Scaling Up Community-based Access to Injectable Contraceptives in Uganda: Lessons Learned from Private- and Public-sector Implementation

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<td>CBD</td>
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<td>CHW</td>
<td>Community health worker</td>
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<td>CTPH</td>
<td>Conservation Through Public Health</td>
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<td>CYP</td>
<td>Couple-years of protection</td>
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<td>DHO</td>
<td>District health office</td>
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<td>DMPA</td>
<td>Depot-medroxyprogesterone acetate (marketed as Depo Provera)</td>
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Executive Summary

In 2003-2005, Family Health International (FHI), Save the Children (SC), and the Uganda Ministry of Health (MOH) collaborated on a pilot study, which showed that properly trained community health workers (CHWs) could safely and feasibly provide injectable contraceptives.

The effectiveness of the pilot study inspired four new scale-up programs in Uganda. Two public-sector programs were started by district health offices (DHOs) in the districts of Busia and Bugiri. Two private-sector programs were started by nongovernmental organizations (NGOs)—Conservation Through Public Health (CTPH) and Minnesota International Health Volunteers (MIHV)—in the Kanungu district and the Mubende district, respectively.

This document describes the results and experiences of these four programs. Although this work is not based on a formal scientific investigation, we did collect service statistics for each program. These statistics provide valuable information, but detailed comparisons between the programs are not possible because each program covered different periods. Also, the data for the NGO implementers was available only for certain measures.

All four programs followed the steps outlined in a 2008 implementation handbook developed by FHI and SC, but the scale-up procedures were slightly different in the private and public sectors.

Our first priorities were to engage potential partners and assess the local capacity for the scale-up. All partners conducted rapid assessments to determine whether injectable contraception was needed and whether the local CBA program was adequate for the task. We also identified potential challenges for each program.

Although the operational support in the private-sector programs was generally stronger, the private sector’s resources appeared to be less reliable because of shifts in donor priorities and funding. In all cases, the establishment of a district-led core team to guide the introduction of the service was necessary for project buy-in, sustainability, and monitoring. Each program was also harmonized with the local systems for procurement, logistics, waste management, and supervision.

All CHWs had been trained with the MOH-approved general CBA-training curriculum for family planning and FHI’s training material for the DMPA component. Compared to private-sector CHWs, the public-sector CHWs needed more refresher trainings in family planning (FP) and reproductive health (RH). Flexibility in the training schedule was an asset; a mid-course change by CTPH extended the training period for CHWs by more than a week to ensure competency.

We also found that creative solutions were needed to overcome stock-outs. For example, some of the districts borrowed from each other during periods of shortage. It’s important for CHWs to be given sufficient supplies of DMPA for their clients to receive their reinjections on time.

Monitoring and supervising the CHWs posed some challenges. The public-sector programs wanted to strengthen the monitoring and evaluation (M&E) and the supervision, but resource constraints made it difficult to hold supervisory meetings on a regular basis. These systems still require further support for continued scale-up.

We also found that the M&E tools needed to be simplified. The rigorous screening of CHWs by the private-sector programs may have averted the comprehension problems associated with monitoring and data collection that were noted in the public-sector programs. Interestingly, a public-sector program was able to fill in some gaps in supervision by designating a CHW leader who provided other CHWs with guidance and support.

The service data supplied some very positive findings. Forty-four CHWs in the public-sector programs provided DMPA to 1,364 women over various survey periods. It amounted to 799 years of protection, or more than 18 years of protection per CHW. Fifty-seven percent of the clients were first-time users. A remarkable 92 percent of all reinjections were received within the required period. And no needle stick injuries were reported by any of the programs.

We found that the CHWs in Busia and Bugiri delivered a combined average of 10 couple-years of protection (CYP) per CHW, whereas the CHWs in the CTPH program delivered an average of 6.8 CYP per CHW. The available data did not permit the calculation of this statistic for MIHV.

A detailed breakdown of the CYP results in Busia and Bugiri permits a comparison with reports from the health clinics in these districts. During a 12-month period, Busia achieved a total of 449 CYP and Bugiri attained 351 CYP. During the same period, health-clinic reports indicate that clinical providers distributed a total of 67 CYP in Bugiri and 48 CYP in Busia. The public-sector programs also initiated more clients for DMPA use than the clinical providers initiated in the same areas. This comparison makes it clear that the CHWs make a substantial contribution to improving access to injectable contraception.

Overall, the experience of the four new programs in Uganda indicates that CBA to DMPA can be integrated easily into the services already provided by CHWs. With appropriate support, scale-up can be equally successful in public and private sectors. Clients, clinic-based providers, and program managers are satisfied with the services. The evidence suggests that a nationwide scale-up of CBA to DMPA programming in Uganda would be beneficial and timely.

In light of these findings, we recommend that Uganda’s MOH review its national service guidelines and allow CHWs in both sectors to provide injectables. Additionally, the MOH should consider developing a document to guide national policy-makers as they plan for scale-up.
1. Background and Introduction

Access to and use of family planning (FP) in Uganda are key factors in achieving the United Nation’s Millennium Development Goals (MDGs) by 2015, but progress in both these areas has been slow. Currently, only 18 percent of married women use modern FP methods, a figure that only marginally increased between 2001 and 2006, while unmet FP needs grew by 5 percent. In Uganda, women have an average of seven children each, although more than 40 percent of married women want to delay or limit parenthood. Additionally, the country has one of the world’s fastest rates of population growth (3.2 percent), a high fertility rate (6.7), and a high maternal mortality rate of 435 deaths per 100,000 live births (Uganda Bureau of Statistics and Macro International Inc., 2007).

Compounding Uganda’s unmet need for FP is its shortage of doctors, nurses, and midwives, particularly in rural areas where the majority of the population lives. In rural areas, not only are few trained personnel available, but access to modern contraceptive methods is limited and the distribution chain is weak.

If current trends continue, the number of people in Uganda who need social services will double within 20 years, thereby greatly increasing the need for healthcare workers, medical supplies, infrastructure, and other resources. Without significant improvements, high unmet FP needs and poor access to contraceptives will worsen the country’s poverty and increase its dependence on foreign aid. Resources available for social services will also diminish, amid an array of competing national priorities.

