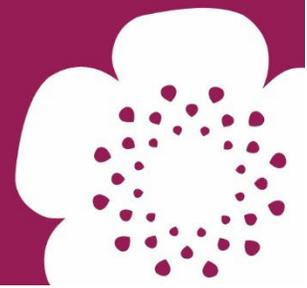


Supporting Health Zones in Introducing DMPA-SC Self-Injection through EngenderHealth's ExpandFP II Project in the DRC: A Pilot Study



Background

In the Democratic Republic of Congo (DRC), reproductive health is characterized by a high fertility rate (nearly seven children per woman) and a national maternal mortality rate of 473 per 100,000 live births (UNICEF 2019). Family planning (FP) can support reductions in maternal mortality, but in 2021, the contraceptive prevalence rate in the DRC was only 15.5% (FP2020 2020) and there was a high rate of unmet need for modern contraception (21%) (United Nations Department of Economic and Social Affairs 2021).

FP is a critical component of basic healthcare and is an essential component of health services. Access to FP is a fundamental human right. FP is one of the priority interventions aimed at reducing maternal mortality. Use of quality modern contraception can help prevent unwanted pregnancies and reduce maternal mortality by more than 30% (WHO 2013). At the national level, the DRC's Ministry of Health (MOH) is committed to implementing the 2014–2020 Family Planning Strategic Plan, which aims to ensure access to and use of modern FP methods to at least 21 million additional users by 2020 (MOH 2014). This plan aims to accelerate access to FP by improving access to and uptake of FP services in health facilities and at the community level by integrating new methods, approaches, and innovations—including self-injection of subcutaneous depot medroxyprogesterone acetate (DMPA-SC) by the client.

The COVID-19 pandemic caused tremendous upheaval to health systems around the world. Beginning in March 2020, as with many countries, the pandemic disrupted access to FP information and services, as well as sexual and reproductive health more broadly, in DRC. Despite the urgent challenges associated with preventing transmission of and treating individuals who contracted COVID-19, the MOH recognized that the need for FP remained the same and that it was essential to continue to provide access to FP care. To address this, the National Reproductive Health Program (PNSR) established effective mechanisms to maintain the provision of reproductive health services and to ensure continued access to and use of quality FP services by diversifying service modalities. In addition, the PNSR integrated guidance related to COVID-19 into sexual and reproductive health tools.

EngenderHealth, through its ExpandFP II project, implemented several innovative approaches to support access to quality FP services during the COVID-19 pandemic in partnership with the PNSR. Recognizing that injectable contraceptives are an important option for preventing pregnancy—chosen by many clients worldwide as a safe, effective, convenient, and private FP method—the project promoted awareness of and access to self-administered DMPA-SC.

Project Strategy

Promoting DMPA-SC can expand access to FP by increasing opportunities for lower-level health workers and even clients themselves to administer injections. EngenderHealth worked closely with the PNSR to support the introduction of the DMPA-SC self-injection approach in 20 selected health centers in four health zones of Kinshasa (Binza Ozone, Kokolo, Nsele, and Police) to ensure continued access to FP services during COVID-19. Several other partners (Association pour le Bien Etre Familiale [ABEF], Pathfinder International, and Tulane) also supported the approach in other health zones and sites not covered by the ExpandFP II project. To implement the strategy, ExpandFP II followed six steps to expand coverage and quality of services prior to the implementation activities.

Step 1: Site identification. EngenderHealth contacted several implementing partners who supported introducing DMPA-SC into the DRC's public health system (ABEF, Pathfinder, Tulane). Through this consultative process, we mapped areas of operation by each implementing partner to avoid duplicating activities across the different health zones. In consultation with the PNSR and other partners, EngenderHealth targeted 20 health facilities across four health zones in Kinshasa.

Step 2: Training. ExpandFP II established a comprehensive, continuous, and sustainable training system for self-injection. We provided capacity strengthening support to maximize retention of provider clinical knowledge, skills, and attitudes—this included facilitating short, digital, simulation-based learning activities, which we reinforced with structured, ongoing practice sessions at the facility-level. EngenderHealth trained 25 clinical providers in the provision of DMPA-SC self-injection and four community facilitators from catchment area health zones to supervise the community-based distributors (CBD) activities. Through a virtual, one-day training using pre-recorded videos, ExpandFP trained providers on the administration of DMPA-SC. Through exercises and demonstrations, the team enhanced provider skills on teaching self-injection techniques for clients. ExpandFP II also supported the training of 100 CBDs (65 female and 35 male) in DMPA-SC. These CBDs had already received basic FP training and were recognized in the community as FP service providers. Clinical providers conducted the training for the CBDs.



Training of CBDs; Photo Credit: ExpandFP II

Step 3: Adapting data collection tools. Health providers needed to have access to standardized data collection tools to be able to routinely collect data on this new method and capture learning around the self-injection interventions. The project supported the MOH in revising and adapting the existing data collection forms, which are completed using registers and cards for each client visit, to include DMPA-SC information.

