Strategies, approaches and tools used to introduce next generation injectable contraceptives in resource poor settings

WORKSHOP REPORT: LESSONS LEARNED FROM EARLY DMPA-SC PROGRAMMING

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This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-14-00038. The contents of this report are the sole responsibility of the International Planned Parenthood Federation (IPPF) and do not necessarily reflect the views of USAID or the United States Government.

Support for International Family Planning Organizations 2: Sustainable Networks (SIFPO2) is a five-year program funded by the United States Agency for International Development (USAID) aimed at improving IPPF's capacity to significantly increase family planning programming worldwide, working in partnership with The Population Council and IPPF Member Associations.

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The workshop itself was organized with extensive support and inputs from numerous people. Particular thanks are extended to Annet Kyarimpa from Reproductive Health Uganda, and the whole team at PATH Uganda including Fiona Walugembe, Siri Wood, Sara Tifft and Stellah Sikyomu. Thanks also to all the experts who gave their time and knowledge during the meeting – including Justine Tumusiime, George Barigye, Fiona Walugembe; Edson Byekwaso (PATH); Fredrick Mubiru (FHI360); Wambui Waithaka (JSI); Liz Bayer & Beth Fredrick (AFP); Dr. Herbert Muhumuza (UHMG); Basil Tushabe (CDFU); Lawrence Were (UNFPA); Raj Gangadia (CHAI).

Thanks also to Elaine Menotti, Kimberly Cole and Cheyenne Cook at USAID for all their support in making this workshop happen.

We thank all of them, and the teams at USAID Washington and USAID Uganda, for their time and encouragement.

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Executive summary

DMPA-SC (brand name Sayana® Press), a recent innovation in injectable contraceptives, has shown the potential to break new ground in family planning service delivery based on its recent introduction in several countries. Due to its unique presentation in the all-in-one Uniject® system, the product is easy to use among those with minimal training, such as community health workers (CHWs) and even women themselves; thus, greatly increasing the potential for reaching women that previously could not easily be reached with modern contraceptives.

Uganda arguably has the foremost experience of rolling out DMPA-SC through its pilot introduction efforts that began in 2014 under the coordination of PATH. The country has seen tremendous success in distributing the product through CHWs and in piloting self-injection by women. As regulatory approval of DMPA-SC is granted in more countries, there is an opportunity to apply lessons from early adopter countries, such as Uganda, in order to ensure effective and efficient product introduction in those places. Towards this end, three service delivery organisations, International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI) and Population Services International (PSI), held a joint operational learning workshop in Uganda, in June 2017, which was attended by 20 participants from 14 organisations and 11 countries, through the support of USAID. The aim of this workshop was to provide select country programmes and member associations with an immersive opportunity to learn from Uganda's experience as they begin to incorporate DMPA-SC into their own services.

The workshop brought out several key lessons and programming considerations from the Uganda experience, which this report highlights. Some of these include:

- Large-scale community-based distribution (CBD) was key to success for DMPA-SC introduction in Uganda, and this was made possible mainly by the existing policy supporting CBD of injectables; a carefully-planned, integrated model of training thousands of CHWs; and government support at all levels. Furthermore, the CBD mode of introduction provided for the opportunity to strengthen the health system and to increase family planning uptake more broadly.
- Self-injection is feasible and acceptable to women and can be effectively integrated into the health system. Uganda demonstrated this through an initial pilot involving a few hundred women and a subsequent district-level pilot involving 100 public providers and over 1200 women.
- While self-injection is becoming an exciting reality, there are still gaps to be filled in order to expand it more widely; namely, making training of women more cost-effective, finding sustainable ways to dispose of used devices, and integrating self-injection into monitoring and evaluation systems.
- An enabling environment for the successful introduction of DMPA-SC must include forward planning and strategy development that involves coordination among all relevant stakeholders. Elements of the final strategy must include new or amended policies and regulations, effective marketing to create demand for the product, supply chain considerations to ensure product availability, and robust monitoring and evaluation systems to enable assessment of progress and outcomes.

The workshop proved to be useful to participants, who left armed with the knowledge and tools to steer their organisation's DMPA-SC introduction efforts into the right direction. The action plans developed by participants, which detail their DMPA-SC introduction goals, challenges that need to be overcome in achieving these goals, and potential mitigating solutions, are summarised in this report. While the content of the plans varied considerably, all participants had the goal of expanding access to DMPA-SC by including it in their organisation's method mix.

IPPF, MSI and PSI are committed to supporting the global effort to incorporate DMPA-SC into voluntary family planning service delivery worldwide and to place the power of contraceptive choice into the hands of women and girls for the very first time. To this end, each organisation will continue to shore up its efforts while also remaining committed to cross-organisational collaborations in order to leverage the collective capacity. We thank our USAID colleagues in Uganda and Washington, our PATH colleagues in Uganda and Seattle, the Uganda Ministry of Health, and many other implementing partners for their support in making this learning opportunity a reality.

Context and background

BACKGROUND

Subcutaneous depot medroxyprogesterone acetate (DMPA-SC) has emerged as a ground breaking method of contraception that has the potential to increase access to voluntary family planning (FP) in resource-poor settings. Pilot introductions of Sayana® Press, a brand of DMPA-SC developed by Pfizer, have shown it to be safe, highly effective, easy to transport, and simple to use with minimal training. This makes DMPA-SC ideal for community-based health workers and women themselves to administer. Unlike intramuscular DMPA (DMPA-IM), which is injected into the muscle using a syringe, DMPA-SC is injected under the skin. This means that women can safely self-administer a 3-month dose of the active ingredient depot medroxyprogesterone acetate without the need to travel to a health facility.

Participating organisations at the DMPA-SC Operational Learning Workshop

COUNTRY	ORGANIZATIONAL PARTICIPANT
Ghana	• IPPF
	• PSI
Kenya	• IPPF
	• MSI
Burkina Faso	• IPPF
Democratic Republic of Congo	• IPPF
	• PSI
Madagascar	• MSI
Niger	• MSI
Nigeria	• MSI
Uganda	• MSI
	• PSI
	• IPPF
Zambia	• PSI

As regulatory approval is granted in more places, there is an opportunity to learn and to apply lessons from early adopter countries, such as Uganda, where DMPA-SC is already distributed by community health workers and has been approved and piloted for self-injection.

With support from the US Agency for International Development (USAID) through the *Support for International Family Planning Organisations 2* (SIFPO2) projects, service delivery organisations, International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI) and Population Services International (PSI) held a DMPA-SC Operational Workshop in June 2017. The purpose of the workshop was to share learnings from Uganda and ultimately to support an increase in access to DMPA-SC within a broad method mix of contraceptive methods through the organisations' networks. Twenty representatives from 14 organisations operating across 11 countries attended the meeting, which took place over the course of a week in Kampala and Mubende District, Uganda.

OBJECTIVES AND DESIGN OF THE WORKSHOP

Increasing access to voluntary FP services in areas with low modern contraceptive prevalence rate (CPR) and high unmet need is a shared goal of all SIFPO2 partners (IPPF, MSI and PSI). As such, the objectives of the workshop were:

1. To share experiences and lessons learned from the introduction and scale up of DMPA-SC through **different service delivery models,** including self-injection, through community providers, and via existing clinic networks.
2. To **identify and share strategies, approaches and tools used to introduce DMPA-SC in areas with low modern CPR** and **use them to inform future roll-out plans.**
3. To **explore how DMPA-SC is being used within the wider method mix** and identify how it can be positioned to expand access to modern contraceptive methods amongst traditionally underserved populations.
4. To develop **action plans** for strengthening high quality DMPA-SC programming and implementation in workshop participants' respective countries.

A schedule of the week is provided in Annex 1, and a summary of the Workshop Evaluation is provided in Annex 2.

HOW TO USE THIS REPORT

This report is split into two sections:

Section 1 – Summarises programming considerations, lessons learned and tips for implementation based on the experiences in Uganda and on global issues affecting DMPA-SC programming. This section is intended for an audience of non-governmental organization (NGO) programme managers and service providers beyond workshop attendees and builds on the guide to implementation and scale-up developed by PATH[1]

Section 2 – Summarises the current status of DMPA-SC programming and future plans of workshop participants from MSI, PSI and IPPF.