The Uganda Ministry of Health (MOH) acknowledges the central role that reduced fertility will play in helping to achieve the country’s MDGs. Its Poverty Eradication Action Plan—the overarching development strategy—cites improved access to FP services as a prerequisite for national development and achievement of MDGs (Uganda Ministry of Finance, Planning and Economic Development, 2004). Explicit targets for improved use of FP services are also mandated by Uganda’s 1999 National Health Policy and its 2005/06 Health Sector Strategic Plan.

The ability to promote FP services depends on the use of effective and innovative strategies to deliver these services to rural populations, given that more than half (51 percent) of Uganda’s population lives more than five kilometers from the nearest health facility. One such strategy is community-based access (CBA) to injectable contraceptives, an approach recently established by USAID as a global technical priority. The injectable depot-medroxyprogesterone acetate (or DMPA, marketed as Depo Provera) is strongly preferred in Uganda, accounting for more than 40 percent of the mix of FP methods available.

Community based access makes DMPA available outside of clinics and within communities, because injections are administered by trained community health workers (CHWs). Training paramedics or non-medically trained workers to administer DMPA can improve women’s access to FP services. This task shifting gives women the contraception method they desire and also addresses Uganda’s health-worker shortage.
Between 2003 and 2005, Family Health International (FHI) partnered with the MOH and Save the Children (SC) to conduct a USAID-funded pilot study to assess the feasibility and safety of community-based distribution (CBD) of injectable contraceptives. The pilot was conducted as part of a SC-run CBD program that was providing contraceptive pills and condoms in Nakasongola, a rural district in central Uganda. The pilot study confirmed findings of other studies in other parts of the world: CHWs can safely and feasibly provide DMPA in settings other than clinics, and the practice is accepted by communities (Stanback, Mbonye, and Bekiita, 2007).

**Expansion with new partners**

Following dissemination of the pilot study’s results, the MOH and its partners wanted to scale up CBA to DMPA in other areas of Uganda. In 2006, SC conducted the initial scale-up in Nakaseke and Luwero, two districts adjacent to Nakasongola. Concurrent advocacy resulted in requests for support by other districts and from NGOs who wanted to implement CBA to DMPA. With the MOH’s endorsement and funding from USAID, FHI provided technical assistance to public-sector CBA programs in the Busia and Bugiri districts in eastern Uganda and provided similar support for two private-sector partners.

One of these NGOs, Conservation Through Public Health (CTPH), is a grassroots nonprofit that promotes conservation and public health by improving primary healthcare for people living in and around national parks.
around protected forests in southwestern Uganda. During the scale-up, CTPH implemented CBA to DMPA in the Kanungu District, within its traditional area of operation. The second NGO, Minnesota International Health Volunteers (MIHV), is a U.S.-based, international nonprofit whose mission is to improve the health of women and children by means of community-based programs. MIHV implemented CBA to DMPA in the Mubende District in south-central Uganda (fig. 1).

The public- and private-sector activities served as expanded pilots to inform countrywide scale-up. Together, they provide evidence that CBA to DMPA could be implemented successfully on a wider scale than the initial pilot was able to demonstrate. The MOH had requested such evidence so it could consider making policy changes more favorable to the practice of CBD of injectables. To this end, FHI and partners identified the lessons learned from the expanded pilots in both sectors and produced this report.

About this report

This report is not based on a scientific research method and does not provide extensive detail about NGO and public-sector implementation of CBA to DMPA. The analysis method used and data limitations are outlined in Appendix A.

The authors summarize and draw conclusions from service statistics from up to one year of implementation by two public-sector partners and two NGO partners. The implementation process is documented and key activities and events related to the phased scale-up are described. The report should provide information needed by key decision-makers to amend national service guidelines and permit CHWs to provide CBA to DMPA.

In short, this report documents lessons learned from targeted scale-up of CBA to DMPA, highlights differences between NGO and public-sector providers in implementing the strategy, and recommends ways forward.

2. The Scale-up Process

In 2007, FHI collaborated with SC in producing an implementation handbook to guide new partners in promoting the uptake of CBD of injectable contraceptives (Weil, Krueger, Stanback, and Hoke, 2009). The scale-up in Uganda followed the steps outlined in this handbook, though the public- and private-sector partners did not pursue scale-up in identical ways. Divergences mainly resulted from organizational differences and approaches and varying situations in districts.

Determining feasibility and need and engaging potential partners

The first phase of the scale-up involved identifying and engaging potential partners and assessing their programs. The costs and benefits of implementation were collaboratively weighed; then the roles and responsibilities of partners who agreed to participate were formalized.
Advocacy and outreach were used to identify and engage potential public- and private-sector partners for the scale-up trials. In May 2007, FHI and the MOH disseminated to every district in Uganda a package of advocacy literature that outlined the evidence supporting the proposed scale-up (Uganda Ministry of Health and Family Health International, 2007). Technical assistance was offered to interested districts.

Family Health International was able to support scale-up by the first two public-sector programs to respond to the offer: one in Busia District and the other in Bugiri District. Community based access to DMPA services were already being provided informally in villages in Busia, and FHI strengthened these innovative efforts to improve access to FP by training CHWs in safe injection procedures, medical eligibility criteria, and waste management.

Outreach to potential NGO partners also occurred in 2007. With assistance from USAID’s Washington office, FHI pursued a partnership with MIHV, reaching out to its headquarters in Minnesota and its office in Uganda. For its part, CTPH, an indigenous NGO, initiated the contact after learning of the successful SC pilot and plans for scale-up. After asking SC for technical help with CBA to injectables, the NGO was referred to FHI. Like the new public-sector partners, the two NGOs had experience with CBA programs in the districts where they planned to introduce DMPA.

Engaging Potential Partners: Lessons Learned

- Identification of partners should involve outreach and advocacy by the MOH and its NGO allies. Quality advocacy materials exist for this purpose.
- When working with a potential NGO partner, it is often necessary to engage decision-makers at its headquarters and in the field.
- Identifying new partners and guiding scale-up requires a convergence of support from donors, the government, and implementing agencies.

