Community-based Distribution of DMPA in Montepuez and Chiure districts in Cabo Delgado, Mozambique

Pathfinder INTERNATIONAL
A GLOBAL LEADER IN SEXUAL AND REPRODUCTIVE HEALTH

Bixby Center for Population, Health & Sustainability
UNIVERSITY OF CALIFORNIA, BERKELEY

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E2A EVIDENCE TO ACTION for Strengthened Reproductive Health

Results from the Operations Research Project

Ndola Prata
Bixby Center for Population Health & Sustainability
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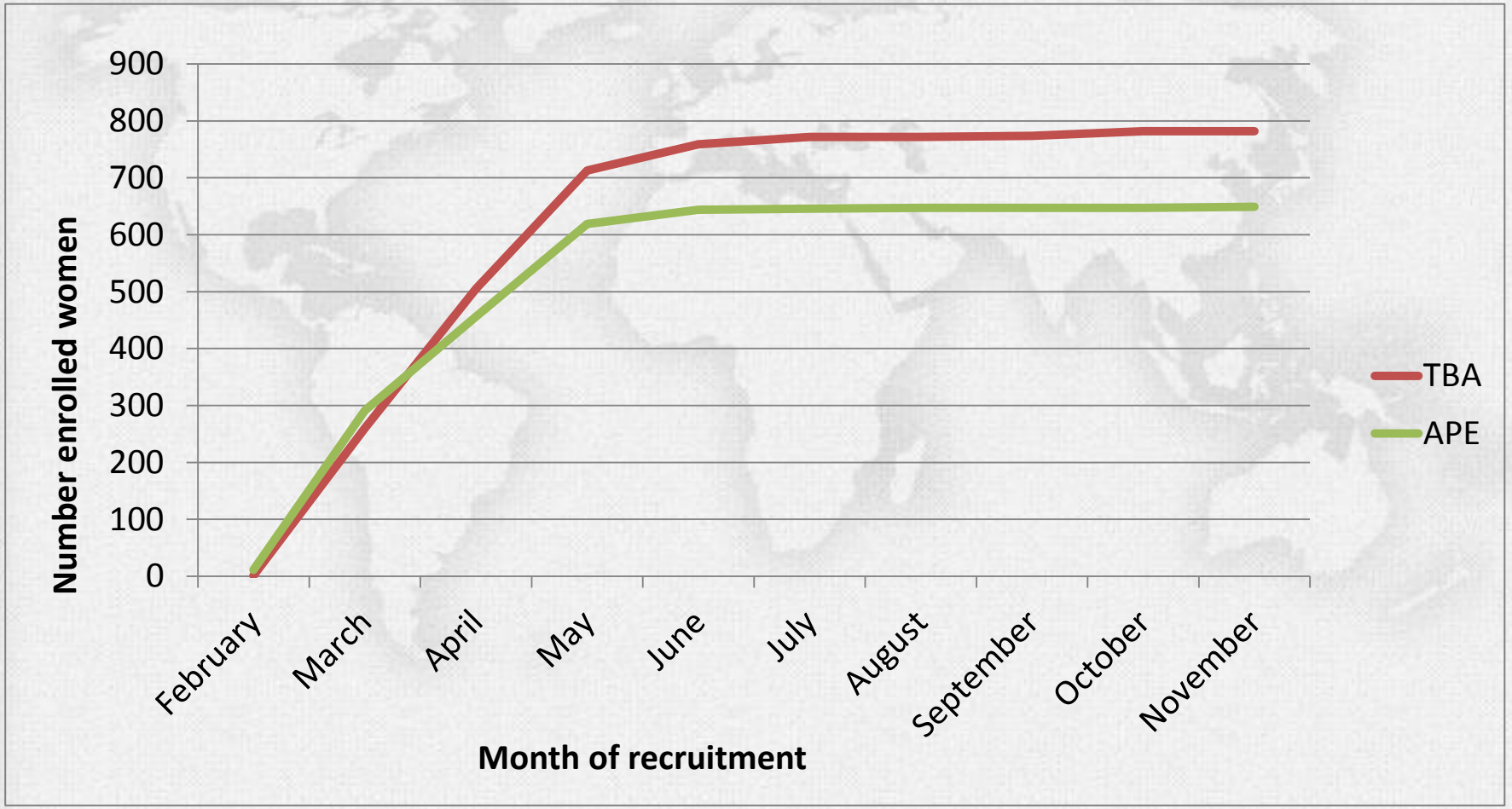
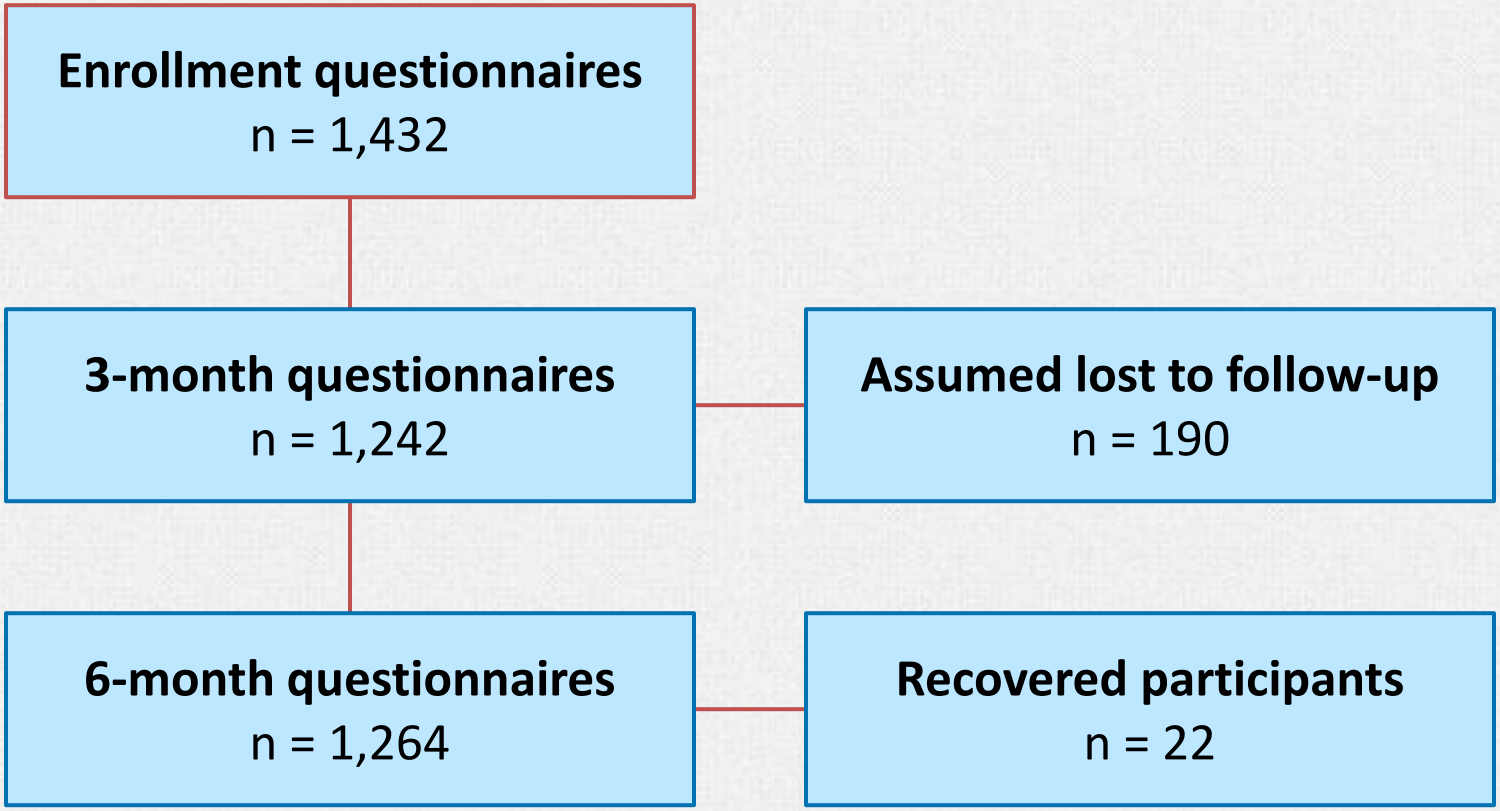
THE MAJORITY OF WOMEN (1,432) WERE ENROLLED IN THE FIRST 4 MONTHS OF THE STUDY