Step 4: Services provided and activities completed at community and clinic levels. Between October and December 2020, the ExpandFP II project supported the provision of DMPA-SC through clinic-based providers at 20 health facilities and during household visits conducted by the CBDs. Providers oriented and counseled clients who chose DMPA-SC as a method of their choice on self-injection. As necessary, providers observed clients in practicing administering the DMPA-SC on a mannequin to ensure that clients had the necessary skills to administer the next dose to themselves in the absence of a provider. Providers also briefed clients on where they could easily obtain a second or follow-up dose of DMPA-SC.

Step 5: Supervision, monitoring, and findings. ExpandFP II supervised the DMPA-SC services and activities at the 20 project-supported health facilities and across the four supported health zones. The project conducted monthly supervision visits to the 20 health facilities and the CBDs. Our approach emphasized mentoring, joint problem-solving, and two-way communication to improve service quality. During the supervision visits, we reviewed key aspects of quality assurance, such as DMPA-SC stock management, client counseling, activity coordination, and data quality. This provided the health system with a clear understanding of the self-care initiative so that the MOH and its partners could identify specific issues common at all levels while assessing the roll out of the intervention.

Step 6: Data reporting and validation. When designing the monitoring system and forms, the project intentionally disaggregated data for the new delivery channels to enable analysis of service innovations. ExpandFP II supported collection of DMPA-SC data at the community level for entry into the national health management information system. CBDs recorded services in data collection forms for each client visit. At the end of the month, the CBDs detached the carbon paper from the register and sent these to the catchment-area health facility. Once the data were collated at the health facility level, the focal point provider compiled all the registers and summarized the information for zonal-level reporting.

Key Findings

Between October 2020 and December 2020, the project reached 1,175 clients (68% aged 25 and older, 23% aged 20 to 24, and 9% aged 15 to 19 years) who adopted a first dose of DMPA-SC as their method of choice through

project-supported services—at facilities and via CBDs. Of these, 5% (80 of the total 1,775) self-injected and 95% received their first dose from the provider.

In addition to the service data, the project demonstrated several other findings obtained from the implementation of supportive supervision activities. These supportive supervision visits provided important opportunities to assess the extent to which the CBDs were adhering the training standards and providing quality services. The monthly data review meetings allowed the health providers and CBDs to reflect on the activities and learn from any challenges. During these meetings, CBDs shared anecdotal accounts of how their household visits provided an opportunity for clients to share feedback on their method. The household visits also created an opportunity for dialogues regarding any concerns with the method and the importance of adherence. A key issue flagged during the monthly meetings was around commodity supply management. Providers cited challenges with replenishing DMCA-SC supplies and flagged that stock-outs were common. Indeed, addressing commodity stock-outs will be an important element for future initiatives.

Challenges

We observed several challenges during the implementation period. First, due to the short implementation period, it was difficult to show progress and sustainability. Second, the project observed that identifying the source of DMPA-SC for resupply was unclear. In the future, efforts must be made to ensure that public and private sector pharmacies can be equipped with adequate DMPA-SC supplies to improve client access. Third, we were not able to observe complaints from side effects, which usually become apparent after the first few repeat doses of DMPA-SC. Likewise we were not able to observe discontinuations resulting from side effects or other factors. To address such potential discontinuation in the future, we trained the clinical providers and CBDs in counseling clients to cope with side effects and emphasized the importance of continued counseling for all clients.

Lessons learned

The importance of stakeholder engagement and coordination was key to the success of this pilot. Building and nurturing strong, two-way relationships with MOH counterparts helped ensure smooth implementation. Furthermore, defining partners' roles and establishing coordination mechanisms was also key to maximizing efficiencies and avoiding duplication of efforts. The routine meetings and supportive supervision visits allowed implementers to learn and adapt. Evidence shows positive collaboration between CBDs and clinical providers influenced the successful integration of the DMPA-SC approach. While the self-administered rates were low during this pilot, we believe that overtime rates will increase as clients became more familiar with the method and more comfortable with self-administering. Given the intervention oriented a number of clients on the method, this could serve as a starting point to promote access to DMPA-SC in the future; and, clients who adopted DMPA-SC could serve to sensitize other community members on this FP option to increase awareness and acceptability.

Conclusions

In conclusion, the three-month pilot showed promising results for scaling up this innovative strategy for increasing access to contraception and strengthening the capacity of future community-based health workers in FP service delivery. The pilot introduced injectable contraception to many communities for the first time. Although continued scale-up of the model will require additional funding, there is an opportunity for future investments to have a lasting impact on health systems more broadly, such as by expanding the number and geography of CBDs. Future initiatives should also explore a variety of public and private delivery channels and consider what additional training, supervision, and communications activities will be necessary to support and sustain access particularly for young women and adolescent girls.

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