributors using an approach that involves the communities.
  - Adapt existing curricula or create new ones.
  - Translate curricula, as appropriate.
- **Create a training curriculum for the distributors.** Make sure that the training curriculum reflects the World Health Organization's (WHO) *Medical Eligibility Criteria for Contraceptive Use* and that it meets the approval of the ministry of health. The WHO document is available at: *www.who.int/reproductive-health/publications/mec*.
  - One advantage of testing the distributors' knowledge of family planning before training is that you may not need to cover every aspect of the subject. You may be able to focus on safe injection techniques and provide detailed information on injectable contraception. In such instances, a few days may be enough to cover the material.

Selecting Distributors for Training in Uganda and Madagascar

KELSEY LYND/FHI

In Uganda, distributors had to have the following qualities:

- **Respected in the community**
- **Mature (over 18 years of age)**
- **Trustworthy**
- **Educated (at least 7 years of schooling)**
- **Interested in family planning**
- **Good counselors**

In Uganda, it was also important for the distributors to have a history of referring many clients for Depo-Provera. To be eligible for training, distributors had to receive high scores on a test of family planning knowledge. Under the Uganda pilot project, 20 of 130 people were chosen to receive training in the Nakasongola district. The number of distributors in the district has increased to 25 since the pilot project ended. An additional 25 distributors now serve in the Luwero and Nakaseke districts.

In Madagascar, distributors were selected for training based on:

- **Literacy**
- **Past performance**
- **Recommendations from community health supervisors**
- **Community acceptance**
- **Acceptance of modern family planning methods**
- **Location**
- **Physical capability**
- **Enthusiasm**

In Madagascar, project coordinators plan to include a pre-test of family planning knowledge as an entrance exam before they train new distributors. Distributors would need to have a minimum test score to participate in the training.

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- In Madagascar and Uganda, trainers used curricula on the CBD of contraceptive services that were produced by the respective ministries of health and family planning. This was complemented by a Depo-Provera-specific curriculum prepared by FHI (*see Appendix 7*).

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- **Procure the relevant training materials.** These may include the following:
  - Checklists or other documents on (1) ruling out pregnancy, (2) initiating pills and injectable contraception, (3) standards for the provision of counseling, and (4) giving injections (*see Appendix 8 or www.fhi.org/en/RH/Pubs/servdelivery/checklists/index.htm*).
  - Visual aids, such as (1) posters displaying all family planning methods, (2) samples of family planning methods, and (3) calendars, client cards, and referral cards.
- **Identify competent trainers.**
  - Focus on trainers who have the necessary skills. Also, consider the benefits of including local stakeholders and supervisors in the training whenever possible, as this strengthens support and buy-in from key colleagues.
  - In Uganda, trainers came from the training teams of district health offices. Coordinators provided them with orientation on community-based services before training began. In Madagascar, trainers included staff from the Ministry of Health and Family Planning, district health supervisors, and NGO implementing partners.

Two Possible Training Models

In Uganda, training lasted for three weeks. During the first week, training took place in the classroom. The distributors practiced their injection techniques on tomatoes and oranges, and they learned how to dispose of the used needles. The second and third weeks involved practical training at health posts under the supervision of medical personnel. In addition to the topics mentioned above, trainers discussed community mobilization, health education talks, how to counsel, logistics management, and recordkeeping.

In Madagascar, training lasted for three days. The first day involved classroom training on theory. At first, the distributors practiced injection techniques on papayas. On the second day of training, the distributors were supervised at the community health facility as they performed their first six injections on people. Most distributors were able to complete at least two injections during the training; they were required to complete the remaining four injections at their respective health centers. This involved between one week and one month of additional time, depending on the availability of clients, the location of the health center, and the distributor's free time. Health center directors, district officials, and technical supervisors also took part in an educational training on the CBD of injectable contraceptives.

- **Conduct training.**
  - Follow the ministry of health's recommendations on training, as well as the curricula you have adapted or created.
  - The length of the training will depend on the number of topics and the depth of information you choose to cover (*see Appendix 5 and the sidebar, "Two Possible Training Models."*)
  - Be sure to include practical training on giving injections. You may choose to have distributors practice on fruits or vegetables, but they will also need to practice on people. Ideally, distributors should give a minimum number of supervised injections to people—during training or after training on theory has ended. Such competency-based training should probably take place at local health facilities. This has the additional benefit of developing the relationship between CBD workers and the health workers who may supervise them.
  - Include sessions on recordkeeping in the training. Distributors should follow a regular schedule of submitting their statistics to project managers. Accurate records are important for monitoring and evaluating the program.
- **Evaluate all training.**
  - Test the distributors before and after they are trained to measure their knowledge and skills *(see Appendices 6 and 14)*.
  - Survey the distributors after the training to elicit their comments on the trainers, the curricula, the materials, the injection practice, and their confidence in providing injectable contraception.
  - Observe the distributors as they give injections and counsel clients about family planning.
  - Monitor the distributors in the coming weeks and months to see how well they retain the knowledge and skills they gained during training.
  - Review the distributors' reports and registers.

Possible Pitfalls During Step 6

- Neglecting to establish criteria for selecting the distributors—including a minimum score on a test of family planning knowledge administered before the selection.
- Spending too much time reviewing family planning issues that should already be familiar to distributors.
- Not spending enough time on practical training—especially administering injections, making referrals, and maintaining good waste management.
- Not providing adequate numbers of auto-disable syringes and DMPA vials for the practice sessions.
- Neglecting to mobilize clients for the distributors' injection-practice sessions. Injecting fruits and vegetables may be a good way to begin, but is not sufficient for practical training.

Evaluating Training in Uganda and Madagascar

JOHN STANBACK/FHI

The durations of the training sessions in Uganda and Madagascar were significantly different. Training in Uganda lasted three weeks, whereas Madagascar's training lasted three days. However, practical training in Madagascar continued until newly trained distributors had each given six injections while they were supervised at a health center. In Uganda the distributors were trained through five supervised injections.

In Uganda, the Save the Children staff learned that distributors need more practice than theory. Some distributors, especially those who are semiliterate, needed a lot of practice giving injections. Small groups also provided the best learning environment.

In Madagascar, project coordinators believe that one day of training was not enough to orient the trainees and to provide a refresher course on reproductive health. They also feel that smaller groups of trainees would have enhanced the learning experience by providing more individualized attention. Smaller groups would also have allowed the distributors to complete all of their supervised injections during the training. The trainees also didn't have enough needles and syringes for the practice injections. Although a radio campaign advertised a day of free contraception at community health centers, not enough clients came for the injections to allow all trainees a sufficient amount of supervised practice. Project coordinators also believe that if training dates could have been set three months before, and if key staff members at the community health centers would have known these dates, they might have been able to recruit clients for the practice sessions. Because of the shortage of clients, distributors who were trained in November did not complete the required number of supervised injections until January.

Coordinators also felt that a test to determine a distributor's eligibility would have increased the quality of the people chosen for training. On a positive note, the trainers were capable, everyone completed the training, and all but one distributor were authorized to begin offering Depo-Provera within six weeks of the training.

STEP 7

Install Mechanisms that Ensure the High Quality and the Safety of the Service

KELSEY LYND/FHI

STEP 7

Install Mechanisms that Ensure the High Quality and the Safety of the Service

7

The following actions will help ensure that project staff can carry out their responsibilities competently and efficiently.

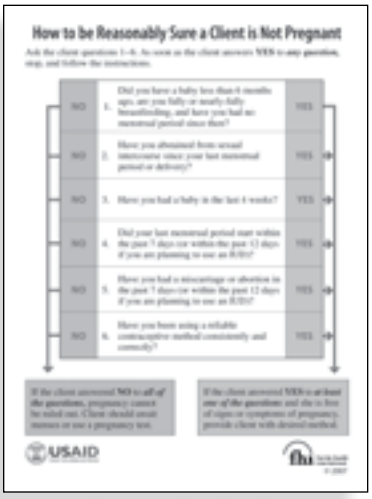
- **Assign tasks for logistics management, equipment, referrals, and waste management.**
  - Project coordinators will need to decide:
    - Who will maintain a steady supply of contraceptives, syringes and needles, cotton, alcohol (if used), and other necessary articles. Within a national health care system, community-level personnel will need to interact with district-level staff, who will need to communicate with the ministry of health (or other people at the national level) to ensure smooth and continuous logistics management.
    - Who will dispense equipment to the distributors. This may be within a community health facility that is sponsored by the government or an NGO. It may be a doctor, a nurse, a dispenser, a midwife, a clinical officer, or someone else.
    - How to handle referrals to other providers for questions that distributors cannot answer or for services the distributors cannot provide *(see Appendix 11)*.
    - Who will manage the waste—such as a safety box full of needles and syringes—that is generated by the service.
- **Establish a system for maintaining injection schedules.**
  - The schedule will depend on how often injections need to be given. Injections of Depo-Provera are administered every three months. Distributors will need to contact their clients no later than the two-week grace period provided by the previous injection.
  - Provide distributors with a calendar and note cards that clearly state the dates of future injections *(see Appendices 9 and 10)*.
  - One advantage of using distributors is that they tend to live near their clients, which allows them to maintain close contact.

Supervision in Uganda

In Uganda, health-extension workers from Save the Children supervise distributors at district and community levels. In Nakasongola District, one supervisor in each subcounty oversees the work of 10 distributors. Health center staff can also provide on-site supervision.

Olivia Nakayiza is one of the supervisors. She has been a health extension worker with Save the Children since 2005, and she has focused on supervising the CBD of Depo-Provera since 2006. She generally tries to keep a low profile when she observes the distributors at work. If they have trouble with a particular activity, such as delivering health education talks to clients, she offers feedback and supplements the information they provide. Olivia also observes counseling sessions and helps the distributors with forms. She thinks the distributors are doing a good job. Olivia and the distributors go through their checklist thoroughly to determine whether clients are eligible for specific methods. Each distributor still needs to be monitored to ensure that he or she is giving proper information to clients.

