



DISC
Delivering innovation
in self-care

HIGHLIGHTS: INSIGHTS SYNTHESIS

INSIGHTS GAINED THROUGH EVIDENCE-BASED DESIGN

JULY 2021



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INTRODUCTION

BACKGROUND

Much of the research on self-injection (SI) of depot medroxyprogesterone acetate (DMPA-SC) contraception to date focuses on what is necessary to set up healthcare systems to integrate SI into services, and the feasibility and safety of SI overall. There was a noticeable gap in evidence on women's experiences, desires, preferences, and needs related to SI. In response, Delivering Innovation in Self-Care (DISC), a five-year project funded by the Children's Investment Fund Foundation, is conducting quantitative, qualitative, and design-based research focused on understanding the decision-making process of individual women. With a focus on early adopters of SI, DISC aims to gain insight into the perspectives of women in consumer segments likely to adopt SI in the future.

Our findings extend into interpersonal power dynamics, such as women's conceptualizations of power, their perceptions of influencers (e.g., male partners and parents), and social norms and associated stigma, as well as perspectives of service providers (public and private clinic-based providers, drug shop owners, patent and proprietary medicine vendors [PPMVs], and pharmacy workers), who act as both facilitators and potential barriers to the use of SI.

Active in Nigeria and Uganda from January 2020 through December 2024, DISC supports women's knowledge and demand for self-care, beginning DMPA-SC, paving a pathway to self-care as a viable cornerstone of sexual and reproductive health (SRH), and placing more power in the hands of women themselves.

DISC's inception period comprised formative research, insight generation, and evidence-based prototyping to develop an intervention to catalyze providers' and consumers' interest in and demand for DMPA-SC and contraceptive self-care more broadly. In 2020, the research and human-centered design phase focused its efforts around three principal workstreams, which frame the findings discussed in this report:

In early 2021, reflecting on insights gleaned from the inception period results, DISC and its stakeholders narrowed its scope to focus more explicitly on fostering women's knowledge and demand for SI. Today, DISC's core focus areas include developing and implementing proven demand generation interventions (see Figure 1) for SI, innovating to bridge key gaps in consumers' use journey, and knowledge translation to enable other key market actors to optimize demand generation and SI support services.



A behavior change ecosystem that supports women throughout their entire self-injection journey - to take up, sustain use of, and advocate for self-injection.



Optimizing the client/provider interaction at the self-inject 'moment of truth' to support frictionless access of self-injection.

FIGURE 1. DISC DEMAND GENERATION & SOCIAL AND BEHAVIOR CHANGE STRATEGIC AREAS



DISC's target consumer segments have evolved according to its research and design findings. In 2020, DISC identified two key segments, who will be discussed in this report: urban youth (UY) ages 18-24 who both are married and unmarried, and urban and some rural women of reproductive age with at least one child (mums). To better reflect the divergent views on the relevance and value of contraception between UY who had not yet begun childbearing and those who had, these segments were further refined into three groups: 1) UY ages 18-24 with no parity (without children); 2) young urban mums ages 18-24 with parity; and 3) urban adult mums ages 25-35 with parity. Each segment includes married and unmarried women living in urban and peri-urban areas.

This report looks at DISC's research findings from a user journey perspective (see Figure 2 below) and summarizes how insights might be further leveraged in the intervention design process. Our hope is that the evidence presented here can support partners and stakeholders in serving as effective thought partners, and, in some cases, implementers of complementary contraceptive self-care interventions, at every stage of the user's journey.

METHODS

DISC research methods included:

- Market segmentation analysis which identified two initial target consumer segments; this was expanded, based on emerging results, to three segments: UY ages 18-24, urban young mums ages 18-24, and urban mums ages 25-35.
- Desk review (including a new review in 2021, to ensure all new evidence was included) of research, relevant publications, country reports, and other relevant documents to identify emerging best practices in DMPA-SC introduction and scale-up.
- Review of key documents, webinars, and meetings to understand the current state of knowledge and supplement the desk review.



- Gathering and reviewing insights from 18 early adopters of DMPA-SC (UY and mums, in urban and rural locations in Nigeria and Uganda), to inform initial program design thinking and further in-depth exploration of consumers opinions.
- Digital landscaping and analysis of smart devices and digital platforms, which serve as conduits of information, support, and advocacy throughout the user journey.
- Market landscape analysis of the DMPA-SC market in both countries, identifying key constraints and opportunities throughout the product's flow from manufacturers to users.
- Human-centered design research (hereinafter referred to as 'design research'), including:
 - » Consumer research interviews and in-depth discussion with a total of 72 consumers and potential consumers of SI in Uganda and Nigeria.
 - » Creative agency consumer-led insights.
 - » Consumer insights from design workshops held in both Uganda and Nigeria.
 - » Interviews with providers in both Uganda and Nigeria.
 - » Provider insights: design workshops and preliminary trainings.
 - » Male influencer insights.

