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

Educational Visit to Uganda – Summary Report
February 18 – 20, 2008

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ACRONYMS

ARFH	Association for Reproductive and Family Health
CBD	Community-based Distributors/Distribution
CPR	Contraceptive Prevalence Rate
CBD AGENT	Community Reproductive Health Worker
CTPH	Conservation Through Public Health
DDHS	District Director of Health Services
DMPA	Depot-Medroxyprogesterone Acetate (Also called Depo-Provera)
EH	EngenderHealth
FHI	Family Health International
FP	Family Planning
MIHV	Minnesota Health Volunteers
MOH	Ministry of Health
NGO	Nongovernmental Organization
RH	Reproductive Health
RHD	Reproductive Health Division
SC	Save the Children
TFR	Total Fertility Rate
USAID	United States Agency for International Development

I. EXECUTIVE SUMMARY

Agenda

An educational tour to Uganda on February 18–20 provided delegates from other countries with an introduction to the community-based distribution (CBD) of the injectable contraceptive DMPA (depot medroxyprogesterone acetate, or Depo Provera). The goal was to learn about Uganda's experiences with the CBD of DMPA and to forge relationships between the delegates so that they could exchange information about such programs in their home countries.

The tour was attended by delegates from Nigeria, Tanzania, and Rwanda, including representatives from the ministries of health (MOH) and partner organizations in each country. The Ugandan delegates were members of two nongovernmental organizations: Minnesota International Health Volunteers (MIHV) and Conservation through Public Health (CTPH).

The tour was funded by USAID through a project—*Promoting DMPA Provision by Community Health Providers*—which is managed by Family Health International (FHI).

Learning Objectives and Activities

The delegates hoped to achieve several objectives:

1. learn about the organizational network of the program, including the roles and responsibilities of various stakeholders
2. identify the costs of launching a CBD of DMPA program
3. identify and understand potential ethical and regulatory issues
4. learn best practices for providing the service
5. examine strategies for sustainability and ownership, including remuneration, incentives, and community involvement
6. learn how to monitor and supervise a program
7. identify weaknesses, strengths, and impediments associated with implementation

Delegates met key stakeholders in Uganda who have supported and implemented the CBD of DMPA program since 2003. The delegates also learned about the program in Uganda from the staff at the Uganda Ministry of Health, FHI, and Save the Children.

The delegates visited the districts of Luwero and Nakaseke, where Save the Children had implemented a CBD of DMPA program. The delegates met with district health officials, local family planning champions, Save the Children staff, and CBD workers who support and implement the program in these districts. The delegates asked questions of the district officials and CBD workers, and they observed a CBD worker provide an injection to a client.

On the final day, the delegates participated in group planning sessions where they outlined the steps needed to implement the CBD of DMPA in their respective countries.

Discussion

All of the delegates expressed a desire to continue the dialogue about the CBD of DMPA. They expressed support for the program—noting how it increases access to disadvantaged communities, creates demand from within a community, and bridges the gap created by the shortage of health care professionals and

medical facilities. They commended Uganda for paving the way for other African countries to replicate the program.

The delegates also made the following recommendations and observations:

1. Encourage greater participation in the program from the community
2. Consult stakeholders about the development of implementation guidelines
3. Data collection and reporting tools seem crucial to a program's success
4. The sustainability of a program was a major concern
5. People cannot wait for their country's health system to improve, so other modes of service delivery, such as the CBD of DMPA, are needed.

Conclusion

All attendees considered the tour to be a great success. Most of the participants believed that the CBD of DMPA was feasible in their respective countries, and they were enthusiastic about implementing a program with FHI's guidance and support. The delegates provided feedback to the tour organizers, district leaders, and CBD agents, which will be shared with the Ugandan National Core Team for the CBD of DMPA to strengthen their program.

II. OVERVIEW

Funded by USAID under Family Health International's (FHI) *Promoting DMPA Provision by Community Health Providers* project (FCO 113108), an educational tour to Uganda by delegates from Nigeria, Tanzania, Rwanda, and two nongovernmental organizations (NGOs) within Uganda was held from February 18-20, 2008. Delegates from each of the visiting countries included FHI staff members and nominees of the respective ministries of health (MOH). The objectives of the trip were:

- To provide an opportunity for the MOH and partner delegates to benefit from the experience of implementing a community based distribution (CBD) of depot-medroxyprogesterone acetate (DMPA or Depo-Provera) program as led by the Ugandan MOH and partners
- To cultivate solid working relationships among countries for continued exchange on the CBD of DMPA innovation

In order to meet trip objectives, several key activities were carried out. First, sessions with key stakeholders in the Uganda CBD of DMPA project were organized, including NGOs with reproductive health (RH) activities and Uganda MOH officials. Next, field visits to the Luwero and Nakaseke districts were undertaken, where Save the Children (SC) has implemented a CBD of DMPA program since 2004. Finally, country team wrap-up sessions and planning for the way forward were arranged.

The tour exposed the delegates both to the details of the Uganda CBD DMPA program and the reality and benefits of CBD workers providing DMPA. The main "take-home" message was that CBD provision of DMPA was feasible, and the majority of country and organizational teams planned to take steps, with FHI's guidance and support, to pursue implementation of CBD of DMPA in their respective countries and programs.

Delegates also received information packages with relevant publications, tools, and presentations included. A detailed list of the informational package materials is included in the appendix.

III. 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 the Uganda MOH, SC, and FHI/Uganda.

Opening remarks by Dr. Anthony Mbonye, Assistant Commissioner for Reproductive Health, Uganda MOH

Dr. Mbonye welcomed the delegations and addressed Uganda's challenges in regards to health and FP (FP). He explained that, like other African countries, Uganda faces certain challenges and has specific concerns, such as the low CPR (23%), high total fertility rates (6.9-7%), high unmet need for FP (40%), as well as poorly run systems, a dearth of providers, problems with stock outs, transport and other logistical issues, poor male involvement, and strong myths and misconceptions about FP. Thus, CBD of DMPA has been an important recent intervention in Uganda's national RH strategy. He encouraged the delegation to investigate the program thoroughly and recommend necessary improvements.

Presentations of Learning Objectives by the Delegates

The delegates from Nigeria, Tanzania, and Rwanda provided a brief summary of their learning objectives for the tour *(see appendix for delegates' presentations)*.

Rwanda:

- Describe how the CBD of DMPA program has been successful in Uganda
- Identify weaknesses, strengths, and constraints in the implementation of the CBD of DMPA program
- Identify the training program and materials used
- Identify cost implications in starting a CBD of DMPA program
- Determine the cost effectiveness of the CBD of DMPA program

Nigeria:

- To have observed the organizational network of the program including the roles and responsibilities of the various stakeholders
- Understand the ethical and regulatory issues encountered in the formative period and at the inception of the program
- Understand the distribution network of commodities to CBD agents
- Observe the guidelines, standards of practice (SOPs) and tools for monitoring the performance of CBD agents and supervisors
- Understand the referral linkages developed for the program to manage complications
- Identify strategies for sustainability and ownership (remuneration/incentives, community involvement)
- Hear the success stories, challenges, constraints, and lessons learned form the program.

Tanzania:

- Learn CBD/DMPA best practices
- Ascertain community acceptance on the CBD/DMPA program
- Identify the CBD/DMPA training modality and duration
- Determine the mechanism for CBD/DMPA monitoring and supervision
- Observe storage of DMPA at the household level
- Recognize challenges and constraints and ways of overcoming them
- Discover effective ways of sustaining a CBD/DMPA program

Presentation 1: Promoting Provision of DMPA by CBD Agents: The Uganda Experience (Dr. Anthony Mbonye, Uganda MOH)

This presentation focused on the status of FP in Uganda, the global history of CBD of DMPA, the 2005 Uganda CBD of DMPA Safety and Feasibility pilot study (methodology, baseline information, intervention, and results) and subsequent study recommendations, and the scale up efforts within Uganda and globally.