FOLLOW-UP AFTER ENROLLMENT



CHARACTERISTICS OF THE STUDY CLIENTS

	TBA clients (n=782)	APE clients (n=649)
Means		
Age at enrollment	29.3±6.9	29.9±7.6
Number of living children	4.2±2.1	4.8±2.6
Marital Status	n (%)	n (%)
Married/living together	655 (83.8%)	539 (83.1%)
Single, never married	52 (6.7%)	52 (8.0%)
Divorced/separated/widowed	64 (8.2%)	40 (6.2%)
Education	n (%)	n (%)
None	488 (62.4%)	472 (72.7%)*
Only read and write	38 (4.9%)	49 (7.6%)
Primary	246 (31.5%)	177 (18.0%)*
Secondary or higher	6 (0.8%)	6 (0.9%)
Husband supportive of using DMPA		
Yes	614 (78.5%)	526 (81.1%)
No	47 (6.0%)	46 (7.1%)
Husband not aware	28 (3.6%)	16 (2.5%)

***Comparison TBA vs APE p<0.05*

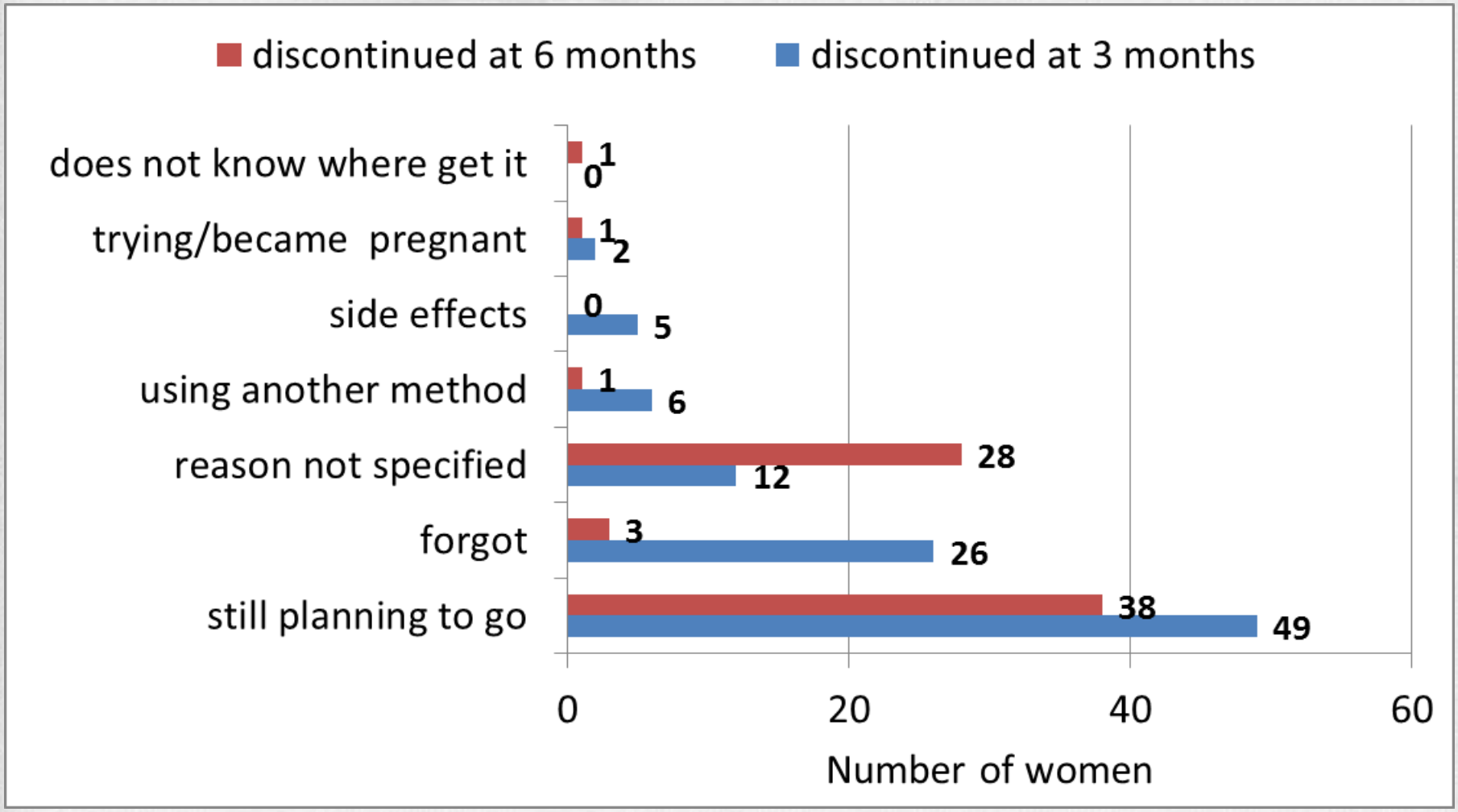