APPROACH

DISC analyzed SI user perspectives at five different stages, along a woman's path from initial awareness of the project through to becoming of a champion of contraceptive self-care who supports other women's ability to adopt and sustain use of SI. These stages are defined as follows below:

Awareness: the point at which the potential user becomes aware of SI and wishes to learn more through credible, trustworthy channels of information.

Decision and intent: the point at which the potential user has received enough information and support to confidently decide on whether or not to use SI.

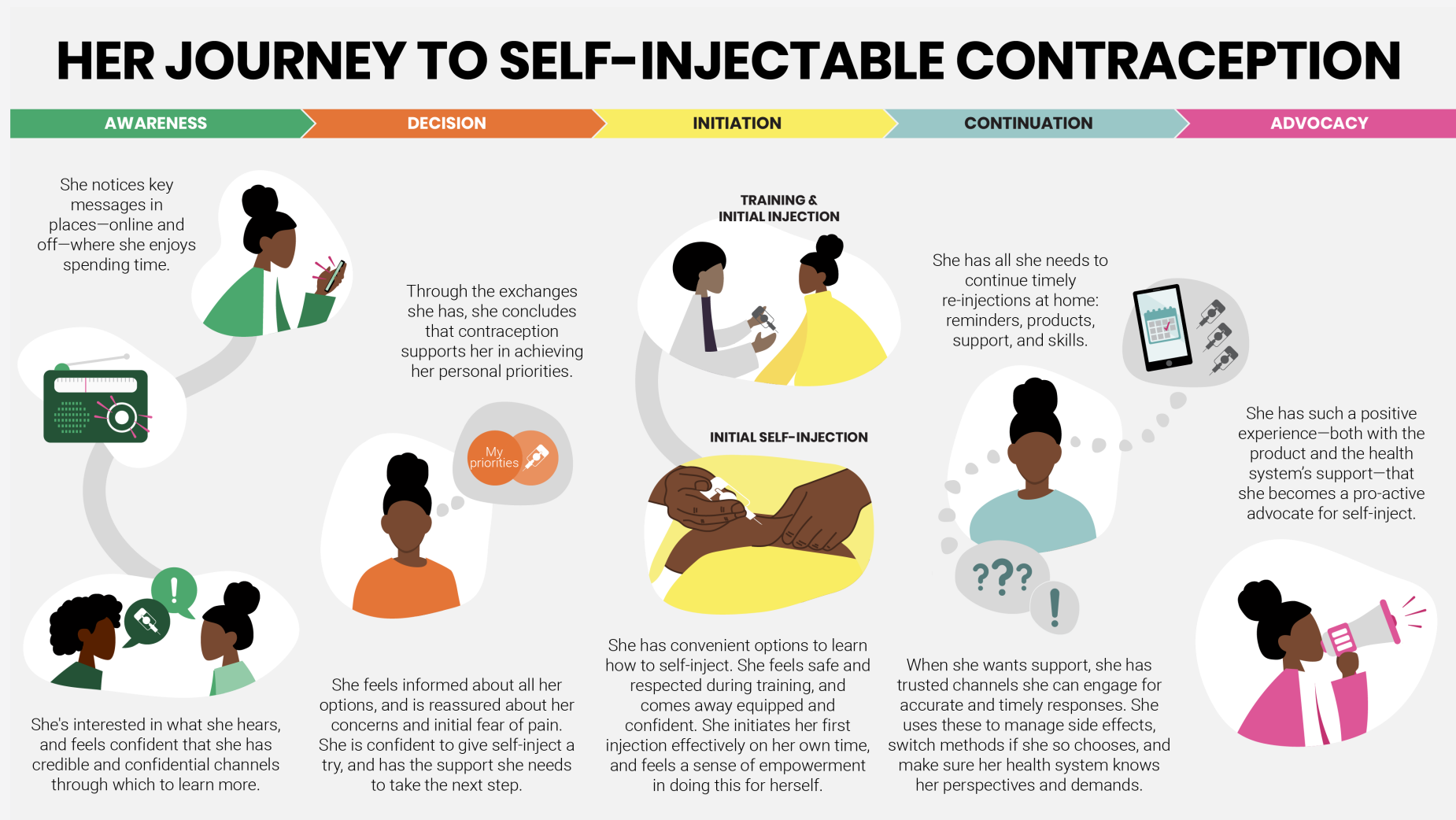
Training and initiation: the point at which the user is provided with training and supplies and receives an initial injection. She now has the capacity to self-inject or use DMPA-SC with the support of a partner.

Continuation: the point at which the user has everything she needs to self-inject at home, including knowledge, skills and confidence, supplies, reminders, and access to ongoing support through trusted and accessible channels.

Advocacy: the point at which the user's experience has been so positive, in terms of both the product and the health system's support, that she becomes an 'advocate' for SI. This may include 'advocacy' of SI to other women, and/or advocating for health system strengthening and policy change.