- **Provide supportive supervision according to a prescribed schedule.**
  - Project coordinators should develop and use a checklist that includes questions on counseling, referral, injection technique, waste disposal, and supply of materials *(see Appendix 13)*.
  - Ensure that the staff members are trained and available to provide supportive supervision to distributors at the field level. This may involve regular visits or the provision of staff at the district or subdistrict level, if feasible, to assist distributors as needed and to ensure services of high quality.
  - Hold a sensitization meeting with supervisors at health facilities or within the program to ensure buy-in and understanding. Hold regular meetings of distributors, supervisors, and health facility staff to discuss safety, quality, and supply issues, as relevant.
  - Supervisors should visit distributors at regular intervals to monitor their work—including counseling, health talks, waste management, and storage of supplies.
  - Determine the types of supportive supervision that are already in place within the NGOs and the district health offices. Can the CBD of injectable contraceptives be easily incorporated into the existing supervisory systems? If not, determine the additional costs of increased supervision (e.g., salaries, transportation costs, or communication).
- **Conduct an on-site performance evaluation of trained distributors at scheduled intervals.**
  - Supervisors—from district health offices or partner NGOs—should be able to evaluate the distributor's performance on a monthly or quarterly basis. The first evaluation should take place soon after the distributors begin providing injectable contraceptives. This will ensure that the distributors are providing correct information about family planning and safe injections to their clients.
  - Evaluations should focus on the following questions:
    - Are distributors providing clients with complete and accurate information about family planning—including potential side effects and the need for dual protection in settings with a high prevalence of HIV?
    - Are distributors using their pregnancy screening checklists?
    - Are distributors correctly determining whether clients are eligible for injectable contraceptives?
    - Are distributors filling out forms—activity reports and client cards—correctly? Do they have enough copies of blank forms?



Pregnancy Checklist

Supervision in Madagascar

There are several levels of supervision in Madagascar. To support the launch of the pilot project, partners of the Ministry of Health and Family Planning traveled to the project communes a month after training to meet with all of the partners and to ensure that the project was running well. Technical supervisors from NGOs, ADRA, and ASOS helped the distributors get started and ensured the village chief was aware of their new capabilities in the provision of DMPA. These NGO supervisors call on distributors at home once or twice a month on a sustained basis to offer technical and moral support. They ensure that the distributors complete their monthly reports correctly. When distributors make monthly visits to the community health center, clinician supervisors have the opportunity to verify the distributor's understanding, answer questions, and assist in resolving difficulties.

- Are distributors using the calendars correctly?
- Are distributors administering injections properly?
- Do distributors refer their clients to health facilities when necessary (e.g., for family planning methods that might be unavailable or for the evaluation of side effects)?

- **Conduct refresher training for the distributors as needed.**

Evaluating the Performance of Distributors

In Madagascar, project coordinators visit each commune to determine how many distributors have been "validated and installed." Supervisors have a form to regularly evaluate the number of injections given and whether the distributors have followed proper procedures. Distributors have had some problems filling out their monthly reports and submitting them on time. In particular, they have difficulty identifying and reporting on new users of family planning services because some clients are new to the CBD program, but they were transferred from the clinic as regular users of Depo-Provera.

In Uganda, supervisors complete quarterly checklists on a distributor's performance. The results have been mixed. Some distributors have weaknesses, such as not providing counsel on informed choices and not keeping accurate records.

Possible Pitfalls During Step 7

- Not clearly explaining to distributors how to give their clients a return date by using a calendar.
- Neglecting to supervise how distributors fill out forms and activity reports.
- Neglecting to ensure that distributors correctly counsel clients about the availability and the potential side effects of various family planning methods. (Not doing so may lead to discontinuation.)

Refresher Training for Distributors in Uganda

In Uganda, officials from the Ministry of Health want to see the CBD of injectable contraception expand nationwide. The motivation of the distributors is an important consideration for such expansions because they are unpaid volunteers. Some officials fear that the program expects too much from the distributors. One way to keep the distributors involved and active is to provide refresher training sessions that remind the distributors that they are part of a bigger picture.

The Uganda program held a refresher training in 2007. The training provided distributors with new information about family planning methods, shared lessons learned with other distributors, and continuing development of their professional skills. Rose Nanyonjo—a distributor in Kiyanja village, Nakasongola district, since 2004—said she gained more skills from the refresher training and that it inspired her to continue her work.

STEP 8

Plan to Document the Processes and the Outcomes

KELSEY LYND/FHI

STEP 8

Plan to Document the Processes and the Outcomes

8

Programs should be routinely monitored (1) to maintain or improve the quality of the services and (2) to track the results. Project coordinators should establish a mechanism to characterize the program's progress, its successes, its challenges, and the important lessons learned from these events. Consider the following actions.

- **Start early.** Ensure that monitoring and evaluation (M & E) is built into your program from the very beginning.
- **Allocate time, money, and staff for M & E.** About 5 percent to 10 percent of the program's budget should be dedicated to monitoring and evaluating activities.
- **Involve program stakeholders in all M & E activities from the beginning.** This is critical to ensuring a common understanding of the program, to maximizing participation, and to fostering a sense of program ownership.
- **Develop a conceptual framework.** Use the framework to articulate your program goals and objectives. Start with your desired impact and work backwards *(see the sample framework on the following page)*.
- **Use the M & E framework to establish performance standards.** Performance standards are program-level goals—the predetermined targets that you should use to evaluate a project. Selecting useful performance standards requires careful thought, a process of refinement, and consensus building among stakeholders. As a rule, performance standards should follow the SMART criteria—**S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**imely. An example of a SMART standard is: "The program will establish a functioning system of referrals with at least one health care facility in each of the five participating districts by July 2008."

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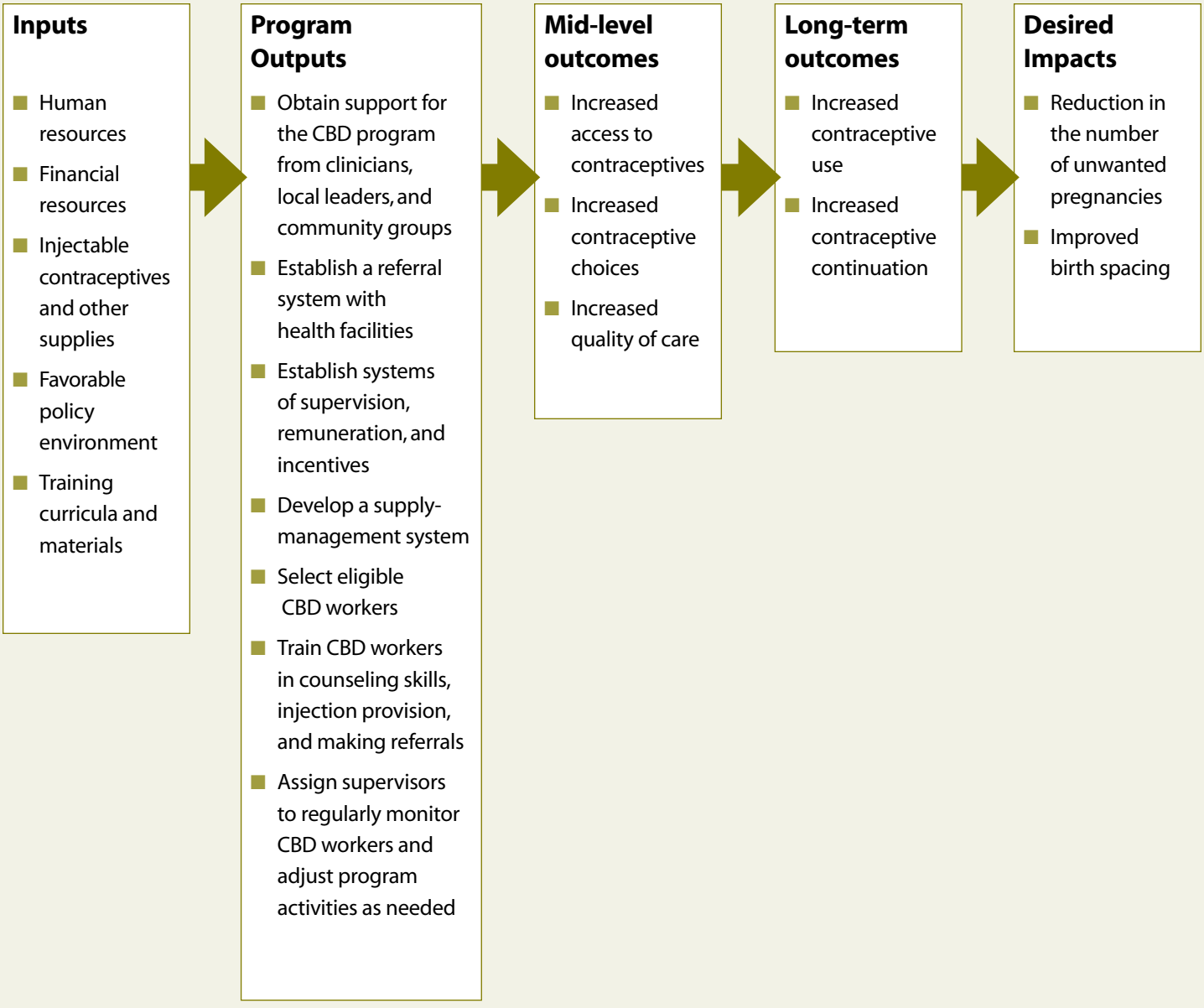
- **Develop a set of measurable indicators based on the established performance standards.** A good indicator will be based on data that are reasonably easy to collect. It will help you to gauge in meaningful units the amount of change that occurred. These indicators will eventually help you to determine whether performance standards have been met. For example, the following types of indicators could measure the program outputs identified in the sample conceptual framework above:
  - Number of people trained to be CBD workers
  - Number of home visits attempted
  - Number of home visits conducted
  - Number of women counseled in family planning methods
  - Number of contraceptive acceptors (women who agree to try a method)
  - Number of women who start a program and then stop
  - Ratio of contacts to acceptors and the dropout rate
  - Number of injections provided
  - Number of written referrals made by CBD workers

A Sample Monitoring and Evaluation Framework for a CBD of Injectables Program



- **Identify your data sources.** Data sources may include monthly service statistics, supply inventory logs, CBD worker notes, input from community leaders on their perceptions of the program, client testimonials and surveys, or other sources.
- **Establish a timeline and develop a plan for data collection.** A table showing your data collection plan—complete with indicators, a timeline, and persons responsible for each activity—is a good way to organize M & E activities *(see the sample table, below)*.