A copy of these presentation slides is available in the appendix.

Presentation 2: Community Based Provision of Depo-Provera: Overview of Implementation in SC Districts (Ms. Martha Bekiita – Save the Children, USA)

This presentation focused on how the introduction of CBD of DMPA was accomplished, partner roles, the background of SC's CBD program, implementation efforts, estimated impact and service statistics, and the challenges and lessons learned.

A copy of these presentation slides is available in the appendix.

Open Discussion

An open discussion followed these presentations. Delegates raised the following points as issues of concern or questions for the presenters to address:

- ***Task shifting*****:** The Nigerian delegates stated that they anticipated stakeholders complaining of task shifting and gave the example of lab scientists taking more than one year to allow non-lab technicians to test in HIV facilities. ***Answer:*** Dr. Mbonye acknowledged that task shifting can be an issue especially for medical people who don't want other cadres to encroach on their work, but he argued that it is one of the best ways to fill up human resource gaps in developing countries.
- ***Ethical Review:*** The Nigerian delegates wondered who reviewed the pilot before allowing it to begin. ***Answer:*** Dr. Mbonye explained that the Uganda National Council for Science and Technology provided ethical approval for the pilot study.
- ***Public sensitivity***: How were public sensitivities addressed? ***Answer:*** Public sensitivities are addressed through community mobilization meetings during which the champion / office of the DHO addresses any concerns from the public
- ***Ensuring commodity security at the health facility****:* How is this secured? ***Answer:*** The health facility in-charges and midwives were trained in effective commodity management, including procurement. The district health officer helps by reaching out to the National Medical Stores (NMS) to ensure that orders sent in are honored. During the study phase, a letter from the MoH to the NMS ensured that adequate stocks of DMPA and syringes were secured for the study.
- ***Motivation for the CBD agents:*** How is this addressed? ***Answer:*** Dr. Akol answered this concern by stating that CBD agents are motivated largely by the recognition they receive in the community, and by the sense of responsibility they feel to the community who selected them to be agents. In the beginning of the program Save the Children provided bicycles, umbrellas and gum boots but these have long expired and the CBD agents continue to be active.
- ***Guidelines:*** Who weighed in on, or was responsible for, drafting the guidelines for the project? ***Answer:*** The Ministry of Health was responsible for drafting and approving guidelines and protocols.
- ***Duration of the practicum:*** Is it long enough? ***Answer:*** The practicum is long enough to give the CBD agents sufficient skills to safely provide an injection. Injections are supervised during the practicum until each CBD agent has successfully given a minimum of five injections.

- ***Language of training:*** In what language is the training held and are materials translated as well? ***Answer:*** Training is mainly in the local language. Training materials are translated into the appropriate language
- ***Storage of DMPA supplies:*** How are syringes and DMPA stored in the community, and is this an issue at all? ***Answer:*** Storage of supplies has not been an issue to date. DMPA stores well at room temperature. CBD agents are taught to store the supplies in a dry place, away from children, and away from hot places, e.g. the kitchen. They are given bags in which to store all the supplies.
- ***Effective waste disposal:*** How is waste handled? For example, are needles incinerated? How are the used syringes transported for disposal? ***Answer:*** Used needles and syringes are disposed of in a special waste disposal box that is given to the CBD agents at the end of the training. When the box is full the CBD agent takes it to the health unit for incineration.
- ***Constraints with religious people and groups and attitudes towards FP****:* How have these been addressed in the program? ***Answer:*** Religious people are involved in the district stakeholders' meeting that is held before the CBD agent training. Any concerns they have are then addressed in the scale up model.
- ***Addressing the fear that CBDs might give other injections:*** Is this fear legitimate? ***Answer:*** This fear has not been realized so far. CBD agents are taught to inject only in the arm, which minimizes their risk of giving other injections. Also, only small capacity syringes are supplied to them, limiting the quantity of drug they can inject.
- ***Community perception:*** How does the community perceive the work of CBD agents? ***Answer:*** The community is extremely welcoming and supportive of their work, because the CBD agents have brought needed services closer to them and in a much more comfortable environment.

The delegates also had the following recommendations at the conclusion of the morning session:

- Continue the dialogue about CBD of DMPA
- The Nigerian delegation recommended that FHI develop a human shoulder model for use during the practical training of injection provision, stating that using a tomato is not the best model, or necessarily appropriate

IV. MEETING WITH DISTRICT OFFICIALS

After the morning sessions the delegates traveled to Luwero district, where they then split into two groups. One group met with district officials from Nakaseke district, the other met with district officials from Luwero district.

NAKASEKE DISTRICT VISIT

Delegates and Officials Present:

1. Mr. Ggubya Mohammed, District Vice Chairperson
2. Dr. Sessimba Badru, District Health Officer
3. Mr. Kyamanywa, Chief Administrative Officer
4. Dr. Violette Nabatte, in charge of Nakaseke health sub district
5. District Health Visitor
6. Enoch Nyongole, district FP champion
7. George Gahenda, Rwanda
8. Daphrose Nyirasafaali, Rwanda
9. Alice Nyiramutuzo, Rwanda
10. Martha Rimoy, Tanzania
11. Zuhura Mbughuni, Tanzania
12. Norah Nakate, MIHV
13. Sylvia Nandago,CTPH
14. Constance Aluzeyo, CTPH
15. Florence Rwabahima, CTPH
16. Angela Akol, FHI

Welcome and Introductions – District Health Officer, and FHI

Dr. Badru welcomed the delegates and introduced the district officials present. Angela Akol then led an introduction of the delegates from Tanzania, Rwanda, and Uganda, and stated that the teams were here on an educational visit of the CBD of DMPA program. Their specific objectives were to learn about implementation of the CBD of DMPA program in the district, especially the specific role of the district and the starting up process; challenges faced; cost effectiveness; logistics and supervision challenges; training processes; and advocacy.

Welcome Remarks – District Chairperson

Mr. Mohammed gave an overview of the district, noting that Nakaseke is a new district (created in 2006) with a population of 150,000 people. He described the socioeconomic activities and stated that the district has 21 health units, including two hospitals, two health center (HC) IVs, and six HC IIIs. These are the facilities at which FP services are provided and are manned by seven doctors and 11 nursing officers.

Mohammed said that since SC's partnership with the district, accessibility to FP had increased from 4% to 10% of the eligible populations. He also mentioned that FP is integrated in other services, such as immunization. As a challenge, he highlighted the inequity of the successful CBD of FP program in four out of eight sub counties in the district.

Transport for the health staff is another challenge, according to Mr. Mohammed. He recommended scale up of SC's program to the rest of the district.

Welcome Remarks – Chief Administrative Officer

Mr. Kyamanywa gave an overview of the administration of the district. Notably, he said that the district has a three-year development plan now being extended to five years, effective July 1, 2008. The plan includes FP and maternal and child health. He mentioned SC as a key development partner for education and health.

Overview of FP in the District and CBD of DMPA implementation – District Health Officer

Dr. Sessimba explained that the CBD of FP in the district is being implemented by SC in Kinyogoga, Wakyato, Ngoma, and Kamira sub counties, specifically by community volunteers trained by the district health office.

He appreciated SC's intervention because the district has a 1:11,482 doctor-to-population ratio and a 1:3,017 midwife-to-population ratio. Nevertheless, there are clinic-based FP services in all facilities. He added that a significant increase in utilization of FP was realized after SC's intervention, and hopes that SC will extend services to other sub counties.

