

Demand for family planning in many countries across sub-Saharan Africa continues to steadily rise,¹ but unmet need for contraception remains high, especially in rural areas. Health programs working to meet this contraceptive need have found that the injectable contraceptive depot-medroxyprogesterone acetate (DMPA or Depo-Provera) is a popular choice among women for many reasons, including its safety, effectiveness, ease of use, privacy, and convenience. However, many women cannot access clinics where DMPA is typically provided.

Experience from Africa, Asia, and Latin America shows that women's desire for access to DMPA can be addressed by offering DMPA through community-based distribution (CBD) programs.² Yet, this approach is underutilized in Africa. For example, while both Kenya and Uganda have large rural populations, low modern contraceptive method prevalence and high unmet need for family planning services, CBD and other outreach programs provide only 0.5 percent and 0.8 percent, respectively, of injectable contraceptives (Table 1).

Table 1. Unmet Need for Family Planning Services

Country	Rural population (%)	Modern contraceptive method prevalence (%)	Unmet need for family planning services (%)	Injectable contraceptives supplied by CBD/ outreach workers (%)
Kenya, 2003	75	29 (rural women)	26.6 (rural women)	0.5
		40 (urban women)	17.2 (urban women)	
Uganda, 2000/2001	88	15 (rural women)	36.2 (rural women)	0.8
		42 (urban women)	23.4 (urban women)	

Source: ORC Macro. MEASURE DHS STATcompiler. Calverton, MD: ORC Macro, 2004. Available: www.measuredhs.com.

Community-based distribution increases family planning access and convenience.

CBD of contraception clearly has the potential to increase family planning access and convenience,³ especially in countries with large rural populations, low ratios of health care providers to population, low prevalence of modern contraception, and high unmet need for contraception. Community-based family planning programs have been implemented in Africa, Asia, and Latin America.

CBD programs can increase contraceptive use by making access convenient and by involving trusted community members. CBD of contraception may take the form of home visits, fixed or mobile community posts, mini-clinics at a CBD worker's home in the community, and one-on-one or group education meetings. Many women wish to receive family planning methods in a private and confidential setting such as a CBD worker's home or their own homes. In general, community members are trained to provide family planning and other services within programs that can be tailored to meet the social, cultural, and religious needs of the communities.

Community-based distribution programs can help meet demand for the contraceptive injectable DMPA.

Provision of DMPA through CBD programs has been implemented through initiatives such as the Nakasongola project in Uganda, APROFAM project in Guatemala, and the Matlab project in Bangladesh. (See case studies in briefs no. 5, no. 6, and no. 7, respectively.) When DMPA has been offered to women through CBD programs, it has been an overwhelmingly popular contraceptive choice due to its safety, effectiveness, ease of use, privacy, and convenience. When DMPA was first offered in 1977 in the CBD program in the Matlab subdistrict of Bangladesh, DMPA accounted for 49.7 percent of all contraceptive use in the study area.⁴ In Guatemala, where APROFAM provided DMPA to over 1,000 women, 65 percent of these users had never used a family planning method before, indicating that CBD provision can help meet unmet contraceptive need.⁵

KEY POINTS

- DMPA is an extremely popular family planning choice due to its safety, effectiveness, ease of use, privacy, and convenience.
- Community-based distribution (CBD) of DMPA can address the unmet family planning needs of women, especially in rural areas.
- In light of improved tools to support the CBD of DMPA, policy-makers, donors, and program managers should consider adding DMPA to CBD programs.



In the Nakasongola project, contraceptive continuation rates among women who received DMPA from CBD workers were comparable to those among women receiving injections at clinics.⁶ In these and other settings, CBD workers have demonstrated that they can safely give injections, refer clients to clinics when necessary, maintain supplies, safely dispose of needles and syringes, regularly administer DMPA every three months, and counsel clients about side effects (even though counseling by both CBD workers and clinic-based providers often needs improvement).

CBD programs can be particularly beneficial in countries facing shortages of trained clinic personnel. Trends in availability of doctors and nurses in some sub-Saharan African countries clearly show too few trained clinic personnel.⁷ According to the World Health Organization (WHO), 36 of 46 African countries currently face critical shortages of doctors, nurses, and midwives.⁸

Few obstacles exist for introducing community-based distribution of DMPA.