FIGURE 2. THE DISC IDEAL SI USER JOURNEY



KEY THEMES

DISC's analysis of evidence regarding the user journey, including our own findings, resulted in user-centered insights that reinforce seven intersecting key consumer-facing themes, and seven intersecting provider-facing themes.



1. POWER

Women's contraceptive choices—and the ways in which they inform themselves, make decisions, and act upon those decisions—are strongly linked to their perception of their power relative to others.¹ Power is a dominant and cross-cutting theme in DISC's SI findings, overlapping and informing the other themes.



2. TRUST AND CREDIBILITY

The ways in which women discern trustworthy and credible sources of information, and their preferences for the types and channels of support and information through which they access SI information, commodities, and support, are often linked to their perceptions of authority in healthcare.



3. PERCEIVED RELEVANCE OF SI AND CONTRACEPTION OVERALL

Women's perception of the relevance of SI varies. For UY who have not yet begun their child-bearing years, contraception in general may not be perceived as relevant without additional targeted outreach and support designed to resonate with their current priorities and self-identity.



4. CONVENIENCE

SI's value proposition as 'convenient,' does not always center on low-cost or availability close-to-home. Women whose priority is absolute confidentiality may deem a journey far from home to obtain a contraceptive as 'convenient.' Messaging about SI's value may thus be modified according to varied consumer profile priorities for 'convenience.'



5. COLLECTIVIZATION

Though women desire opportunities to consider SI with others who they deem credible and who are knowledgeable about SI use, these opportunities must be available in fora that recognize and uphold their varied needs for anonymity. Thus, efforts to support women's ability to normalize SI information seeking and use may benefit from varied channels through which women can collectivize around SI.



6. VOICE AND AGENCY

Women's sense of identity is strongly linked to their perception of agency and self-efficacy to speak out and to act to shape their lives and pursue their ambitions. A majority of respondents are not proactively inclined as advocates for SI becoming a part of standard care available to all women.



7. PHYSICAL SAFETY AND SOCIAL RISK

Risks or perceived risks are associated with adopting SI or being recognized as having adopted SI, including safety concerns such as danger of the needle as well as gender-based violence and social risks such as ostracization. Interventions to support women's demand for and initiation of SI are well-served to consider the needs of covert users in particular.

¹ See www.justassociates.org/en/power for further information on the definitions of power

Specific to service provider segments, DISC has identified and explored seven themes relevant to healthcare providers' perspectives on supporting women's SI use journey:

1

MOTIVATION

Intrinsic and external: Providers have both personal perspectives as well as business interests and regulatory requirements that inform how they engage with SI. Profit is a primary motive in the private sector, but is not all-encompassing.

2

BIAS

Many providers hold biases (intentional or not) which lead to withholding SI information and support from broad 'categories' of women whom they consider less suitable for SI, due to their perceived inability to use the product, and/or due to stereotyping and social norms. The types of women that providers cited as 'less suitable' include women with lower educational attainment or lower income, unmarried or young women, and women who are afraid or lack confidence.

3

PERCEIVED RESPONSIBILITY TO THE FULL USER JOURNEY

Clinic-based providers appeared more inclined toward supporting women's SI use from training and initiation through continuation, than drug shop owners, PPMVs, and pharmacy respondent groups.

4

GATEKEEPING

Findings confirm that providers who harbor misgivings about SI may raise barriers to women's access to SI information and support services. Gatekeeping may take the form of opting not to carry SI commodities at their outlet or seeking to influence method selection.

5

ACCOUNTABILITY

While public sector providers are part of a formal chain of accountability in the health system, private sector providers' perspectives on accountability to support SI vary.

6

CONFIDENCE AND CAPACITY

Providers, like clients, appear to need confidence-building related to SI. Providers demonstrate hesitancy to train women to self-inject, in part due to their own concerns over training them sufficiently to ensure women's own safety.

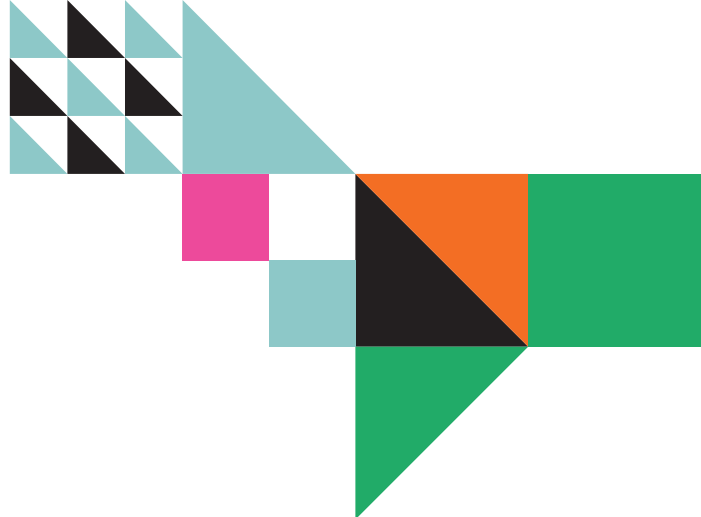
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DELIVERING CONVENIENCE

Providers may benefit from support to convey this value proposition and deliver on it through their interactions with women consumers.