Performance standard	Indicator	Data source	Data-gathering method	Frequency of data collection	Expected completion date	Person responsible

- **Design data-collection tools.** Data-collection forms used by CBD workers should be simple to understand and easy to carry *(see Appendix 10)*. The data points needed should be included on records maintained by the CBD worker. Think carefully about the information you need to collect to adequately measure the program's progress. Do not include indicators just because they are "interesting." Make sure you can rationalize how each indicator will be used to manage and improve the program. Be sure to field test all forms with CBD workers and others, and try to minimize the information-gathering burden you place on the distributors.
  - CBD workers might collect information on:
    - Name and address of client
    - Client information (age, level of education, number of living children, etc.)
    - Dates of first visit and follow-up visits
    - Injectables:
      - New acceptor
      - Continuing acceptor
      - Dates of injections
    - Dates of referrals made and nature of referrals
    - Clients lost during follow-up and the reason (e.g., they discontinued family planning, they switched methods, or they get the method from a health facility)
    - Unused stock at the end of the month
  - Supervisors might collect information on:
    - Name of agent
    - Zone or district assigned
    - Number of clients and visits per client
    - Number of injections provided
- **Train distributors and supervisors to record information.** Emphasize the importance of capturing accurate statistics on their work. For example, you can stress that complete information can help to ensure future funding and that accurate stock-keeping will avoid stockouts.

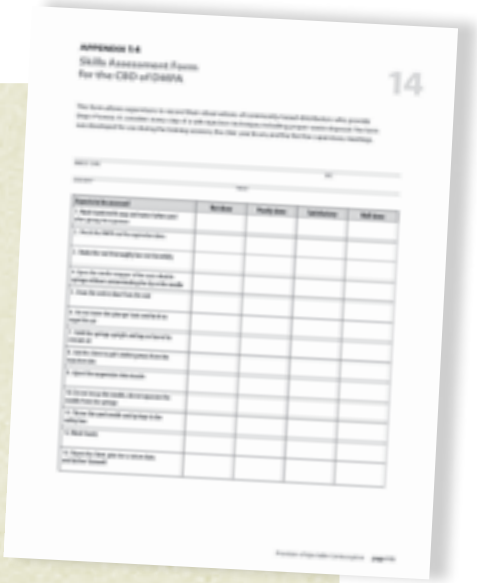
- **Compile information for activity reports, quarterly reports, and annual project reports.** Consider including reports on contraceptive supplies, as well as statistics from the community health facility, to determine the total number of people who use the different family planning methods. You might also include reports on trips, trainings, and finances.
- **Consider the programmatic implications of your findings.** Did the number of contraceptive acceptors increase during the course of the program? Did the program maintain an adequate supply of commodities?
- **Disseminate the reports when appropriate.** Depending on the type of report, it may be appropriate to distribute information on the program's output and outcome to stakeholders, including officials at the ministry of health, international donors, NGO partners, district health offices, and community health facilities.
- **Share the results with those involved in the program, including distributors and staff members at the community health facility.** Those closest to the work often have the best ideas about how to improve it. Seeing the sum total of their work can also serve as an incentive for distributors and health facility staff.
- **Use the approved formats when submitting your findings to the district health office.** Standard forms and indicators, particularly those that are already in place for the national health management information system, should be used whenever possible to accommodate the needs of established data collection systems.
- **Encourage use of the findings.** Evaluation results are only good if they are put to use. Advocate new measures to improve the program based on your results. For example, if data collected from CBD worker logs and participant surveys reveal that women in certain districts are not receiving their injections on time, it should be reported immediately to program managers so that program activities can be suitably modified.

Possible Pitfalls During Step 8

- Neglecting to plan for M & E early in the project.
- Neglecting to develop some predetermined, quantifiable indicators to measure program outputs.
- Failing to adequately train CBD workers and supervisors to record relevant data about their services.

The Importance of Monitoring and Evaluation in Uganda

Documenting how distributors do their jobs, how they are supervised, and what is happening in the field is very important, according to Dr. Anthony K. Mbonye, the head of the Reproductive Health Division at the Uganda Ministry of Health. "Once other districts realize that [distributors] can help increase access to family planning and deliver services, they will want to get on board," he says.



STEP 9

Ensure the Successful Scale-up of the Pilot Project

KELSEY LYND/FHI

STEP 9

Ensure the Successful Scale-up of the Pilot Project

9

If your pilot project is successful, the final step is scaling up the program to other regions of the country. Scaling up is easier to accomplish if it is part of the program's goals and activities from the outset—as early as the developmental phase of the pilot project. Many of the steps previously described set the stage for a successful scale-up. However, there are other factors to consider:

- How will you define scaling up?
- What is the strategy for scaling up?
- Who will take responsibility for guiding scale-up activities?
- How much will it cost, and who will finance the scale-up?

Uganda began to extend its program to the Luwero and Nakaseke Districts in 2006, including the training of 25 more distributors. Here are some lessons learned from that experience.

- **Scaling up may need to be gradual and selective.**
  - It may not be possible to scale up your pilot project to all regions of the country at the same time. Focus on the regions with the greatest need and the necessary infrastructure (including the existing CBD programs).
  - It may not be desirable to extend the CBD of injectable contraceptives to all parts of the country. Regions with large urban populations and an extensive network of health facilities may not have the same need for community-based distribution as rural areas.
- **Budget carefully for scale-up activities.** It is important to sustain the scale-up. If you obtain support from international donors and NGOs for your pilot project, will it continue during the scale-up?
- **Official support for the CBD of injectable contraception is helpful, especially for scale-up.** "Policy support for CBD of DMPA helps conquer concerns about [the providers'] lack of medical training," according to Ms. Liliane Luwaga, the Senior Health Educator at the Reproductive Health Division of the Uganda Ministry of Health.
  - National health policy and service delivery guidelines may not officially support the CBD of injectable contraception during your pilot project.

REBECCA CALLAHAN/USAID

Sustaining the Scale-up in Uganda

Dr. Godfrey Kasibante, the Acting District Health Coordinator from Nakasongola said, "The government has a good plan. It would be good to expand it to every part of Uganda." But he also added, "Sustainability is difficult. We need to consider what happens if Save the Children and FHI are no longer offering support."

However, you can take advantage of a successful pilot project to advocate for official support, which can facilitate the scale-up.

- **Stakeholder buy-in is essential for the success of scaling up.**
  - South-to-south exchanges or educational tours are helpful in creating collaborative environments and creating stakeholder buy-in.
- **You may need to adapt your model for the CBD of injectable contraception over time as the environment changes.** At the same time, it is important not to lose the essential characteristics of the model in this process.
  - One example of a program element you may need to modify is the incentives for the distributors. Providing training and basic supplies may be sufficient in the beginning, but that may not be enough to maintain a distributor's motivation over time.
- **Monitoring and evaluation are necessary for a successful scale-up.**
  - Monitoring and evaluation will help you refine your pilot project while it is under way. It will also convince key partners and stakeholders that the CBD of injectable contraceptives is valuable, and thereby create greater support for scale-up activities.
  - Scaling up is also a process that requires evaluation and documentation. Scale-up activities should be measurable and transparent so that other programs can learn how to scale up effective and essential programming.

Examples of Successful Scale-up

The Matlab Project in Bangladesh

In 1975 the government of Bangladesh, in collaboration with the International Centre for Diarrhoeal Disease Research, Bangladesh, initiated a community-based distribution of condoms and oral contraceptives in 150 villages in the Matlab subdistrict. Depo-Provera was made available in only six of the villages to assess its effect on the program.

In 1977 the program was modified to make Depo-Provera available to all participating villages and to improve the training and supervision of local providers—changes that substantially increased contraceptive acceptance and almost doubled the one-year contraceptive-continuation rate.

By early 1979 Depo-Provera had replaced oral contraceptives as the most popular method, accounting for roughly half of all contraceptives used. The CBD of contraceptives was successfully expanded to the Abhoynagar and Sirajganj subdistricts in 1984, more than doubling the contraceptive use in those regions and increasing the use of injectables from 0.1 percent to 25 percent. The CBD of contraceptives was further expanded to eight more subdistricts in 1993.

The APROFAM Project in Guatemala

In 1995 the Guatemalan family planning association, Asociación Pro-Bienestar de la Familia de Guatemala (APROFAM), in partnership with the Population Council, compared the relative success of medical clinics and CBD programs in the provision of Depo-Provera. The community-based distribution of Depo-Provera reached more than 750 women in four districts. After 15 months, the continuation rate for CBD clients was 90 percent, which was identical to the continuation rate at the clinics. Distributors also achieved high rates of acceptance and continuation among rural Mayan women, an important goal of the program.

Successful distributors tended to be women over 30 years old who were recognized as community leaders. Only three infections were reported among all the clients served by the distributors. Due to the success of this program, APROFAM expanded the CBD of Depo-Provera throughout the country to all 22 districts of its operation. All community-based distributors, or *promotoras*, in APROFAM's rural development program are trained to provide injectable contraceptive services. Distributors now provide the monthly injectable Cyclofem (which contains progestin and estrogen), in addition to Depo-Provera (which contains only progestin).

Possible Pitfalls During Step 9

9

- Not planning for scale-up while the pilot project is in progress.
- Not designating a group of individuals responsible for guiding the scaling-up process.
- Not understanding what is being scaled up. Failure will be more likely if you only scale up the clinical or technical aspects of the model. The most overlooked aspects are the "softer" ones, such as supportive supervision, building community awareness, and advocacy for policy change. Identify the essential aspects to be scaled up so that the effectiveness and quality of the program are maintained.
- Failing to secure supportive policies for scale-up at the national level.

JOHN STANBACK/FHI

KEY POINTS TO REMEMBER

- **Distributors can play an important role in the delivery of health care services. This is recognized by stakeholders at all levels.**

  When they first heard about the CBD of injectable contraception, officials and health providers from Madagascar's Ministry of Health and Family Planning were skeptical. However, just a few months after the project was implemented, the CBD of injectable contraception was in high demand in other areas.

- **Across-the-board collaboration is essential for a program to succeed.**

  In Madagascar, project coordinators found that "to succeed in implementing community activities, you have to involve regional officials from the beginning. You have to reach agreement with all partners (including NGOs) and devise a specific collaborative structure for family planning." A steering committee involving a range of partners also helped to consolidate the collaboration.