Assessing capacity and formalizing partnerships

The FHI implementation handbook includes a rapid assessment tool that can be used to evaluate the need for CBA to DMPA services within a community as well as a program’s capacity to add the services (Weil, Krueger Stanback, and Hoke, 2009). Using this tool, FHI staff assessed the community-based reproductive health programs of the MOH in Busia and Bugiri. The two NGOs also used the tool to conduct rapid assessments of their respective programs in Kanungu and Mubende.

Service statistics on FP use and the reports of clinic providers evidenced substantial unmet need for FP in the four districts. In addition, assessments of the public-sector service areas revealed that CBA programming had weakened over the previous year. Between 1999 and 2006, the United Nations
Population Fund (UNFPA) funded public-sector CBA to FP programs in Busia and Bugiri, but the 2007 rapid assessment revealed that the number of active CHWs had declined, that their volume of work had shrunk, and that supervision and monitoring and evaluation (M&E) mechanisms needed to be strengthened.

Both CTPH and MIHV were able to demonstrate that their private-sector CBA programming was strong enough to incorporate provision of DMPA and that the service was needed in their districts. During the assessment, MIHV was not sure it would be able to secure funding for the program after the pilot. That problem was quickly resolved, and MIHV agreed to a formal partnership with FHI for technical assistance.

Challenges that had emerged from the rapid assessments began to be addressed. In the public sector, district officials determined that the benefits of adding the provision of DMPA to their community health services would outweigh costs, and they agreed to allocate more funding and staff time to support the areas that needed strengthening: management, supervision, and M&E.

Family Health International agreed to provide ongoing technical updates, help train CHWs and adapt tools they were using to support the provision of DMPA, and support quarterly review meetings within each district. The meetings were used, in part, to receive data from the CHWs for analysis, provide technical updates, and monitor implementation.

To address concerns of the MOH and others about the ability of NGOs to sustain private-sector CBA to DMPA programs, CTPH and MIHV agreed to coordinate their services as much as possible with public-sector health clinics and with district health officials in Kanungu and Mubende. For example, it was agreed that the main implementer was the DHO, and MIHV was only a technical assistance organization. In that way, if either NGO lost funding, public-sector teams in those districts would have the knowledge and capacity to continue the services. Linking to the public sector was also the best way to ensure that referral, logistics, and waste-management systems would function efficiently and cost-effectively.

At this point, the four implementing partners signed formal agreements that outlined the roles and responsibilities of all parties. Subsequently, all four partners designated a core team in each district to guide implementation, supervision, and M&E. FHI did not provide additional support to any of these core teams.

Core teams in the public sector comprised district health officers, clinic managers, clinic midwives, and health assistants in charge of sub-counties. To avoid increasing their workloads, core-team members discussed CBA to DMPA programming during monthly district meetings they were already attending.

Private-sector core teams comprised local NGO staff and key representatives of district health teams. These core teams met monthly, but it was a challenge to maintain the link with the district health team in Kanungu because of the remote, mountainous terrain where CTPH operates. District involvement thus became limited to receipt of monitoring reports.
Assessing Capacity and Formalizing Partnerships: Lessons Learned

- The need for CBA to DMPA must be weighed against the operational costs of providing the service.
- Any identified weaknesses of a CBA program must be addressed before injectables are introduced.
- FHI and authorities in each district collaborated to strengthen capacity and commit resources. Within public-sector programs, supervision and M&E systems appear to be insufficient, and more support will be needed for continued scale-up.
- Private-sector programs typically appear to be stronger than public-sector programs, in terms of supervision and other operational support. However, private-sector programs may be financially weaker in the long term due to shifts in donors’ grant cycles, priorities, and funding.
- To sustain the service and CBA, NGOs collaborated with district health offices and used governmental logistics, referral, and waste-management systems.
- The establishment of a district-led core team to guide the introduction of the service is necessary for project buy-in, sustainability, and monitoring.

Implementation and adaptation

Once implementing partners assessed feasibility and needs and the partnerships were formalized, they prepared to implement the program.

Harmonizing CBA to DMPA with existing health care systems

Partners were concerned about their ability to sustain the new program, and all four shared the goal of integrating it into district health systems to make it more sustainable. Similar processes were used in both sectors to harmonize scale-up activities with existing logistics, waste-management, reporting, and supervision systems, but all four partners needed some help from FHI to accomplish these ends.

Family Health International assisted public-sector partners by adapting data collection tools, training supervisors, and orienting clinic-based providers and CHWs to the added service. For private-sector partners, FHI shared its technical expertise with NGO and clinic staff in Kanungu and Mubende, offering a one-day workshop to train them in their supervisory roles. Afterwards, the NGOs coordinated all other activities related to harmonization, such as integrating the new data with district health management information systems (HMIS), liaising with clinical staff, and providing technical support for the procurement of supplies.

No new systems were created by any program to manage the provision of DMPA, and no formal incentives were given to any of the CHWs when this task was added to their scope of work.
Harmonizing Scale-up Activities: Lessons Learned

- For success and sustainability in both sectors, CBA to DMPA needs to be harmonized with current systems used for procurement, logistics, waste management, and supervision and monitoring.
- Harmonization requires the good will of everyone involved and a willingness to adjust and adapt current practices.
- To harmonize activities, key clinic staff need to receive on-site orientation to their new roles and responsibilities.
- A new contraception method can be added to existing FP services without creating new management systems or adding formal incentives.

Promoting CBA to DMPA and sensitizing communities

Public- and private-sector implementing partners made targeted efforts to promote acceptance of and support for CBA to DMPA within the communities served. Regular community sensitization meetings on FP were ongoing and supported by the two implementing NGOs, so community members were aware of the CHWs and supported their work. Because similar meetings were not being regularly held by public-sector CHWs, FHI supported community meetings that provided information and encouraged acceptance of the new service. FHI also worked with district health offices (DHOs) to lead sensitization meetings for political and civil-society leaders who could influence district-level decision-making.