USER JOURNEY

The following sections summarize DISC's insights across each of the five stages of the user journey: awareness, decision and intent, training and initiation, continuation, and advocacy. Direct quotes from interviewees are shared to illustrate some of the sources from which the findings were derived.



AWARENESS



POWER

There is a wide spectrum of needs and preferences, from mums reporting confidence and ease in shared decision-making with their partners, to women in both segments who require full anonymity across the entirety of their contraceptive journey.



TRUST AND CREDIBILITY

Healthcare workers remain the most consistently trusted source of information, when they demonstrate unbiased care.

SUMMARY HIGHLIGHTS

- **Knowledge of SI is currently low.** Most participants in the consumer research interviews were unaware of DMPA-SC prior to their first interview.
- **There is a clear appeal of SI for women.** Most women interviewed as part of the consumer research, be they youth or mums, rural or urban, found aspects of SI appealing.
- **Women want to learn about SI from women “like me.”** Across all segments and regions, we found a need to understand how women self-identify, to shape messages and materials that align with their identities and priorities.
- **The importance of confidentiality is complex, with varied ramifications throughout the user journey.** DISC's evidence confirms a wide spectrum of needs and preferences, from mums reporting confidence and ease in shared decision-making with their partners, to women in both segments who require full anonymity across the entirety of their contraceptive journey.
- **Healthcare workers (HCWs) are the most consistently trusted source of information when they demonstrate unbiased care.** HCWs can be supported to effectively reach and influence potential users through online formats.
- **The private sector has a role to play in both geographical contexts** even where regulations are not supportive. Service providers in Nigeria and Uganda see a clear role for themselves in helping to create demand through the provision of information and training.
- **There needs to be a focus on clear and informative messaging via multiple channels to enable women's autonomous decision-making as to whether and how best to move forward with SI.** Both digital and in-person pathways hold promise for increased accessibility and relevance of SRH services and products.

LEVELS OF AWARENESS

DISC found a critical gap in the understanding of women's perspectives and levels of knowledge of SI, as well as trends and preferences for accessing information, training, and support. Very few DISC research participants were aware of SI prior to their initial interview, and some who initially indicated knowledge later realized that they were thinking of the intramuscular depot medroxyprogesterone acetate (DMPA-IM) and had not heard of SI. This suggests the need for a customized approach to targeting specific population segments (including HCWs and other common sources of SRH information) to effectively raise awareness. Young women ages 18-24, particularly those without children, may differ in their motivations to use SI from older women of reproductive age, requiring messages and outreach strategies which make the case for why contraception is important, followed by how SI can support achieving their life goals.

HEALTHCARE WORKERS

Trust and direct positive relationships with individual providers are highly valued. HCWs are often named as the preferred channel for all stages of their contraceptive use journey, even where alternative sources, e.g., friends and family or published content, were identified. Not all women have existing strong relationships with specific providers, though, and many women travel far away to unknown providers for contraception, prioritizing anonymity over familiarity. It is therefore advisable to pursue multiple channels for promoting contraceptive self-care.

"I normally want to get the information from the main source because I know when I go to the hospital or the pharmacy and am inquiring, I know that person would give me enough information than what the friend would give me."

Mum, Uganda

WORD OF MOUTH AND COLLECTIVIZATION

Word of mouth is a prevalent source of contraceptive (not specific to SI) information, but covert users may avoid discussing with friends and family from fear of exposure. Peer training/referral may be more effective later in the user journey.

"Most people buy it and just keep at home, they forget to take when due and they come back to us complaining that they are already pregnant. So that's why there is need to follow-up on the clients. That's the only disadvantage I see there."

*Community-Based Distribution Agent/Midwife,
Urban Edo*

PROFIT AS MOTIVATION

The majority of service provider participants indicated interest in providing DMPA-SC to their clients, but some were concerned about low profitability (for private providers), loss of professional oversight of their clients, and women not having adequate capacity. They indicated a need for support with raising consumer awareness and creating demand to drive high volumes of sales. Some were concerned that selling DMPA-SC might reduce their sales of short-term methods (STMs) that provide a regular and frequent cash flow and are more profitable, as more women use STMs. Also, the nature of SI reduces income associated with providing an injection, tempting providers to counsel women to return to the provider for injections. Some providers indicate that they, or their peers, are making family planning (FP) recommendations to women based on profitability.

Creating demand and pricing strategies are important in determining whether DMPA-SC is profitable enough for providers to promote and keep in stock. Purchase price is very sensitive and linked to providers' reputations. High prices—particularly where supplies are available for free elsewhere—risk the provider being seen as

profiteering, while low prices risk perception that the product is counterfeit or of poor quality. User feedback supports these findings.