**One client of the total recruited was missing provider type.*

CONTINUATION RATE WAS HIGH: 81% OF WOMEN RECEIVED THEIR THIRD CONSECUTIVE INJECTION

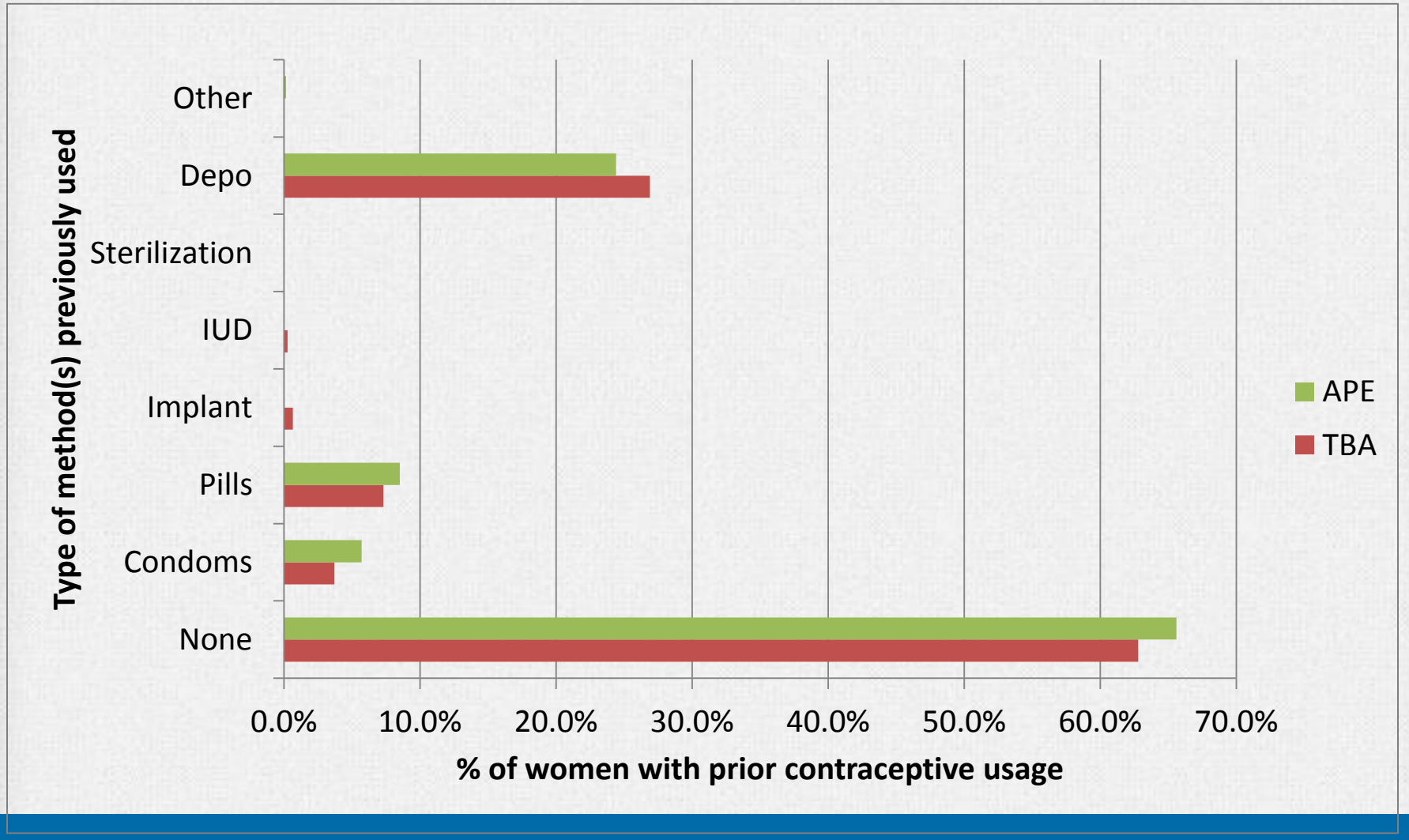
	Second injection		Third injection		Total after 3 injections
	TBA clients	APE clients	TBA clients	APE clients	All clients
Received Injection	627 (80.2%)	442 (68.1%)*	716 (91.6%)	445 (68.6%)*	1,161 (81.1%)
Discontinuation (did not receive injection)	11 (1.4%)	89 (13.7%)*	5 (0.6%)	69 (10.6%)*	74 (5.2%)
Lost to follow-up (includes missing data)	144 (18.4%)	118 (18.2%)	61 (7.8%)	135 (20.8%)*	197 (13.8%)
Total clients at recruitment	782	649	782	649	1,432**