The relationships established helped stakeholders to take ownership of the new program—a necessary condition for sustaining the service. As a result, community leaders committed to supporting implementation, and stakeholders in both groups were updated on current use of FP in the country and on the findings of the pilot study on CBD of DMPA (Stanback, Mbonye, and Bekiita, 2007).

Promoting CBA to DMPA and Sensitizing the Community: Lessons Learned

- Meaningful involvement of district stakeholders and community members is key to building awareness of CBA to DMPA and the adoption of the program.
- Ongoing community meetings held by NGOs can be easily used to inform local villages and citizens about the new service.
Training CHWs

All programs had trained CHWs in FP and were already distributing pills and condoms. However, CHWs in public-sector programs had not received any recent FP training and required refresher updates. These updates were provided by FHI and district health officers during quarterly review meetings, which served to keep costs down. CHWs in private-sector programs had been recently trained and did not require similar updates.

Training in CBD of DMPA was provided in December 2007 in Busia, in January 2008 in Bugiri, in May 2008 for CTPH, and in June 2008 for MIHV. Public-sector implementers trained all their CHWs to provide DMPA, while the NGO implementers selected for training only those CHWs who were already performing well.

The DHO or the NGO assembled a team of trainers in each district. Before these teams began their work, FHI provided a one-day orientation that introduced the tools and training manual they would use. In addition, FHI supported a master trainer who had conducted the pilot-program’s DMPA training. This master trainer assisted public-sector and MIHV teams, but a language barrier prevented him from assisting the CTPH trainers.

All teams of trainers used the MOH-approved general training curriculum for FP and CBD, as well as the manual developed by FHI on the practice of CBD of DMPA (Family Health International, 2007). Trainings for CHWs working in the public sector and for MIHV took two weeks: one devoted to theory and the other to provision of injections. At the NGO’s cost, the CTPH trainers added an additional week to ensure that the CHWs had mastered the material. During that week, trainers observed each CHW providing five injections—the number recommended before a certificate of completion was awarded.

Training CHWs: Lessons Learned

- Public-sector CHWs needed more refresher trainings in FP and reproductive health than did their counterparts in the private sector.
- Flexibility in the training schedule is an asset. A mid-course change by one NGO extended the practicum period for CHWs by more than a week.
- Standardization is important, both for the approach to training and the materials used, and it can be achieved by assembling a training team that brings master trainers and district and NGO trainers together.
Managing logistics and waste

Overall, there were no significant differences in how public-sector and private-sector programs managed logistics, waste, and procurement. Prior to the public-sector scale-up, FHI obtained items that DHOs were to dispense to CHWs: seed stocks of DMPA, syringes, and boxes for safe disposal of medical waste. The NGOs handled this initial procurement. Once scale-up was underway, all four implementing agencies managed procurement as well as monthly supervision of CHWs.

Early in the scale-up, all CHWs would receive five vials of DMPA at a time. As the service’s popularity grew, CHWs received more vials during each resupply to circumvent stock-outs and keep clients on schedule with their reinjections.

MOH health clinics stored supplies for the scale-up in all four districts. NGOs made an extra effort to ensure that supplies did not run out, acting as liaisons between the CHWs and the clinics, and collecting supplies and distributing them to the CHWs. This support was not available in the public sector, and stock-outs were more frequent. When these occurred, district teams borrowed supplies from each other.

FHI addressed urgent needs for depleted items by working with the MOH to speed procurement and encouraged DHOs to make timely requests to meet the increasing demand for DMPA. When stock-outs became crippling midway through the public-sector implementation, FHI reached out to the DELIVER Project, which is working to improve the security of contraceptive supplies by strengthening in-country supply chains. DELIVER sent a trainer to meet with public-sector CHWs and train them in logistics management. This alleviated the problem in part, but commodity security is still a significant, ongoing challenge at the national level.

No new waste-management systems were developed. CHWs took their filled safety boxes to health clinics in their districts for safe incineration and received new safety boxes there.
Managing Logistics and Waste: Lessons Learned

- During training and start-up, seed stocks of DMPA and related supplies are needed. These should be specifically procured by the organization responsible for training.
- During scale-up, regular resupply and waste disposal can be coordinated within existing systems.
- NGOs responsible for the provision of DMPA by CHWs can play a large role by helping districts to request and distribute commodities and ensure adequate supplies.
- Training CHWs to anticipate their supply needs can help to prevent stock-outs.
- Until there are system-wide improvements for supply systems, creative solutions must be employed to overcome stock-outs. Examples include FHI’s collaboration with the MOH, districts borrowing from each other, and provision of DMPA to CHWs in large enough increments to ensure that clients are on time for reinjection.

Monitoring and supervising CHWs

For the public-sector program, the monitoring and supervision framework developed by FHI and partners was based on the DHO supervisory structure, since DHO staff supervised the trained CHWs to ensure service quality. In the private-sector, this function was fulfilled by health extension workers employed by the NGOs.

To integrate the reporting of routine service statistics into the health management information systems (HMIS) in use in the public sector, FHI convened district clinic staff and HMIS officers to advise on adapting the reporting forms CHWs would use during DMPA provision so their data would be compatible with existing reporting tools. In conjunction, CHW supervisors received a day-long orientation that was planned and convened by FHI.

Public-sector programs experienced the greatest data-collection challenges, since several CHWs did not clearly understand how to use the client-tracking form they were given, though they had all been trained in its use. Instead of using the form, these CHWs collected information in their own daily notebooks. To compile this report, the authors consulted these notebooks and resolved any data conflicts. Later, a data collection tool adapted from the SC program was successfully introduced to ease the data-collection task.