Another key consideration is consistency in the supply of DMPA-SC. For clients, the lack of consistency causes inconvenience and can result in discontinued use. For providers, it causes loss of sales and potential reputational risk.

Some providers were also motivated by non-financial incentives to promote SI, such as a certificate of participation after training, free samples from suppliers, laptops for data collection, and subsidized prices from manufacturers.

"I am motivated by presents by marketers that come and gives us free products."

Patent and Proprietary Medicine Vendor, Nigeria

"I have seen healthcare workers being judgmental, and it comes from the profit margin who look at how much they make from each family planning method and brand. Some women come with an open mind ignorant on what family planning method to use but the healthcare workers will choose for them what makes more profit for hence making a choice for the client."

Clinic-Based Service Provider, Uganda

FRIENDS, FAMILY, AND PARTNERS

Some women were comfortable seeking information from friends and family, while others feared stigma, disapproval, or potentially worse, from an unsupportive partner or parent who learned of their use of contraceptives. The level of trust in partners is nuanced, depending on whether the male partner is deemed safe. Mums respondent groups were more likely to discuss FP with male partners, but



every respondent group had women who might make their own private arrangements for their SRH, without disclosing this to a partner. Partners in some contexts were the sole decision maker on FP, suggesting that consultation about SI would not be feasible.

"I think that it's difficult because most of them [male partners] don't know about reproductive health so I can't trust them."

Mum, Uganda

"WOMEN LIKE ME"

Despite their general preference for anonymity and confidentiality, women trust and want to receive information about SI from women "like me." The value of someone who women can relate to resonates across both UYs and mums in both countries, but in Nigeria we found geographical variations. In Northern Nigeria, women wanted to hear about SI experiences from girls and women of their same age or older, and expressly distrusted celebrities and social media influencers. Conversely, in Southern Nigeria,

women—particularly UY—considered celebrities and social media influencers to be “like me.” Ugandan consumer research participants distrusted information from celebrity influencers and religious or community leaders, while design workshop participants in Uganda identified religious leaders and churches as a source of trusted information and a place of safety for women, and more frequently lacked trust in the product itself, fearing being sold a counterfeit product.

DIGITAL CHANNELS AS SOURCES OF INFORMATION FOR SELF-INJECTION

In addition to market-level barriers to women’s use of digital platforms, the reasons for women not widely using digital platforms to access information include lack of electricity and lack of sole control of a smartphone or computer, making some women wary of their searches being monitored by others in their household. Women also reported concerns over the trustworthiness of online sites and platforms (including how personal data may be used) and a lack of interaction and Q&A opportunities. Women need to be reached with information about SI through a variety of digital and non-digital channels.

“It’s good for those people who have phones and those who are always with their phones and they can read whatever they receive but those who do not have phones it’s not good at their side at all because it means they will not get the information.”

Urban Youth, Uganda

PRIVACY CONSIDERATIONS

Privacy across the entire journey is a key driver both when women are seeking information and making decisions about SI. Absolute privacy may be necessary for women considering or using contraception without the knowledge or consent of male partners, parents, and/or parents-in-law. This is particularly true when male partners do not approve of contraception in general or are actively hoping to conceive children. For some—including all participants in the UY design workshop in Uganda—maintaining confidentiality was the highest priority, with these women valuing privacy over the proximity of a supplier. For other women, fear of stigma or of being labelled as an FP/SI user influences how they access support and information.



DECISION AND INTENT



POWER

Women perceive themselves as decision makers, but do not trust others to uphold their decision-making power.



PERCEIVED RELEVANCE OF SI AND CONTRACEPTION OVERALL

Compelling, tailored messaging is often necessary to establish the importance of contraception in young women's lives.

SI has a compelling (but varied) value proposition to women; it is one they would be willing to pay for.



TRUST AND CREDIBILITY

A number of women indicated that it would be useful at the 'Decide' stage to have information and testimonials from women "like me" who are self-injecting.



PHYSICAL SAFETY AND SOCIAL RISK

Fear of needles and/or pain is a barrier for some women at both the decision and initiation stages.

Concerns because SI does not prevent HIV infection are potential barriers to SI uptake, especially among UY.

