

# Promoting Community-Based Distribution / Community Reproductive Health Worker Provision of DMPA



## Educational Visit to Uganda – Summary Report

20-22 March, 2007



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## ACRONYMS

<b>CBD</b>	Community-based distributors/distribution
<b>CRHW</b>	Community reproductive health worker
<b>CPR</b>	Contraceptive prevalence rate
<b>DDHS</b>	District Director of Health Services
<b>DRH</b>	Division of Reproductive Health
<b>DMPA</b>	Depot-medroxyprogesterone acetate (Also called Depo-Provera)
<b>EH</b>	EngenderHealth
<b>FHI</b>	Family Health International
<b>GTZ</b>	German Technical Cooperation
<b>JHPIEGO</b>	John Hopkins Program for International Education in Gynecology and Obstetrics
<b>KCOA</b>	Kenya Clinical Officers Association
<b>KOGS</b>	Kenya Obstetrics and Gyneacological Society
<b>FP</b>	Family planning
<b>MOH</b>	Ministry of Health
<b>NGO</b>	Nongovernmental organization
<b>NNAK</b>	National Nurses Association of Kenya
<b>RH</b>	Reproductive health
<b>RHD</b>	Reproductive Health Division
<b>SC</b>	Save the Children
<b>TFR</b>	Total fertility rate
<b>USAID</b>	United States Agency for International Development

## **I. OVERVIEW**

An educational visit to Uganda by Kenyan reproductive health professionals was held from March 20 to 22, 2007. This visit was funded by USAID under FHI's *Promoting DMPA Provision by Community Health Providers* project (FCO 113108). Delegates were invited from cooperating agencies (CAs) and professional associations that had participated in one-on-one advocacy meetings led by the Kenya DRH. These organizations were represented: KOGS, NNAK, The Nursing Council, the Kenya MOH/GTZ CBD programme, KCOA, and JHPIEGO. The objectives of the trip were:

- To gain first-hand experience of Uganda's efforts at using CBDs to provide injectable Depo-Provera/DMPA at the community level;
- To identify lessons learned from the Uganda initiative and approaches used to overcome challenges and obstacles;
- To identify specific issues and concerns that would need to be addressed in replicating a similar initiative in Kenya; and
- To gather lessons, suggestions, and recommendations that will be presented at a larger stakeholders' meeting on CBD of DMPA in Kenya in 2007.

The following key activities were carried out:

- Sessions with key stakeholders in the Uganda CBD of DMPA project, including NGOs with RH activities and Uganda MOH officials;
- Field visit to the Nakasongola district, where Save the Children (SC) has implemented a CBD of DMPA programme since 2004; and
- The Kenyan team's wrap-up session and agreement on "take home" messages.

The tour exposed the delegates to the details of the Uganda CBD programme and to the reality of CBDs providing DMPA. The main "take home" message was that CBD provision of DMPA was feasible and should be pilot-tested in Kenya. Each of the organizations represented pledged their support for a pilot study in Kenya and recommended that a project advisory committee be formed. This committee will be responsible for reviewing the process of conducting the pilot study, and the study's outcomes.

## **II. INTRODUCTORY SESSION WITH KEY STAKEHOLDERS IN THE UGANDA CBD OF DMPA PROJECT**

This session, held on the first day of the trip, included representatives from USAID, Save the Children, and FHI/Uganda. There were introductions, opening remarks, presentations, review of advocacy and implementation materials, and open discussions.

### **Opening remarks by USAID: Sereen Thaddeus (Reproductive Health Advisor)**

Ms. Thaddeus reported that Uganda's family planning (FP) programme is considered one of USAID's successes. However, unmet need for FP in Uganda has risen, according to last year's Demographic and Health Survey (DHS), and the contraceptive prevalence rate has stagnated. These trends call for more focused programmes in FP and changes in the way reproductive health (RH) care services are provided. Women need access to a broad range of RH services; hence, those in decision-making positions must think creatively, innovatively, and boldly and design appropriate programmes. Ms. Thaddeus noted that past and current approaches locked out a significant proportion of women who require RH services. In her view, the approach of waiting for women to come to health facilities for FP lacks innovation, and there is critical need to follow other approaches, such as CBD of DMPA, that take the services to the women.