**Comparison TBA vs APE p<0.05*
One client was missing provider information

MOST WOMEN WHO DISCONTINUED THE METHOD WERE STILL PLANNING TO USE IT



63% OF TBA AND 66% OF APE CLIENTS HAD NEVER USED CONTRACEPTIVES BEFORE STUDY

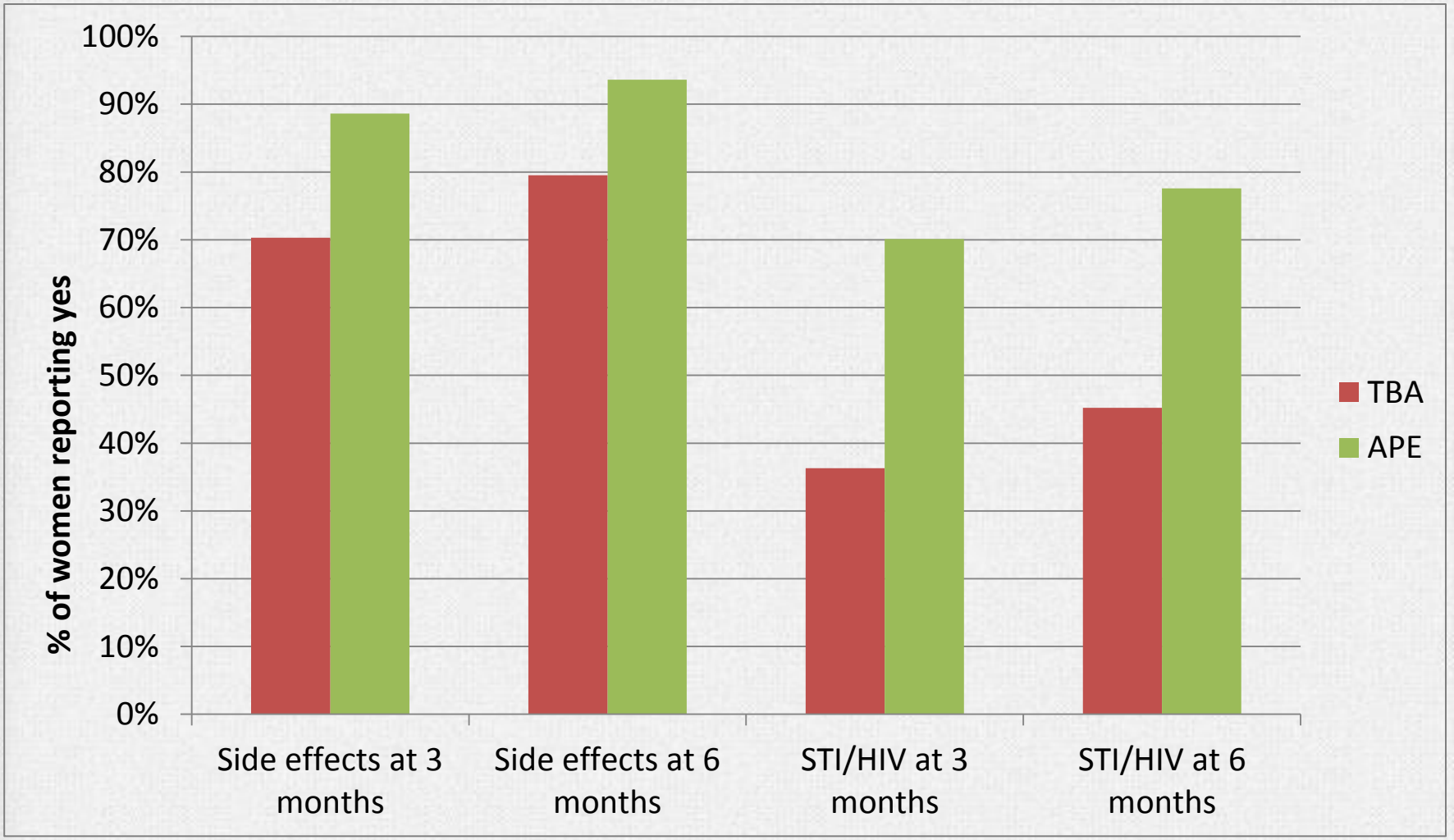


THE MAJORITY OF STUDY PARTICIPANTS USE DMPA DUE TO ITS LONG LASTING EFFECT

	TBA clients (n=782)	APE clients (n=649)
Women's responses**	n (%)	n (%)
More convenient	74 (9.5%)	12 (1.9%)
Fewer side effects	38 (4.9%)	157 (24.2%)
Used before	26 (3.3%)	6 (0.9%)
It is the only method I know	59 (7.5%)	38 (5.9%)
Husband allows	228 (29.2%)	129 (19.9%)
Privacy	14 (1.8%)	12 (1.9%)
It is a method that lasts longer	492 (62.9%)	391 (60.3%)
Other reason reported	0 (0%)	11 (1.7%)