1 http://www.path.org/publications/files/RH_sp_dmpa_sc_practical_guidance_2017.pdf

Section 1: DMPA-SC programming considerations

GLOBAL ISSUES AFFECTING DMPA-SC PROGRAMMING

As experience of DMPA-SC service delivery evolves, so too does the operating environment for FP service delivery. The current implementation context is characterised by:

EXPANDING REGULATORY APPROVAL. Registration is a complicated process and the approval status of Sayana® Press is constantly changing. Additionally, changes made to the product's label and packaging in recent years have required updates to its official registrations. As of August 2017, 16 countries in Africa had registered Sayana® Press, and 6 had approved use of Sayana Press for self-injection. Details of registration are available from Pfizer directly, through national drug authorities, or from The Subcutaneous DMPA Access Collaborative project, led by PATH and John Snow Inc. (JSI).[2]

EVOLVING GUIDANCE ABOUT THE USE OF HORMONAL CONTRACEPTIVES AMONGST WOMEN AT RISK OF ACQUIRING HIV. In March 2017, the World Health Organisation (WHO) issued revised guidance on the eligibility criteria for hormonal contraceptives. The revised medical eligibility criteria recommends women at high risk of HIV infection can use progestogen-only injectables, including DMPA-SC, but advises that there are concerns that these methods may increase the risk of HIV acquisition.

IMPROVED COORDINATION OF PROGRAMMING EFFORTS. Between 2017 and 2020, the newly formed Subcutaneous DMPA Access Collaborative, led by PATH and JSI, will work with ministries of health and partners in 8 to 12 countries to facilitate planning for introduction and scale up of subcutaneous DMPA-SC. The Access Collaborative will provide technical assistance to ensure implementation of each country's total market plan. For more information, email Sara Tifft at PATH (stifft@path.org).

DMPA-SC IN UGANDA: LESSONS LEARNED AND TIPS FOR PROGRAMMING

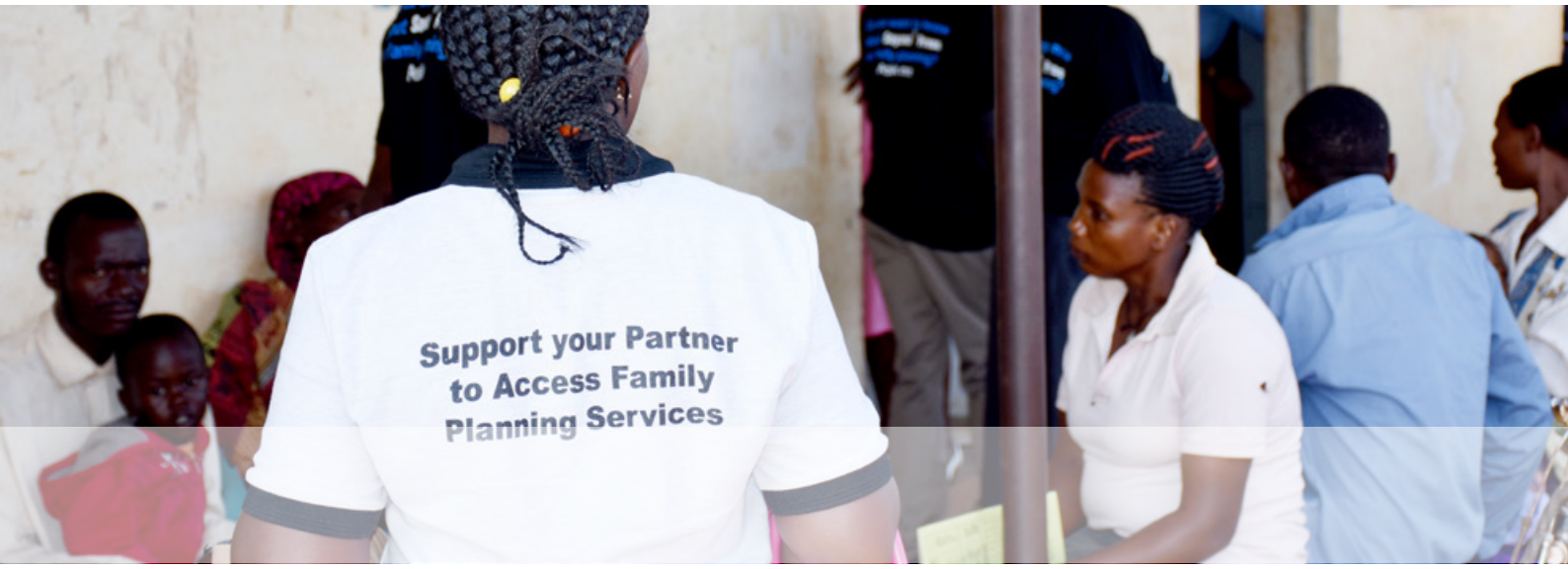
Injectable contraceptives are the most popular modern contraceptive method in Uganda, representing about 56% of contraceptive use for married women. Recent Demographic Health Survey (DHS) data reflects that the share proportion of women in the country using injectables increased significantly from 14% to 18.5% between 2011 and 2016, while the total fertility rate decreased from 6.2% to 5.4% in the same period. Some of this change can undoubtedly be attributed to the introduction of DMPA-SC, which has attracted many first-time users of modern contraception.

Between 2014 and 2016, PATH led DMPA-SC pilot introduction efforts through community-based distribution (CBD) in 28 districts. This entailed training more than 2,000 community health workers (CHWs) – called Village Health Teams (VHTs) in Uganda – in the service delivery system and implementation of a self-injection pilot, which demonstrated the feasibility and acceptability of self-injection. This CBD effort proved to be a success; the volume of DMPA-SC delivered by VHTs far outpaced DMPA-IM volume distributed when both products were offered side-by-side. Additionally, DMPA-SC made up 75% of total injectables delivered by trained VHTs in the introduction period. The existing policy supporting CBD of injectables was a key enabling factor for this success.

With DMPA-SC growing in popularity and Family Planning 2020 (FP2020) commitments looming, Uganda is currently in the scale-up phase of a MoH-led task force. PATH and partner's scale-up activities have included: training of hundreds of facility-based providers and additional VHTs on administration of all FP methods, including DMPA-SC; a soft launch of self-injection within Mubende district, where 100 facility-based providers have been trained to offer self-injection services to women; and integration of DMPA-SC in the rollout of the national Implanon NXT® training. In 2017, PATH launched a one-year, self-injection best practices project which promises to provide evidence for the practical implementation of DMPA-SC self-injection. The approval of self-injection in February 2017, the pending approval of policy to permit pharmacies and drug shops to administer injectables, and the ongoing efforts to integrate DMPA-SC into the national health management information system (HMIS) are enabling factors for successful implementation of the national scale-up plan.

2 http://sites.path.org/rh/recent-reproductive-health-projects/sayanapress/collaborative/

Service delivery models



COMMUNITY-BASED SERVICE DELIVERY

In Uganda, DMPA-SC and DMPA-IM are approved for distribution by VHTs. A range of NGOs, including FHI360, PATH and Reproductive Health Uganda (RHU), are supporting the MoH to train public VHTs to administer DMPA-SC as part of a wider mix of methods. Partners use government-approved training packages. Initially, the MoH curriculum took 10 days to conduct: five days of theory, four days of practicum and one day of M&E and planning. PATH later worked with MoH to reduce the theory and modules so that injectables could be delivered in seven days. Implementing partners also provided system strengthening support to local facilities, which supervise VHTs.