- **Community participation is crucial to the success of programs for the CBD of injectable contraception.**

  In Madagascar, project coordinators made sure that mayors, village chiefs, and others were involved from the beginning. They also collaborated closely with the staff and directors of community health facilities, helping to ensure a supportive environment for distributors.

- **Gaining public-policy support can play an important supportive role in the CBD of injectable contraception, although it is not essential for launching a pilot project.**

  Supportive policies may convince key stakeholders to participate in a project. Stakeholders at national and district levels may find supportive policy—such as the inclusion of CBD in national health policy and service delivery guidelines—especially convincing.

- **A steady supply of commodities is essential for the CBD of injectable contraception.**

- **Be sure to implement monitoring and evaluation during your pilot-project phase.**

- **Community-based distribution is a complement to the services available at the local health facilities, not a replacement.**

  Distributors complement the health facilities, particularly in rural areas where people do not have easy access to formal health care. However, distributors receive training to perform specific tasks, not to replace the entire range of care and services available at community health facilities. When planning your pilot project and scaling up, be sure that this is clear to the community (as well as the district and national) health system.

APPENDICES

JOHN STANBACK/FHI

APPENDIX 1
Resources

1

Training providers

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APPENDIX 2
Abbreviations

2

ADRA: Adventist Development Relief Association

APROFAM: Asociación Pro-Bienestar de la Familia de Guatemala

ASOS: Action Socio-sanitaire Organisation Secours

CBD: community-based distribution *or* community-based distributor

CRHW: community reproductive health worker

DMPA: depot-medroxyprogesterone acetate

FDA: U.S. Food and Drug Administration

FHI: Family Health International

M & E: monitoring and evaluation

NGO: nongovernmental organization

PSI: Population Services International

WHO: World Health Organization

USAID: U.S. Agency for International Development

APPENDIX 3
Glossary

3

acceptor: A woman who agrees to use a contraceptive method.

CBD agent or CBD worker: *See* community-based distributor.

community-based distributor: Trusted members of the community who are trained to provide injectable contraceptives in a private and confidential setting.

couple-year of protection: The contraceptive protection provided by a family planning method to a couple for one year. Often used as an index to compare the relative costs of two or more methods.

Depo-Provera: A brand name of depot-medroxyprogesterone acetate.

Depo-subQ Provera 104: A new formulation of Depo-Provera, which is administered subcutaneously. It provides the same efficacy as the original formulation with less hormone.

depot-medroxyprogesterone acetate: A synthetic version of the female sex hormone progesterone. The most commonly used injectable contraceptive. Usually abbreviated as DMPA.

distributor: *See* community-based distributor.

inputs: The resources, contributions, and investments that go into a program.

injectable: A hormonal contraceptive, such as Depo-Provera, that is introduced to the body by means of a syringe.

monitoring and evaluation: The process of evaluating performance and impact using indicators that measure progress toward achieving intermediate targets or ultimate goals. Data collection, analysis, and reporting are used to monitor the progress.

Noristerat: A progestin-only injectable contraceptive, which must be administered every two months. It contains the synthetic hormone norethisterone enanthate.

outcomes: Results or changes for individuals, groups, communities, organizations, and systems.

progestin: A synthetic version of the female sex hormone progesterone.

program outputs: Activities, services, events, and products that reach the people targeted by a specific program.

provider: *See* community-based distributor.

sharps: Used needles and other sharp objects that can cause serious injuries.

stockout: When the demand exceeds the supply of a product, and the inventory is zero.

Uniject: A single-use, non-reusable, prefilled injection device.

APPENDIX 4

Rapid Assessment Guide for Site Identification of the CBD of DMPA

4

This assessment tool may be adapted and used to determine whether a particular CBD program is suited for the addition of injectable contraceptives to the existing method mix. Sections include information about the geographic location, local health system, CBD program details, and supervision resources.

NAME/POSITION OF RESPONDENT: _____

DISTRICT AND CONTACT INFORMATION: _____

ASSESSMENT DATE: _____

Assessment sites *(please list):*

_____

_____

A. About the district

Sources of information *(please list):*

_____

_____

1. **What is the district contraceptive prevalence rate?** _____
2. **What is the main challenge in the district with respect to family planning (FP) services?** _____

   _____
3. **Are there underserved populations? What special characteristics do these populations have?** _____

   _____
4. **How many health facilities are there in the district? Hospital – level II and above** ***(by name)*** _____

   _____
5. **How many health workers are trained in FP at each of the health facility levels?** ***(indicate facility and number trained)*** _____

   _____
6. **What FP services are provided at level II?** _____

   _____
7. **What is the FP commodity status of the district? Is stockout common?** _____

   _____

8. What is the most used FP method in the district? _____

9. Does the use of FP services vary by other geographic boundaries in the district, such as divisions or service delivery points? *(indicate exact variations by locations)* _____

10. Did you participate in the stakeholders' meeting on increasing access to injectable contraceptives through CBD systems? _____

11. Are you familiar with the practice of CBD of DMPA (Depo-Provera)? _____

12. Are you aware of the country's interest in and plans for implementing a demonstration project for the CBD of DMPA? _____

13. Would the district be interested in an intervention to improve access to DMPA through CBD systems? _____

B. Information about CBD Activities in the District

Sources of information *(please list):*

_____

_____

1. In which specific areas of the district is the CBD of contraceptives implemented? _____

2. Which specific health facilities have linkages with the CBD activities? _____

3. How long has the CBD program been running? _____

4. How is it funded? _____

5. What is the duration of current funding? If funding ends soon, what are the plans for securing new funds? _____

6. What is the total number of CBD workers? _____

7. What are the CBD workers' activities? _____

8. **Is there regular reporting of CBD activities at the health facilities?** _____

9. **What is the average number of clients per worker every month?** _____

10. **Are there records showing the quantity of commodities supplied by the health facility to CBD agents?** _____

11. **Are there referral records for the CBD workers? What is the most common reason for referral?** _____

12. **How are CBD workers selected? What are the criteria?** _____

13. **How are CBD workers trained? Are trainings on a routine schedule? If so, when? When was the last training conducted?** _____

14. **How are CBD workers supervised?** _____

15. **How is follow-up of clients monitored?** _____

16. **Are CBD workers linked to the government health facilities? What is the nature of the link?** _____

17. **Are there any incentives for the CBD workers?** ***(please specify)*** _____

18. **Who are the point people for CBD activities within the district?** _____

19. **Please provide your opinion about the current and past operation of the CBD program.** _____

20. **Which areas of the CBD program need improvement?** _____

21. Assuming the CBD of DMPA was to be implemented in your district, how would you ensure the following? *(your response should assume district responsibilities, with no financial aid from FHI)*

    a. Adequate stocks _____

    b. Quality control (hygiene, safety) _____

    c. Adequate supervision _____

    d. Referral _____

    e. Integration into the district health system _____

22. If not already present at today's meeting, who would be the district-level point person for coordination of a pilot project? Are there other key stakeholders who should be involved? _____

23. Is there someone you consider to be a champion or leader—such as a district official, supervising nurse or physician, or CBD worker—within the CBD program? _____

C. Information about DMPA Provision at Health Facilities Linked to CBD

Source of information *(facility supervisor):*

_____

_____

1. What is the average **monthly** number of clients who receive **all** family planning methods (e.g., combined oral contraceptives, injectables, implants, and IUDs) from this facility? _____
2. What is the average **monthly** number of clients who receive DMPA injections at this facility? _____
3. What is the average **monthly** number of patients who are attended to at this facility? _____
4. How many trained health workers provide DMPA injections at this facility? _____
5. Do you think there are an adequate number of trained health workers who can provide DMPA injections to clients at this facility?

_____

_____

APPENDIX 5

Sample Outline for the CBD of DMPA Training

5

This example of an improved training program was adapted from projects in Uganda and Madagascar. The lessons learned include suggestions on the training objectives, the duration of the training, the ideal numbers of trainers and trainees, and the certification of the trainees.

Sample Outline for the CBD of DMPA Training

Duration of the training: About 3 to 5 days for classroom and supervisory training (duration varies with the need for administrative sessions and the review of family planning sessions). About 1 to 2 weeks for a hands-on workshop in a supervised health facility (duration varies with the number of clients in the practice clinics).

Number of participants: About 15 to 20 CBD workers and relevant CBD program staff or health facility supervisors.

Number of trainers: About 2 to 3 trainers (may include CBD program trainers and local district trainers).

Certification: After successful completion of training, including pre- and post-test and 5 or more injections provided under supervision.

Training objectives: By the end of training, participants will be able to:

- Explain the need for family planning (FP) services at the community level
- Provide accurate information about modern FP methods, including injectable contraceptives
- Demonstrate counseling skills for informed decision-making
- Demonstrate counseling skills for clients who want injectable contraceptives
- Use the injectable contraception eligibility checklist to screen at least 5 clients
- Start at least 5 clients on injectable contraception
- Provide information on injection safety and demonstrate infection-control techniques
- Maintain accurate records on clients and contraceptive supplies

Time	Day One	Day Two	Day Three	Day Four
0800 - 0915	Courtesy visit (regional and district ministry of health)	Opening and participant introductions Training objectives	Supervised practice of counseling, screening checklists, and safe injection technique	Role-play Supervised practice of counseling, screening checklists and injection practice
0915 - 0930	Break			
0930 - 1200	Team building	FP and CBD review DMPA overview		
1200 - 1300	Lunch			
1315 - 1515	Supervisor training session	Using the screening checklist Steps for injecting DMPA with autoblock/auto-disable syringe	Feedback from technical assistants Screening checklists and injection practice	Review of checklists, injection safety, waste disposal, logistics and supplies, supervision, and management tools
1515 - 1530	Break			
1530 - 1800	Supervisor training session	Safety precautions and waste disposal Practice DMPA injections using fruits	Supervision system and referral Logistics and supplies Completing management tools/documentation	Post-test (45 minutes)* Closing

**Pre-test to be given prior to training as an entrance exam.*

APPENDIX 6

Training Pre-test and Post-test for the CBD of DMPA

6

This test was used with community-based distributors before and after training in Madagascar to assess whether they were ready to add injectable contraceptives to their services. The test should be adapted to match the content of the training, which may vary depending on the need to review family planning methods or to include other stakeholders. Some programs may consider using the test as one of the selection criteria for CBD workers to provide injectables. In areas where literacy is very low, the pre-test may identify distributors who have unacceptable reading and writing skills.

