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

Enrollment questionnaires
n = 1,432

3-month questionnaires
n = 1,242

6-month questionnaires
n = 1,264

Assumed lost to follow-up
n = 190

Recovered participants
n = 22
### CHARACTERISTICS OF THE STUDY CLIENTS

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

**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

<table>
<thead>
<tr>
<th></th>
<th>Second injection</th>
<th>Third injection</th>
<th>Total after 3 injections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TBA clients</td>
<td>APE clients</td>
<td>TBA clients</td>
</tr>
<tr>
<td>Received Injection</td>
<td>627 (80.2%)</td>
<td>442 (68.1%)*</td>
<td>716 (91.6%)</td>
</tr>
<tr>
<td>Discontinuation (did not receive injection)</td>
<td>11 (1.4%)</td>
<td>89 (13.7%)*</td>
<td>5 (0.6%)</td>
</tr>
<tr>
<td>Lost to follow-up (includes missing data)</td>
<td>144 (18.4%)</td>
<td>118 (18.2%)</td>
<td>61 (7.8%)</td>
</tr>
<tr>
<td>Total clients at recruitment</td>
<td>782</td>
<td>649</td>
<td>782</td>
</tr>
</tbody>
</table>

*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

- does not know where to get it: 1
- trying/became pregnant: 2
- side effects: 5
- using another method: 6
- reason not specified: 28
- forgot: 3
- still planning to go: 38

Number of women: 0-60
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

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

*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

- Side effects at 3 months
- Side effects at 6 months
- STI/HIV at 3 months
- STI/HIV at 6 months

% of women reporting yes

- TBA
- APE
MORE APE CLIENTS WERE OFFERED CONDOMS IN ADDITION TO DMPA

% of women offered condoms

- 3 months
- 6 months

- TBA
- APE
COMMUNITY-DISTRIBUTION OF DMPA IS SAFE: THE VAST MAJORITY OF CLIENTS DID NOT HAVE ANY MORBIDITIES AT INJECTION SITE
EXPERIENCED SIDE EFFECTS WERE RARE

3 month
- Amenorrhea
- Spotting
- Heavy bleeding
- Irregular bleeding
- None

6 month
- Amenorrhea
- Spotting
- Heavy bleeding
- Irregular bleeding
- None

Amenorrhea
- 3 month: 0%
- 6 month: 0%

Spotting
- 3 month: 0%
- 6 month: 0%

Heavy bleeding
- 3 month: 0%
- 6 month: 0%

Irregular bleeding
- 3 month: 0%
- 6 month: 0%

None
- 3 month: 80%
- 6 month: 100%

APE
- 3 month: 0%
- 6 month: 0%

TBA
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

<table>
<thead>
<tr>
<th>Preferred location</th>
<th>13 Week Questionnaire</th>
<th>6 Month Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TBA clients</td>
<td>APE clients</td>
</tr>
<tr>
<td>Health center</td>
<td>n=680</td>
<td>n=561</td>
</tr>
<tr>
<td>Health center</td>
<td>57 (8%)</td>
<td>27 (4.8%)</td>
</tr>
<tr>
<td>Client’s home</td>
<td>102 (15%)</td>
<td>79 (14%)</td>
</tr>
<tr>
<td>Health worker’s home</td>
<td>466 (69%)</td>
<td>403 (72%)</td>
</tr>
<tr>
<td>DK/no response</td>
<td>55 (8%)</td>
<td>52 (9.2%)</td>
</tr>
</tbody>
</table>

One case is missing type of provider
*Comparison TBA vs APE p<0.05
SIGNIFICANTLY MORE TBA CLIENTS ARE WILLING TO PAY FOR DMPA

% of women responding yes

- 6 month
- 3 month

APE
TBA
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 counseling 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!