Lessons learned from Uganda

- **Active involvement of District Health Teams has been essential to ensuring program ownership and acceptance**. National and central governmental support for DMPA-SC roll-out is high in Uganda, but district-level officials have been less involved in plans for the introduction of DMPA-SC. DMPA-SC partners report that it has therefore been essential to hold district-level stakeholders' meetings as early as possible to create awareness, dispel rumours and build support for implementation at the district level.
- **DMPA-SC introduction can provide an opportunity to strengthen quality of care at community and facility level more broadly.** Both FHI360 and RHU have incorporated quality improvement and system strengthening activities as part of their DMPA-SC introduction efforts.
  - FHI360 implemented the *Community-Based Family Planning Collaborative Quality Improvement Approach* to strengthen community-based service delivery. This approach entailed teams of VHTs, their supervising midwives and the District Health Team identifying key improvement issues, jointly developing a change package and collaboratively implementing interventions for the purpose of improving service quality.
  - RHU has provided system strengthening support to local facilities to enable effective community distribution by minimising FP commodity stock-outs and by building the capacity of volunteers to provide comprehensive balanced counselling on FP methods.

- **A holistic approach to DMPA-SC introduction seems to improve FP uptake more broadly.** Analysis of service delivery data conducted by the Biostatistician Busia District shows that following the application of the quality improvement approach by FHI360, the contraceptive prevalence rate increased from 16% to about 30%. RHU also anecdotally reports that following the training of VHTs on all methods, there has been an increase in uptake of implants at the community level (service statistics are still under review at the time of writing). Using the introduction of DMPA-SC as an opportunity to improve capacity on voluntary FP service delivery more widely appears to pay dividends in terms of widespread uptake.
- **Qualitative data collected by RHU indicates that many providers report the introduction of DMPA-SC did not have an impact on their workload, but a small stipend to support their travel is crucial in enabling them to reach underserved communities**. VHTs report that since they were already offering FP services including injectables, the addition of DMPA-SC to their services is manageable. However, the funding they receive through projects such as SIFPO is essential to enabling them to reach more remote and underserved communities.

- **Human resource constraints in public health facilities continue to limit effective delivery.** Partners report that chronic understaffing in government health facilities, as well as regular unplanned staff transfers after training, affects continuity of care and results in calls for additional training.

TIPS FOR PROGRAMMING

- **Build in time for district sensitization meetings** during the early months of implementation. Include local government officials and public health officials in charge of community health worker (CHW) training, education and management.
- **Entry meetings with community gatekeepers** and stakeholders are essential before initiating work in communities.
- **Include budget for a CHW travel allowance** to enable CHWs to reach the most underserved populations in remote areas. Consider lobbying the government to include budget for VHT expenses nationally.
- **Integrate wider training on FP service delivery** and counselling into CHW training on DMPA-SC delivery.
- **Explore what wider system improvements can be made** through the introduction of DMPA-SC, for example through the development and implementation of community based quality improvement plans.
- **Plan to hold multiple trainings** across the year for facility staff to allow for regular staff transfers.

SELF-INJECTION

Uganda is one of the few countries where self-injection of DMPA-SC has been piloted[3]. PATH led an initial self-injection pilot involving 380 women in 2015, which showed that self-injection of DMPA-SC is highly feasible and acceptable. As a result of the pilot's success, a district-level pilot of self-injection involving 1,208 women was launched in Mubende District in November 2016. This pilot aimed to assess feasibility of integrating self-injection within the day-to-day realities of the health system. For this soft launch, 100 facility-based providers were trained to offer self-injection to women. Within designated facilities, trained providers were able to offer DMPA-SC as part of a broad mix of methods, and clients who chose DMPA-SC were given the choice between having the product administered by the provider or being trained to self-inject. With the approval of self-injection by the Uganda National Drug Authority in February 2017, there are plans to roll out self-injection in additional districts and in the private sector. PATH's new one-year self-injection 'best practices' project promises to provide evidence for practical implementation of DMPA-SC self-injection programmes outside of research settings. This will be useful to inform programming as self-injection expands across Uganda and beyond.

Importantly, in order to fill the gap in evidence about the effectiveness and cost-efficiency of self-injection, PATH recently completed a study comparing continuation rate and cost-effectiveness of DMPA-SC self-injection vs. intramuscular DMPA administered by clinic providers. Results from this study will soon be disseminated.

Lessons learned on self-injection in Uganda

- **It is possible to effectively train clients to self-inject, but there are lessons to be learned on the most practical and cost-effective way to do this.** In the initial pilot of self-injection, a majority of women demonstrated competence after being trained. They went on to self-inject and to re-inject three months later. However, training can be cumbersome and expensive as it can take over one hour to train each woman. Materials used for training include demonstration models, placebo product, and a training booklet, and add substantial cost when training large numbers of women. PATH is exploring alternative training modules and materials that will be more cost-effective.
- **Women like DMPA-SC.** Factors women report as making self-injecting favourable are reduced need to travel, increased discretion afforded by reduced frequency of visits to facilities where neighbours, friends and relatives may see them, and fewer side effects as compared to DMPA-IM. While there is no scientific evidence that DMPA-SC carries less side effects than DMPA-IM, there have been consistent reports of reduced side effects from women in Uganda who have switched from DMPA-IM. This may suggest a need for a rigorous research study to support or refute this anecdotal finding.
- **Safe storage of DMPA-SC at home by self-injecting women is possible.** In contexts where disapproval of FP use by male partners is high, keeping products stored discretely in the home is important. The Uganda experience demonstrated that women could do this effectively by storing the product in handbags or in luggage.
- **Safe disposal of used devices is of paramount importance for sustaining self-injection successfully**. Safe disposal of spent DMPA-SC units is important, especially in high HIV prevalence contexts. The question of how to do this effectively continues to be debated. In the initial self-injection pilot in Uganda, women were instructed to place spent units in an impermeable container (such as a Vaseline jar) and to dispose of it in a latrine or return it to a health facility. Many clients showed preference for disposing in a latrine, which depending on the depth of the local facilities may be possible. In order to make this practice more environmentally friendly and sustainable it may be necessary to seek alternative solutions. Efforts in the Mubende district soft launch have focused more on training women to return the used device in a container to the health facility or give them to a VHT who can return spent devices to the health facility. In addition, efforts are being made to provide a disposal container to women during their initial training, as this increases likelihood of safe disposal. Alternative methods include burning the used device with household garbage, a common practice in the area. Safe disposal remains an area of discussion in each implementing country

3 PATH resources on self-injection: http://sites.path.org/rh/recent-reproductive-health-projects/sayanapress/home-and-self-injection-with-sayana-press/

and should be finalized locally while a method for innovative safe and efficient disposal could be developed.

- **Collection of monitoring data for self-injection requires additional effort.** Because self-injecting women will have decreased contact with the health system, additional efforts are needed to ensure that data are collected on their FP use and entered into the national HMIS. An additional challenge is presented when considering the fact that VHTs also administer DMPA-SC in the community, and that many different partners are often providing DMPA-SC in the same areas. Thus, there are concerns about possible double-counting of clients. These concerns will possibly intensify when VHTs receive the authorisation to become self-injection trainers, when the product becomes more widely available through pharmacies and drugs shops, and/or when self-injection becomes available through the private sector. These changes may mean women will have less contact with health facilities. As it stands, Uganda has not yet harmonised the data capture system for self-injection and CHW provision; and while the recent effort to tie VHTs to health facilities has facilitated supervision and monitoring, the system is not yet standardised.

TIPS FOR PROGRAMMING

- **Ensure that buy-in is secured from providers** and MoH because self-injection will require a great deal of effort from these stakeholders, especially in the initial stages. Buy-in is crucial for success.
- **Before rolling out self-injection, develop a solid plan and system for monitoring** and ensure that the system is harmonized against the main HMIS system. Think about the various players and possible sources of data, and coordinate closely with all of them.
- **Ensure that careful** planning goes into preparing for rollout of training. Consider what options for training exist, including who provides training, training format (individual vs. group training) and materials are needed. Consider which factors make the most sense for your context.
- **Consider sustainability:** the most sustainable way to deal with disposal of sharps; to train women and to train the providers who will train women; and to monitor women who are self-injecting in order to capture valid data about FP use.

Cross cutting themes

SUPPLY CHAIN, QUANTIFICATION AND PROCUREMENT

What's happening in Uganda?

The MoH requested in 2013 that DMPA-SC be distributed via a private distributor instead of the National Medical Stores (NMS) system during the pilot introduction phase. This was due to a limited geographic scope and because the product had not yet been included in the national Essential Medicines List (EML). As such, since introduction the Uganda Health Marketing Group (UHMG) has been responsible for product distribution and supply management across the country.