I. General knowledge of reproductive health and health care structure

1. **Reproductive health is:**

2. **Name at least three components of reproductive health.**

3. **Explain (or draw) the health care structure in Madagascar.**

II. General knowledge of family planning

Mark the correct answer(s):

4. **Menstrual Cycle:**
   - ❑ Starts on the first day of menstruation
   - ❑ Is of equal length in all women
   - ❑ Ends 21 days before the next menstruation starts

5. **Ovulation:**
   - ❑ Takes place on average 14 days before the next menstruation starts
   - ❑ Takes place on average 7 days before the next menstruation begins
   - ❑ Takes place on average 7 days after menstruation

6. **Contraceptive methods available to community-based distributors include:**
   - ❑ Injections (DMPA or Depo-Provera)
   - ❑ Pills
   - ❑ Condoms
   - ❑ Foams or spermicide
   - ❑ IUD
   - ❑ Norplant or Implanon

7. **Contraceptive methods available at health facilities in Madagascar include:**

III. Knowledge of contraceptives and the disposal of used equipment

Mark the correct answer:

8. DMPA contains:
   - ❑ Estrogen
   - ❑ Estrogen and progesterone
   - ❑ Progesterone

9. DMPA prevents pregnancy in women for a period of:
   - ❑ 6 months
   - ❑ 3 months
   - ❑ 1 month

10. After the injection is given:
   - ❑ Cover the needle before its disposal into the sharps container
   - ❑ Do not cover the needle and dispose of it immediately into the sharps container
   - ❑ Take the needle apart, but be careful not to injure yourself

11. Containers for contaminated sharps should be disposed of and burnt when:
   - ❑ They are full
   - ❑ They are almost full
   - ❑ There is some used equipment in the container

12. Containers for contaminated sharps should:
   - ❑ Be close to the place where the injection is given
   - ❑ Be far away from the place where the injection is given
   - ❑ Be disposed of and burnt every evening

13. Name the different steps to be followed for administering DMPA.

14. Who is eligible for DMPA? Give at least two examples.

15. Provide at least two examples of clients who are not eligible for DMPA.

16. Name at least three side effects of DMPA.

17. What are the steps for disposing of used injection equipment?

18. What part of the injection equipment should not be touched?

IV. Knowledge of the counseling process for providing contraceptive methods and knowledge of management tools

19. What is the counseling process for providing contraceptive methods?

20. What management tools are used by community-based workers?

APPENDIX 7

Training Curriculum: DMPA Provision by Community-Based Reproductive Health Workers in Africa

This training manual was originally developed in 1998 for a program in Bolivia. It has been updated and adapted for use in Africa, where it has been translated into local languages. The manual has also been used by CBD workers as a reference on essential aspects of DMPA provision and counseling.

DMPA Provision by Community-Based Reproductive Health Workers in Africa

USAID FROM THE AMERICAN PEOPLE

fhi Family Health International

Save the Children.

This booklet is based on the document *Guidelines for Promoters: Depo Provera* written by Dr. Oscar Zuna, Maria Lopez, and Sarah Johnson and produced in Bolivia by FHI and CIES in 1998.

The illustrations are by Ambrose Hoona-Kab and are based on those by Jenny Espinatto, La Paz, Bolivia. Thanks to Tita Oronoz for her help in producing this document and to Heather Bannan for her production assistance.

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Maternal Mortality and Family Planning

Worldwide, more than half a million women die each year due to complications from pregnancy and childbirth, with the greatest incidence in developing countries. In Uganda, for example, it is estimated that there are approximately 13,000 pregnancy- and childbirth-related deaths per year. This translates to about 35 deaths each day.

One very good way to prevent maternal mortality is to ensure that women have access to family planning services so that they can make decisions freely and voluntarily about the number and spacing of their pregnancies. In cities and towns, women usually have access to contraceptive services, but in rural areas, it may be difficult for women to reach clinic-based family planning. In many places, community-based distribution (CBD) of family planning fills the gap, but such services do not typically provide the most popular contraceptive method, Depo-Provera (DMPA). This manual is designed to provide key information about Depo-Provera to community-based reproductive health workers so that they can "fill the gap" in services and provide safe, high-quality services that meet local demand.

Who can use DMPA?

Almost any woman of childbearing age can use DMPA. If a woman decides to use DMPA, you should provide accurate, clear, simple, and complete information on the injection and make sure your client is confident in her choice of method. This will prevent the woman from being frightened by any side effects, thus minimizing negative rumors in the community about DMPA's safety.

- *If side effects do occur, she will be well informed and will know whether the symptoms are normal or if she requires medical attention.*

Responsibilities of the Community-Based Reproductive Health Worker

The community-based reproductive health worker informs women about various family planning methods so they can freely make informed decisions about their sexual and reproductive health.

The health worker should:

A. Make sure that the client knows about the family planning methods available.

B. Clearly explain the methods' characteristics, benefits, limitations, and side effects.

C. Listen and respond to the client, considering her situation, needs, and feelings. Allow the client to make her own informed decision concerning what family planning method, if any, she wants and needs.

DO NOT FORGET...

- *The role of a community-based reproductive health worker is not only to provide information, but to listen to the client, tailor information to her needs, and support her in her decision. Community-based reproductive health workers SHOULD NOT make the decisions for their clients.*
- *Although community-based reproductive health workers can safely provide contraceptive injections, it is very important to remember that they are not health professionals with the clinical skills of doctors, nurses, and midwives.*
- *When questions arise that require any clinical expertise, community-based health workers should refer clients to local health care professionals.*

What is DMPA?

• DMPA is an injectable contraceptive.

• Each dose contains 150 mg of a synthetic progestin, which is similar to the natural hormone that a woman's body makes. The hormone is slowly released into the blood stream.

• DMPA, or depot-medroxyprogesterone acetate, (also called Depo-Provera) is given every three months. The dates above are for example. Each client will have a different start date. CBD agents will count twelve weeks forward for the re-injection.

3

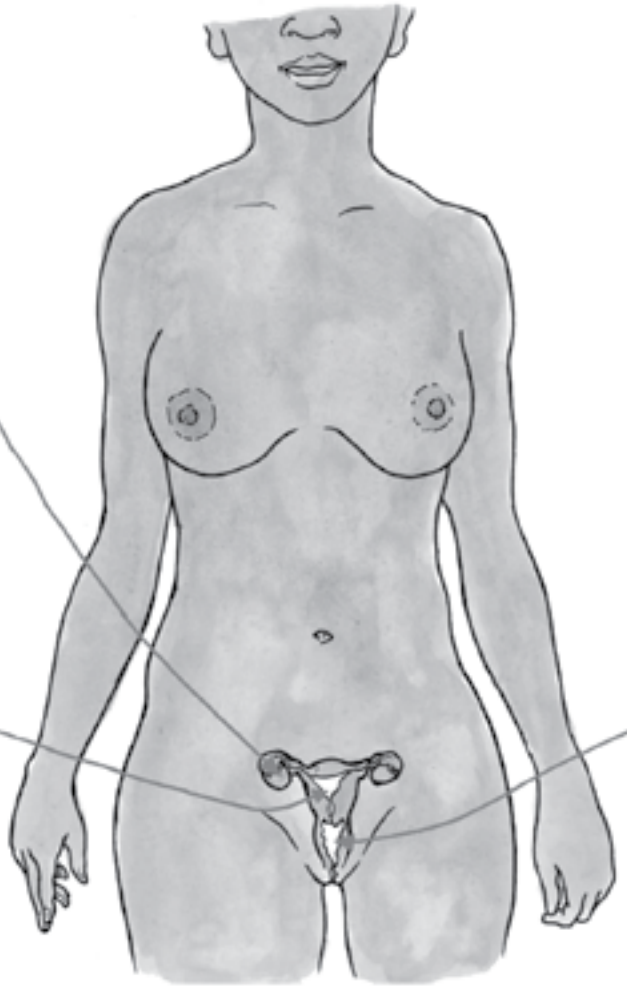
Safety and Efficacy of DMPA

- DMPA is highly effective. Only ONE of every 333 women using DMPA becomes pregnant in the first year of use. Its effectiveness is very similar to that of female sterilization.

- It is used by more than 10,000,000 women worldwide.
- It has been used for about 30 years.
- It is very safe; more than 100 countries, including Uganda, have approved its use.
- It does not cause cancer, birth defects, or sterility; nor does it produce any significant change in blood pressure.

4

How Does DMPA Work?



- Prevents eggs from maturing and leaving the ovaries
- Thins the lining of the uterus
- Thickens the cervical mucus
- DMPA does **not** cause an abortion

5

Primary Mechanism of Action:

DMPA prevents eggs from maturing and leaving the ovaries. After being injected with 150mg of DMPA, a woman does not ovulate for at least 14 weeks (approximately three months).

Secondary Mechanisms of Action:

It thickens the cervical mucus. The cervical mucus becomes thicker than normal, which makes it more difficult for the sperm cells to enter the uterus.

It thins the lining of the uterus. Due to changes in hormone level (progesterone and estrogen), DMPA thins the endometrium (lining of the uterus), which makes it unable to support implantation of the fertilized egg.

Who Can Use DMPA?