SUMMARY HIGHLIGHTS

- **To decide to use SI, women require multiple types of information—particularly those who wish to use SI covertly.** This includes standard contraceptive counselling information as well as logistical information such as where to acquire and how to store the product.
- **Women have many considerations to balance when selecting a contraceptive method,** including affordability, concern over counterfeit or poor-quality products, side effects, and fear of needles. The COVID-19 pandemic may be increasing interest in self-care generally, including SI.²
- **Women perceive themselves as decision makers, but do not trust others to uphold their decision-making power.** Women's own power within themselves to achieve and to decide is consistent across segments and DISC countries, but action is influenced by key influencers and social stigma.
- **Compelling, tailored messaging is often necessary to establish the importance of contraception in young women's lives.**
- **SI has a compelling, but varied, value proposition to women, one they would be willing to pay for.** Women's degree of power and/or sense of safety in their lives and in their households significantly influences the SI value proposition that resonates for them. Those who see SI as meeting their specific needs safely and effectively are willing to sacrifice to pay for the product.
- **Fear of needles and/or pain is a barrier for some women at both the decision and initiation stages.** Fear of pain, side effects, and incorrect injection during SI are also obstacles to decision-making. SI can be particularly intimidating compared to provider-administered injections, due to both the visual aspect (i.e., not being able to look away) and the greater sense of personal responsibility for outcomes.
- **Lack of protection from HIV infections.** The fact that SI does not prevent HIV infection is a potential barrier to SI uptake, especially among UY. Marketing messages should reinforce that DMPA-SC should be paired with an HIV prevention method for dual protection.
- **Service providers can play a role in influencing women's decisions.** HCWs influence women's decisions in relation to contraception. Biases and misunderstandings on the part of either providers or clients can preclude women from making fully informed decisions about contraception and SI.

² Given that the evidence included within the scope of the report was gathered in 2020, data on the impacts of COVID-19 on SI decision-making were not yet available. This report is 'capped' at 2020, however subsequent DISC reports may include data on the effects of the pandemic.

AFFORDABILITY

Despite some concerns that DMPC-SC should be provided free of charge through public health systems in both countries, most participants indicated that cost, provided it was not prohibitively expensive, would not be a barrier to deciding to use DMPA-SC if they saw it as high-quality and uniquely beneficial. Many respondents stated that they would find ways to save or borrow money, if needed, to purchase DMPA-SC. Some said that DMPC-SC should cost less than DMPA-IM and more than pills, or that the product should be priced according to its length of coverage.

"I think self-inject should cost less than [Depo] to enable everyone to use it, even those in villages."

Mum, Uganda

Private sector providers reported several pricing strategies for maximizing profit. These include pricing to maximize the volume of sales, offering discounts in exchange for referrals, and referring women to the public sector when they are unable to pay. A small number selectively allow for payment in installments, and rarely offer the product as a free sample. Government (or other actor) subsidies for the product are needed to catalyze uptake within the private sector, since prices might otherwise be prohibitively high.

PERCEPTIONS OF PRICING AND QUALITY

Perceptions of affordability are often linked with wider considerations such as convenience, perceived value for money, trust, and avoiding counterfeit products. Fear of counterfeit goods is an emerging theme in all geographical contexts. Many respondents need reassurance from a trusted authority on the product's safety, and indicated they would value packaging that featured an endorsement from a reputable agency such as the World Health Organization (WHO).

"In case it's cheap then it could be expired."

Mum, Uganda

UNDERSTANDING THE BROADER VALUE PROPOSITION

Value propositions go beyond cost alone. Continued inquiry is needed to understand women's motivations to try SI, particularly how they balance cost against perceived benefits offered by the product, and how purchasing decision-making varies. 'Convenience' is central to the value proposition of SI, but what exactly it means varies by individual and population segment, with 'convenient' broadly defined and some side effects considered inconvenient.

DMPA-SC is a small, discreet contraceptive product that lasts three months, has a considerable 'shelf life,' and can be purchased in drug shops, pharmacies, and PPMVs, and other public sector clinics, creating appeal for users desiring proximity to suppliers, ability to 'stock up' and store product at home, reduced travel (and travel costs), and the option of concealing their use. Some prospective users highlighted the product's efficacy, ease of use, return to fertility, and (inaccurately perceived) lack of side effects. Still others talked about the convenience of buying the product close to home after being trained, in contrast to long-acting methods. The assurance of privacy was the most important factor in 'convenience' for users who wished for their contraceptive use to be kept secret from others. For these women, the lack of visible signs of use were also considered convenient.

"There are things worth sacrificing for. Image is one of those."

Urban Youth, Uganda

A woman's past and current choice of contraceptive method(s) influence her perception of SI's convenience related to the duration of protection. If a woman's point of reference is using pills or condoms, the three-month duration of SI was perceived as convenient. Convenience was also mentioned with regard to saving time spent "taking the pills constantly." In contrast, managing side effects of hormonal birth control, especially as it related to periods, was mentioned as inconvenient.

PERCEPTION OF RELEVANCE FOR YOUNG WOMEN

Young women may not consider themselves to be sexually active when only having infrequent sex, when having transactional sex rather than sex within a relationship, or when sexual contact is initiated by a partner rather than herself. Thus, public health messages communicating the relevance of contraception based on a woman's sexual activity status do not resonate with many young women. Messages that appeal to young women's positive identity and goals for their future may have greater traction.