Both UHMG and DKT International (DKT) have plans underway to introduce DMPA-SC into the Uganda market via social marketing activities. UHMG is planning to introduce a brand of the product using a social marketing approach, while DKT will be introducing an over-branded product using a commercial approach.

Where to go for more information

- JSI DMPA-SC quantification guide[4]:
- Other supply chain tools and resources can be accessed from the JSI website[5] and more support is available from fpaccessprogram@jsi.com.
- For routine information on the stock status of all FP products and urgent needs: The GHSC-PSM project manages the Procurement Planning and Monitoring Report via which FP programs report contraceptive stock level information on a routine basis. To learn more about PPMR or to report data contact psmppmr@ghsc-psm.org.
- For information on DMPA-SC introduction and scale-up that can affect future procurement: E-mail Maggie Murphy at maggie_murphy@jsi.com.

4 JSI DMPA-SC quantification guide http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=INTL&id=18364&thisSection=Resources

5 http://supplychainhandbook.jsi.com and http://tinyurl.com/JSIquant

LESSONS LEARNED AND TIPS FOR PROGRAMMING

Uncertainty around new project introduction adds to supply chain challenges. The newness of a product means that there are no historical consumption or services data to help estimate demand or uptake. Furthermore, country systems (e.g. Logistics Management Information Systems and Health Management Information Systems) have not yet been updated to capture data about the new product, and uncertainty exists around length and process of product registration, as well as whether introduction will proceed as planned. Introduction of new products can also create some challenges in forecasting for existing products, as some effect of new product introduction on use of other methods is expected, but the magnitude and timing are unknown.

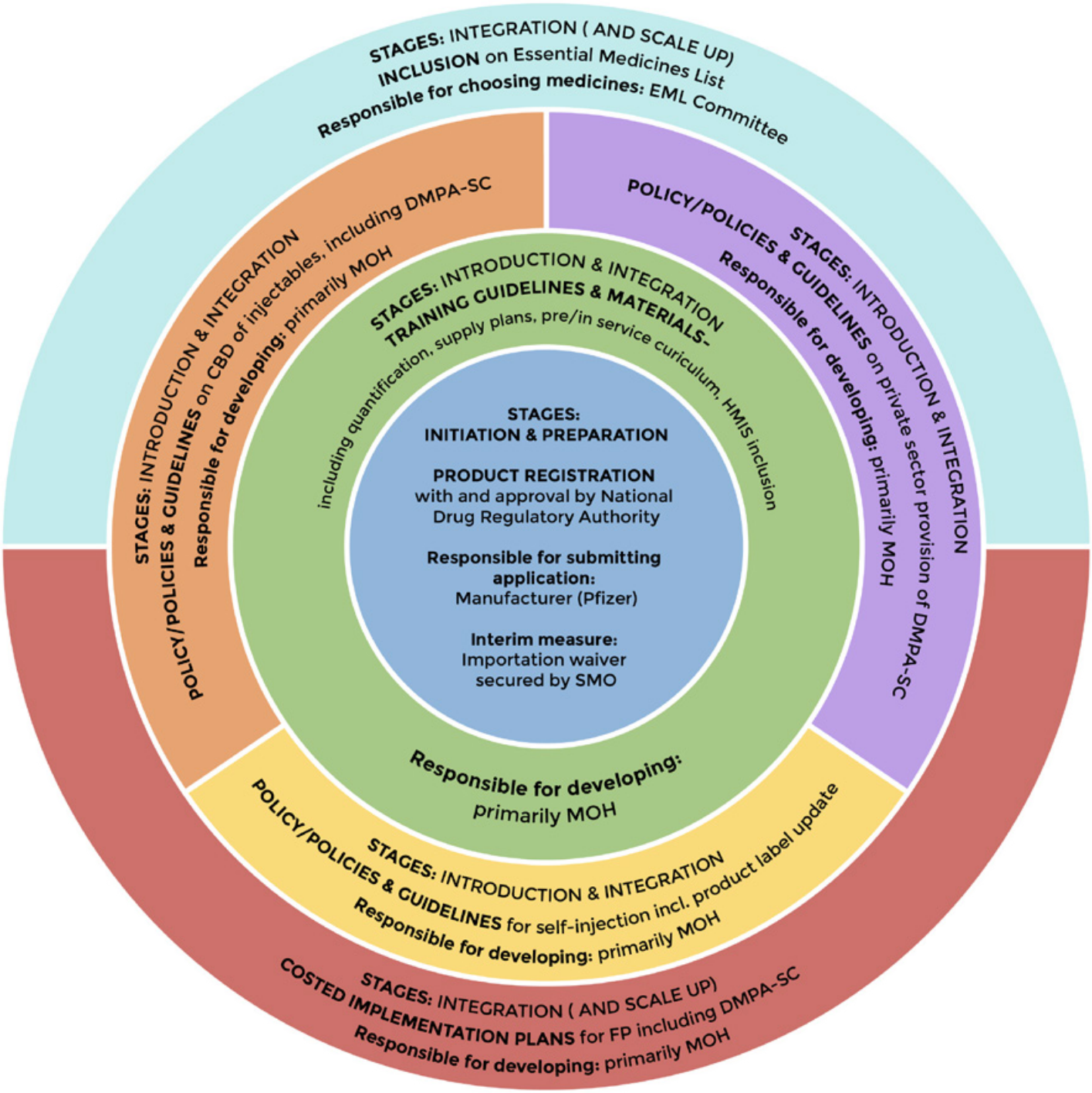
Coordination among program and supply chain planners can help minimise supply chain issues. Quantification is necessary to help ensure an uninterrupted supply of the product, and a clear and realistic introduction plan is a prerequisite for this. Changes to the introduction plan can affect need for a product, and require corresponding changes to supply plans. Similarly, changes to supply plans may affect the country's ability to pursue its introduction plan, so close communication and coordination among program and supply chain operators is essential. In order to be useful, the introduction plan must specify the following:

- Geographic area(s) covered
- Program expansion plans and timelines
- Health system levels and service provider cadres involved
- Provider training needs and timing
- Whether DMPA-SC is provided alongside other injectables (DMPA-IM) or is the sole injectable offered

Forecasting is important for estimating expected consumption of commodities, and supply plans must be monitored and adjusted regularly. Evidence of DMPA-SC introduction in other settings can be used to estimate expected uptake of DMPA-SC in a new country. It is important to account for the supply needed for training. As many uncertainties introduce risk of over- or understock, it is important to update forecasts and supply plans to account for changes in the DMPA-SC introduction plan, and incoming data on consumption, shipments, etc. Given the expected relationship between DMPA-SC and DMPA-IM use, joint monitoring of DMPA-SC and DMPA-IM supply plans is also important.

Uganda successfully avoided stock-out issues due to investment in a private distribution system. In the Uganda DMPA-SC introduction experience, using an alternative distributer to NMS became expensive; however, this parallel funding for a private distribution system kept stock-outs in Uganda to an extremely low level during the introduction period. Throughout the pilot period in Uganda, volumes of DMPA-SC distributed to health facilities stayed far ahead of consumption volumes. The highest stock out period in June 2016 affected only 9% of facilities (18 facilities), and this was only due to a delay in new stock arrival.

Illustrative map of DMPA-SC related regulations and national policies



Based on RHSC's important policies for advancing access to subcutaneous DMPA & PATH/RHSC's DMPA-SC staging tool. Please note all country contexts will differ somewhat; this map is intended to be an illustrative example.

ADVOCACY FOR ACTION

What's happening in Uganda?

Ugandan NGOs, service delivery organisations and sexual and reproductive health rights activists have advocated for a series of systems changes and policy amendments to enable the introduction of DMPA-SC. The achievements seen through these coordinated advocacy efforts have accelerated introduction and scale up nationally.

Where to go for more information

- Funds to support advocacy for DMPA-SC access are available via the PAI Opportunity Fund[6] – a flexible source of financial and technical assistance for focused advocacy at national, state and district levels. The Fund is part of the five-year AFP project, whose aim is to increase access to FP through advocacy, working with partners in 10 focal countries.
- AFP's advocacy portfolio[7] includes information about AFP SMART and their work more broadly:
- A comprehensive set of materials to support advocacy efforts on DMPA-SC access are available through the Reproductive Supplies Coalition DMPA-SC Advocacy Pack[8]. Resources include staging tools, details of important policies for advancing DMPA-SC access, case studies and much more.