Efforts to introduce DMPA provision into CBD programs should consider local concerns and issues such as national regulations, health system requirements, supplies, characteristics of CBD workers, training, quality control, client confidentiality, and sustainability.

Safety concerns must also be addressed. For example, several African countries have resisted CBD of DMPA because of concerns that clients cannot safely receive injections from paramedical personnel. However, this argument is weakening as nonreusable syringes have become the norm, and projects such as the Nakasongola project in Uganda have demonstrated safe and successful CBD of DMPA. A new checklist for the safe provision of DMPA, based on the World Health Organization's (WHO's) *Medical Eligibility Criteria for Contraceptive Use*, provides a simple tool that CBD workers can use to effectively assess women's eligibility for DMPA use. (See *Checklist for Clients Who Want to Initiate DMPA [or NET-EN]*.) Safe disposal of syringes and needles remains a serious concern that requires planning and vigilance in any program, but this can be easily planned for and accomplished.

Given DMPA's popularity, evidence of its safety and effectiveness, and improved tools to guide and support its community-based distribution, policy-makers, donors, and program managers should carefully consider adding DMPA to CBD programs.

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

- 1 Westoff CF, Bankole A. Trends in demand for family limitation in developing countries. *Int Fam Plann Perspect* 2000;26:56-62.
- 2 Stanback J, Mbonye A, LeMelle J, et al. *Final Report: Safety and Feasibility of Community-Based Distribution of Depo Provera in Nakasongola, Uganda*. Research Triangle Park, NC: Family Health International, 2005; Bhatia S, Mosley WH, Faruque ASG, et al. The Matlab Family Planning-Health Services Project. *Stud Fam Plann* 1980;11:202-12; Fernandez VH, Montufar E, Ottolenghi E, et al. Injectable contraceptive service delivery provided by volunteer community promoters. Unpublished paper. Population Council, 1997.
- 3 Prata N, Vahidnia F, Potts M, et al. Revisiting community-based distribution programs: are they still needed? *Contraception* 2005;72(6):402-7.
- 4 Phillips JF, Hossain MB, Huque AA, et al. A case study of contraceptive introduction: domiciliary depot-medroxyprogesterone acetate services in rural Bangladesh. In Segal SJ, Tsui AO, Rogers SM, eds. *Demographic and Programmatic Consequences of Contraceptive Innovations (Reproductive Biology)*. New York, NY: Plenum Press, 1989.
- 5 Fernandez VH, Montufar E, Ottolenghi E, et al. Injectable contraceptive service delivery provided by volunteer community promoters. Unpublished paper. Population Council, 1997.
- 6 Stanback J, Mbonye A, LeMelle J, et al. *Final Report: Safety and Feasibility of Community-Based Distribution of Depo Provera*. Research Triangle Park, NC: Family Health International, 2006.
- 7 Munjanja OK, Kibuka S, Dovol D. The nursing workforce in sub-Saharan Africa. *The Global Nursing Review Initiative. Issue 7*. Geneva, Switzerland: International Council of Nurses, 2005.
- 8 World Health Organization (WHO). *Working Together for Health: The World Health Report 2006*. Geneva, Switzerland: WHO, 2006.

This brief was produced by the Ministry of Health and its collaborating partners with technical assistance from Family Health International's CRTU program. Financial assistance for the work was provided by the US Agency for International Development (USAID). The contents do not necessarily reflect USAID policy.

For more information or additional copies, please contact:

Head, Division of Reproductive Health, Kenya Ministry of Health
Old Mbagathi Road, P.O. Box 43319-00100, Nairobi, Kenya
Tel: 254-020-2725105 Fax: 254-020-2716814

or
Regional Director, Population and Reproductive Health Programs

Family Health International
The Chancery, 2nd Floor, Valley Road
P.O. Box 38835-00623, Nairobi, Kenya
Tel: 254-020-2713913-6
Fax: 254-020-2726130
E-mail: publications@fhi.org

January 2007



Republic of Kenya



USAID
FROM THE AMERICAN PEOPLE



Family Health
International



Save the Children®