Sessimba listed the stakeholders in the program: the DHO, CAO, SC, and the District Health Team. The district provides the DMPA to the CBDs, as well as other supplies, and it supports the CBDs through technical support, observing their work and reviewing their records.

Listing results of the CBD of FP program, Sessimba highlighted the following:

- The program will soon be launching in Kikamulo sub county
- 40 CBD agents will be trained to provide FP

- 2,382 clients received CBFP services between January 2007 and January 2008 out of an estimated 7,000 eligible clients
- Referrals to health facilities have increased
- Couple years of protection (CYPs) provided by the district FP program have increased. In 2006 10, 000 CYPs were provided, compared to 50,361 in 2007
- Workload on health facilities has decreased
- CBD agents are accepted at the health facility and are accessing supplies and other assistance

As next steps, Sessimba said there is need to mobilize communities to further support the CBD agents through information sharing. He also reiterated the need to extend to other sub counties, and he ended by expressing his gratitude to SC and donor partners.

A question-and-answer session followed this presentation

George Gahenda of Rwanda asked for more specificity on supportive supervision to the CBD agents. Who actually does it – HC or hospital staff? How is this coordinated from the district to the community? **Answer:** The SC health extension workers do the supportive supervision in the community in conjunction with the health facility staff.

Gahenda also enquired about standard materials for training the CBD agents. ***Answer:*** Standard materials and guidelines from the MOH are used to screen for eligibility and service provision. There is a standard CBD of DMPA training manual produced by FHI.

On community sensitization; how does the district deal with resistance e.g. from religious groups? ***Answer:*** To date, there is no significant resistance from religious groups.

A query was raised on community acceptance of FP, considering the vast spaces of unoccupied land in the district. Are there challenges with under population, especially with families with low levels of education? ***Answer:*** The benefits of smaller family size are taught and the clients make an informed choice.

Martha Rimoy of Tanzania was impressed with the results of the program, given that the district is still new. She wondered if there was a problem with dropouts of CBD agents. She also asked about any support to CBD agents from the community either in kind or cash. ***Answer:*** The CBD agent dropouts are insignificant but are a potential problem since the communities are nomadic. One CBD agent moved out of the region and was replaced. When one moves, the community elects a replacement. ”In kind” appreciation from clients to CBD agents is possible, but motivation is more in terms of community recognition than monetary rewards.

Florence Rwabahima from Kanungu district, Uganda, asked if stock-outs of FP methods were a problem. ***Answer:*** The district gets emergency supplies from Luwero and Nakasongola when they run out of DMPA. Sometimes they go directly to the National Medical Stores. When a supply of drugs comes without FP commodities, another order is made for only FP supplies, which can be honored in one day. There is need for proper planning and assertiveness from the district.

Nyirasafali from Rwanda asked about the working relationship between the health facility and the CBD agents. She thought the health centre staff should train the CBD agents rather than SC. She also questioned the wisdom of CBD agents initiating methods. She thought the health center should initiate and the CBD agent should replenish. She further wondered about the role of men in the program ***Answer:*** Health center staff are trained to handle volunteers (e.g. re-supply, handling side effects, supervision, and

technical support). Also, there are specially designated staff at the health facility to receive CBD agents and their complaints. Further, the whole process involves the health facility staff. Also, men are still a challenge, and there is still a problem with men accessing services.

Sylvia from CTPH asked about the relationship between CBD agents and health unit staff. She wondered if there were any conflicts, especially if the health unit staff get money and the CBD agents are offering free services. **Answer**: The relationship between CBD agents and health facilities is cordial. Services at the facilities are free.

Martha Rimoy asked how many households are covered by the CBD agents and if there is a related guideline. She also enquired about gender balance in selection of CBD agents. ***Answer:*** One CBD agent covers more than 100 households. There are two CBD agents in each parish. There are no special guidelines from the national level on coverage. Also, male CBD agents are recruited. Male CBD agents are instructed to give DMPA in the open. And CBD agents are charged with meeting men in community health talks.

Rwabahima of Kanungu/CTPH asked about transfers, specifically about who is the link person for the CRWH when health workers are transferred. ***Answer:*** Attachment of the CBD agents is not to individuals, but to the facility. In addition, there was a referral form that had specific health worker names, but that was changed to a generic form.

Review of advocacy activities – District FP Champion

Mr. Nyongole explained that his role as District FP Champion is to sensitize the community to the benefits of FP. He meets individuals, community leaders, and heads of families. He provided a brief of activities he had undertaken. He mentioned that a parish is extensive, about 20 sq km., and the extreme ends of the parish have poor access.

Nyongole highlighted challenges such as low levels of household education within the community. Consequently, resistance to FP is high. In addition, polygamy is prevalent and leads to competition among spouses for children; there are strong cultural preferences for boys; early marriages are common; large land distances that need to be covered present challenges for advocacy and sterilization; CBD agent motivation is low; permanent methods are not widely available at health facilities, and CBD agents refer clients who receive no methods; and some health workers are not trained on FP.

His proposed way forward is to increase advocacy and sensitization, using the media to update journalists on FP and identify the media's role in advocacy; facilitate transport for the champion; and optimize use of market days.

Questions to Champion

Aluzeyo of CTPH asked if champion activities are related to the CBD agents and if he had utilized radio slots and religious services. ***Answer:*** He informs CBD agents when possible that he will be in their area. Sometimes the gatherings act as health education talks. He has used radio and other venues (including the church) for mobilization. However, there is a need to target religious leaders.

George Gahenda from Rwanda presented a vote of thanks on behalf of the delegates to the district. A group photograph was taken and the visiting team departed.

LUWERO DISTRICT VISIT

***Delegates and Officials Present**:*

1. Ruth Acham, District Health Visitor
2. Musisi Erasmus, District Champion
3. Kyeyune Foldelie, District Chief Administrative Officer
4. Joseph Okware, District Health Officer
5. Ronald Mdaula, District Chairperson
6. Barbara Makumbi, Save the Children
7. Bonita Birungi, Save the Children
8. Olivia Nakayiza, Save the Children
9. Queen Ogbuji, Nigeria
10. Usman Gwarzo, Nigeria
11. Adeyemi Adekunle, Nigeria
12. Adebusola Salako, Nigeria
13. Abosede Adeniran, Nigeria
14. Pulcherie Mukangwije, Rwanda
15. Etienne Munyaneza, Rwanda
16. Eugene Rwabuneza, Rwanda
17. Maurice Hiza, Tanzania
18. Leah Mpogole, Tanzania
19. Eric Ramirez, Tanzania
20. Sister Mary Semumwe, MIHV
21. Amanda Abbott, FHI

Welcome and Introductions – District Health Officer, District Chairperson, Chief Administrative Officer

Dr. Okware, Mr. Ndaula, and Mr. Foldelie welcomed the delegates and introduced themselves to the delegates. Introductions of the delegates to the officials were also made.

Overview of FP in the district and CBD of DMPA implementation – District Health Officer

Dr. Okware gave a presentation outlining the profile of Luwero district and the CBD of DMPA activities that have been initiated there. The district of Luwero is divided into two counties, 10 sub districts, three autonomous town councils, 90 parishes, and 594 villages for administrative purposes. The population of Luwero is about 400,000, and has an average growth rate of 2.5%. The doctor-to-population ratio is 1:50,000, nurse-to-population ratio is 1:6,000, and midwife-to-population ratio is 1:8,000. Sixty-four percent of the health sector staff is manned by formerly trained health workers. CBD of DMPA was initiated in July/Aug 2006 in two of the 13 sub counties in Luwero. Okware described the selection and training process that the CBD agents underwent with the community's involvement.