LESSONS LEARNED AND TIPS FOR PROGRAMMING

! **Depending on the country context, there are many policies that can expand access to DMPA-SC.** The policy and advocacy 'ask' in any country will depend entirely on how far DMPA-SC roll-out has progressed. Examples of policy changes that can expand access include: product registration with the national drug regulatory authority; the inclusion of DMPA-SC on the EML; allowing community based distribution of DMPA-SC; and introducing new policies or policy amendments on self-injection.

! **A coordinated strategic approach is essential to achieve any policy change.** Advance Family Planning's (AFP's) *SMART* advocacy approach can be used to develop a targeted advocacy strategy. In developing such a strategy:

- Mobilize existing advocacy resources and engage expert and influential stakeholders to develop and implement the strategy.
- Set a clearly defined SMART (Specific, Measurable, Achievable, Relevant and Time bound) goal, and a series of short term SMART objectives that will help contribute to the overall goal.
- Identify the decision-maker who has the power to help ensure that your issue is addressed, and craft a request for action that aligns with their interests and priorities.
- Ensure that the objective is met, create a plan and budget that assigns responsibilities and deadlines for completion of activities.

6 PAI Opportunity Fund: https://pai.org/articles/apply-for-the-opportunity-fund-2/
7 http://advancefamilyplanning.org/portfolio
8 Reproductive Supplies coalition DMPA-SC Advocacy Pack: https://www.rhsupplies.org/activities-resources/tools/advocacy-pack-for-subcutaneous-dmpa/

DEMAND GENERATION

What's happening in Uganda?

Communication for Development Foundation Uganda (CDFU) helped to raise awareness of DMPA-SC and FP by using a multi-channel demand creation approach. Their campaign included:

- Utilising the toll-free hotline for information, counselling and referral for FP.
- Using peer-to-peer and community-centred communications.
- Training VHTs on interpersonal communication (IPC) and supporting them to conduct community dialogues (outreach sessions) and household dialogues.
- Development and dissemination of provider/client communications materials.
- Broadcasting information about DMPA-SC through mass media channels including radio talk shows and radio spots.

LESSONS LEARNED AND TIPS FOR PROGRAMMING

! **Facilitating community dialogues can address concerns about FP and dispel myths about DMPA-SC.** Although resource intensive, community dialogues appear to help create an enabling environment for service delivery by preventing opposition to DMPA-SC and voluntary FP more widely. CDFU found that satisfied user testimonies collected at community dialogues were particularly powerful in addressing community concerns, including anxieties about contraceptive side effects, which are a major barrier to uptake.

! **Engaging with existing community structures can enable wide reach at community level**. Working with Mothers' groups, Village Saving and Loans Associations and other established groups enabled CDFU to maximise community penetration.

! **There appears to be an association between FP uptake and the number of community health workers trained on family planning.** CDFU found that the higher the number of VHTs trained in DMPA-SC, the greater the knowledge and uptake of DMPA-SC and other FP methods in the community. This suggests that in Uganda, VHTs are central to increasing awareness about family planning at the household level.

! **Radio is key to raising awareness**. CDFU found that radio was the most common source of messages about DMPA-SC. 52% of survey respondents reporting having heard about DMPA-SC over the radio in Uganda.

Where to go for more information

- PATH's Communications Guidance for Introducing DMPA-SC[10]

10 https://www.path.org/publications/files/RH_sayana_comm_intro_guide.pdf

SCALING UP

What's happening in Uganda?

In the early stages of scale-up, individual implementing partners took steps to integrate DMPA-SC into their family planning projects, and were funded by a range of donors. In order to coordinate national scale-up, the Ugandan MoH is establishing a DMPA-SC Task Force and PATH is working with the Ugandan MoH to develop an overall coordinated strategy for scale-up.

LESSONS LEARNED AND TIPS FOR PROGRAMMING

- **Stakeholder engagement and coordination**. Coordination of implementing partners with different donor deliverables has been a major challenge to scale-up in Uganda. The MoH technical working group has provided a valuable forum for ensuring that stakeholders are engaged and informed closely during pilot, introduction and expansion phases.
- **Quantification, procurement and logistics management**. The quantification process is key to the development of the scale-up plan. Stakeholders should prioritize and agree to a centralized process. It is recommended that quantification efforts be housed in the MoH, included in national supply plans and projected to ensure consideration of issues like replacement of DMPA-IM, overstocks, and drug expiry. The quantification process should consider current national stocks and the planned roll-out.
- **Training and supervision.** Training is a critical path for scaling up. It is costly to cover an entire country, therefore there should be a deliberate effort to integrate and leverage existing resources to maximise reach through mapping of existing opportunities to train and supervise providers. Close supervision of 'training of trainers' is key because as training cascades to secondary training sessions and beyond, training messages can become distorted.

Where to go for more information

- The new PATH/JSI initiative on global roll-out of DMPA-SC, to be launched in late 2017, will provide support for scale-up across countries. For more information, contact Sara Tifft at stifft@path.org.
- A new PATH Guide provides practical steps to scale up programming: *How to Introduce and Scale up Sayana® Press (DMPA-SC in Uniject) : Practical Guidance from PATH Based on Lessons Learned During Pilot Introduction*[11]

11 http://www.path.org/publications/files/RH_sp_dmpa_sc_practical_guidance_2017.pdf

MONITORING AND EVALUATION

What's happening in Uganda?

- Development of a monitoring system for DMPA-SC in Uganda happened as part of a multi-country process, in order to ensure that consistent data were reported from the four countries where PATH was coordinating DMPA-SC introduction efforts. This process included development of a set of global indicators, and then integration of these indicators into the national data collection systems.
- In Uganda, PATH implemented a system that made it possible to collect data pertaining to CBD of contraception through VHTs. Client visit data were collected at the facility level monthly and reported to the PATH monitoring focal point by the four partners involved in CBD activities in various districts. The partners are PATH, Pathfinder, WellShare International and FHI360. Along with reporting to PATH, these facility-level data were also rolled up and included in the country's national health information system.

Where to go for more information

- PATH Guide: *How to Introduce and Scale up Sayana® Press (DMPA-SC in Uniject) : Practical Guidance from PATH Based on Lessons Learned During Pilot Introduction*[12]

LESSONS LEARNED AND TIPS FOR PROGRAMMING

! **Monitoring data is crucial for quality improvement, plans for scale-up and introduction strategy in other settings.** One year of monitoring data in Uganda provided an adequate evidence base to inform MoH decisions on scale-up, without a formal program evaluation. For example, the data from across the four PATH pilot countries reveal how different introduction strategies drive consumption volumes and reach new users. Strategies that prioritized making DMPA-SC available through established channels at all levels of the health system resulted in higher volumes of DMPA-SC being administered, but the strategies that prioritized delivery in remote and underserved areas of the country reached higher proportions of first time users of modern contraception.

! **It is critical to start early and budget the necessary resources from the outset.** Developing key indicators and designing the monitoring system and data collection tools should coincide with planning the project strategy. It is also important to adequately budget the human and financial resources needed to implement the monitoring approach as early in the planning stage as possible. To minimize costs and enable sustainability, it is advisable to begin with as much of the existing data system as possible, and with a focus on only the most necessary indicators. Furthermore, several iterations of tools may be required and pilot-testing of tools and strategies is important, so these should be accounted for in both the timeline and the budget. Delays in designing and implementing the monitoring system will translate to delays in data collection and reporting, which risks missing data from the early phases of introduction.

! **Coordination adds value.** To be successful, monitoring and evaluation plans where DMPA-SC has been introduced through multiple channels and partners require high levels of coordination from the very beginning. This helps to improve the reliability and validity of data.

! **Monitoring data has important limitations.** It may not be possible to track individual users over time from regular data monitoring. Data reflects only the number of doses administered and not the number of individual women receiving those doses. Therefore, indicators on age, new users and switching methods do not tell us the true proportion of 'clients' in each of those categories. If there is need to capture data at the individual client level, it may be useful to plan and budget for an evaluation early in the process.

