



## Conclusions from a Technical Consultation

# Community-Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives

In June 2009, a technical consultation held at the World Health Organization (WHO) in Geneva concluded that evidence supports the introduction, continuation, and scale-up of community-based provision of progestin-only injectable contraceptives. The group of 30 technical and programme experts reviewed scientific and programmatic experience, which largely focused on the progestin-only injectable, depot-medroxyprogesterone acetate (DMPA). (See box inside on terminology.) The experts found that community-based provision of progestin-only injectable contraceptives by appropriately trained community health workers (CHWs) is safe, effective, and acceptable. Such services should be part of a family planning programme offering a range of contraceptive methods.

### Need for Injectable Contraception Expands

Currently, 35 million women worldwide use injectable contraception to prevent pregnancy, twice as many as a decade ago. In sub-Saharan Africa, more than one-third of users of modern contraceptives rely on injectables, more than any other modern contraceptive method. Even so, most countries report levels of unmet need for injectables between 25 percent and 50 percent of women who intend to use contraception in the future (see box inside on unmet need). While other temporary methods, such as pills and condoms, are available through community-based distribution, pharmacies, and commercial outlets, injectables are available primarily through clinics.

Injectables are among the most effective contraceptive methods, after intrauterine devices, implants, and sterilization. The majority of injectable clients use DMPA, an intramuscular injection of 150 mg given every three months. Most women can safely use a progestin-only injectable. WHO has identified only a few medical conditions that limit or prohibit its use.<sup>1</sup> Prior to initiating use, providers need to be able to screen clients for pregnancy and for medical eligibility. In addition, they should be able to provide injections safely and to inform women about delayed return to fertility and potential side effects, including vaginal bleeding irregularities, amenorrhea, and weight gain.

Task shifting, also referred to as task sharing, has been used successfully to address the critical shortage of medical professionals and to expand access to a range of health services. With task sharing, a concept endorsed by WHO, providers with less medical or paramedical training can deliver some of the same services with the same quality as providers with more training. In the last decade, CHWs have provided DMPA in more than a dozen countries, including Afghanistan, Bangladesh, Bolivia, Guatemala, Ethiopia, Haiti, Madagascar, Malawi, Nepal, and Uganda.

In an effort to inform future policies and programmes, WHO, the U.S. Agency for International Development (USAID), and Family Health International (FHI) convened the Technical Consultation on Expanding Access to Injectable Contraception, held on 15-17 June 2009.

### Terminology: Progestin-Only Injectables and DMPA

The overall and policy conclusions address DMPA, which was the focus of the evidence reviewed at the consultation. Some of these conclusions might logically apply to other injectable contraceptives, if comparable research existed. The broader conclusions regarding programmatic guidance and operational issues do apply to other injectable contraceptives. In this report, the term “DMPA” is used when necessary to limit the conclusions to the evidence reviewed. “Progestin-only injectables” and “injectables” are used, when possible, to avoid the appearance of promoting a single product or manufacturer or excluding the possibility that community-based programmes might consider using another injectable.

### Evidence Review and Operational Systems

At the consultation, 30 technical and programme experts from eight countries and 18 organizations reviewed the scientific evidence and experiences from programmes that had expanded access to injectable contraceptives through CHWs. This evidence and programmatic experience came from Africa, Asia, and Latin America and largely focused on DMPA. The consultation used the term “community health worker” to refer to a broad range of providers, including community-based distributors and village health workers; the term does not include physicians, nurses, or other facility-based providers.

The evidence review focused on the following issues: competency of CHWs, acceptability among clients and providers, and uptake and continuation rates of injectable contraceptives. The review identified 16 CHW projects with documented evidence on these issues from a database search of more than 500 articles and 55 additional sources identified by key informants and other resources. The 16 projects covered nine countries: six projects in Bangladesh, two each in Guatemala and Uganda, and one each in Afghanistan, Bolivia, Ethiopia, Haiti, Madagascar, and Peru.

The review looked at outcomes in seven areas: client screening, injection safety, counselling on side effects, client perspective, provider perspective, uptake of services, and continuation of use. Two independent reviewers assessed and rated the quality of the reports and studies from the 16 projects prior to the consultation, using the quality-of-evidence rating system developed by the U.S. Preventive Services Task Force.<sup>2</sup> Background papers on the seven review

areas, including the independent assessment, were distributed to the participants prior to the consultation. During the meeting, the participants agreed the evidence was sufficient and consistent to arrive at conclusions, based on the assessment of the independent reviewers and their own review of the evidence.

In addition, the participants discussed five operational issues that affect the safety, effectiveness, and quality of community-based provision of injectable contraception: supply management, commodities, and waste management; training, supervision, and monitoring; sustainability of community-based programmes; other nonclinical delivery systems (pharmacies, drug shops, and social marketing); and policy issues.

### Consultation Conclusions

The participants identified five overall conclusions, two key policy implications, and four primary issues for programmatic guidance. They also addressed related operational issues and developed a prioritized list of six new research issues to fill gaps in knowledge.

#### *Overall conclusions*

- Given appropriate and competency-based training, CHWs can screen clients effectively, provide DMPA injections safely, and counsel on side effects appropriately, demonstrating competence equivalent to facility-based providers of progestin-only injectables.
- Provision of DMPA by CHWs will expand choice for underserved populations and is likely to lead to an increased uptake of family planning services, especially under conditions of low contraceptive prevalence, high unmet need, poor access to a range of methods, and limited access to clinic-based services.