Ms. Thaddeus explained that USAID was committed to increasing access to RH services and, hence, to providing financial and technical assistance to the governments of Kenya and Uganda through NGOs such as FHI and Save the Children. She reiterated that USAID supports the provision of DMPA by community-based RH workers especially given that DMPA is the most preferred contraceptive in Uganda and increasing access will address the current unmet need. Uganda currently has an FP revitalization working group (led by MOH) that meets quarterly. Ms. Thaddeus advised the Kenyan delegation not only to take in all they learned in Uganda, but also to share with Ugandans successful approaches that had been employed to achieve better reproductive health outcomes in Kenya.

### **Opening remarks by Save the Children: Mr. Peter Nkhonjera (Country Director)**

Mr. Peter Nkhonjera welcomed the Kenya delegation and reiterated that CBD of DMPA was an important intervention in Uganda's RH strategy; hence, there is great interest in its process and overall results. He encouraged the delegation to investigate as much as possible and also advise on necessary improvements.

### **Presentations**

Highlights of the meeting's three presentations are provided below.

*Presentation 1: Overview of FP in Uganda (Dr. Angela Akol, FHI/Uganda on behalf of the MOH, whose representative could not attend the meeting)*

This presentation focused on the following:

- Targets of the Health Sector Strategic Plan
- Benefits of FP
- The growing demand for FP
- FP uptake
- Regional variations in FP uptake
- Challenges in FP
- Strategy for strengthening FP

*Presentation 2: CBD of DMPA Feasibility Study (Dr. Angela Akol)*

The delegates were given an overview of the feasibility study. This included a brief introduction, components of the study, and key results and recommendations.

### Presentation 3: Overview of Implementation and Scale up of CBD/DMPA (Dr. AfroDavid Bakunda)

Activities related to actual implementation of the study were discussed in detail during this presentation. These included components such as training, logistics, and supervision. The following issues were discussed after the presentation:

#### 1. Counseling on FP methods

The Kenya team asked whether the CRHWs providing DMPA were counseling clients on all methods. Dr. Bakunda reported that the CRHWs are providing pills and condoms and are referring clients to health centres for other methods such as implants and tubal ligation.

#### 2. Reaction of Professional Associations

Professional associations might be reluctant to support such an initiative because it involves provision of injectables by non-medical personnel. The Kenya team enquired if there had been resistance from medical associations in Uganda. Dr. Bakunda explained that many stakeholders were initially skeptical but are now willing to give the project a chance, thanks to the positive results of the pilot study.

#### 3. Role of the Head of the Division of Reproductive Health

The Kenya team asked about the MOH's involvement in the project. Dr. Bakunda explained that in Uganda, the Assistant Commissioner heads the RH division of MOH. He was instrumental in ensuring the success of the project. The MOH had been familiar with and supportive of the activities carried out by Save the Children even before the CBD of DMPA project was initiated. Much discussion took place between FHI, SC, and the MOH before the project was initiated. The key medical professional associations were also involved.

#### 4. Supervision

The Kenya team asked whether there were other mechanisms for supervision apart from the monthly meetings of CRHWs, SC, and health providers. SC explained that they conducted a good deal of sensitization work about CBD of DMPA within the community. Hence, they were able to select capable CHRWs and to ensure that the CHRWs only provided DMPA and did not attempt any medical procedures for other health conditions. Health workers were also sensitized, and they took a lead in training CRHWs. Therefore, the health workers had confidence in CRHWs' work.

#### 5. Gender ratio

Among the CRHWs providing DMPA in Uganda, the proportion of women to men is higher in Nakasongola, while for the new districts, the proportion is almost equal. This is attributed to the cultural practices within these communities. In Nakasongola, women play an important role in running their homes and are "allowed" to ride bicycles. This is not the case in the new districts, where women are more reserved. There, male CRHWs are just as accepted in the communities as the female CRHWs are.

## 6. Prior existence of the CRHW programme

The SC CRHW programme had been in existence for two years before introduction of the DMPA initiative. In selecting the CRHWs to provide DMPA, SC gave higher priority to those who had made a greater number of referrals for permanent and long-acting FP methods.