ROLE OF SERVICE PROVIDERS IN DECISION-MAKING

Service providers, especially HCWs, are consistently among the most trusted sources of SRH information, and are key influencers over many women's decision to initiate and sustain use of SI.

against hormonal methods, particularly for young women, which may have a negative impact on young women's perceptions of the relevance of DMPA-SC (and other hormonal methods) to them. One concerning finding was early adopters' numerous reported experiences of biased or disrespectful care.

Biases were acknowledged by providers themselves, with most providers preferring to recommend SI to married women who have completed their families, and some specifying that they would limit this to married women who can verify approval from their husbands to use SI. This may be related to the HCWs' own gender biases, and/or stem from concern over being held accountable by angry husbands.

INFORMATION TO SUPPORT DECISION-MAKING

Early adopters often had little information or support available and had little knowledge of or appetite for using media such as apps or the internet to support decision-making. This is possibly due to lack of awareness, concerns over security, and practical issues such as the cost of data and lack of access to computers/smartphones. Providers, particularly in Uganda, indicated that they either take shortcuts or refer clients to other service providers for FP/SI counselling.

"The particular aspect I like about the training is that if you teach a client to inject herself, it is like you are giving her the ownership of her own health."

Nurse Midwife (In-Charge), Urban Kano, Public Hospital

However, provider bias can result in selective counselling of some client profiles to try SI, but not others. In both Nigeria and Uganda, some providers are more likely to recommend SI to "elite" educated women who are perceived as being better able to understand SI instructions, remember injection dates, self-inject correctly, and monitor their body's response. Some providers show bias



Many women believed that every woman reacts differently to FP methods, but indicated they could still be influenced by a past SI user sharing positive experiences. Women influenced by their friends, partners, and current users, preferred to verify the information with a healthcare provider and online sources, some actively sought out the comments sections on social media posts, in addition to the posts themselves. One quarter of Ugandan UY participants distrusted social media.

"Taking women through all the FP methods is an activity I don't even give time [to] because it is time-consuming and needs a lot of time for someone to understand. I refer them to a nearby midwife in Mulago Hospital, Kampala who gives them the information and they pay for the services."

Pharmacy Owner, Uganda

POWER TO DECIDE REGARDING CONTRACEPTION

Women's experiences are linked to their degree of power. In these contexts, prospective and actual SI users may think of themselves as more powerful when they can overcome their safety concerns and avoid risks due to the discretion that SI affords them. Similarly, women's decisions about using, and

"[HCWs] just have to continue to tell us how to do it, giving us confidence through guidance, counselling and like they can be telling us like, the pain is not much."

Mum, Uganda

particularly storing and disposing of SI units, are shaped by their power and security in their homes. Discretion is less important for many in the mums respondent group. UY also overwhelmingly confirmed they would not want to keep SI commodities at home.

Women across all geographical contexts, and particularly among UY, who felt unlikely to adopt SI cited its lack of protection against sexually transmitted infections and the desire for a longer-term method.

Consideration of potential side effects is likely to take place early, prior to "Training and initiation," and plays a prominent role in women's decision-making about whether to initiate, continue, or advocate for others to use SI. Many women foresee side effects based on inherited knowledge and/or experience, including misconceptions or inaccuracies. Myths about the product may be transmitted by people who have never used it themselves.



TRAINING AND INITIATION



CONVENIENCE

There is a continued need for discretion and confidentiality during training and initiation.

Some women do not desire de-medicalization of their user journey.



COLLECTIVIZATION

Women who enjoy greater freedoms—particularly among mums—express interest in peer ‘training’ and other means of group-based learning about SI.



VOICE AND AGENCY

Information and support must be available at three months following training, when women may require additional focused support to self-administer DMPA-SC for the first time.

SUMMARY HIGHLIGHTS

- **Lack of availability of SI commodities and trained providers at outlets has the potential to pose barriers to training, initiation, and continuation.** Women have varied learning profiles, baseline knowledge, and degrees of confidence in self-administering SI for the first time. Accordingly, the appropriate level, number, and duration of learning sessions may vary.
- **Customized training is necessary.** Some learners prefer one-on-one, others prefer group learning. Prefabricated, didactic modules may be suitable for some, while others need individualized, practice-based content.
- **Service providers play a critical role in training women to be competent and confident for SI.** Providers support adopting new and digital methods to improve provider training, but remain hesitant to decrease face-to-face training. Some use heavily biased or prejudiced criteria to determine which women should be offered information and support to consider SI.
- **Information and support must be available at three months following training, when women may require additional focused support to inject DMPA-SC for the first time.** Given that currently most women’s first injection is provider-administered or provider-observed, training and support platforms should be designed to reach women at their first moment of *actual SI*.
- **Fear of needles and lack of confidence prior to first self-administration of SI are significant factors in women’s failure to decide to self-inject after being trained to do so.** The three-month delay between training and the initial self-inject, with a provider present, and the reality of SI alone exacerbates this.
- **There is a continued need for discretion and confidentiality during training and initiation.** Privacy is important to most women using, or considering using, DMPA-SC. For some, the consequences of others learning of their use of DMPA-SC are substantial, and training offers a risk of exposure.
- **Some women do not desire de-medicalization of their user journey.** Some women prefer interactions with HCWs as part of their contraceptive use, suggesting the importance of continuing to provide women the option of being injected by HCWs (or others) during the continuation stage.
- **The act of self-injecting may itself be a ‘spark’ for consumers’ sense of power, self-efficacy, and agency.** Early adopters reported feelings of ‘relief’ and enthusiasm after having initiated SI. This confidence may have value in subsequent stages of women’s user journeys.
- **Organizing women to advocate for self-care through fostering opportunities for collective knowledge or action may be possible among some subsegments.** Women who enjoy greater freedoms—particularly mums—express interest in forms of group-based learning about SI. Some UY desired this to be online and fully anonymous, with any personal interaction left up to the user.