12 http://www.path.org/publications/files/RH_sp_dmpa_sc_practical_guidance_2017.pdf

Section 2: DMPA-SC within IPPF, MSI and PSI

Status of IPPF, MSI and PSI DPMA-SC programs: Where are we now?

In advance of the meeting, participants from MSI, PSI and IPPF developed individual situational DMPA-SC posters to both provide a standardized way of sharing country contexts with other participants, as well as to help participants think through their questions and goals for the workshop. Poster headings included the country context related to DMPA-SC, their organization's work to date in DMPA-SC implementation, their top three implementation questions, their organizations' goals related to DMPA-SC and any further references they wanted to share.

Reviewing these presentations, it is clear that DMPA-SC-related activities across our participants vary widely. For the purposes of this report, we are applying *PATH/Reproductive Health Supplies Coalition's advocacy DMPA-SC staging tool*[13] to categorize the country stage context for our participant countries:

13 https://www.rhsupplies.org/fileadmin/uploads/rhsc/Tools/DMPA_Kit/Files/Tools_to_inform_advocacy_and_communications/DMPA-SC_advocacy_tools_1_staging_2017.pdf

COUNTRY	ORGANIZATION	COUNTRY STAGE	CURRENT ACTIVITIES
Ghana	IPPF	1 – Initiation	None as yet; engaging with MoH on future role
Ghana	PSI	1 – Initiation	None as yet; plans for training of pharmacies and private sector distribution once/if DMPA-SC approved
Kenya	IPPF	2 – Preparation	Advocacy and engagement at national level
Kenya	MSI	2 – Preparation	Advocacy and engagement at national level
Burkina Faso	IPPF	3 – Introduction	Training of and distribution through CHWs; demand generation; advocacy for self-injection and task sharing
DRC	IPPF	3 – Introduction	Stakeholder engagement and coordination; demand creation and advocacy; training and supervision of clinical providers; M&E; distribution through clinics,
DRC	PSI	3 – Introduction	Training of medical student cadre of DMPA-SC providers; engagement with MoH
Madagascar	MSI	3 – Introduction	Implementing pilot introduction through static clinics, mobile outreach, social franchises and MS ladies; providing CHW training and supervision; communications; data collection
Niger	MSI	3 – Introduction	Distribution at MSI clinics, MS ladies, and mobile outreach; demand generation; training and supervision of providers; market studies
Nigeria	MSI	3 – Introduction	Training outreach teams, MS ladies, and public providers; supporting distribution through social marketing
Uganda	MSI	3 – Introduction	Training in 2014 of VHTs; none at present
Uganda	PSI	3 – Introduction	None as DMPA-SC not approved for private sector
Zambia	PSI	3 – Introduction	Training public CHWs and CHW supervisors; demand generation; advocacy for scale up

Where next?

LEARNING ACTION PLANS:

To draw a clear link between participants' pre-workshop poster presentations, their week of learning, and post-workshop implementation, country participants spent the last day of the workshop developing 'learning action plans'. Participants developed their plans in line with the implementation focus of the workshop, and included sections on the following: 1) their vision for continuing/future implementation of DMPA-SC through their particular organisation; 2) answers to the original key questions they brought to the workshop (per their situational posters); 3) an action table outlining implementation challenges, action steps, and support needed to take those steps; and 4) how they perceived their workshop experience.

While the content of the plans varied considerably, all were rich with detail. Participants identified both external and internal challenges and actions they would need to address before being able to expand access to DMPA-SC through their organizations. All participants were able to answer the questions they had brought to the workshop with the learning they acquired during the week.

Details for the vision of each participant were as follows:

COUNTRY (ORG)	STAGE	VISION FOR ONGOING/FUTURE IMPLEMENTATION
Ghana (IPPF)	1 – Initiation	Planned channels: fixed clinics, partner clinics, outreach
		Projected populations: 10-24, 25-49, vulnerable women
		Geographic coverage: urban and rural
		Planned providers: facility-based providers
		Demand creation: community mobilisation, stakeholder forums
		Advocacy focus: creating an advocacy network

COUNTRY (ORG)	STAGE	VISION FOR ONGOING/FUTURE IMPLEMENTATION
Ghana (PSI)	1 – Initiation	Planned channels: franchised clinics, private sector, social marketing
		Projected populations: 25-49 (quintiles 4&5), new users, switchers
		Geographic coverage: urban and peri-urban
		Planned providers: some facility-based, self-administration
		Demand creation: social media, mass media, IEC
		Advocacy focus: self-injection (also the Ghana Health Services' interest)
Kenya (IPPF)	2 – Preparation	Planned channels: fixed clinics, partner clinics
		Projected populations: 15-49
		Geographic coverage: rural and urban
		Planned providers: facility based workers
		Demand creation: stakeholder forums
		Advocacy focus: training and coalition building
Kenya (MSI)	2 – Preparation	Planned channels: fixed clinics, social marketing, school outreach
		Projected populations: 15-24, 25-49
		Geographic coverage: urban and per-urban
		Planned providers: facility-based providers and CHWs
		Demand creation: IEC, community mobilisation, social media campaigns
		Advocacy focus: EML inclusion, CBD and self/pharmacist injection approval
Burkina Faso (IPPF)	3 – Introduction	Planned channels: fixed clinics, mobile teams, CHWs
		Projected populations: 15-49 in Boulmiougou, Nouna, Hounde, and Ouahigouya
		Geographic coverage: rural, per-urban and urban
		Planned providers: facility-based providers and CHWs
		Demand creation: mass media, IPC, FP week, FP days
		Advocacy focus: community support for DMPA-SC, authorization of PTFs

COUNTRY (ORG)	STAGE	VISION FOR ONGOING/FUTURE IMPLEMENTATION
DRC (IPPF)	3 – Introduction	Planned channels: fixed clinics, partner clinics, mobile teams, CBD
		Projected populations: 15-24, 25-49
		Geographic coverage: rural, peri-urban and urban
		Planned providers: facility-based providers, ADBCs
		Demand creation: FP days, IPC, mass media, community mobilisation
		Advocacy focus: authorization for self-injection
DRC (PSI)	3 – Introduction	Planned channels: private clinics, CBD
		Projected populations: 15-24, 25-49
		Geographic coverage: urban and peri-urban
		Planned providers: facility-based providers, pharmacists, ADBCs (medical & nursing students currently allowed to administer DMPA-SC)
		Demand creation: IEC, IPC, mass media, provider behaviour change communication
		Advocacy focus: authorization of CBD
Madagascar (MSI	3 – Introduction	Planned channels: fixed clinics, franchised clinics, public franchises, MS ladies, CHWs, outreach
		Projected populations: under 20, 20-25, new users, switchers
		Geographic coverage: rural, peri-urban, urban
		Planned providers: facility-based providers, CHWs
		Demand creation: mass media, IPC
		Advocacy focus: authorization for CBD and self-injection
Niger (MSI)	3 – Introduction	Planned channels: fixed clinics, mobile teams, MS ladies
		Projected populations: 15-24, 25-49 in Niamey, Maradi and Tillaberi
		Geographic coverage: rural and urban
		Planned providers: facility-based providers, CHWs, social marketing agents
		Demand creation: IEC, youth communications, IPC
		Advocacy focus: champion building, pharmacy distribution, self-injection