## 7. Payment for the CRHWs

The CRHWs work on a voluntary basis and their services are also free of charge. However various forms of motivation include:

- Provision of work tools such as bicycles, gum boots, umbrellas, and bags for carrying their supplies
- Refresher trainings to enhance skills
- Monthly forums where the CRHWs provide updates to SC project officers and emerging issues and concerns are addressed
- Recognition by the community

## 8. Linkages of CRHW programme with MOH

Concern was raised over the issue of sustainability of the project – strong linkage with MOH is essential for any project to be sustainable. SC facilitated the programme's implementation, and the programme works within and is supported by the MOH structure. The team noted that it is important for the community to have a sense of ownership to ensure the programme's sustainability beyond donor funding. Uganda representatives acknowledged that sustaining CBD programmes can still be challenging, given that volunteerism might not be possible forever.

The project implementers were positive that the programme can sustain itself beyond donor funding, because the programme is entrenched within the community and the CRHWs are linked to respective health facilities. Further, the community recognizes the important role played by the CRHWs in enhancing access to DMPA.

## 9. Client Preferences

Most DMPA clients prefer to get their injections from CRHWs because:

- The CRHWs live within the community; hence, clients do not have to walk long distances in search of DMPA services.
- The CRHWs have a personal relationship with the clients.
- There are no queues at the CRHWs' homes, so clients rarely need to wait long when they go for the injections.
- For clients whose spouses are not supportive of FP, CRHWs are a better alternative because they can assure privacy and confidentiality.

## 10. Effect of the CRHW programme

Anecdotal experiences suggested that the CBD of DMPA could be having a spill-over effect on demand for other long-acting and permanent methods because CRHWs counsel clients on a broad range of methods. Further studies within the project sites will provide evidence about this effect.

### 11. Record keeping

SC provides reporting forms in which client details--such as the name, method provided, date of next visit, and whether they are switching methods--are recorded. CRHWs also use referral cards.

### 12. Other issues

The Kenya team asked whether the use of auto-disabling syringes would continue beyond support from SC. SC clarified that the current syringes were provided by the MOH, which would continue to do so because of a national commitment to ensure universal availability of auto-disable syringes for all medical injections.

## **Review of advocacy and implementation materials**

The FHI/Uganda project director reviewed the implementation process and advocacy materials that have been used in this programme. These include:

- Checklist for support supervision
- DMPA training manual (English and Luganda versions)
- CBD of DMPA Advocacy kits (including research and program briefs)
- Nakasongola feasibility study report

## **Open discussion**

The Kenyan delegates informed the Ugandans of a perception in Kenya that there was a huge pool of trained but unemployed or retired nurses or midwives who could be employed to provide DMPA instead of lay CBDs. The delegates wondered whether similar concerns had been raised at the introduction of the CBD of DMPA project in Uganda. The Ugandan team explained that similar suggestions had been made there. However, there are not an adequate number of trained providers within the communities, hence the need to train CBDs to provide DMPA.

A team from Busia District in Uganda shared information about the CBD programme they were running. Theirs was a government initiative, and the CRHWs provided only pills and condoms. There were 11 CRHWs (six males and five females) within the district.

The Kenya team informed the audience about the current Kenya MOH strategic plan, which focuses on the community and considers it to be the first level of service delivery. If the CBD of DMPA initiative was to be implemented in Kenya, it would build upon and derive its legitimacy from this policy strategy.

## **III. EVENING SESSION WITH OTHER STAKEHOLDERS AND UGANDA GOVERNMENT OFFICIALS**

The team met briefly with other government stakeholders, as well as collaborating agencies, to share experiences in reproductive health. Organizations represented included USAID, Population Secretariat, EngenderHealth, Minnesota University Health Volunteer, JHU-CCP, Uganda Parliament, and FHI/Uganda.

The key messages to emerge from this session were the need to support approaches that will increase access to RH services and also to focus on programmes that build the capacity of the community.

#### **IV. FIELD TRIP TO NAKASONGOLA DISTRICT**

The field trip was undertaken on the second day of the tour. The team was welcomed to the SC offices by the Program Manager for Food Security/Development Activities, Dr. Brima Fatorma Ngombi. This welcome was followed by brief speeches from Nakasongola District leaders, highlights of which are provided below.