Private-sector programs added data-entry fields for provision of DMPA to existing M&E tools that tracked the distribution of pills and condoms. CTPH also added a one-year tracking card (originally developed by FHI) to their package of monitoring and supervision tools.
Though each of the partners had determined prior to implementation how they would report activities and provide supervision, plans did not always match reality. A challenge arose when public-sector core teams acknowledged they could not financially afford to meet each month with the CHWs to obtain reports, as agreed upon during the planning phase. Instead, data collection, reporting, and technical updates took place when FHI convened quarterly meetings with district core teams and the CHWs. FHI played this central role because the meetings accomplished both data collection and supervision and timely collection of service statistics was important for reporting outcomes. It remains unclear whether these meetings will be sustained by DHOs without additional support.

Additional support for M&E and supervision may also be an issue for private-sector scale-up, given that CTPH and MIHV—not the district health teams—supported quarterly supervision, and the NGOs routed their quarterly reports of service statistics to FHI for assessments of progress and outcomes.

Overall, public-sector CHWs encountered no problems meeting with their assigned clinic supervisors for regular resupply, referral follow-up, and general supervision. These supervisors—usually nurse-midwives—had been provided with the training and tools to conduct supportive supervision. However, it should be noted that an evaluation of the quality of the supervision was not conducted, because it was not within the scope of the phased scale-up.

Basic mechanisms for ensuring quality and safety were similar in all programs. While CHWs were supervised and resupplied by public-sector clinic staff on a regular basis, the NGOs provided extra supervision. Before the DMPA initiative began, the NGO health extension workers had been meeting with CHWs individually and providing supportive supervision on a quarterly basis, and they continued to do so throughout the observation period.

Interestingly, the CHWs in Busia created their own supervisory innovation that addressed any need for more regular supportive supervision: a designated “CHW leader” who would provide regular and impromptu support and leadership for peers. This innovation was later adopted by the CHWs in Bugiri and those with CTPH. CHWs with SC also adopted this concept after their exchange visit to Busia in June 2008.
Monitoring and Supervising: Lessons Learned

The public-sector program was intended to strengthen M&E and CHW supervision, but resource constraints made it difficult to hold supervisory meetings on a regular basis.

Selective screening of CHWs by the public-sector program may have warded off problems down the road with monitoring and data collection.

M&E tools needed to be simpler, though they had been tailored to the CHWs and training provided in their use.

For ease of use and to promote sustainability, the new program’s M&E tools should be adapted to or incorporated into existing tools.

Designating CHW leaders who provide their peers with ad-hoc guidance and support can fill gaps in supervision.

3. Scale-up Data and Results

Scale-up data on CBA to DMPA were collected on public- and private-sector implementation, but during varying periods ranging from five months to one year (see Appendix B). For comparison purposes, DMPA service-delivery reports for the same periods were obtained from government health clinics in implementation areas.

Starting at the beginning of scale-up activities, data from Busia and Bugiri were collected for a period of one year (February 2008 to February 2009). Data on MIHV activities were reported for six months (June to December 2008), and data on CTPH activities were reported for five months (July to December 2008). CTPH faced a funding shortfall after December 2008; CHWs were no longer supervised and service data were no longer collected.

MIHV trained an additional 18 CHWs in November 2008. Because the NGO reported aggregated service statistics for all CHWs, the available data pertain to the 21 CHWs who began to provide services prior to November 2008 and to the 39 CHWs who were providing services after this date. To facilitate the interpretation of results, the authors limited their analyses to the period between July and December 2008.

Several measures were derived from service statistics, including couple-years of protection, number of clients served, continuation rates, and timing of reinjections. Findings are summarized below, and Appendix A describes the methods used to analyze the data.
DMPA coverage

Couple-years of protection (CYP) for DMPA is a measure of contraceptive coverage achieved through CBA to DMPA. This is calculated as an estimate of the projected length of protection against pregnancy provided by DMPA during a one-year period, if all injections required are administered. CYP indicates a contraception program’s volume of activity.

Table 1 summarizes CYP by program, calculated over a five-month period in the public-sector and the CTPH programs, and over a six-month period in the MIHV program. Because these periods differ, direct comparisons cannot be drawn.

Table 1. Couple-years of protection from DMPA provided by CHWs

<table>
<thead>
<tr>
<th>Program</th>
<th>Number of CHWs</th>
<th>Total CYP provided</th>
<th>Average CYP per CHW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bugiri</td>
<td>24</td>
<td>196</td>
<td>8</td>
</tr>
<tr>
<td>Busia</td>
<td>20</td>
<td>249</td>
<td>12</td>
</tr>
<tr>
<td>Private sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTPH (Kanungu)</td>
<td>13</td>
<td>89</td>
<td>6.8</td>
</tr>
<tr>
<td>MIHV (Mubende)</td>
<td>21²</td>
<td>90</td>
<td>N/A</td>
</tr>
</tbody>
</table>

One CYP = Total number of injections given, divided by 4.
(Each woman must receive 4 injections every year for protection.)

1 For the public-sector and CTPH programs, CYP was calculated over a 5-month period (July to December 2008). For the MIHV program, CYP was calculated over a 6-month period (June to December 2008).

2 Between June and December 2008.

On average, CHWs in Busia and Bugiri delivered a combined average of 10 CYP per CHW. This is more than their counterparts did in the CTPH program, who delivered an average of 6.8 CYPs per CHW. Available data did not permit calculations of the average CYP per CHW for MIHV.

Table 2 provides a more detailed breakdown of CYP achieved through CBA to DMPA in Busia and Bugiri. Total CYP provided over a 12-month period was 351 for Bugiri and 449 for Busia, which translates into an average of 15 CYP per CHW in Bugiri and an average of 22 CYP per CHW in Busia.
By comparison, health clinic reports in subdistricts implementing CBA to DMPA indicate that clinical providers distributed a total of 67 CYP in Bugiri and 48 CYP in Busia. These data suggest that CHW provision of DMPA in the public sector makes a substantial contribution to contraceptive coverage. The greatest amount of CYP delivered by CHWs was in the Buluguyi subdistrict of Buguri, a variation that might derive from differences in population density as well as other factors.