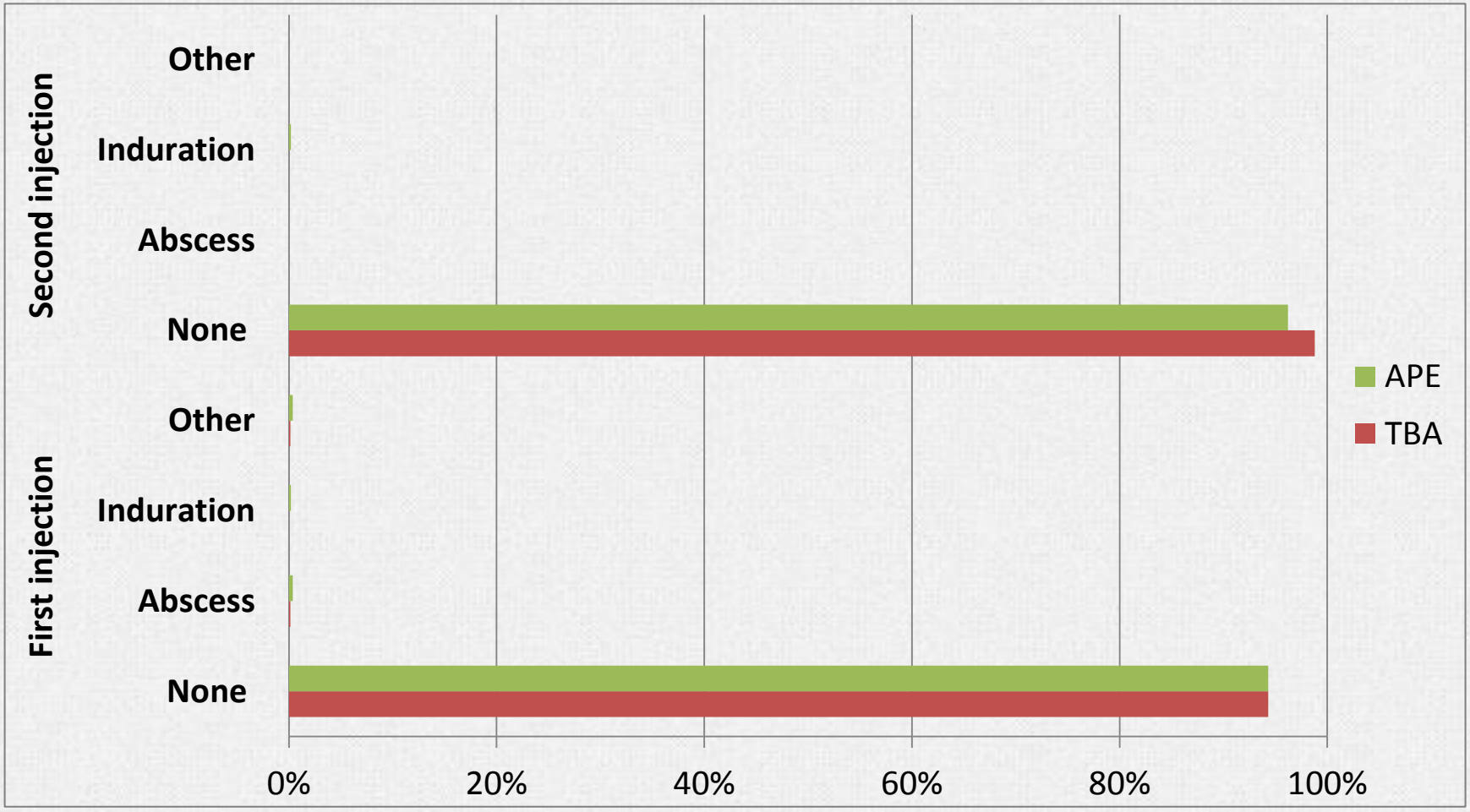
**One client of the total recruited was missing provider type.*
***Women were invited to select all that applied.*