##### *Dr. Kasibante, District Director of Health Services (DDHS)*

He reported that the CBD of DMPA programme supported by SC was initiated in 2001 with the aim of improving FP services. This programme has led to an increase in CPR from 9% to 14% in Nakasongola District.

The introduction of DMPA into the programme was initially viewed as radical and therefore not acceptable, but this perception has changed with time. Ensuring continuous contraceptive supply remains a challenge that the MOH continues to try to address. On-going supervision is also challenging, because of a shortage of trained healthcare providers at local health facilities.

Through the CBD of DMPA programme, the district leaders have learned that they can deviate from the traditional channels of service delivery and support innovations.

##### *Mr. Chrisostom Kaise, Chief Administrative Officer (CAO)*

The CAO reiterated the importance of effective collaboration among the central and district local governments, CRHWs, development partners, and beneficiaries for the success of such an initiative.

Another challenge the FP programme faces, according to the CAO, is lack of political support. He said that local politicians were fond of making contradicting and negative statements about FP. Some politicians encourage people to produce more children and even advocate for gifts to families that comply.

##### *Mr. James Wandere, District Chairperson for Health*

Mr. Wandere thanked SC for the work they had done and noted that both Uganda and Kenya had a lot to learn from each other. He commented that providing family planning is key to improving health services.

The CBD of DMPA programme was developed to empower the community to achieve desired family sizes.

### Field visits

After hearing speeches from the district leaders, the team was divided into three and each smaller team was accompanied by SC staff to visit CRHWs in Kalungi, Kisaazi, and Nakitoma.

#### i) Kalungi field visit

The Kalungi Health Centre IV has seven active CRHWs, three of whom provide DMPA. Two of the CRHWs are male and five are female.

The visiting team met two CRHWs who provide DMPA, the person in charge of the facility, and the midwife in charge of the CRHWs. One of the CRHWs has served nine clients and the other one 50. The following key issues were noted during the discussion with the two CRHWs:

- The maximum number of Depo units each CRHW is allowed to stock is 10.
- There have been stock-outs, but clients usually buy Depo from drug stores and take it to the CRHWs for injection. The cost of Depo is Ush 1000 (Approximately Kshs 40).
- Clients rarely report any problems. There have been a few cases of spotting. Such cases are referred to the nearest health facility for further investigation.
- Clients are counseled on all FP methods and those who opt for longer-acting methods are referred to health facilities.
- CRHWs work on a voluntary basis. They have been provided bicycles for transportation. They like their work because the community appreciates them. They also receive recognition from the health facilities.
- From the facility-in-charge's experience, the CRHW clients report to the health facilities with side effects such as headaches, spotting, and backaches.
- CRHWs get clients through outreach and home visits.
- The CRHWs are optimistic that the CRHW programme will continue beyond SC funding since the community elected them and has trust in them. Further, they joined this programme with the knowledge that SC would support them for only five years.
- The facility-in-charge acknowledges that the CRHWs have relieved the burden on facility staff since many DMPA clients are now attended to by the CRHWs.

The Kalungi team also visited one CRHW (Faith Mulekwa) at home and found five clients waiting to see her. One of the clients was new. The team observed the CRHW provide DMPA to two clients, one of whom was receiving DMPA from the CRHW for the first time. This new client was first counseled then screened using the DMPA checklist developed by FHI and adapted by MOH. The following key points were noted during injection provision:

- The CRHW observed infection prevention techniques such as washing hands before providing the injection.
- The new client was counseled.
- The CRHW was advised not to recap the needle after use but to discard it as it is. This reduces the chances of needle pricks.
- Advice was given against drawing in a lot of air when drawing DMPA into the syringe.
- The CRHW was encouraged to spend more time counseling new clients to ensure they received comprehensive information to aid their choice of a FP method.

The CRHW said that she faces two main challenges: (1) men are not supportive of FP and do not attend related meetings and (2) because of stock-outs, clients have to buy Depo and bring it to the CRHW for administration.

ii) Kisaazi field visit

Kisaazi Health Centre (Level 2) offered outpatient treatment, immunization, FP, and diagnosis and treatment of sexually transmitted infections. The facility had three trained health care providers: one enrolled midwife and two nursing assistants. For FP methods such as implants and tubal ligation, the facility referred to Level 3 health facilities. Kisaazi Health Centre serves two sub-counties, each with seven CRHWs. Two CRHWs from each of the sub-counties were trained to provide DMPA. The Kenya team met with four of the CRHWs (one male and three females), the health facility's staff, and SC's field supervisors for each sub-county.