As a result of the programming, Kamira subcounty had seven CBD agents trained to provide DMPA. Although one CBD agent was replaced due to poor performance, the rest are doing very well. In Kalagala subcounty five CBD agents were selected and trained on the provision of DMPA.

Okware also introduced the work of the district champion in sensitizing the community to the services available. He explained that stock outs remain a problem for the district, but that the MOH, district health officers, SC and FHI were all working together to reduce this problem, and that stock outs had dropped from 61% to 5% in three months during the program.

Okware reported that overall, the results of the program showed the FP uptake had increased in the district and uptake of DMPA in particular. Supportive supervision, logistics management, and quality had also improved under the program.

The challenges still faced by the district included a continued resistance from policy makers and health professionals; stock outs, sustainability and continuity is uncertain; maintaining confidentiality, especially given the lack of space in agents' homes; and the management of the side effects of DMPA.

The lessons learned by the district were that when faced with meager resources, the use of CBD agents may be necessary in order to improve health indicators. Also, there must be cooperation among all leaders at all levels to ensure success.

Review of advocacy activities – District FP Champion

Mr. Musisi Erasmus provided an informative review of his work. He explained that the role of the champion was defined by a national advocacy strategy which incorporated various levels of work; that is, the district champion works at the sub-county level.

Mr. Erasmus launched his work at the end of January 2007, when he drew up a work plan. He coordinated with various groups in the community to orient them to the program before the CBD agents were trained. For example, several meetings were held to orient service providers, women were mobilized to understand the benefits of FP, cultural leaders were sensitized, and radio programs were launched to increase the champion's reach. The champion explained how there are still some challenges to increasing awareness and uptake of FP, including male involvement, and sustainability of champion activities after SC finishes, especially in regard to transport.

A question and answer session followed these presentations

Abosede Adeniran of Nigeria asked what the distribution structure was for commodities, and if Uganda had considered a cost recovery system like Nigeria used for commodities. **Answer:** Dr. Okware responded that Uganda did once use a cost recovery scheme, but that even though the amount collected was so small, people were still locked out of the system by that cost. So, in 2001, there was a presidential mandate that prohibited the exchange of money in public health facilities.

Maurice Hiza for Tanzania asked how the motivation of CBD agents would be sustained, and asked how it was being maintained currently in Nakasongola. **Answer:** Through donation of bicycles to ease movement and regular visits, the CBD agents are motivated to do their work. They are also given lunch and transport reimbursement when they attend meetings at the health units.

Queen Ogbuji of Nigeria asked about the gender selection of CBD agents, and questioned why so many men were selected. **Answer:** The district champion explained that the CBD agents were selected by the community and that he assumes the majority were men because fewer women wanted to volunteer without their husbands' consultation. He explained that there are other social, cultural, and economic reasons for women not volunteering. For example, fewer women probably met the educational level selection criteria, and women do not always have control of their own time and resources. Finally it was suggested that women might not trust other women to keep their anonymity.

Adeyemi Adekunle from Nigeria asked the champion what he would do, as a member of the government, to put resources in place so that when SC was no longer in the district, the program could continue. **Answer:** The district champion stated that he did intend to help integrate the program into the district system and that he will plan with politicians how to get this started.

Eugene Rwabuneza of Rwanda thanked the district leaders and champion for sharing their successful multisectoral collaboration with the delegates. He proposed using a primary seven educational level as the criteria rather than primary four. He also encouraged the program to increase its gender counseling, stating that women should not have to be using contraception in secret, and he advised that Uganda consider launching a national campaign for CBD of DMPA, in much the same way as Tanzania launched a national advocacy campaign for VCT services.

At the end of the meeting, the district leaders introduced Rep. Geoffrey Kyomukama, the president's representative in Luwero district. Mr. Kyomukama addressed the delegates, noting that Uganda is often the first to act in important matters, citing the example of the president being the first to speak out against HIV. He thanked the development partners and the delegates and encouraged them to share their feedback and advice with district leaders.

V. FIELD TRIPS TO SUBDISTRICTS IN LUWERO AND NAKASEKE DISTRICTS

On the morning of February 19, the delegates were split into four groups and traveled to four health centers in Luwero and Nakaseke Districts. The following details the visits to Kinyogoga and Wakyato in Nakaseke district, and those to Kamira and Kalagala in Luwero district.

Kalagala HC IV, Luwero District

Delegates and Officials Present:

1. Ruth Acham, District Health Visitor, Luwero
2. Sinani Maguya, Clinical Officer in Charge, Kalagala
3. Esther Mutesi Lubega, midwife in charge of Kalagala HC IV Maternity unit
4. Kayima David Kiyimba, CBD agent
5. Tujunge Milly, CBD agent
6. Sempa Wilson, CBD agent
7. Henry Kivumbi Salongo, CDB agent
8. Wasswa Ssekandi, CBD agent
9. Mulangila Ssimbwa Joseph, CBD agent
10. Kityo Chris, CBD agent
11. Ruth Kafeero, enrolled midwife
12. Nabadda Milly, registered midwife
13. Usman Gwarzo, Nigeria
14. Zuhura Mbughuni, Tanzania
15. Maurice Hiza, Tanzania
16. Eric Ramirez Ferrero, Tanzania
17. Mary Sewamuwe, MIHV

Introductory Remarks:

Ruth Acham welcomed the team and led introductions. Sinani Maguya, the Clinical Officer In-Charge, then briefed the visitors on the health facility operations and services offered. The health centre serves an eight-mile radius. The services provided include minor operations, FP services, HIV services such as counseling and testing, as well as PMTCT, outpatient diagnosis and treatment services, dental care (on-site and outreach), and immunization (on-site and outreach).

Sinani stated that, historically, the turn out for FP has been poor, mainly due to male spousal resistance to FP. The clinic serves a large Muslim and polygamous population. The turn out improved when SC trained CBD agents. To illustrate: In July 2007 no FP client was served with oral contraceptive pills at the clinic, but since that time the CBD agents served 150 clients. In the same month no condoms were distributed at the facility, but the CBD agents distributed 1,197. Also, 11 DMPA clients were served at the facility, compared to 38 by the CBD agents. He noted that before the CBD agents were introduced in the district, there were Community Owned Resource Persons (CORPS) whose roles did not include the provision of FP. The CBD agents were then selected from the CORPS.

Mutesi, the health center midwife, reiterated that clients come to the health centre in secrecy for FP services, largely because of spousal resistance but also because of long distances. After the CBD agents were trained it became more convenient for the clients to get services from the community. She noted that

the facility has a good relationship with the CBD agents who come regularly for re supply, and submission of reports.

Mutesi highlighted challenges she faces with the CBD program, such as contraceptives received close to expiry, the inability to supervise the CBD agents in the field to ensure they are offering a quality service, and the long distances and poor roads, particularly in the rainy season, that make it difficult for the CBD agents to come to the facility promptly.

A question and answer session followed these presentations

Ramirez asked if the health facility had done anything to sensitize men in the community about the benefits of FP. **Answer:** Mutesi replied in the negative to-date.

Gwarzo shared his experience with FP in Muslim communities in Nigeria. He said that the term "child spacing" is more attractive to Muslims than "family planning" because the Koran recommends 30 months of child spacing. Muslims are more likely to practice child spacing than FP.

Hiza enquired about the nature of service integration and how client flow is organized. **Answer:** FP and HIV services are offered on the same day in different locations and the client entry point is the outpatient department.

Hiza also asked the CBD agents what their major challenges were. **Answer:** Their main challenge is the long distances they have to cover, and lack of transportation. Also, referrals are not always followed through by the clients.