Any woman of reproductive age who:

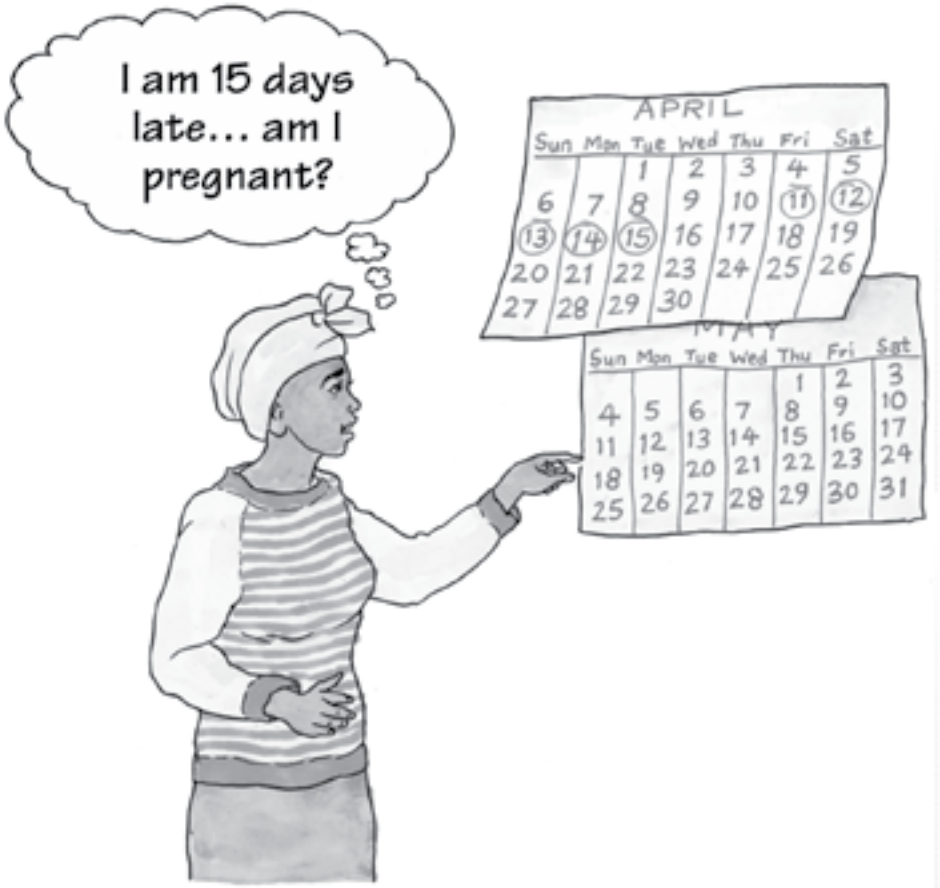
- Desires an effective, reversible, and long-lasting method of contraception
- Is breastfeeding her baby and wishes to use a hormonal method
- Wants a method that does not interfere with sexual relations
- Does not want to keep contraceptives at home
- Does not want others to know she is using a contraceptive method
- Cannot use contraceptives that contain estrogen
- Has or has not had children

- Any woman who has had her desired number of children but does not want a permanent method, such as sterilization

Who CANNOT use DMPA?

Women should not use DMPA if they:

- Are pregnant



- Suspect they are pregnant

Women with the following conditions should be referred to a higher-level provider to decide if they can use DMPA or choose another method:

• Presence of abnormal vaginal bleeding

• Suspicion or confirmation of breast cancer

• Heart disease

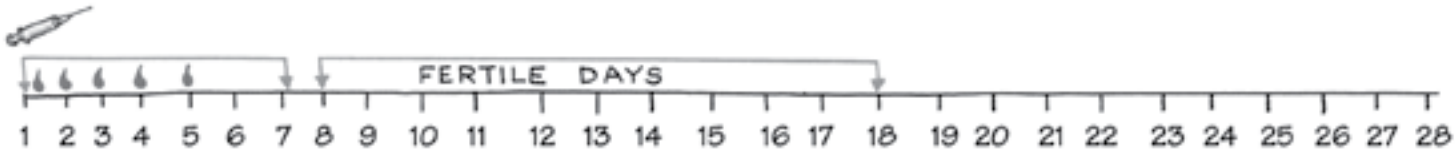
• Liver disease

• Diabetes

• High blood pressure

Note: *If clients have any of these conditions, refer for care.*

When Can DMPA be Used?



1. When a woman is having regular menstrual cycles.

- DMPA can be provided any time it is reasonably certain the woman is not pregnant.

You can offer DMPA during the first seven days after your client's menstruation (period) starts (it is not necessary to verify bleeding) and at any time during the rest of her cycle if she has not had sexual relations since menses. After day eight of her cycle, she should abstain from sex or use condoms for at least seven days.

2. After miscarriage or abortion.

- DMPA can be initiated immediately or within seven days after abortion or miscarriage.

After day eight, DMPA can be provided if she has not had sexual relations since the abortion or miscarriage. (She should abstain from sex or use condoms for at least 48 hours.)

3. After childbirth if not breastfeeding.

- Initiate DMPA the same day of delivery or any time in the first four weeks postpartum. Beyond four weeks, you can initiate DMPA if she has abstained from sexual relations.

4. After childbirth if breastfeeding.

- If the woman is fully breastfeeding, she is protected against pregnancy for six months or until she has a menstrual period. (This method of family planning is called the **Lactational Amenorrhea Method** [LAM].) However, if she wants extra protection, she can use DMPA starting the sixth week after delivery.

- Correct use of LAM means that the woman should meet these three requirements:

  a. She is exclusively breastfeeding every three hours, during both day and night.

  b. She has not had menses since giving birth.

  c. She is less than six months postpartum.

5. When a woman stops using another method (oral contraceptives, the copper IUD, barrier methods), she can be given DMPA immediately.

DO NOT FORGET...

- *The client should receive a DMPA injection every three months.*
- *In the event that she cannot return to her next scheduled injection, she can come up to four weeks earlier or two weeks later. Keep accurate records of the client's injection dates and try to follow up with her before the two-week grace period ends.*
- *Once you have ruled out pregnancy and other conditions, provide DMPA and a backup contraceptive method as needed.*

• It is important to remember to:

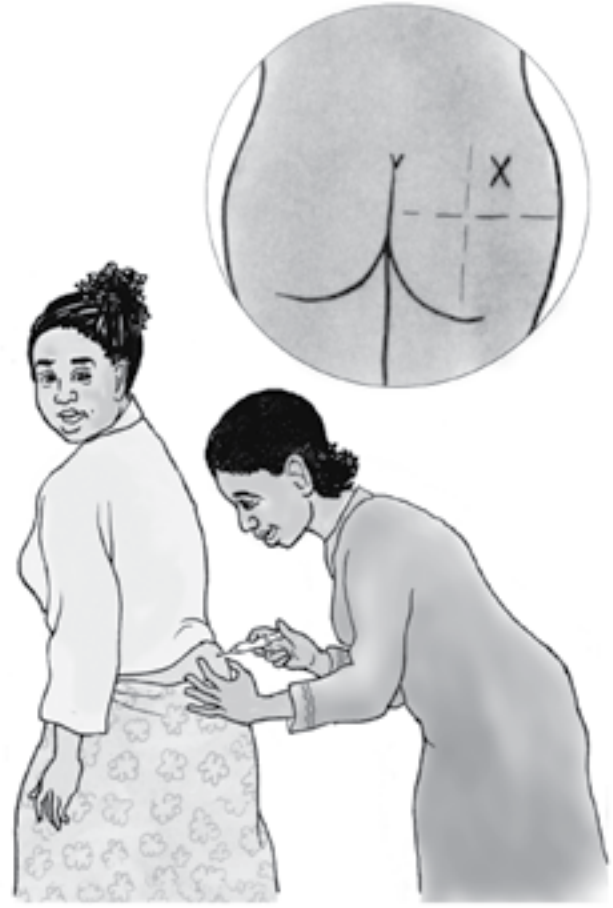
1. Provide clients with a confidential environment.
2. Show the user the expiration date and contents listed on the bottle of DMPA.
3. Ask her where she wants to receive the injection Most women can choose to receive the injection in the arm or the buttock. However, if the woman is very thin, the buttock is the preferred site.

4. Before giving the injection, explain the steps you will be following.
5. Show the client the package that contains the needle and the syringe before opening them, so that she can confirm that they are sterile and new.
6. Remind the client that she needs another injection in three months. Explain that she can speak to you or visit a health center at any time if she has problems, questions, or doubts.

How is DMPA Provided?

The injection can be given in:

• The arm (deltoid muscle)



• The buttocks (gluteal muscles)

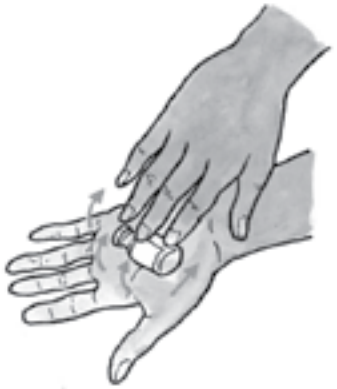
• How to give the injection:

First, familiarize yourself with the syringes and needles used by your program. Then follow these general instructions.

1. Wash your hands well with soap and water.

2. Dry your hands with a clean towel or let them air dry.

3. Check the bottle for content, dose, and expiration date.



4. Roll the bottle between the palms of your hands to mix the solution, or shake it gently. (Do NOT shake it vigorously because the contents will become frothy.)

5. Open the sterile package containing the syringe and the needle.

6. Hold the bottle of DMPA and remove the plastic top that covers the fluid.

7. Turn the bottle upside down, insert the needle into the bottle's rubber cover, and empty all the contents into the syringe. Be careful not to contaminate the needle. Expel the air from the syringe without pushing out any of the DMPA.

8. Clean the injection site with cotton and alcohol or a clean cloth and water, wiping in a circular motion.
9. Allow the alcohol to dry before giving the injection.

10. Insert the needle, making sure it is not inserted into a blood vessel. If you draw blood (this happens rarely), take out the needle and try again in another spot. Inject DMPA deep into the deltoid muscle (upper arm) or in the gluteal muscle (buttock), emptying all the contents of the syringe.

18

11. After injecting the DMPA, gently PRESS the injection site (do not rub or massage) with a new cotton ball soaked in alcohol, or with a clean cloth.

12. Place the used syringe in a puncture-proof container. Use great care to avoid a needle-stick injury to yourself and others. Follow local regulations on disposal of sharps containers.

13. Instruct the client NOT to massage the area after the injection. Massage could cause DMPA to absorb faster and make it less effective.

14. Wash hands again with soap and water.

• When Does the DMPA Take Effect?

DMPA takes effect immediately if it is given between day one and seven of a woman's cycle, where day one is first day of menstruation.

When the injection is given after the seventh day, a condom should be used or the couple should abstain from sex for the next seven days.

• When should the client return?

Instruct the client to return in three months for her next injection. Explain that she can return any time if she has problems, questions, or doubts.