APE CLIENTS REPORTED HIGHER COUNSELING ON SIDE EFFECTS AND STI/HIV

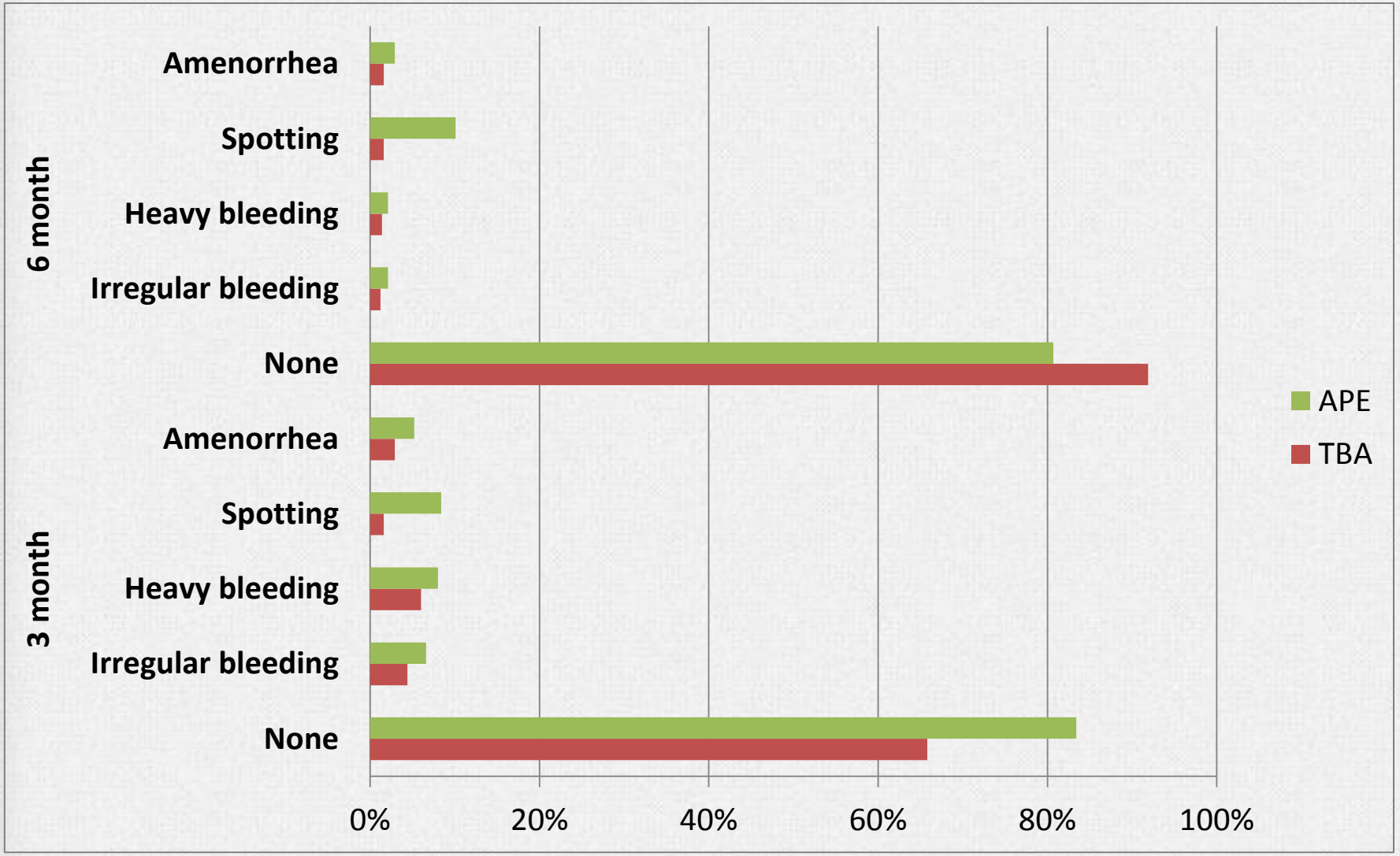


MORE APE CLIENTS WERE OFFERED CONDOMS IN ADDITION TO DMPA

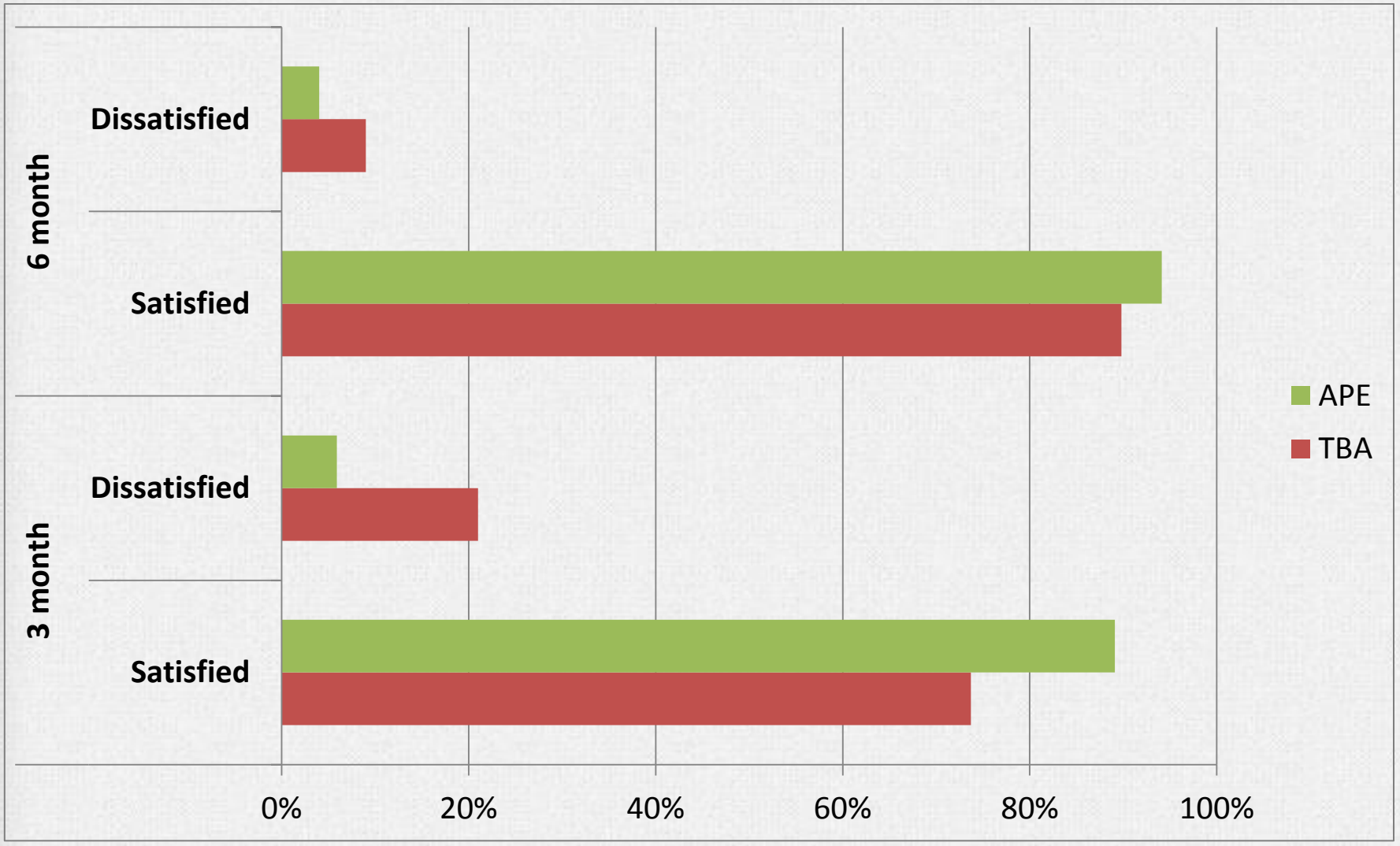
COMMUNITY-DISTRIBUTION OF DMPA IS SAFE: THE VAST MAJORITY OF CLIENTS DID NOT HAVE ANY MORBIDITIES AT INJECTION SITE