The enrolled midwife reported that CBD of DMPA had reduced the workload of the trained health care workers, even though it was initially difficult for them to come to terms with lay people providing injections. The midwife also confirmed that the health facility attended to a few clients referred by CRHWs. The most common side effect for which referral was made was headache.

CRHWs report

The three CRHWs reported that they received an average of two to four new DMPA clients and four to eight revisits monthly. The highest number of revisits by a single client (ten injections) was reported by the male CRHW, while the two female CRHWs had recorded a maximum of seven to nine injections per client.

The Kenyan delegation enquired how the CRHWs were able to meet their livelihood needs since their work was being done on a volunteer basis. The CRHWs explained that they were involved in other income generating activities to sustain themselves and, therefore, had no problem providing an essential service to women for free. They were, however, motivated by community members' appreciation and recognition of their role. They also explained that occasionally, some satisfied clients gave them material rewards such as a half litre of paraffin from a client after a successful injection, money from a satisfied husband, and regular supply of milk from a loyal client.

Constraints reported by and recommendations of the CBDs and health providers

- Attending monthly meetings in Nakasongola was cumbersome because of the long distance.
- The CRHWs reported that they sometimes encountered resentment from people in their community who were jealous of their new skills.
- The midwife recommended that nurses at the facility be trained on additional FP methods, because level 3 facilities were far away and many clients often came to them for advice on other long-acting FP methods.

Next, the team went to a CRHW's home to observe an actual DMPA injection. However, the CRHW did not have a client scheduled for injection on that day, but the team met two clients who provided a detailed testimony of their experience.

One of the clients seen was due to receive her 12th DMPA injection from the same CRHW and reported not to have had any serious side effects. The other had received eight three-monthly DMPA injections. Both of the clients expressed their satisfaction with the DMPA injections.

The CRHW maintained an elaborate record of the clients seen, referrals made, and follow-up injection schedules. She also drew a map of her village on which she noted the homes of her clients, nearest health facilities, and follow-up visit schedules. The visitors were exceptionally impressed by the CRHW's level of organization and proper storage of DMPA and other materials.

iii) Nakitoma field visit

At Nakitoma Health Centre, the study team interacted with the health centre in-charge, the midwife, and three CRHWs. The team included the champions from Luwero and Nakasongola. Later, the team visited the home of one of the CRHWs, where they were able to hold discussions with two clients and witness storage of supplies and record keeping.

The health facility staff reported cordial relationships with the CRHWs. The clinical officer in charge of the health facility declared support for the initiative. The CRHWs present were able to demonstrate to the visitors that their records are accurate and up to date. When they had no DMPA in stock, they reported that clients had gone to private clinics.

Challenges identified included:

- **Referral:** The CRHWs were referring clients to the clinic for side effects, but were not following up on the referrals to determine what treatment their clients received. The health workers reported that they were receiving clients referred by CRHWs, mainly for headaches.

Reciprocal referrals, i.e., from the clinic to CRHWs, were not made. In an ideal situation the clinic should be able to refer to CRHWs clients who come from deep in the villages and have no health complications.

- **Record keeping at the health facility:** The health facility records did not capture all CRHW doses of DMPA and provision of other FP methods. The health facility staff were encouraged to capture CRHW outputs as their own.
- **Transport:** The CRHWs reported that if they had means of transport they would be able to cover larger areas of the village and help more couples. They were restricted to giving DMPA only to clients within walking distance of their homes. Save the Children promised that bicycles given to the CRHWs four years ago would be replaced.

The study team proceeded to the home of a CRHW where they were able to observe hygienic and safe storage of DMPA supplies; safe disposal of waste; correct and accurate record keeping; and safe administration of two DMPA injections by two CRHWs. The team also interacted with clients who had been receiving DMPA from the CRHW for up to 12 doses. Discussions were also held with the spouse of the CRHW and the CRHW herself on challenges they faced. The main challenge reported were stock-outs and lack of support from male spouses of clients.