Ramirez asked the CBD agents if they feel they have got sufficient training, and what further training is needed. **Answer:** The CBD agents said some CBD agents are not yet DMPA-trained and would need this training; management of side effects was not well taught and, as a result, CBD agents meet challenges managing side effects when they occur in the community; and counseling skills need more training.

Zuhura wondered about the support received by the CBD agents from local community leaders. **Answer:** The CBD agents responded that the local leaders help to mobilize for community health talks. During these talks the CBD agents mention the most convenient time for clients to approach them. By doing this the leaders endorse the work of the CBD agents.

Usman asked the CBD agents what motivates them to continue doing a seemingly thankless job. **Answer:**

- Working with the community and a sense of responsibility to the community that selected them
- Increased popularity, which may be helpful in the future (i.e., if the CBD agent wanted to pursue a political life)
- However, there is need for other motivators (i.e., a development fund, or some gratuity at the end of the year).

Observation of Records

The study tour team was oriented to the different record keeping forms. These included the client card, the referral form, the daily activity register, and the client books. An explanation was included that explained how the DMPA checklist is helpful. The health unit summary form was also observed to demonstrate that the CBD agent data is received at the health facility.

Ramirez then offered a vote of thanks to the health facility staff and the CBD agents before the team departed for the home of one of the CBD agents.

Visits to the CBD agent's home

Sarah, the CBD agent, welcomed the study tour team to her residence. A question-and-answer session followed once the team and the purpose of their visit was introduced. She discussed the following:

Storage of supplies: Supplies were kept in a box under lock and key, away from children's reach.

Challenges:

- Spousal resistance and lack of male involvement is indeed a challenge, but it is reducing.
- A misperception from the community that she is earning an income from the CBD agent work, with some men believing she is using their wives to make money. As a solution, it was proposed that SC and the DHO's office organize a community meeting to talk about the CBD agents' work.
- Her husband sometimes gets impatient because she spends a lot of time on non-paying CBD agent activities at the expense of family activities.

Usefulness of tools:

The pregnancy and DMPA checklists are extremely useful for screening. Clients gain confidence in her because of the detailed questions she asks, as opposed to the clinics where the health workers do not ask as many questions.

Clients:

- She has received clients requiring other injections that are not DMPA and she has turned them down, referring them to the health facility
- None of her clients had reported any adverse events from injection
- She has not received any young unmarried girls seeking FP services. She has received young men, to whom she gives condoms.
- Many potential clients do not use FP because of rumors and misconceptions, and fear of side effects

The study tour team then witnessed a skillfully given injection by the CBD agent to a client, with correct counseling and instructions on return date.

<u>Kamira Health Centre III, Luwero District</u>

Present:

1. Patricia Wamala – FHI
2. Alice Nyiramutuzo, Rwanda
3. Etienne Munyaneza, Rwanda
4. George Gahenda, Rwanda
5. Adeyemi Adekunle, Nigeria
6. Abosede Adeniran, Nigeria
7. Martha Rimoy, Tanzania
8. Norah Nakatte, MIHV

Kamira Health Center has nine staff. Services offered include outpatient, inpatient, antenatal, FP (oral contraceptives, DMPA and condoms), VCT, and laboratory services. The staff provides refills of DMPA supplies to CBD agents and hosts CBD agent monthly meetings.

Successes of the program include increased use of FP services; collaboration with SC; improved relationships with the community; and a surgical camp last year to provide other FP methods, like TL, that are not available at the health unit.

Challenges of the program result from drug and supply stock out; lack of skilled staff to provide other FP methods; and private clinics that do not support the work of the CBD agents.

Visit to the CBD agent's home **involved** interaction with him and witnessing how he stored supplies around his home; and meeting with a satisfied client.

CBD agents are motivated by the training received from SC; community recognition; being entrusted by the community to perform the tasks they do; and making a contract with SC to be part of the program, thus obliging them to continue with the program.

Wakyato Health Centre III, Nakaseke District

Present:

1. Daphrose Nyirasafali, Rwanda
2. Pulcherie Mukangwije, Rwanda
3. Chidinma Queen Ogbuji, Nigeria
4. Mrs. Adebusola Salako, Nigeria
5. Ms. Sylvia Nandago, CTPH
6. Ms. Martha Bekiita, Save the Children
7. Enock Nyongole, Champion
8. Dr. Badru Sessimba, DHO, Nakaseke
9. Dr. Sekito Gerald, DHO, Nakasongola
10. Dr. Violette Nabatte, Medical Officer, Nakaseke
11. Grace Kuteesa, FHI-Uganda

Welcome and introductory remarks:

The delegates were warmly welcomed to Wakyato Health Centre III, and these remarks were given by Dr. Nabatte Violette of Nakaseke hospital, and the Assistant Health In-charge of the health facility. The health centre staff and the delegation were introduced.

Bakisa Yusuf, a health extension worker from SC, gave a brief introduction. He works with the CBD agents in Wakyato. Ten CBD agents were trained in pills and condom distribution in the community. Three among the 10 were selected and trained in DMPA distribution. For the other FP methods, referrals are made to the Health Centre III or to the hospital.

The CBD agents work hand in hand with Wakyato HC III. They depend on them for supplies. The CBD agents have simple order forms that they use to request for more supplies when their stock is finished. The CBD agents submit their monthly reports to the HC III, and depend on the HC for supervision and referrals.

Limitations:

- Male involvement in FP is very limited, and some women refrain from accessing some of the FP methods like DMPA for fear of harassment from their husbands. In other cases, women who use FP methods may lose their husbands.

- Most fears of side effects are based on "hearsay." Still, many women are not aware of the side effects, so they often make uninformed decisions.
- The community is nomadic, so women are not in a position to receive the three-month DMPA injection (no continuity).
- These are pastoralists whose custom offers a cow to the family for every child born. As a result, the value for more children is very high. This limits the access to FP and it is made worse by the poverty that is biting at the communities.

Questions and answers:

Daphrose asked if the CBD agents were trained in other methods. **Answer;** Yes. Apart from the DMPA, the CBD agents are trained in other FP methods like pill and condom distribution. For example, if a client is interested in a Long Acting and Permanent method (LAPM), she is referred to the HC III or the hospital.

Queen asked if screening for blood pressure is done before the DMPA injection is administered and, if so, who does it? **Answer;** In most cases the client will be asked if they have high blood pressure. However, if the client is not sure whether they have it, then she is referred to the HC for screening.

Concerns raised by the delegates:

Some suggested that asking the client about high blood pressure is not good enough. Every client intending to seek DMPA injection should be referred to the HC for proper screening before the injection is administered. It was believed that this would rule out unnecessary side effects because the administration of DMPA would be based on an informed decision.

The visit to the CBD agent's home – Zawedde Lovinsa:

Zawedde is one of the CBD agents in Wakyato that administers DMPA. She lives in a humble home with her six children. She is also using DMPA and serves as a good example to her fellow women. Zawedde has a total of 24 clients. She has done a good job with FP promotion in the community. She has educated women on the use of pills and she has tried to talk to the youth in schools about condom use. Unfortunately, school leaders have not given her permission to talk to the youth.

Storage of supplies: She keeps them in a safe and clean place out of reach of children.

Disposal of used syringes and cotton: The used syringes are disposed of in a safety box which is then taken to the Health Facility when full. Other materials like cotton are disposed of in another box that is burned when full.

Challenges:

- Male involvement in FP is limited. She mentioned that women secretly come to her home for the injection. As an example, Zawedde gave the following scenario: A woman secretly came to her one night for an injection. Unfortunately, unbeknownst to the woman, her husband had followed her. After the woman had received her injection, the husband seized her and beat the arm where the injection had been administered. The woman's arm became swollen and she asked Zawedde for advice. Zawedde referred her to Wakyato HC III, but the woman was not willing to seek treatment there because she was scared that her husband might find out and beat her again. The woman decided to go to a nearby clinic for help. Zawedde does not know the status of her client now because

they shifted to another, nomadic community. The woman's husband warned Zawedde that if she ever saw her with his wife again, he would take her to court.