Table 2. CYP from DMPA provided by public-sector CHWs, February 18, 2008 – February 17, 2009

<table>
<thead>
<tr>
<th>District and subdistrict</th>
<th>Number of CHWs</th>
<th>Total CYP provided</th>
<th>Average CYP per CHW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bugiri</td>
<td>24</td>
<td>351</td>
<td>15</td>
</tr>
<tr>
<td>Bandai</td>
<td>8</td>
<td>88</td>
<td>11</td>
</tr>
<tr>
<td>Budaya</td>
<td>7</td>
<td>92</td>
<td>13</td>
</tr>
<tr>
<td>Buluguyi</td>
<td>9</td>
<td>171</td>
<td>19</td>
</tr>
<tr>
<td>Busia</td>
<td>20</td>
<td>449</td>
<td>22</td>
</tr>
<tr>
<td>Buhehe</td>
<td>10</td>
<td>201</td>
<td>20</td>
</tr>
<tr>
<td>Bulumbi</td>
<td>10</td>
<td>247</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
<td><strong>800</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

One CYP = Total number of injections given, divided by 4. (Each woman must receive 4 injections every year for protection.)

Meeting demand

Over one year, 1,364 women received at least one DMPA injection from 44 CHWs in Bugiri and Busia. As Table 3 shows, 522 women accepted DMPA from 24 CHWs in Bugiri and 842 women accepted DMPA from 20 CHWs in Busia. Over the same period, the five clinics within whose catchment areas these CHWs were located delivered DMPA to significantly fewer women: to only 265 in Bugiri and 192 in Busia.

Most of the DMPA clients in public-sector programs were new adopters (using the injectables for the first time): 66 percent of the clients in Bugiri and 51 percent of those in Busia were in that category. Among DMPA clients in Busia, 48 percent had previously received the injectable in a clinical setting.
Table 3. Summary of DMPA provision by public-sector CHWs, February 18, 2008 – February 17, 2009

<table>
<thead>
<tr>
<th>District and subdistrict</th>
<th>Number of CHWs</th>
<th>Number of DMPA clients served by CHWs</th>
<th>% of CHW clients new to DMPA</th>
<th>% of CHW clients who previously received DMPA from clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bugiri</td>
<td>24</td>
<td>522</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>Banda</td>
<td>8</td>
<td>175</td>
<td>57</td>
<td>42</td>
</tr>
<tr>
<td>Budaya</td>
<td>7</td>
<td>130</td>
<td>82</td>
<td>19</td>
</tr>
<tr>
<td>Buluguyi</td>
<td>9</td>
<td>217</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>Busia</td>
<td>20</td>
<td>842</td>
<td>51</td>
<td>48</td>
</tr>
<tr>
<td>Buhehe</td>
<td>10</td>
<td>396</td>
<td>40</td>
<td>58</td>
</tr>
<tr>
<td>Bulumbi</td>
<td>10</td>
<td>446</td>
<td>61</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
<td><strong>1,364</strong></td>
<td><strong>57</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

In Bugiri and Busia, more women initiated DMPA from CHWs than from clinics. Table 4 provides data on new DMPA users served by CHWs in these districts between June 1 and 31 December 31, 2008, compared with the number of new users served by clinical providers in whose catchment areas the CHWs were providing services. During this period, CHWs in Bugiri served 183 first-time DMPA users, while clinics recorded 172 first-time users. In Busia, CHWs served 226 new DMPA users, while 90 new users were served by government clinics.
Table 4. First-time DMPA clients served by public-sector CHWs and by government clinics, June – December 2008

<table>
<thead>
<tr>
<th>District and subdistrict</th>
<th>Number of new DMPA clients served by CHWs</th>
<th>Number of new DMPA clients served by clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bugiri</td>
<td>183</td>
<td>172</td>
</tr>
<tr>
<td>Bandai</td>
<td>44</td>
<td>25</td>
</tr>
<tr>
<td>Budaya</td>
<td>61</td>
<td>58</td>
</tr>
<tr>
<td>Buluguyi</td>
<td>78</td>
<td>89</td>
</tr>
<tr>
<td>Busia</td>
<td>226</td>
<td>90</td>
</tr>
<tr>
<td>Buhehe</td>
<td>93</td>
<td>30*</td>
</tr>
<tr>
<td>Bulumbi</td>
<td>133</td>
<td>60*</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>409</strong></td>
<td><strong>262</strong></td>
</tr>
</tbody>
</table>

*Includes 1 month stock-out

The absence of multi-year, baseline data on DMPA clinic provision prior to the beginning of scale-up activities precludes further analysis about the contribution of CBA to DMPA, including whether the number of new DMPA clients reflects increased access to DMPA or more general trends favoring DMPA use, whether task shifting from clinics to CHWs is occurring, and whether CBA to DMPA affects the number of new acceptors in clinics.

Satisfaction with services and quality of service

Reinjection rates

There is no standard measure for quality of CBA to DMPA services. However, acceptance of a reinjection is a very proximate, direct outcome of clients’ experience. Reinjection suggests some degree of satisfaction with the method and services received, including presumably the quality of counseling and of the injection experience itself.

Table 5 shows the proportion of eligible clients who received a reinjection from a CHW (after enough time had passed since the previous injection). The vast majority of eligible clients accepted this second injection: 77 percent of those in Bugiri and 68 percent of the clients in Busia. Further, among women receiving a second injection, 68 percent in Bugiri and 72 percent in Busia went on to receive a third. The proportion of continuing acceptors was highest at the nine-month interval, with 84 percent of the women who had received three injections accepting a fourth from CHWs, or 82 percent in Bugiri and 88 percent in Busia. This may suggest that women develop a strong commitment to the method and its delivery by CHWs by the time they receive three injections.
Avoidance of needle-stick injuries is an important aspect of safe delivery of DMPA at the community level, given Uganda’s relatively high HIV prevalence. No needle-stick injuries were reported by any of the public-sector or private-sector programs.