- Continuation rates of DMPA by clients of CHWs are as high as those of clients receiving injections at clinics.
- The vast majority of clients express satisfaction with CHW provision of DMPA.
- Trained CHWs are comfortable in their ability to provide DMPA.

### *Policy implications*

- Sufficient evidence exists for national policies to support the introduction, continuation, and scale-up of community-based provision of progestin-only injectable contraceptives, especially DMPA.
- Operational guidelines should reflect that appropriately trained CHWs can safely initiate use of DMPA and provide reinjections.

### *Programmatic guidance*

- Continued monitoring of provider competency in screening and counselling clients, including the use of screening checklists, should be a part of every community-based programme.
- Guidance and supervision of providers enhance their skills and strengthen their confidence in providing injectable contraceptives.
- Auto-disable syringes increase injection safety and should be used when available, in accordance with WHO guidelines.<sup>3</sup> Providers should be properly trained in their use and safe disposal.
- According to WHO medical eligibility criteria,<sup>4</sup> it is desirable to measure blood pressure before initiating use of a progestin-only contraceptive. However, in some settings blood pressure measurements are unavailable. In many of these settings, pregnancy morbidity and mortality risks are high, and injectable contraceptives are among the few methods widely available. In such settings, women should not be denied

a progestin-only injectable simply because a means for measuring their blood pressure is not available.

### *Operational issues*

- *Supply management.* Product availability is critical for clients of community-based programmes, who likely have no alternative source in the event of a stock out. Supply chains and any cost-recovery systems need to be adapted to the training and education levels of the CHWs.
- *Commodities.* Generally, community-based programmes should use one injectable method and a consistent branding to avoid confusing providers and clients about the injection procedure and duration of action.
- *Waste management.* Used injection devices could pose significant potential risks for health workers, clients, communities, and the environment; thus waste disposal must be addressed adequately within local conditions.
- *Training.* Training for CHWs and others who provide injectable contraception needs to emphasize competencies, and refresher training is necessary to maintain skills.
- *Supervision and monitoring.* Planning, budgeting, and implementation of supervision and monitoring systems are an integral part of a CHW programme, as is training for the supervisors themselves.
- *Sustainability of community-based programmes.* Delivery of injectable contraceptives by CHWs should be addressed in new and existing community-based programmes, and should be part of a larger effort to strengthen family planning and improve contraceptive choice. Key issues include supplies, remuneration, human resources, and overall health systems.

### **Unmet Need for Injectables**

The term “unmet need” refers to the percentage of women who are at risk of unintended pregnancy but not using contraceptives. Demographic and Health Surveys (DHS) from 32 countries include data on the percentage of women with unmet need who express preference about contraception in the future. In these countries, between 25 percent and 50 percent of women with an unmet need and an expressed desire to use contraception in the future would prefer to use injectables.

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For a full meeting report on the consultation, including background papers and the evidence review, please go to: <http://www.fhi.org/en/research/projects/progress/gtl/concoba2i.htm>.

- **Pharmacy, drug shops, and social marketing.** Both pharmacies and drug shops provide injectable contraceptives in some countries through commercial distributors or social marketing programmes. More information on the quality and safety of these delivery systems is needed to inform future programming and policies. Some social marketers are now trained to sell oral contraceptives and other products, and may also be appropriate for training to provide injectable contraceptives (see priority research, below).
- **Policy.** Evidence-based advocacy, policy dialogue, and policy development are essential components of a national programme for injectable contraceptives at the community level. These activities should link with national goals such as the Millennium Development Goals and should involve medical professional associations and regulatory authorities.

### *Priority issues for new research*

- Safety of injections in private retail outlets such as pharmacies and drug shops
- Training pharmacists and drug shop operators as community-based distribution agents
- Improving contraceptive continuation in community-based distribution programmes
- The role of remuneration in CHWs' performance, retention, and satisfaction
- Feasibility and acceptability of home- and self-injection
- Pattern-of-use dynamics, reasons for discontinuation, and expected range of discontinuation rates

Because of increased demand for injectable contraception coupled with an overburdened clinical health system, countries, particularly in sub-Saharan Africa, have recently expanded the use of nonclinic-based approaches in

providing this method. In this first review of the available evidence of these efforts, this consultation concluded that there is sufficient evidence to support expansion of community-based health workers providing progestin-only injectable contraceptives, especially DMPA.

### References

- 1 World Health Organization (WHO). Medical eligibility criteria for contraceptive use. Geneva: WHO; 2004. Updated 2008. Available from: [http://www.who.int/reproductivehealth/publications/family\\_planning/9241562668index/en/index.html](http://www.who.int/reproductivehealth/publications/family_planning/9241562668index/en/index.html).
- 2 Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow CD, Teutsch SM, et al. Current methods of the US Preventive Services Task Force: a review of the process. *Am J Prev Med.* 2001;20(3 Suppl):21-35.
- 3 WHO-UNICEF-UNFPA Joint Statement on the Use of Auto-Disable Syringes in Immunization Services. Geneva: WHO; 2003. Available from: <http://www.who.int/vaccines-documents/DocsPDF99/www9948.pdf>.
- 4 WHO, updated 2008.

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