COUNTRY (ORG)	STAGE	VISION FOR ONGOING/FUTURE IMPLEMENTATION
Nigeria (MSI)	3 – Introduction	Planned channels: MS ladies, social marketing, public CHWs
		Projected populations: 15-24, passive and aspiring mothers
		Geographic coverage: Northern region, rural and peri-urban
		Planned providers: CHWs, nurses/midwives, self-injection
		Demand creation: IEC, community mobilisation, mass media
		Advocacy focus: internal discussions, build evidence for self-injection
Uganda (MSI)	3 – Introduction	Planned channels: MS ladies, fixed clinics, franchised clinics, outreach
		Projected populations: 15-25; new users
		Geographic coverage: peri-urban and rural
		Planned providers: nurses, midwives and clinical officers
		Demand creation: community mobilization, local champions, provider based change communication
		Advocacy focus: SRH integrated into education, and approval of DMPA-SC administration by drug shops and CHWs
Uganda (PSI)	3 – Introduction	Planned channels: private sector, public facilities
		Projected populations: 15-24, 15-49
		Geographic coverage: rural and urban
		Planned providers: facility-based providers and CHWs
		Demand creation: IEC materials, community mobilisation
		Advocacy focus: internal advocacy for social marketing
Zambia (PSI)	3 – Introduction	Planned channels: public CBD
		Projected populations: 15-24, 25-49
		Geographic coverage: rural and urban
		Planned providers: CHWs
		Demand creation: coalition building, community mobilisation, 1-1 talks, FP days, VCT Day and World AIDS Day
		Advocacy focus: MoH and regulatory bodies

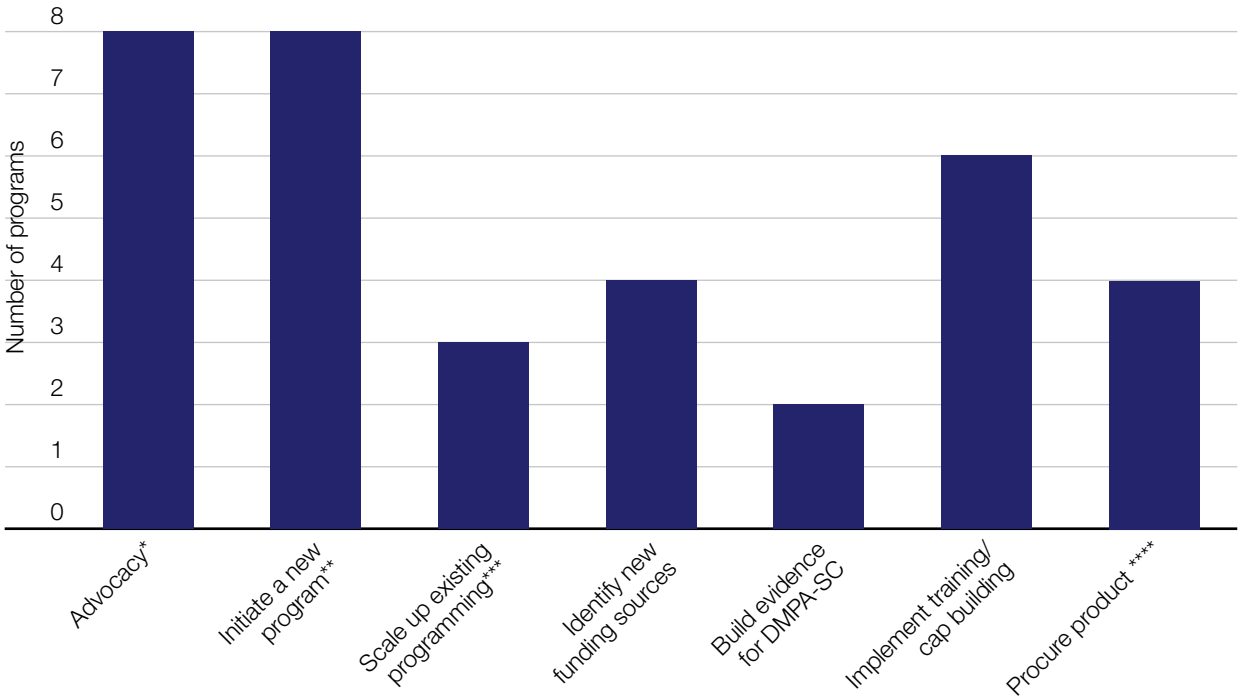
In terms of their action tables, participants cited lack of organizational/national scale up plans and need for capacity building as common obstacles. For countries still in the initiation and preparation stages (i.e., Ghana and Kenya), lack of product is an unsurprising implementation challenge. Participants from Nigeria and Burkina Faso thought that self-injection laws need to be approved or widened, while participants from Kenya and Uganda saw the feasibility of DMPA-SC as a socially marketed product as important to their plans. To address these challenges, participants proposed the changes shown in the graph below.

ORGANISATIONAL EFFORTS TO ACHIEVE CHANGE

In order to incorporate DMPA-SC within the voluntary FP services provide globally, IPPF, MSI and PSI are committed to take concerted action to put DMPA-SC at the centre of organisational FP strategies. This will involve coordinating with existing projects such as PATH's TML project, providing support to country members to execute their DMPA-SC programming and continuing to engage with AFP's advocacy on a global, regional and national level.

By taking these steps, FP-focused service delivery organisations like ours have the potential to greatly increase access to voluntary FP for the millions of underserved by putting contraceptive choice in the very hands of women and girls around the world for the very first time.

What next? Action steps



* Advocacy with decision makers (MoH, TWG, task forces, coalitions)
** Included pilots, demand creation and IEC programs, and social marketing
*** MSI Nigeria, IPPF DRC, PSI DRC
**** IPPF Ghana, PSI Ghana, IPPF Kenya, MSI Kenya

Annex 1: Meeting schedule

OPERATIONAL LEARNING WORKSHOP ON SERVICE PROVISION OF NEXT GENERATION INJECTABLES – UGANDA: 11TH – 16TH JUNE 2017

Schedule

DAY 0: SUNDAY 11TH KAMPALA (KABIRA COUNTRY CLUB)	
Time	Session
6.30 pm	Registration, welcome and soft drinks

DAY 1: MONDAY 12TH: KAMPALA (KABIRA COUNTRY CLUB) AND MUBENDE (PRIMEROSE HOTEL)			
Time	Session	Session lead	Objective
8.30 – 9.00	***Arrival and coffee***		
9.00 - 10.00	Opening		To create a shared understanding of the meeting's objectives and logistical arrangements
	Welcome remarks and introductions	RHU	
	Opening remarks from the MoH Uganda	MoH Assistant Commissioner	
	Review of workshop objectives and schedule	IPPF SIFPO	
10.00 - 10.45	**The introduction of DMPA-SC in Uganda: The story so far** Overview on the journey of DMPA-SC in Uganda to date – from research, to piloting, to scale up, to soft launch and national roll out	PATH	To provide an overview of how DMPA-SC has been introduced in Uganda
10.45 - 11.15	***Break and collect luggage***		
11.15 - 13.30	***Travel to Mubende***		
13.30 - 14.30	Lunch		
14.30 - 15.00	**The basics! DMPA-SC Overview / Team quiz** Overview of how DMPA-SC works, how it differs from other Family Planning commodities	IPPF, SIFPO	To ensure that all participants understand of what the potential value proposition of DMPA-SC is, how it works and how it differs from DPMA-IM
15.00 – 15.15	***Break***		

DAY 1: MONDAY 12TH: KAMPALA (KABIRA COUNTRY CLUB) AND MUBENDE (PRIMEROSE HOTEL)			
15.15 – 16.15	**Group work and poster presentations** Review of poster presentations and clarification of learning objectives / questions	Facilitated by team leads	To ensure that participants have a realistic set of learning objectives for the week and an understanding of each other's work
16.15 - 17.15	**DMPA-SC in the News**	IPPF	To allow participants to reflect on the global factors effecting the availability and roll out of DMPA-SC
	WHO guidance on hormonal contraception and women at high risk of HIV	PSI	
	Gates / Pfizer collaboration and project registration	IPPF	
	Technical Market Lead project	PATH	
17.15 – 17.30	**Evaluation**	IPPF	
17.30 -	*Check into the Primerose hotel*		

DAY 2: TUESDAY 13TH: MUBENDE (PRIMEROSE HOTEL AND SITE VISIT)			
Time	Session	Session lead	Objective
8.30 - 9.00	**Introduction, welcome and overview of day**	PATH	To provide participants with a practical understanding of how self-injection services are being delivered to ensure improved access to voluntary FP for women in areas with high unmet need through self-injection programmes in Mubende
9.00 - 9.30	*Travel to self-injection sites*		
9.30 - 12.30	**Site visits: Self-injection** Group 1: Kansera Group 2: Gayaza	PATH	
12.30 - 13.00	*Travel back to hotel*		
13.00 - 14.30	*Lunch with district officials*		
14.30 - 15.00	**District Health Team's role in managing the introduction of DMPA-SC in Mubende District**	Mubende District Health Office Team	
15.00 - 15.30	*Break*		
15.30 - 16.15	**Presentation: Detailed overview of research findings from self-injection and best practices project**	PATH	
16.15 16.45	**Questions and discussions**	Facilitated by PATH	
16.45 - 17.30	**Group review and Evaluation**	Group facilitators	