## V. DEBRIEF WITH MINISTRY OF HEALTH - UGANDA

On the third day of the tour, the study team met with the Assistant Commissioner for Reproductive Health, Dr. Anthony Mbonye.

Dr. Mbonye provided some brief background about the collaboration between the MOH, FHI, and SC. He acknowledged that CBD provision of DMPA was one way of increasing access to this method. Dr Mbonye noted that there was low uptake of facility-based interventions, hence the MOH's keenness on service provision at the community level, through CBDs, for example. He observed that the use of CBDs to provide DMPA could be perceived as moving services away from health facilities, which could appear to contradict the Government's policy to ensure access to medical services through trained personnel. However, he added that the Government also espoused a policy to enhance access to FP through community-based initiatives.

Dr. Mbonye explained further that the current Uganda RH policy does not allow injections by non-medical staff, hence the 'slow' approach adopted by the CBD of DMPA project. Noting that "you can't do one study in one district and change a policy," Dr. Mbonye explained that the Government was keen on seeing results and experiences from the new districts in which the initiative was being scaled up to inform policy change. This approach is appropriate because it allows CRHWs to improve their skills and also gives the community adequate time to fully accept the project. He reiterated that all stakeholders, including the district leaders, have been actively involved, which has contributed to the success of this project.

### **Comments following Dr. Mbonye's welcoming remarks**

The Kenya team asked how the MOH came to support the CBD of DMPA project. Dr. Mbonye explained that the MOH programme manager (Assistant Commissioner) was the first to be convinced. He then took up the challenge and discussed the project with other key MOH staff, who then pledged their support. Once the results of the pilot study were ready, they were disseminated to a wider group of stakeholders. Despite the MOH's support of the project, stock-outs at the lower-level health facilities remain a challenge.

Then the Kenya team asked how the project meets the RH needs of youth, given that majority of CRHWs are elderly and youth might be reluctant to seek services from them. The MOH explained that the UNFPA programme was initiating a strategy that would cater to youth. The SC programme also has a youth programme running alongside the CRHW programme.

The Kenya team mentioned factors that have contributed to Kenya's success in CPR, including:

- Support from development partners in securing contraceptives and logistics management.
- Good leadership from the Division of Reproductive Health.
- Support from the government, including a new line item in the national budget for RH.
- Integration of FP into other services such as voluntary counseling and testing and prevention of mother to child transmission of HIV, among others. This has led to leveraging of resources.

SC briefly discussed some of the lessons they had learned during the implementation of the project:

- Active participation and support from MOH is important during planning. Uganda has a CBD of DMPA core team that guides the activities of the project. The core team meets on a monthly basis.
- During training, the MOH has to take the lead and provide trainers. Collaboration with other stakeholders is beneficial in that they can support the development of the necessary training materials.
- Ensuring a constant supply of contraceptive commodities enables the CRHWs to continuously improve upon their skills.
- Supportive supervision is crucial for ensuring provision of quality services.

The Kenya team provided the following general feedback on the field visit:

- The Nakasongola CRHW DMPA programme is working well on the ground. The CRHWs are familiar with their work, they are popular, and they have many clients. The community has confidence in them. However, the health facilities they are associated with should give the CRHWs more recognition, especially when they go to the facilities to collect DMPA and other supplies. The health facility staff and the CRHWs need to regard each other as partners.
- The referral system needs to be strengthened to ensure that clients are advised appropriately about and treated for any side effects.
- The CRHW provision of DMPA is safe, but supervision needs to be continuous to ensure that the CRHWs' skills remain up to date.

## **VI. KENYA TEAM WRAP UP SESSION AND TAKE HOME MESSAGES**

The Kenya team met alone on the last day of the educational tour to discuss among themselves their experiences from the field visit and to agree on a common message to bring home. The following 'take home' messages were agreed upon:

- Uganda's CBD of DMPA programme is relevant and should be implemented in Kenya. The MOH has to take a lead for such a project to succeed.
- If a similar programme is implemented in Kenya, constraints observed during the Nakasongola field visit should be addressed. These include issues of contraceptive supply, integration within the health system to enhance sustainability, motivation of CBDs, and linkages with health facilities. One way to motivate the CBD agents would be to conduct yearly awards for best performers.
- As in the Nakasongola case, such a project is only possible where there is an existing CBD programme. Kenya's MOH/GTZ CBD programme can be used for the pilot study.
- All the delegates should be advocates for the Kenya CBD provision of DMPA project.
- The need to increase access to contraceptive services should be the overriding factor when implementing the programme.
- Although many of the medical associations had suggested the use of unemployed or retired nurses to provide DMPA, the group recognized that this cadre of health providers rarely stays within the communities. Thus, CBD agents still have a role to play.