- One reason for problems of continuity is that the people that Zawedde serves are nomads, so it is hard to keep track of clients and also very hard for the clients to continue to receive the DMPA in the different communities they move to.
- Another problem with continuity is that many women do not go with their return cards because they fear that if their husbands find them, they could harass them, beat them, or chase them away from home. Therefore, it becomes difficult for the clients to keep track of their return dates. Some come back far past their return dates — say, six months after the previous injection, and they could even be pregnant. To solve this problem, she reminds the women to go for their injections during the market days, because that is when she can freely interact with them.
- The long distance from health centers discourages clients from going for referrals. Instead, clients go to nearby clinics that do not have trained personnel. The husband who might have a mode of transport (i.e., a bicycle) for easier movement to the HC does not agree with FP, therefore he is not willing to help transport his wife to the HC.

Zawedde then gave a demonstration on how she administers DMPA to the clients. The client that was receiving DMPA that day was previously taking pills but changed to DMPA because she wasn't taking them correctly and consistently. She was receiving her third injection since she started using DMPA.

Kinyogoga Health Center III, Nakaseke District

1. Leah Mpogole, Tanzania
2. Florence Rwabahima, CTPH
3. Constance Aluzeyo, CTPH
4. Eugene Rwabuneza, Rwanda
5. Amanda Abbott, FHI-NC
6. Trevor, Save the Children CHEW
7. Moses Amonde, Clinical Officer

Trevor, the SC Community Health Extension Worker, introduced himself and explained that seven community members are currently active CBD agents working with the Save program in Kinyogoga. Four of these were trained in the provision of DMPA (two men and two women). However, one female CHRW then relocated to another village. The CBD agents that were trained were selected by the community because of their abilities. These trainings occurred in Luwero and were residential for the CBD agents for the classroom phase. The practicum was completed in the district hospital. The CBD agents were also trained in eligible couple mapping for three days. When asked if the clinic staff were involved in the trainings, Trevor explained that SC trained the district trainers and that they then train the CBD agents, and so the clinic staff were not involved in this case. Each CBD agent covers approximately 300 households.

Trevor introduced the Health Center Clinical Officer, who explained that the clinic was staffed by himself, a nursing officer, and three nursing assistants. At the time of this tour, the clinic was well stocked with contraceptives, including DMPA. Trevor explained that DMPA is the most popular method because of its efficiency and the privacy that it affords. When asked about the other methods, he explained that condoms were most often used by youth in the community, and that pills were not popular because they are hard to remember. However, he stated that the women who do use pills are satisfied with them and are in communication with their husbands about their use.

Trevor introduced two male CBD agents, Robert and John, to answer questions, but who had not been trained in DMPA provision. Also present to answer questions was the Health Center Clinical Officer.

Questions and Answers:

What women are served through the CBD agents? Are any considered ineligible due to age, etc.? **Answer:** The CBD agents serve married women only. However, the CHRW can provide contraceptives at his/her discretion, if they think it is necessary (including school girls).

How were politicians and religious leaders involved in the process? **Answer:** Local politicians were involved in the community mobilization process. Religious leaders were involved in the local health committee meetings.

What is the status of referrals in the program? **Answer:** Referrals have been good. There are five men in the village looking to have vasectomies. As a result, Save will be coordinating a mobile unit to come to serve them.

How is supervision conducted? **Answer:** Trevor from Save supervises the CBD agents twice per month. The clinical officer conducts village outreach on a monthly basis, and he may or may not meet with CBD agents during these visits. The CBD agents receive incentives such as bicycles, umbrellas, and gum boots, and when they meet they receive sodas and snacks, and are provided meals during trainings.

What motivates the CBD agents? **Answer:** John and Robert explained that they are motivated because they want to improve the health of their communities.

How far do the CBD agents live/work from the health clinic? **Answer**: John lives 25 km from the clinic, and Robert 15 km. It takes John six hours roundtrip on his bicycle to come to the clinic twice per month to resupply.

What can be done to improve CBD agent performance? **Answer:** Provide a salary of 200,000 shillings per month.

Do they receive any support from the community? **Answer:** No.

How are men involved? **Answer:** The CBD agents are trained to advocate for communication between partners about FP. They are aware of low male involvement, and therefore appreciate that they were selected as men to participate in the program.

Trevor then introduced a female CBD agent who had been trained in the provision of DMPA. The delegates visited this CBD agent's home to observe her interaction with a client. The client that presented explained that she had three children, the youngest being four months old and she didn't know if she wanted more children. She had also used DMPA in the past, and wanted to start using it again. The CBD agent successfully greeted and counseled the client on her options, and screened for pregnancy by using the pregnancy checklist. The CBD agent then successfully injected the client, calculated her return date and filled out the paperwork required by SC.

VI. DEBRIEF WITH KEY STAKEHOLDERS AND DISTRICT OFFICIALS

Feedback from the delegates who visited Kalagala Health Center:

The delegates reported that they met successfully with the health unit staff and in-charge. The delegates learned of the successes and challenges of the program. They reported having observed and learned about the following:

Successes included *the observation of a CBD agent successfully delivering a DMPA injection; witnessing an increased number of FP service users via CBD; and seeing how CBD agents helped the health centre reach distant FP clients.*

Challenges included *the fact that CBD agents still have to travel long distances; the expiry of available contraceptives; the stubborn issue of religious resistance, despite having CBD agents carry out sensitization to address the issue; men being unsupportive of the CBD program in some cases; the task of following up DMPA users; and managing side effects due to the distance between referral points for clients and CBD agents*

Finally, the Nigerian team shared an experience of how best to counter religious resistance: Instead of using the term "family planning" "child spacing" was used.

Feedback from the delegates who visited Wakyato Health Centre:

The delegates reported that they met successfully with the health unit staff and in-charge, then gave a brief overview of the health center services and coverage. They reported having observed and learned about the following:

Successes included *observing a CBD agent successfully deliver a DMPA injection. Also, the CBD agent has 24 clients and was motivated to be part of the CBD program due to personal experience of having six poorly spaced children.*

Challenges included cultural barriers to FP that scare women from accessing FP services; limited male involvement or resistance (the CBD agents cited an incident where a woman was threatened with court action by a client's husband for administering DMPA); and the pastoral community, which leads to delays in receipt of follow-up injections.

Feedback from the delegates who visited Kinogoga Health Centre:

The delegates reported out that they met successfully with the health unit staff and in-charge, and gave a brief overview of the health center services and coverage. They reported having observed and learned about the following:

- They observed a CBD agent successfully deliver a DMPA injection
- Five clients have requested for vasectomy and Save is planning to get a mobile camp to reach these clients.
- The CBD agents enjoy a good relationship with the community but the relationship to the health center is not clear

Delegates from Rwanda suggested that more information be gathered about improvised incinerators so that CBD agents might be able to dispose of the waste boxes safely without having to deliver them to the health centers.

Feedback from the delegates who visited Kamira Health Centre:

The delegates reported out that they met successfully with the health unit staff and in-charge, and gave a brief overview of the health center services and coverage. They reported having observed and learned about the following:

Successes included observing a CBD agent successfully deliver a DMPA injection and meet with a satisfied client; increased use of FP services; successful collaboration with SC; an improved relationship

with the community and health center; and a surgical camp to provide methods not regularly available at the health center, which was held last year.