Table 5. Reinjection rates and reported needle-stick injuries among public-sector CHW clients, June 1 to December 31, 2008

<table>
<thead>
<tr>
<th>District</th>
<th>Eligible clients receiving reinjections</th>
<th>Reported needle-related injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At 3 months</td>
<td>At 6 months</td>
</tr>
<tr>
<td>Bugiri</td>
<td>77% (n=618)</td>
<td>68% (n=413)</td>
</tr>
<tr>
<td>Busia</td>
<td>68% (n=800)</td>
<td>72% (n=464)</td>
</tr>
<tr>
<td>Total</td>
<td>72% (n=1418)</td>
<td>70% (n=877)</td>
</tr>
</tbody>
</table>

Attrition

It is useful to examine when attrition occurs when assessing reasons why clients discontinue CBD of DMPA services. To this end, the authors looked at all DMPA clients who could have received up to three reinjections over the reporting period. A total of 467 women received their first injection early enough to be eligible for a third injection before the reporting period ended. Of these, 239 were in Bugiri and 228 in Busia. Table 6 shows the percentage of clients in this category who received one, two, and three reinjections, at three, six, and nine months, respectively. As could be expected, continuation rates show a declining trend with each reinjection. Among the 239 clients in Bugiri, 47 percent received a fourth injection at nine months; among the 228 in Busia, 39 percent received a fourth injection.

Attrition is represented by the difference in the proportions continuing the service between two consecutive injections. As seen in Table 6, attrition in Bugiri is 14 percent between the first injection, received by 100 percent of these clients, and the second injection, received by 86 percent. Attrition between the second and third injection is 27 percent of the initial cohort, and it is 12 percent between the third and fourth injections. As a proportion of the initial cohort in Busia, attrition at each of the three stages is 28 percent, 21 percent, and 12 percent. The biggest loss to follow-up occurred between the second and the third injections in Bugiri (27 percent of the cohort) and between the first and the second injections in Busia (28 percent of the cohort).

Women may choose to stop receiving DMPA services from CHWs for many reasons. Some providers reported in their notes that their clients had experienced side effects, but they did not appear to have kept consistent records of side effects, associated referrals, and follow-ups. Among 123 clients...
for whom reasons for discontinuation of DMPA services were recorded in Bugiri and Busia, 64 reportedly did so because they had moved, 21 because they wanted to conceive, 11 because they had divorced or split from their partners, 17 because they wanted a different method, and 10 because they had uncomfortable side effects.

Table 6. Continuation rates among public-sector clients who could have received four injections during the study period

<table>
<thead>
<tr>
<th>District</th>
<th>Eligible clients receiving reinjections¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At 3 months</td>
</tr>
<tr>
<td>Bugiri (n=239)</td>
<td>86%</td>
</tr>
<tr>
<td>Busia (n=228)</td>
<td>72%</td>
</tr>
<tr>
<td>Total (n=467)</td>
<td>79%</td>
</tr>
</tbody>
</table>

¹Continuation rates are calculated among clients who received their first injections early enough to have had the opportunity to receive a total of four injections during the study period.

Timeliness of reinjections

To maintain protection against pregnancy, it is recommended that clients receive DMPA injections every three months. The World Health Organization further recommends a grace period of two weeks before the scheduled reinjection date and four weeks after, resulting in a 10- to 16-week reinjection window after the last injection.

To evaluate their timeliness, reinjections were categorized according to when they were provided by CHWs:

- Prior to the beginning of the reinjection window (less than 10 weeks after the last injection)
- Within the reinjection window (10–16 weeks after the last injection)
- After the end of the reinjection window (more than 16 weeks after the last injection)

As shown in Table 7, among clients who received DMPA from public-sector CHWs, only 2 percent were given injections prior to the beginning of the reinjection window, 92 percent received them within the window; and 6 percent were given injections after the end of the reinjection window. These data speak to the ability of CHWs to appropriately manage the reinjection calendar. It should be noted that half of all injections were given on the exact day they were due, 12 weeks after the previous injection. The reasons that 8 percent of injections were given outside of the reinjection window cannot be explained, though client-scheduling problems may have contributed.
Table 7. Timing of reinjections in the public sector\(^1\) (n=1962)

<table>
<thead>
<tr>
<th>Time of reinjection</th>
<th>Number of weeks since previous injection</th>
<th>Number of injections</th>
<th>% of all injections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to beginning of reinjection window</td>
<td>&lt;10</td>
<td>37</td>
<td>2%</td>
</tr>
<tr>
<td>Within reinjection window</td>
<td>10–16</td>
<td>1803</td>
<td>92%</td>
</tr>
<tr>
<td>After end of reinjection window</td>
<td>&gt;16</td>
<td>122</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total reinjections received within reinjection window</strong></td>
<td>10–16</td>
<td>1803</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Total reinjections received outside reinjection window</strong></td>
<td>&lt;10 or &gt;16</td>
<td>159</td>
<td>8%</td>
</tr>
</tbody>
</table>

\(^1\)For clients who missed an injection but had subsequent injections, the missing injection and all subsequent injections are excluded. The total excluded is 31; 20 injections were missed due to stock-outs.

4. Conclusions

The experience in Uganda is an excellent model that can be used to assess scale-up of CBA to DMPA with different types of community health programs. The need for this service is high in the areas served by the NGOs and public-sector agencies. In the four districts studied, the private sector had more technical and financial capacity than the public sector to implement CBD of DMPA, and this is likely to be true in many other districts. However, private-sector capacity may be weakened by funding uncertainties. To address this potential threat, the private sector must liaise with public sector through a DHO to ensure the sustainability of the program.

To be successfully implemented and sustained, private-sector and public-sector programs providing CBD of DMPA need to be harmonized with existing monitoring and supervision, logistics, and waste-management systems. This requires commitment from all stakeholders and key players, and clinic staff need to be oriented to their new roles and responsibilities. The experience in Uganda shows that harmonization with the existing health structure is feasible for private-sector implementers.

Success and sustainability also depend on community acceptance of the CBD program and demand for the services. While meetings with key district stakeholders should be held prior to implementation, there is also a need for continuous community sensitization. However, the holding
of regular community-sensitization meetings is likely to be constrained by the limited financial and human resources inherent in most government-run programs.

The private sector was more rigorous in selecting, training, and providing supportive supervision for CHWs than was the public sector. This suggests that there are stronger mechanisms for ensuring quality in private services.