- The selection of pilot study sites needs to take into account the Kenyan context and consider such factors as distance from health facilities, community goodwill, political influences, and hard-to-reach groups.
- Stakeholders should explore ways to revive the Kenya CBD programme in order to provide a strong backbone for CBD of DMPA.
- To ensure greater attention to quality and safety concerns that had been expressed by all the organizations, key actors in the initiative (DRH and FHI) should create a broader advisory committee to review the pilot study process and its outcomes.

## **VII. CONCLUSION**

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**The Kenya team unanimously agreed that Uganda’s experience of CBD of DMPA was relevant and that a similar programme should be pilot-tested in Kenya. The team recognized that this model has the potential to increase CPR.**

## APPENDIX A: LIST OF PARTICIPANTS

Name of participant	Name, address of organization	Designation	Email/Telephone contact
<b>KENYA DELEGATES</b>			
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Lydia Nabuya	Save the Children	Extension worker	
Kevin			

<b>Name of participant</b>	<b>Name, address of organization</b>	<b>Designation</b>	<b>Email/Telephone contact</b>
Samuel Lugobe	MOH – Kalungi Health Centre III	In-charge	
Justin Nakasi	Kalungi Health Centre III	CRHW	
Chrisostom Kaise	Nakasongola District	Chief Administrative Officer	
Lovincer Nabitale	Kalungi Health Centre III	CRHW	
Edinance Gahwerra	Save the Children	Health officer	
Annette Nalule	Kalungi Health Centre III	Registered midwife	
Faith Mulekwa	Kalungi Health Centre III	CRHW	

## APPENDIX B: STUDY TOUR PROGRAMME

### Programme of Events – CHW/DMPA Study Tour to Uganda

Day One: Tuesday, 20<sup>th</sup> March 2007

#### Introductions/Overview Meetings – Mosa Courts Apartments

Study tour objectives: (1) To provide an opportunity for the Kenya MOH and partners to learn about and benefit from the recent experience of implementing a CBD of DMPA programme as led by the Ugandan MOH and partners in preparation for Kenya adaptation in 2007; (2) To cultivate solid working relationships between countries for continued exchange on the CBD DMPA innovation.

Time	Session	Responsible
8.35a.m	Flight departs from NBI	Delegates/FHI-K
9.40 – 11.00	Arrival in Entebbe Airport Transport to hotel/Kampala	Mini-bus
11.00 – 11.30	Check-in Grand Imperial Hotel	Delegates/FHI-K
11.30 – 12.00	Transport to Mosa Courts	Mini-bus
12.00 – 12.10p.m.	Welcome and Introductions	Dr. A.K. Mbonye, Asst. RH Commissioner, U-MOH
12.10 – 12.20	Agenda Review	FHI-U
12.20 – 12.30	Learning Objectives	FHI-K/Kenya Delegation Lead
12.30 – 12.45	Remarks by USAID	Ms. Sereen Thaddeus, RH Senior technical Advisor, USAID- Uganda
12.45 – 1.00	Presentation: Overview of Family Planning in Uganda	Dr. A.K. Mbonye, U-MOH
1.00 – 2.00 p.m.	LUNCH	FHI-U
2.00 – 2.30	Presentation: Recap of Uganda CBD DMPA Feasibility Study	Dr. A.K. Mbonye, U-MOH
2.30 – 3.00	Presentation: Overview of Implementation and Scale up of CHW / DMPA	Ms. Bonita Birungi, Social Services Manager, Save the Children
3.00 – 3.30	Review of CBD DMPA Advocacy and Implementation Materials	Dr. Angela Akol, Project Director, FHI-U
3.30 – 4.30 p.m.	Open discussions	All
4.30 p.m.	Tea break and Close	All