Challenges included *drug and supply stock out; lack of skilled staff to provide other FP methods; and private clinics not supporting the work of the CBD agents.*

The delegates also reported that the following aspects motivated the CBD agents to continue their work:

- The training received from SC
- Community recognition
- Being entrusted by the community
- Having a contract with SC to be part of the program

General Observations

- There is support from the local district councilors, which makes the work of the CBD agents easier. They help with mobilizing people for sensitization on FP.
- While some CBDs will make mistakes, the DHO Nakasongola reminded delegates to consider how the mistakes of CBD agents relate to feared problems, and how many feared problems arise out of CBD agent activities.

Areas for improvement:

- CBD agents need to be taken through proper infection control. In one of the visits, the CBD agent did not properly clean the site of injection.
- CBD agents need further training in record keeping for proper accountability of supplies.
- CBD agents didn't seem very comfortable with the checklists as they assessed clients' eligibility.
- It is hard to track whether the CBD agents are effectively using the checklist, or whether there is evidence of how they address/assist clients who are contraindicated.

General Concerns:

- There was initial concern that CBDs are replacing clinic services. One of the CBD agents visited lived right next to the clinic, and it didn't make apparent sense to have people go to a CBD agent when there is a health unit. However, it was argued that despite the easy access, the clinic was not able to provide the required services.
- Health workers/units are not involved enough in the supervision, which could cause some problems when the SC program ends.
- The CBD agents visited didn't highlight supervision from the health unit, which is essential for quality control/assurance.

Support to CBD agents

- When asked about motivation, CBD agents seemed to have short-term interests. There is need to put in place a system to sustain interest, beyond bicycles and community recognition.
- In addition to the other things given as motivation to the CBD agents, they would also like to receive some remuneration.
- Political support is critical, as it motivates CBD agents.

Recommendations

- Hold a refresher training for the CBD agents and health workers.
- Use satisfied clients to mobilize more clients. Speaking from experience motivates people to change.
- Enable CBD agents to do pregnancy tests and take blood pressure.

- Hold a meeting with all the CBD agents (under the different health units) participating in the CBD of DMPA program.
- Health center workers and in-charges should be more involved in supervision.
- SC should ensure resupply to CBD agents at their homes, especially for those who live far from the clinic.
- Build incinerators to facilitate safe waste disposal.
- Emphasize a mentorship style of supervision over data collection and use a "star" to mentor other CBD agents.
- Avoid creation of new levels of health service delivery.
- In regard to the tools, both the cover of the *Implementation Handbook* and the cartoon manual show the injection site as lower than the recommended site.
- For future study tours, delegates should get an opportunity to talk with the community in addition to talking with the CBD agents. Also, clearly define for the delegates what skills that CBD agents should gain during the training e.g. injection safety, referrals.
- Supervision visits by the health workers could serve as the point of initiation of injections, ensuring proper supervision and screening of clients.

Closing Remarks by Sereen Thaddeus – RH Advisor, USAID-Uganda

Sereen emphasized that USAID is a strong believer in exchange visits and study tours. The goal of the innovative program is to increase access to reproductive health services, specifically FP, and that there is now a need to move services to where the women are. She stated that the interest of CTPH and MIHV within Uganda shows that this intervention can work. Sereen stated that she heard it was important to consider more client-to-client interactions, for example having happy users speak about their experiences with other potential clients, and that it was important to keep the program focused, simple, and voluntary.

Sereen concluded her remarks with an example from Morocco, where the CBD program was once strong and now no longer exists. That program was stopped not because of sustainability issues, or other such concerns, but in part because it had helped to contribute to the education of clients. Women learned about their options and started accessing services, but not necessarily form CBDs. The effects of such efforts are evidenced today in Morocco's high contraceptive prevalence rate of 62%.

VII. The Way Forward – Country Team Planning Sessions

On the third day of the study tour, Amanda Abbott presented on "The Way Forward" for the country teams. This presentation focused on how the delegates planned to move forward with the information they gathered from the study tour, and the assistance that they could expect from FHI. The presentation included the following key points:

- Next steps
- FHI's role
- Resources available
- Examples of next steps from Kenya

After this presentation the delegates broke off to work individually on a "country team planning form" drafted by FHI. This form guided the delegations to answer key questions about the possibility of introducing CBD of DMPA into their respective contexts. The delegates outlined what the next steps for their teams would be. The following is a summary of those next steps as described by each delegation.

***Conservation Through Preservation and Health (CTPH)**:*

- Seek technical assistance through FHI
- Host a district stakeholders meeting to ensure that they are involved in planning
- Report on the tour to stakeholders

***Minnesota International Volunteers for Health (MIHV)**:*

- Report out to funding organizations
- Convene a meeting with the project staff
- Seek technical assistance from FHI
- Host a stakeholders meeting
- Identify sites for introduction & identify CBD agents to be trained
- Secure funding for the program

Nigeria

- Brief the Hon. Minister of Health
- Host a stakeholder meeting for consensus building
- Devise a suitable recruitment criteria for volunteers
- Develop plan for the introductory phase of the program
- Seek technical assistance and support from FHI

Tanzania

Before CBD of DMPA can be introduced, Tanzania needs to strengthen FP generally. Therefore, the team recommended the two actions: Form a coordinating committee to strengthen FP at both the facility and community-based level; and advocate for repositioning FP in general.

VIII. TOUR REFLECTIONS AND TAKE-HOME MESSAGES

The delegates were then given the opportunity to report on their reflections of the tour and take-home messages. CTPH and MIHV did not participate in this session. The following are highlights from these presentations given:

Nigeria: The Nigerian delegation reported that CBD of DMPA is a good initiative, which increases access to the disadvantaged community and bridges the gap created by low human resources and access to the facilities (between need and uptake). Additionally, the program encourages community participation, and is cost effective to the Government and consumer. Overall, the Nigerian delegation saw the program as feasible and replicable in other countries. The team shared the following positive observations and concerns:

Positives

- Uganda is marching towards the vision, and there is strong political will and support
- The program has found patriotic, committed and self-motivated CBD agents
- There has been a successful coordination of resources between developmental partners and the Government
- The Government is in the driver's seat with the synergistic support of partners

Concerns

- There is no observable sustainability plan in place
- Facilitative supervision and mentoring of the CBD agents can be improved
- Quality assurance can be improved
- Tools can be made more user-friendly
- The logistics management system can be strengthened to ensure regular supply of commodities to the CBD agents
- Referral systems can be strengthened

Rwanda: The Rwandan delegation reported that CBD of DMPA through the CBD agents, if well implemented, helps in creating and meeting demand for FP services. They observed that the program helps in increasing accessibility of FP services, and like the Nigerian delegates, they felt that the program increases community participation in managing their own health. The team shared the following as lessons learned from the study tour:

- Training, and re-training coupled with supportive supervision of the CBD agents, is key to successful implementation of a CBD of DMPA program
- With respect to the minimum package of activities defined for specific levels in the health care system, health facility service providers should be trained to train the CBD agents and also offer supportive supervision
- The involvement of political leaders, including community leaders/opinion leaders as champions right from the inception of the program, is key to its success
- Ensuring a constant supply of FP products to all levels of FP service provision is also key to the success of the program
- Community participation in health service provision through CBD agents improves working relationships with health facilities
- Through collaboration with health care facilities, the CBD agents appreciate problems/constraints encountered during service provision and help communities in understanding such problems

The Rwanda team shared the following as take-home messages:

- CBD of DMPA is doable and CBD agents are capable of offering such services to their communities
- Stakeholder consultations in development of implementation guidelines, data collection and reporting tools, and other training material is essential to the success of the program
- Considering that our countries are still burdened with economic problems, motivation/compensation of the CBD agents should not be mainly tied to monetary gains because it is not sustainable.