DAY 3: WEDNESDAY 14TH: KAMPALA (KABIRA COUNTRY CLUB)			
Time	Session	Time	Session
08.30 - 09.00	*Check out*		To give a practical understanding of how services are being delivered to ensure improved access to voluntary FP for women in areas with high unmet need through clinic based service delivery programmes by RHU
09:00 - 11.30	*Travel back to Kampala*		
11:30 - 13.00	*Lunch*		
13.00 - 13.45	**Community based distribution of DMPA-SC: Overview of RHU's work**	RHU	
13.45 - 14.45	**Panel discussion: Delivering services in the community** An opportunity to hear the perspective of service providers	Panel of Village Health Teams and Service Providers	
14.45 - 15.15	*Break*		
15.15 - 15.45	**Process evaluation findings** Summary or research findings from the Population Council evaluation of RHUs work on community based distribution	RHU, IPPF	
15.45 - 17.00	**Group review and evaluation**	Group facilitators	
17.00	*Check in to hotel*		

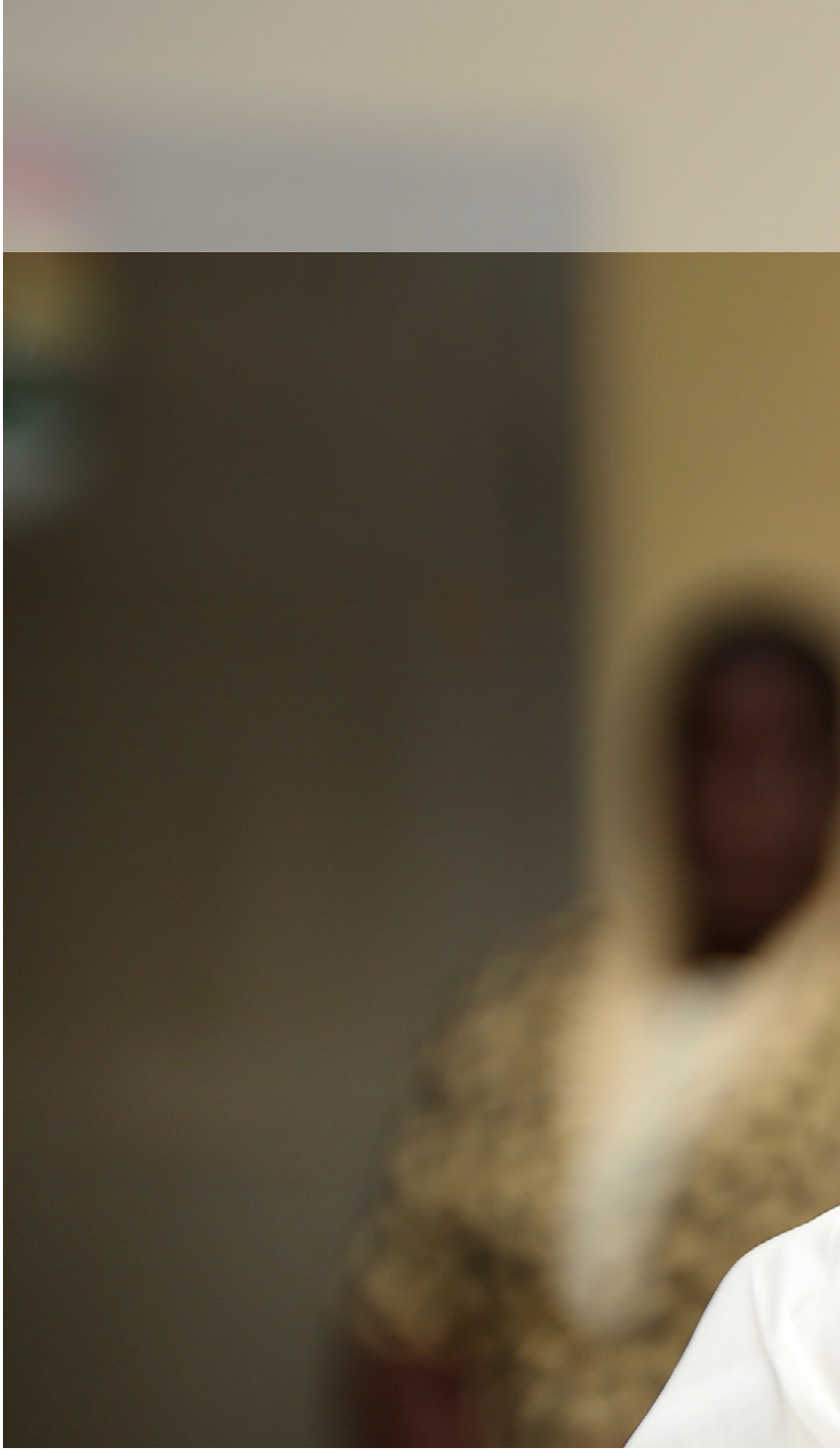
DAY 4: THURSDAY 15TH: KAMPALA (KABIRA COUNTRY CLUB)			
Time	Session	Lead person	Objectives
08.30 – 08.45	**Welcome and warm up**	IPPF	
08.45 – 10.15	Cross cutting strategies for reaching the unreached: Master Classes **Supply chain, quantification and procurement** Estimating future consumption and planning for adequate supply of DMPA-SC	JSI, UNFPA	Participants have the technical skills required to enable them to plan the introduction / roll out of DMPA-SC within their programmes
10.15– 11.15	Advocacy for action How advocacy can be used as a tool to create an enabling environment	AFP	
11.15 – 11.45	*Break: Group photo*		
11.45 – 12.45	Generating awareness Use of social marketing and social and behaviour change communications to increase awareness of DMPA-SC	UHMG, CDFU	
12.45 – 14.00	*Lunch*		
14.00 – 15.00	**Scaling up** Lessons from experiences scaling up DPMA-SC in Uganda	PATH, CHAI	
15.00 – 15.45	Community-based delivery Experiences from FHI 360's work providing DMPA-SC at community level	HI360	
15.45 – 16.00	*Break*		
16.00 – 17.00	M&E and demonstrating results How to design monitoring and evaluation activities to effectively measure and capture results	PATH	
17.00 – 17.30	**Group review and Evaluation**	Group Facilitators	

Annex 2: Workshop evaluation

In their learning action plan presentations during the last day of the workshop, participants fed back their thoughts on what they felt was the most interesting thing they learned during the week, what support they would need in the future, and what workshop learning they felt would help them most. Nearly 75% of participants cited the visit to Mubende to the self-injection site as either the most interesting or useful learning from the week. Other common responses regarding the most interesting learnings included understanding the enabling environment for DMPA-SC, the acceptability and value-add of DMPA-SC and how Uganda was using CHWs to effectively distribute DMPA-SC. Most useful learnings included the technical presentations on the 4th day of the workshop, the opportunity to exchange information with colleagues during the week and the testimonials given by the CHWs. Common support needs cited included support to advocate and engage with the MoH, funding to support programming, further experience exchanges between countries and development of training and communications plans using existing materials such as those developed by PATH.

Participants were also asked to complete an online post-workshop evaluation in either English or French. Of eight respondents, more than 60% said that their overall assessment of the workshop was as a '1', on a scale with 1 being excellent and 5 being very poor. The remaining 40% assessed the workshop as a '2'. All respondents said the workshop fully met its objectives of sharing experiences and lessons learned from implementation, as well as identifying and sharing strategies to help introduce DMPA-SC in new areas. 75% of respondents felt the knowledge and information gained from the workshop met their expectations, and 100% said they felt the information and knowledge gained from the workshop would be useful in their work.

Notes



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