## **CHW/DMPA Study Tour to Uganda –Evening Programme**

**Day One: Tuesday, 20<sup>th</sup> March 2007 – 7:00 – 8:30pm**

**Informal Dinner at Grand Imperial Hotel**

**Didi's Dining Hall**

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<b>7.00 – 7.20 p.m.</b>	Arrival of Guests
<b>7.20 – 7.30 p.m.</b>	Introductions and Welcome Remarks – FHI
<b>7.30 – 8.00 p.m.</b>	Dinner is served
<b>8.00 – 8.05 p.m.</b>	Remarks by the MOH – Dr. A.K. Mbonye
<b>8.05 – 8.10 p.m.</b>	Remarks by USAID – Ms. Sereen Thaddeus
<b>8.10 – 8.20 p.m.</b>	Remarks by Chief Guest – Minister of State for Primary Health Care, Hon. Dr. Emmanuel Otaala
<b>8.20 p.m.</b>	Closure and Departure

Dinner and reception will include partners from the Uganda National Family Planning Working Group

## Programme of Events – CHW/DMPA Study Tour to Uganda

Day Two: Wednesday 21<sup>st</sup> March 2007

Field visit with District Leaders, CBD supervisors, agents, and clients

Zion Centre, Nakasongola District

Time	Session/Locale	Responsible
7:15 am	Assemble in Grand Imperial Lobby	Delegates
7:30 – 10:00	Transport to Nakasongola district	Mini-bus
10:00 – 10:30	Welcome remarks, introductions, and refreshments <i>Save the Children-Nakasongola office</i>	Save the Children
10:30 – 11:30	Meet with District Leaders <ul style="list-style-type: none"> <li>• Welcome Remarks from DDHS, CAO, Secretary for Health/District Champion, LCV Chairperson</li> <li>• Overview of field visits and depart for subdistricts in 3 groups</li> </ul> <i>Zion Guest House</i>	SC/DDHS-Nakasongola
11:30 – 3:00	Field visits with clinic staff and CHWs <ul style="list-style-type: none"> <li>• Testimonials, recommendations, and Q&amp;A from supervisors, agenda, clients</li> <li>• Picnic lunch</li> </ul> <i>Health centres and CHW homes in 3 subcounties</i>	SC/DDHS-Nakasongola
3:00 – 3:30	Transport back to SC-Nakasongola office	Mini-bus/SC
3:30 – 4:30	Field visit debrief and Q&A with MOH, SC, FHI <i>Save the Children-Nakasongola office</i>	SC
4:30	Transport to Kampala/Hotel	Mini-bus

## Programme of Events – CHW/DMPA Study Tour to Uganda

Day Three: Thursday 22<sup>nd</sup> March 2007

Policy considerations, Lessons Learned, and Kenya Application

Uganda MOH Boardroom

Time	Session	Responsible
8:00am	Hotel checkout/baggage stowed	Delegates
8:30	Transport from Grand Imperial Hotel to MOH office	Mini-bus
9:00 – 10:00	Policy considerations <ul style="list-style-type: none"> <li>• MOH's buy-in journey</li> <li>• Plans/status for policy change</li> <li>• Roll-out vision</li> <li>• Challenges/strengths ahead</li> <li>• Q&amp;A from delegates</li> </ul>	Dr. Sam Okware, MOH Director of Clinical and Community Health
10:00 – 11:00	Implementation Lessons Learned <ul style="list-style-type: none"> <li>• From planning to supervision</li> <li>• Q&amp;A from delegates</li> </ul>	Dr. Peter Nkhonjera, Uganda Country Director, Save the Children-US
11:00 – 11:30	Transport to FHI-U office	Mini-bus
11:30 – 1:00	Kenya replication <ul style="list-style-type: none"> <li>• Tour reflections</li> <li>• Challenges and ideas for Kenya context</li> <li>• Kenya stakeholder planning</li> </ul>	FHI-K Delegates
1:00 – 2:00	Lunch	FHI-U
2:00 – 3:00	Any other business and Close	All
3:00 – 4:30	Opportunity for email, excursion, baggage pick-up	All
4:30 – 5:30	Transport to Entebbe Airport	Mini-bus