Tanzania: The Tanzanian delegation reported that the tour was very useful and educative, and that their objectives and expectations for the study tour were met. The delegates acknowledged that Uganda is paving the way by demonstrating that CBD of DMPA is possible and successful. Before embarking on introduction of CBD of DMPA in Tanzania, there are several areas that need to be adequately addressed. The first step in Tanzania is to strengthen FP services that are offered through clinical and community-based outlets, and filling in the existing gaps. The delegates concluded that it is possible to provide DMPA through CBD agents, but this needs adequate preparation, which will include repositioning FP. The delegates voiced that they will need support in conducting advocacy efforts, and in designating champions to work toward repositioning FP services in both clinical and community-based programs in their country.

IX. CONCLUSION

Overall, the study tour was a success. Participants expressed enthusiasm for the work and commitment to pursuing its introduction in their respective contexts after the conclusion of the tour. Additionally, the feedback given by the delegates to the study tour organizers, district leaders, and CBD agents will be shared with the Ugandan National Core team for CBD of DMPA and used to strengthen the program.

APPENDIX A: LIST OF PARTICIPANTS

Rwanda Delegates			
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9. Adebusola Salako	FMoH		
10. Abosede Adeniran	FMoH		
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Tanzania Delegates			
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16. Mr. Eric Ramirez-Ferrero	FHI		

Minnesotta International Health Volunteers (MIHV) Delegates			
17. Sr. Mary Semumwe	MIHV		
18. Norah Nakatte	MIHV		
Conservation through Public Health (CTPH) Delegates			
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Sereen Thaddeus	USAID-U	RH Advisor	sthaddeus@usaid.gov

APPENDIX B: STUDY TOUR PROGRAM

Program of Events – CBD/DMPA Study Tour to Uganda
February 17th-20th, 2008

Study tour objectives: (1) To provide an opportunity for the MOH and partner delegates from Rwanda, Nigeria and Tanzania to learn about and benefit from the experience of implementing a CBD of DMPA program as led by the Ugandan MOH and partners; (2) To cultivate solid working relationships between countries for continued exchange on the CBD of DMPA innovation.

Day One: Monday, 18 February 2008
Meeting at the Grand Imperial Hotel

Time	Session/Locale	Responsibility
8.50 -9.00 AM	Assemble at Mosa Court, move to Grand Imperial Hotel	Delegates/FHI
9.00 – 9.20	Welcome remarks and introductions	Dr. Anthony Mbonye, Asst Commissioner (RH), Ministry of Health
9.20 – 9.30	Review of Study Tour Program	Ms. Patricia N Wamala - FHI
9.30 – 9.45	Learning Objectives • Rwanda (5 min) • Nigeria (5 min) • Tanzania (5 min)	Study Tour Delegates
9.45 – 10.15	Presentations on: • Overview of FP in Uganda • The original feasibility study • Overview of implementation	Dr. Anthony Mbonye Ms. Martha Bekiita – Save the Children
10.15 – 10.45	Discussion	
10.45 – 11.00	Review of CBD of DMPA materials	Dr. Angela Akol -FHI
Districts Visits		
11.10	Departure for Luwero from the MOH	FHI
11.10 – 1.30PM	Travel to Luwero	
1.30 – 2.30	Arrive at Lydrinenes Hotel, Check into rooms and have lunch at the hotel	
2.30 – 3.15	Transport to District Health Offices • Team A will stay in Luwero. • Team B will leave for Butalangu directly after lunch (45 min. travel to district).	FHI
3.30 – 3.40	Welcome Remarks Introduction of District Officials	District Health Officer Dr. Okware- Luwero Dr. Ssesimba Badru -Nakaseke

Day One: Districts Visits Continued		
3.40 – 3.45PM	Introduction of delegates and their learning objectives	Angela Akol – Luwero Patricia Wamala - Nakaseke
3.45 – 4.00	Welcome Remarks • District Chairperson (5 min) • Chief Administrative Officer (5 min) • Resident District Commissioner (5 min)	
4.00 – 4.20	Overview of FP in the district and CBD of DMPA implementation.	District Health Officer Dr. Joseph Okware– Luwero Dr. Ssesimba Badru - Nakaseke
4.20 – 4.30	Review of advocacy activities	Champion Mr. Mugerwa Musisi – Luwero Mr. Enoch Nyongole - Nakaseke
4.30 – 5.00	Q&A with district health officials	
5.00	Closing remarks and departure	

Monday, 18 February 2008 – Evening Program
Informal Dinner at Lydrinenes hosted by Save the Children

7.00 – 7.20 p.m. Arrival of Guests

7.30 – 7.40 p.m. Welcome Remarks by Mr. Peter Nkhonjera,
Country Director Save the Children

Introduction of Invited guests

7.40 – 8.40 p.m. Dinner

8.40 – 8.50 p.m. Closing remarks from LCV Chairperson and departure

Program of Events – CBD/DMPA Study Tour to Uganda
Day Two: Tuesday, 19 February 2008
Field visit with CBD supervisors, agents, and clients in Luwero and Nakaseke

Time	Session/Locale	Responsibility
8.00 AM	Arrival of cars at Lydrinenes	DHV-Luwero
8.30	Check out of hotel and stow baggage at hotel	All delegates
9:00	Assemble in Lydrinenes Reception	All delegates
9.15	Departure for the field Team A to Kamira and Kalagala sub districts in Luwero Team B to Wakyato and Kinyogoga sub districts in Nakaseke	FHI
10.15 – 11.15	Meet at health facility in sub districts Welcome by health facility in-charge Q&A with health workers and CBD agents	Health-in-charge
11.15 – 12.15PM	Interact with CBD agent in her compound Inspection of records Observe injections Observe waste management and storage of supplies Free Q&A with CBD agents and clients	Save the Children Health Extension Worker
12.15	Depart for Hotel	FHI-U
1.30 – 2.30	Lunch	
2.40 – 3.30	District feedback meeting at Lydrinenes Team A and B provide impressions, findings and key learning points Kamira (10 min) Kalagala (10 min) Wakyato (10 min) Kinyogoga (10 min)	
3.30 – 4.00	Closing remarks	District Health Officer Save the Children – Martha Bekitta Ms. Sereen Thaddeus - USAID
4.00	Return to Kampala	FHI -U
6.00	Arrive at Mosa Court Apartments * Delegates will be responsible for their own dinners *	

Program of Events – CBD/DMPA Study Tour to Uganda
Day Three: Wednesday, 20 February 2008
Debriefing and Way Forward

Time	Session/Locale	Responsibility
8.45 – 09.00 am	Assemble in conference hall at Mosa Courts	All delegates
9.00 – 9.15 AM	Opening Remarks	FHI
9.15 – 9:40	Tour reflections and Key Take home messages (5 min each delegation)	Rwanda Tanzania Nigeria MIHV CTPH
9.40 – 10.00	The Way Forward	Amanda Abbott – FHI
10.00 – 11.00	Country team planning sessions – facilitated by FHI staff	All delegates
11.00 – 11.25	Report back to group on planning sessions (5 min each delegation)	Rwanda Tanzania Nigeria MIHV CTPH
11.25 – 11.40	Discussions	
11.40 – 12.00PM	Closing and presentation of souvenirs	MoH and FHI
12.00 - 5.00	Check out, email time, excursions, departures	FHI

APPENDIX E: INFORMATIONAL PACKAGE CONTENTS LIST

- Study tour program
- CBD of DMPA cartoon training manual (English version)
- CBD of DMPA Advocacy kits (including research and program briefs)
- Nakasongola feasibility study report
- CBD of DMPA Implementation Handbooks
- Checklists for preparing to implement CBD of DMPA
- Copies of all PowerPoint presentations