Tell her to return or visit a clinic if any of the following symptoms occur:

- Profuse vaginal bleeding (constant bleeding in greater quantity than menstruation)
- Severe headaches
- Severe abdominal pain

- **Common side effects:**

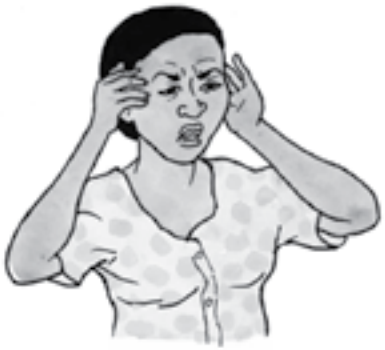
- You will not menstruate regularly while using DMPA. Irregular spots or mild bleeding can last up to a year, but usually less.

- Amenorrhea (absence of menstruation) will occur eventually with continued use of DMPA.

- Weight gain

Ask the user to visit the clinic if she has any concerns.

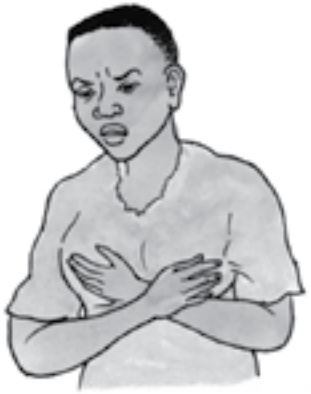
• Less frequent side effects:



• Headaches

• Mood swings

• Nausea



• Breast tenderness

Do not forget that:

1. DMPA does **NOT** cause cancer.

   Research has clearly proven that DMPA does not cause cancer; in fact, it has been demonstrated that it protects against endometrial cancer (cancer of the lining of theuterus) and cancer of the ovaries.

2. DMPA does not cause sterility.

   Although it may take an average of nine months for a woman to become pregnant after discontinuing Depo-Provera, DMPA does not cause a woman to become permanently infertile.

3. A woman who uses DMPA produces enough milk while breastfeeding.

   Studies have demonstrated that the quantity of milk does not diminish when a breastfeeding woman uses DMPA. It does not affect the milk's composition, the initiation or duration of lactation, or the growth and development of the child.

4. Amenorrhea, or absence of menstruation, is **NOT** harmful to a woman's health.

   Amenorrhea is an expected side effect of DMPA, since women who use it DO NOT produce eggs. This type of amenorrhea is NOT harmful, since it helps prevent anemia and frees women from the inconvenience of bleeding every month.

5. DMPA does NOT cause abnormal or deformed babies.

   There is no evidence that DMPA causes abnormalities in children. Studies conducted in children who were exposed to DMPA in the uterus did not show increases in birth defects.

Notes

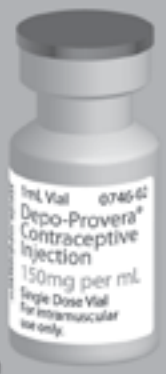
APPENDIX 8

Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)

8

This checklist is intended for use by clinical and nonclinical health care providers, including community-based distributors. The clients should make an informed decision to use DMPA before they are screened. The checklist is based on the World Health Organization's *Medical Eligibility Criteria for Contraceptive Use* (WHO 2004). FHI also developed a reference guide for the provider checklists (*see Appendix 1*).

Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)



Research findings have established that depot medroxyprogesterone acetate (DMPA) and norethisterone enantate (NET-EN) are safe and effective for use by most women, including those who are at risk of sexually transmitted infections (STIs) and those living with or at risk of HIV infection. For some women, DMPA and NET-EN are usually not recommended because of the presence of certain medical conditions such as liver tumors and breast cancer. For these reasons, women who desire to use DMPA must be screened for certain medical conditions to determine if they are appropriate candidates for DMPA.

Family Health International (FHI), with support from the U.S. Agency for International Development (USAID), has developed a simple checklist (see center spread) to help health care providers screen clients who were counseled about contraceptive options and made an informed decision to use DMPA. This checklist is a revised edition of the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)* produced by FHI in 2002. This checklist is based on recommendations included the *Medical Eligibility Criteria for Contraceptive Use* (WHO, 2004). The main changes in this version of the checklist include the addition of high blood pressure (systolic ≥160mmHg or diastolic ≥100mmHg) as a condition that would prohibit the use of DMPA and the inclusion of a series of questions to determine with reasonable certainty whether a woman is not pregnant before initiating the method.

The checklist is designed for use by both clinical and nonclinical health care providers, including community health workers. It consists of 13 questions designed to identify medical conditions that would prevent safe DMPA use or require further screening, as well as provide further guidance and directions based on clients' responses. Clients who are ruled out because of their response to some of the medical eligibility questions may still be good candidates for DMPA after the suspected condition is excluded through appropriate evaluation.

This checklist is part of a series of provider checklists for reproductive health services. The other checklists include the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives*, the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD*, and the *Checklist on How to be Reasonably Sure a Client is Not Pregnant*. For more information about the provider checklists, please visit www.fhi.org.

Assessing Medical Eligibility for DMPA

1. Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?

This question is intended to identify women with already known serious vascular disease, not to determine whether women might have an undiagnosed condition. Women with these conditions may be at somewhat increased risk of blood clots if they use DMPA. Women who have had any of these conditions will commonly have been told that they have the condition and will answer "yes." Answering "yes" to any part of the question means that the woman is not a good candidate for DMPA.

2. Have you ever been told you have breast cancer?

This question is intended to identify women who know they have had or currently have breast cancer. These women are not good candidates for DMPA because breast cancer is a hormone-sensitive tumor, and DMPA use may adversely affect the course of the disease.

3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?

This question is intended to identify women who know that they currently have a serious liver disease and to distinguish between current severe liver disease (such as severe cirrhosis or liver tumors) and past liver problems (such as treated hepatitis). Women with serious liver disease should not generally use DMPA because it is processed by the liver and hence its use may adversely affect women whose liver function is already weakened by the disease.

4. Have you ever been told you have diabetes (high sugar in your blood)?

This question is intended to identify women who know that they have diabetes, not to assess whether they may have an undiagnosed condition. Women who have had diabetes for 20 years or longer or those with vascular complications should generally not use DMPA because of the increased risk of blood clots. Evaluate or refer for evaluation as appropriate and, if these complications are absent, the woman may still be a good candidate for DMPA.

5. Have you ever been told you have high blood pressure?

This question is intended to identify women who may have high blood pressure. These women should be evaluated or referred for evaluation as appropriate. Based on evaluation, women with blood pressure levels of 160/100 Hg or more should not initiate DMPA.

6. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?

This question is intended to identify women who may have an underlying pathological condition. While DMPA use does not make these conditions worse, it may change the bleeding pattern and mask a serious underlying condition. Unusual bleeding changes may indicate pregnancy or tumor that should be evaluated soon or treated by a higher-level health care provider. DMPA use should be delayed until the condition can be evaluated. In contrast, women for whom it is not unusual to have heavy or prolonged bleeding, or irregular bleeding patterns, may safely initiate DMPA use.

7. Are you currently breastfeeding a baby less than six weeks old?

This question is included because of the theoretical concern that hormones in breast milk can have an adverse effect on a newborn during the first six weeks after birth. A breastfeeding woman can initiate DMPA six weeks after her baby is born.

Determining Current Pregnancy

Questions 8–13 are intended to help a provider determine, with reasonable certainty, whether a client is not pregnant. If a client answers "yes" to any of these questions and there are no signs or symptoms of pregnancy, it is highly likely that she is not pregnant. The client can start DMPA now.

If the client is within 7 days of the start of her menstrual bleeding, she can start the method immediately. No back-up method is needed.

If it has been more than 7 days since her first day of bleeding, she can start DMPA immediately but must use a back-up method (i.e., using a condom or abstaining from sex) for 7 days to ensure adequate time for the DMPA to become effective.

If you cannot determine with reasonable certainty that your client is not pregnant (using the checklist) and if you do not have access to a pregnancy test, then she needs to wait until her next menstrual period begins before starting DMPA. She should be given condoms to use in the meantime.

Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)

To determine if the client is medically eligible to use DMPA, ask questions 1–7. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions below.

NO	1.	Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?	YES
NO	2.	Have you ever been told you have breast cancer?	YES
NO	3.	Do you have a serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	4.	Have you ever been told you have diabetes (high sugar in your blood)?	YES
NO	5.	Have you ever been told you have high blood pressure?	YES
NO	6.	Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?	YES
NO	7.	Are you currently breastfeeding a baby less than 6 weeks old?	YES

If the client answered **NO** to ***all of questions 1–7,*** the client can use DMPA. Proceed to questions 8–13.

If the client answered **YES** to ***any of questions 1–3,*** she is not a good candidate for DMPA. Counsel about other available methods or refer.

If the client answered **YES** to ***any of questions 4–6,*** DMPA cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

If the client answered **YES** to ***question 7,*** instruct her to return for DMPA as soon as possible after the baby is six weeks old.

Ask questions 8–13 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions below.

YES	8. Did your last menstrual period start within the past 7 days?	NO
YES	9. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	NO
YES	10. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	11. Have you had a baby in the last 4 weeks?	NO
YES	12. Have you had a miscarriage or abortion in the last 7 days?	NO
YES	13. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to ***at least one of questions 8–13*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can start DMPA now.

If the client began her last menstrual period ***within the past 7 days,*** she can start DMPA immediately. No additional contraceptive protection is needed.

If the client began her last menstrual period ***more than 7 days ago,*** she can ***be given DMPA now,*** but instruct her that she must ***use condoms or abstain from sex for the next 7 days.*** Give her condoms to use for the next 7 days.

If the client answered **NO** to ***all of questions 8–13,*** pregnancy cannot be ruled out.

She must use a pregnancy test or wait until her next menstrual period to be given DMPA.

Give her condoms to use in the meantime.

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FROM THE AMERICAN PEOPLE

fhi Family Health International

APPENDIX 9

2008–2010 Calendars

9

These calendars may be used by community-based distributors to determine the dates for return appointments and the "grace period" for clients who arrive late for their scheduled reinjections. According to WHO guidelines, clients who receive DMPA or NET-EN can be up to two weeks late (the grace period) for their scheduled reinjection without the need for a pregnancy test.

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SEPTEMBER

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NOVEMBER

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SEPTEMBER

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NOVEMBER

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DECEMBER

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APPENDIX 10

One-Year Client-Tracking Card for the CBD of DMPA

10

Existing CBD programs will have their own form for keeping track of each client's service needs, return dates, and referrals. This example follows DMPA clients for one year (or four injections). Other key information is also collected, such as whether the client is a new acceptor or was previously receiving DMPA from a clinic. In combination with continuation rates and complications, this information can help program managers to assess the effectiveness of the DMPA program.