No matter which sector is implementing the program, logistics management is likely to remain a challenge. Stock-outs, especially in the public sector, slowed down the work of the CHWs and delayed client-return for repeat injections in some areas. Addressing this problem requires coordination at the district level as well as CHW training on logistics management. Other creative solutions can be used to address stock-outs. Districts can borrow from each other, and CHWs can be provided with sufficient DMPA to anticipate future stock-outs. These options can reduce the problem significantly, although more attention should be directed to systemic issues at the national level.

Challenges notwithstanding, the experience shows that CHWs in the public sector delivered on average more CYPs from DMPA than those in the private sector. This could be related to the motivation derived from DHO engagement in the project.

The quality of services provided by the CHWs in both sectors was high, client satisfaction is evident from the high reinjection rates reported, and no needle-stick injuries were reported. Moreover, almost all women served by the public-sector program received their reinjections within the recommended time frame.

Overall, this project shows that CHWs can play a significant role in improving access to FP for women in remote areas in Uganda and other low-resource settings. CHWs can provide many women with DMPA—their preferred FP method—and can play a role in increasing community knowledge and acceptance of injectable contraceptives.

The evidence suggests that nationwide scale-up of CBA to DMPA programming in Uganda would be beneficial, safe, and timely. The intervention has great potential public-health impact and the capacity to help Uganda meet her development goals. It is hoped that the lessons learned and challenges highlighted in this report will help to guide implementers and policy-makers in this direction.

5. Recommendations for Future Scale-up

1. The MOH should review the national service guidelines and rewrite them to support the provision of injectables by CHWs.

2. The MOH and its partners should consider developing a document to aid national policy-makers in planning for scale-up.
3. Flexibility is an asset for those integrating this innovation in existing systems, but they must pay close attention to the details of scale-up to maintain service quality.

4. DHOs need to be actively engaged for the program to win community acceptance and become sustainable.

5. Monitoring and supervision should be harmonized within existing systems used by public- and private-sector implementers.

6. CHWs should be carefully selected, with an emphasis on high-performing workers, to ensure good reporting and alleviate the need for intensive supervision.

7. The experiences of other CBA programs should be used to teach innovative approaches and adaptations. Early adopters should be seen as sources of learning.

8. Public-sector agencies with low financial and technical capacity need extra support before scale-up.

9. A cost analysis should be conducted to establish the relative benefits and costs of the supervisory approach taken by the NGOs. The more intensive supervision they undertake is likely to raise program costs, owing to supervisors’ salaries and monthly supervisory trips.

6. References


7. Appendices

A. Data Collection and Analysis

Data collection

CHWs used patient cards to record information about injections—due dates as well as the dates the injections were given—and other relevant information, such as where a client lived and whether she had previously received DMPA from a clinic. The CHWs also used the cards to record a client’s reason for discontinuation and the side effects she may have experienced, although this was not done consistently.

During the analysis period, the patient cards were collected at a central location four times: July 31, 2008; October 17, 2008; February 17, 2009; and April 2, 2009. The data were then aggregated into an Excel spreadsheet, which was modified and converted into a Stata dataset for analysis. In the aggregated data, patient ID codes were used in place of names. All analysis was conducted using Stata 9.

Data were queried and cleaned by staff at Family Health International/North Carolina and Family Health International/Uganda. Decision rules were developed to guide the inclusion and exclusion of observations and the inclusion or exclusion of specific injections.

Inclusion and exclusion criteria

- Some CHWs provided DMPA to women at a clinic during a practicum or during another CHW training event held at a clinic. These clinic injections were excluded from the analysis, and 22 women who were injected only at a clinic or during a practicum were excluded.
For each of 17 women who received their first injections in a clinic or during a practicum but received subsequent injections from a CHW, the date of the first injection was removed and the date of the second was entered in the spreadsheet column for first injections.

Three women were excluded because they never received a DMPA injection from a CHW.

One woman was excluded because she died before receiving a second injection.

Two women said they had received reinjections at clinics because they were away from home when their injections were due. Because the women returned to their CHWs for subsequent injections, they were treated as if they had received their clinic injections from the CHWs.

A total of 13 women—five in Busia and eight in Bugiri—were reported to have switched CHWs. However, there was little or no information about the CHWs to whom they switched—for example, whether a woman switched to another public-sector CHW in her district. The fact that these women switched was ignored. Instead, they were counted as discontinuing from their first CHW and included in the number of women who discontinued because they moved. To the extent that the 13 women continued with a different public-sector CHW in Bugiri or Busia, each was counted again as a new client with a new CHW.

For four women in Busia, recorded injections show gaps—for example, first and third injections, but no second injection and no reason why it had been missed. The missing injection and the subsequent injections were excluded from the study’s calculation of reinjection rates and timeliness.

For 20 women in Busia who missed an injection because of a stock-out of DMPA but had subsequent injections, the injection they missed and any injections subsequent to it were excluded from the analysis of reinjection rates and of timeliness.

Reinjection calculations

Reinjection rates were calculated among those clients who were eligible for a second, third, or fourth injection. Clients in this category whose due dates fell past the end-date of data collection for this study were not considered eligible for those reinjections and were excluded from the calculation.

For clients who had missed an injection but followed through with subsequent injections, the missed injection and all subsequent injections were excluded from the calculation of reinjection rates.

The total number of injections excluded 16 women who missed their three-month reinjections (13 due to stock-outs), 11 women who missed their six-month reinjections (seven due to stock-outs), and four women who missed their nine-month reinjections.
B. Scale-up Timeline

- May 2007: MOU signed with Busia and Bugiri.
- September 2007: MOU signed with CTPH and MIHV.
- February 2008: Start of MIHV implementation and data collection.
- May 2008: Start of CTPH implementation and data collection.
- June 2008: Data collection for CTPH and MIHV programs ends.
- July 2008: End of 12-month reporting period and scale-up data for the public sector.
- December 2008: FHI and the MOH advocate to all Uganda districts with offer to assist in scale-up.
- February 2009: End of 12-month reporting period and scale-up data for the public sector.