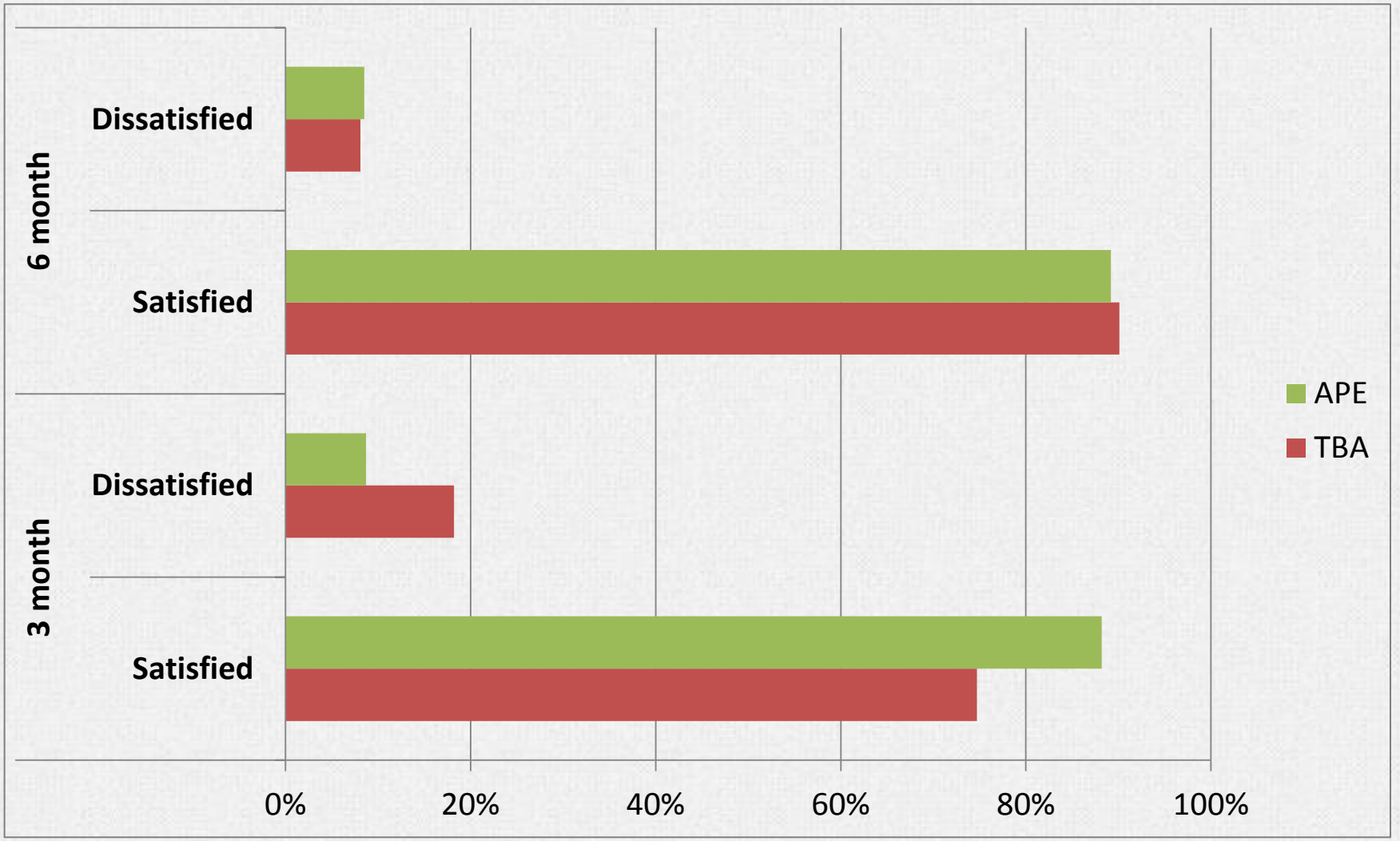
EXPERIENCED SIDE EFFECTS WERE RARE



BOTH TBA AND APE CLIENTS REPORTED BEING SATISFIED WITH THE PROVIDER



THE VAST MAJORITY OF APE AND TBA CLIENTS WERE SATISFIED WITH DMPA

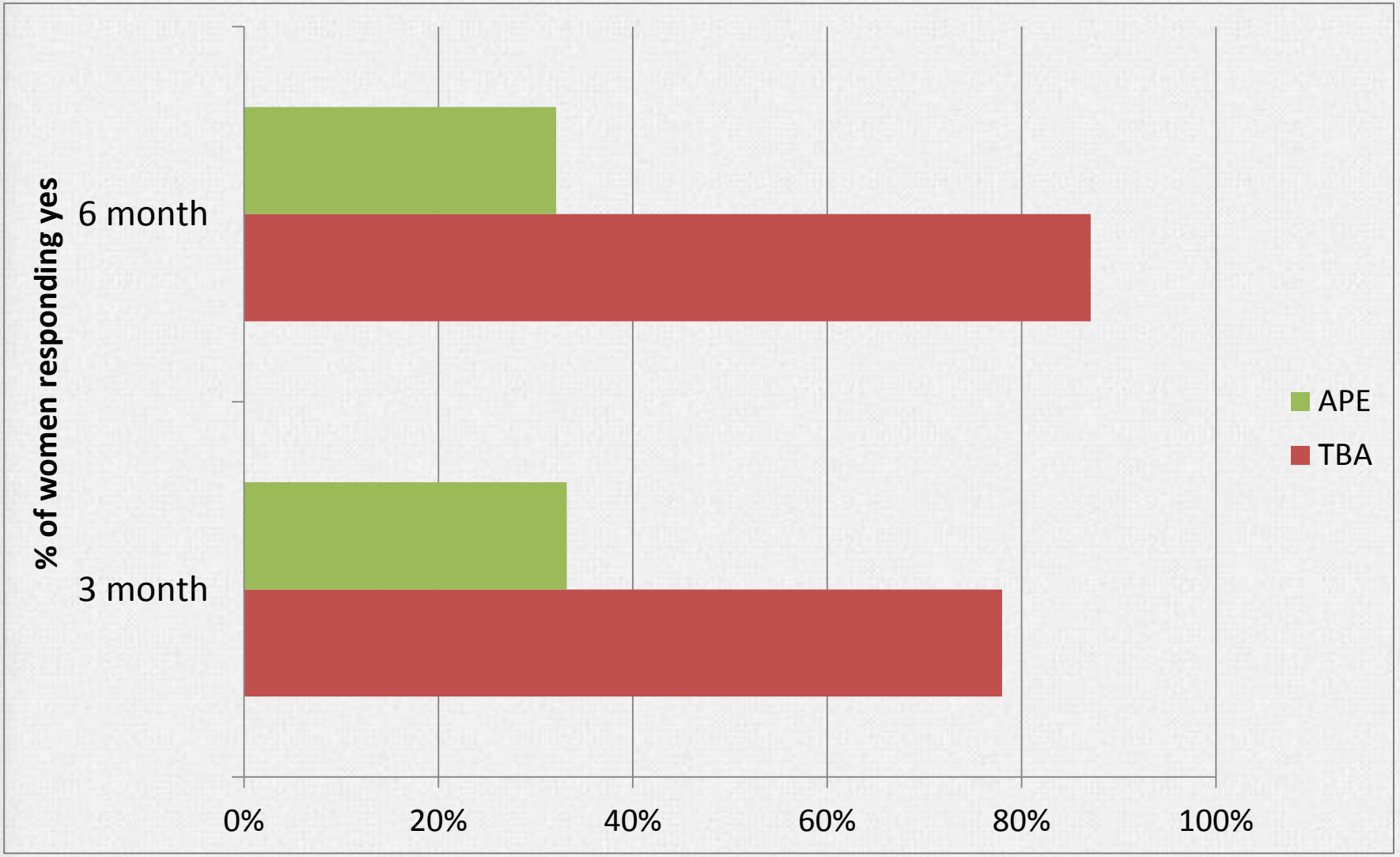


CLIENTS PREFER TO RECEIVE DMPA IN THEIR HOMES OR PROVIDER'S HOME

	13 Week Questionnaire			6 Month Questionnaire		
Preferred location	**TBA clients** (n=680)	**APE clients** (n=561)	**Total** (n=1,241)	**TBA clients** (n=737)	**APE clients** (n=527)	**Total** (n=1,264)
Health center	57 (8%)	27 (4.8%)	84 (7%)	57 (7.7%)	8 (1.5%)	65 (5.1%)
Client's home	102 (15%)	79 (14%)	181 (15%)	538 (73%)	25 (4.7%)*	563 (44.5%)
Health worker's home	466 (69%)	403 (72%)	869 (70%)	104 (14.1%)	460 (87.3%)*	564 (44.6%)
DK/no response	55 (8%)	52 (9.2%)	107 (8%)	38 (5.2%)	34 (6.5%)	72 (5.7%)

One case is missing type of provider
**Comparison TBA vs APE p<0.05*

SIGNIFICANTLY MORE TBA CLIENTS ARE WILLING TO PAY FOR DMPA



STUDY LIMITATIONS AND LESSONS LEARNED

- Follow up is problematic in areas with limited or challenging physical access
- Continuation and discontinuation estimation
- 13 and 26 week questionnaire response rate
- Supervisors vs. researchers
- APE and TBA training in DMPA provision should emphasize the importance of the following:
  - Repeated client follow-up to ensure adherence to DMPA without risk of pregnancy;
  - Counseling on side effects;
  - STI/HIV counseling and condom provision;
  - Supportive supervision to ensure these strategies are carried out in each interaction between DMPA providers and clients.

CONCLUSION

- DMPA can be administered safely and effectively by APEs and TBAs. Both cadres should be considered as part of community-based family planning provision efforts.

- Administration of DMPA by APEs and TBAs increases access, particularly to first-time contraceptives users, and should therefore be a central component of family planning programs in rural areas.

RECOMMENDATIONS AND IMPLICATIONS FOR PROGRAMS

- Integrate APEs and TBAs in FP service provision with emphasis on demand generation and provision of DMPA in the community
- Ensure quality counseling about all methods, including dual protection, with focus on informed choice
- Reinforce APEs and TBAs counselling about the importance of visiting HF for other RH services (such as screening for other diseases and long acting reversible contraception).
- Increase facilitated supervision to ensure that community health workers provide quality services in the provision of DMPA at community level
- Adapt data collection tools to improve commodities logistics while ensuring its availability.


Thank You!