Purpose

This card should be used during the first year that DMPA services are added to CBD programming.* Its purpose is to assess the health and efficacy of the DMPA component of the CBD program based on client continuation, new clients, and potential complications. It will be used by CBD workers to track the services provided to the clients, including the dates of follow-up services and the dates of any referrals.

Directions

Each CBD worker should be trained to use this tracking card. The CBD workers should fill out this card every time they provide a service for a client. The card should be shared with the supervisor, who will record the information and use it in regular reporting.

Description of Fields

Name/Client ID: Record the client's name and ID number, which can be used as a cross-reference to any other health records on file.

Former clinic DMPA user?: "Yes" indicates that the client has received DMPA services at a clinic in the past. "No" indicates that the client has never received DMPA from a clinic in the past. (This will help determine whether clients are switching from clinic-based services to CBD services.)

New DMPA user?: "Yes" indicates that the client has never used DMPA in the past. "No" indicates that the client has used DMPA in the past.

Date of 1st CBD injection: Record the date of the first injection you give to the client.

Location given: Record the place where you provide the 1st injection *(e.g., client's home, CBD worker's home)*.

Date 2nd, 3rd, or 4th injection is due: Record the date that the next injection is due.

Date delivered: Record the date that the injection was *actually delivered*.

Referrals (for what; to whom; date): Record any referrals. It is important to record the purpose of the referral, to whom it was made, and on what date.

Referral follow-through?: Record whether the client followed through with the referral.

Complications or complaints (abscess, needle sticks, other—please specify): Record any complication associated with DMPA and the date it was reported.

Additional comments: Record any other notes you feel are important.

**Adaptations of this card can be made for monitoring activities beyond the first year. Existing CBD monitoring tools could be adapted to include the monitoring of DMPA services so as to limit paperwork for CBD workers.*

One-Year Client-Tracking Card for the CBD of DMPA

CBD WORKER'S NAME:

CBD WORKER'S LOCATION:

	Name Client ID	Former clinic DMPA user? Yes / No	New DMPA user? Yes / No	Date of 1st CBD injection Location given	Date 2nd injection is due Date delivered	Date 3rd injection is due Date delivered	Date 4th injection is due Date delivered	Referrals (for what; to whom; date)	Referral follow-through? Yes / No	Complications or complaints (abscess; needle sticks; other — please specify; provide dates)	Additional comments
1	Client Name 012345	No	Yes	02/12/07 Client's home	02/03/08 05/03/08						
2											
3											
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11											

APPENDIX 11

Client Referral Form for Community Reproductive Health Workers

11

CBD programs have a mechanism for referring clients to health facilities for care and services that are not offered by the program. This example from Uganda is included here to reiterate the importance of maintaining a link between community-based distributors and the clinical personnel at a health facility.

Part A. Client Referral Form for Community Reproductive Health Workers

(to be retained by the clinic health worker/staff member)

_____

DATE:

Dear Clinic Health Worker/Staff Member:

I am referring Mr./Ms. _____ *(Patient)* of _____ *(Village)*

_____ *(Parish)* _____ *(Subcounty)* to you for:

1. **Contraceptive method *(specify)*** _____
2. **Side effect management *(specify)*** _____
3. **Maternal health services *(specify)*** _____
4. **STD management *(specify)*** _____
5. **Other *(specify)*** _____

_____

CRHW NAME

_____

SIGNATURE PARISH

Part B. Client Referral Form for Community Reproductive Health Workers

(to be completed by the clinic health worker and returned to the referring community reproductive health worker)

_____

DATE:

Client's name: Mr./Ms. _____ *(Patient)* has received services at this health facility as per the referral.

_____

SIGNATURE

_____

NAME OF SERVICE PROVIDER

_____

NAME OF HEALTH FACILITY

_____

SERVICE PROVIDED *(in brief)*

APPENDIX 12

Contraceptive Stock-Control Form for Community Reproductive Health Workers

12

This form adds Depo-Provera to a document commonly used to track contraceptive stocks by community-based distributors, supervisors, and program managers.

Contraceptive Stock-Control Form for Community Reproductive Health Workers

Date	CRHW Name	Received Contraceptives *(indicate quantity)*					Used Contraceptives *(indicate quantity)*				
		Pill cycles			Condoms	DMPA	Pill cycles			Condoms	DMPA
		Microgynon	Lofeminal	Ovrette			Microgynon	Lofeminal	Ovrette		

APPENDIX 13

Supervision Checklist for the CBD of DMPA

13

This checklist was developed in Madagascar to guide discussions between supervisors and distributors on the routine provision of Depo-Provera. Topics include waste disposal, resupply, referral, and needle-stick injuries. It can be adapted to complement existing guidelines on CBD supervision.

Answers to be recorded by the supervisor.

1. **How many injections did you provide over a time period of _____?**
   (insert number of months/weeks since last contact with the CBD worker)
   - ❑ **First injections: _____ *(number)***
   - ❑ **Repeat injections: _____ *(number)***

2. **Did you experience any problems while screening your clients with the DMPA checklist?**
   - ❑ **No**
   - ❑ **Yes *(explore the nature of the problems, record below, and clarify issues for the CBD worker)* _____**

     _____

3. **Did you deny DMPA to any of your clients based on the screening checklist?**
   - ❑ **No**
   - ❑ **Yes *(record the reasons for not providing DMPA)* _____**

     _____

4. **Briefly describe your counseling sessions with new DMPA clients. *(record whether the CBD worker addressed the following)***
   - ❑ **Safety and effectiveness**
   - ❑ **How it prevents pregnancy**
   - ❑ **How it is used**
   - ❑ **Common side effects**
   - ❑ **Return to fertility (possible delay getting pregnant after DMPA stopped)**
   - ❑ **When to return for the next injection**
   - ❑ **Where to go in case of symptoms (such as profuse bleeding and severe headache), questions, or concerns**

5. **Briefly describe your counseling sessions with returning DMPA clients. *(record whether the CBD worker addressed the following)***
   - ❑ **Asked the client about any new health conditions since the last visit**
   - ❑ **Asked if the client had any questions or concerns about DMPA**
   - ❑ **Asked about any side effects and reassured as needed or referred client to a health facility**
   - ❑ **Explained when the client should receive the next injection**

6. **Do you have clients who were late for their next injection by more than 2 weeks?**
   (explore what the CBD worker is currently doing to ensure timely injections and what could be done differently if needed)
   - ❑ **No**
   - ❑ **Yes**
   - ❑ **Discussed strategies with the clients to ensure timely injections _____**

     _____

7. **Describe how you administer the injection.** ***(record whether the CBD worker does the following)***
   - ❑ **Check the expiration day on the DMPA vial and syringe package**
   - ❑ **Wash your hands with soap and water**
   - ❑ **Wipe the injection site with alcohol (where available)**
   - ❑ **Gently roll the vial of DMPA between your palms to mix the solution without creating bubbles**
   - ❑ **Remove the plastic cover from the vial without touching the rubber stopper**
   - ❑ **Open and assemble the syringe without touching the needle**
   - ❑ **With vial tilted slightly, insert the needle and draw all solution out of the vial, keeping the needle tip in the fluid to avoid getting air in the syringe**
   - ❑ **Insert the needle deep into the muscle (deltoid in the arm or upper-outer quadrant of the buttock)**
   - ❑ **Pull back on the plunger before injecting to check for appropriate placement of needle**
   - ❑ **If no blood is seen in the syringe, inject DMPA slowly and then withdraw the needle**
   - ❑ **Apply pressure to injection site with cotton, but do not rub**
   - ❑ **Discard assembled needle and syringe in a puncture-proof container without recapping, breaking, or bending the needle**
   - ❑ **Instruct the client not to massage the injection site**
8. **Describe how you dispose of used syringes.** ***(record whether the CBD worker does the following)***
   - ❑ **Place the sharp container within reach when giving an injection**
   - ❑ **Do not recap the needle**
   - ❑ **Place the syringe with needle in the sharps container immediately after use**
   - ❑ **Do not overfill sharps containers**
   - ❑ **Do not re-use containers; discard after they are full (according to local guidelines)**
9. **Do you experience any problems maintaining supplies, including DMPA and syringes?**
   (explore what the CBD worker is currently doing to maintain supplies and what could be done differently if needed)
   - ❑ **No**
   - ❑ **Yes**
   - ❑ **Supervisor and CBD worker to discuss strategies for maintaining supplies** _____

     _____
10. **Did you refer any new clients to a clinic for DMPA or another method?**
    - ❑ **No**
    - ❑ **Yes** ***(record whether the CBD worker followed up to see whether the client followed through on the referral)*** _____

      _____
11. **Did you refer any continuing clients to a clinic for problems?**
    - ❑ **No**
    - ❑ **Yes** ***(record examples of problems experienced by the clients)*** _____

      _____
12. **Did you suffer any needle-stick injuries?**
    - ❑ **No**
    - ❑ **Yes** ***(record if the CBD worker sought treatment for a needle stick)*** _____

      _____

APPENDIX 14

Skills Assessment Form for the CBD of DMPA

14

This form allows supervisors to record their observations of community-based distributors who provide Depo-Provera. It considers every step of a safe injection technique, including proper waste disposal. The form was developed for use during the training sessions, the clinic practicum, and the first few supervisory meetings.

NAME OF CRHW DATE

SUBCOUNTY PARISH

Aspects to be assessed	Not done	Poorly done	Satisfactory	Well done
1. Wash hands with soap and water before and after giving the injection				
2. Check the DMPA vial for expiration date				
3. Shake the vial thoroughly but not forcefully				
4. Open the sterile wrapper of the auto-disable syringe without contaminating the tip or the needle				
5. Draw the entire dose from the vial				
6. Do not move the plunger back and forth to expel the air				
7. Hold the syringe upright and tap on barrel to remove air				
8. Ask the client to pull clothing away from the injection site				
9. Inject the suspension into muscle				
10. Do not recap the needle, do not separate the needle from the syringe				
11. Throw the used needle and syringe in the safety box				
12. Wash hands				
13. Thank the client, give her a return date, and bid her farewell				

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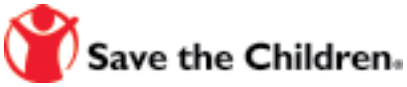
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