WOMEN'S MOTIVATION FOR TRAINING IN SELF-INJECTION

As in prior stages of the user journey, convenience is a significant motivation for SI, but criteria for convenience differ. The value of self-administration was generally seen across all locations and cohorts, though some, such as the early adopter moms in Southern Nigeria, self-identified as needing support from their providers. Some women do not want to de-medicalize their user journey, preferring to continue interactions with HCWs as part of their contraceptive use. Several moms independently mentioned that they would like to have their husbands trained to execute or support SI at home.

CLIENT TRAINING MODELS AND BEST PRACTICES (TRAINING WOMEN FOR SELF-INJECTION)

Effective and comprehensive training—generally considered in terms of women's continuation with SI and their levels of confidence with it—is important to ensure competence and understanding of side effects. One training model may not be effective for all contexts and demographic groups to become confident and competent. Access to a variety of training formats and locations allows women to choose a training that best meets their needs and is effective among provider segments.

"The training has made me confident because I understood the explanation and we were trained on how to self-inject. And I can explain to others too. I have enlightened others too and I have not heard any complain from them."

Mum, Early Adopter, Northern Nigeria

CONTINUED NEED FOR DISCRETION AND CONFIDENTIALITY

Women's desire for confidentiality both outside the home, and, for some, within the home, remains relevant for training and initiation. Many participants associated privacy with private providers and the involvement of a HCW. Concerns over privacy and confidentiality can outweigh correct procedures, such as women not following correct disposal practices (e.g., disposing of used units in pit latrines) for fear of the used unit being seen. Privacy issues are also important when accepting training aids such as calendars.



"They [women] get concerned about their husbands finding out they are using self-injections ... What we do must remain a secret and it means that those women have trusted us."

Trained Village Health Team Member, Uganda

PERCEPTIONS OF SELF-INJECTION AND INCREASED AGENCY

Five of the early adopters felt happy or excited when they self-injected, suggesting that SI may be linked to a feeling of achievement. This may indirectly influence other women's user journeys, within the context of peer-to-peer engagement and collectivization. It may also have a ripple effect at the 'Advocacy' stage, to advocate to health system decision makers to make self-care a part of standard SRH services.

TRAINING FOR SERVICE PROVIDERS

There is a clear link between the efficacy of training and a woman's confidence in her readiness to self-inject. Supply constraints do not apply to only the product itself, but to the limited pool of healthcare service providers who are sufficiently skilled and knowledgeable to train consumers to self-inject. Training of providers to initiate provision, counselling, and training for SI is resource intensive, and access to protocols may be limited within the private sector.

"The challenge is lack of funds. They [the training sessions] are kept short I think because of poor funding, they are rushed. So you remember little from the training, but when you are given handouts you keep checking by yourself."

Community-Based Village Health Team, Urban Uganda

NATIONAL POLICIES ON TRAINING

National regulations provide a framework for consumer training. For example, in Nigeria, consumers who learn of self-inject and wish to adopt must do so through a two-point contact with a trained health care provider: both counselling, initial injection, and then subsequent injection must be administered by a provider before consumers are permitted to self-administer without the presence of a provider. However, as there is no current system to track the consumers' required two visits with a provider, it is unclear how well this requirement is enforced and/or adhered to.



CONTINUATION

**PERCEIVED RELEVANCE OF SI AND CONTRACEPTION OVERALL**

Evidence suggests that those who SI may have lower discontinuation rates than users of provider-assisted DMPA-SC.

**VOICE AND AGENCY**

Some women continue DMPA-SC but do not transition from provider-initiated injection to actual SI.

**PHYSICAL SAFETY AND SOCIAL RISK**

Safe storage and disposal are considerations in women's experience at the "Continuation" stage.

SUMMARY HIGHLIGHTS

- **Evidence suggests that those who self-inject may have lower discontinuation rates than users of provider-assisted DMPA-SC**, but discontinuation remains a concern. Few service providers see their role as continuing beyond counselling, training, and supply of DMPA-SC, suggesting a need for focused support to bolster their motivation and ability to support clients, particularly young clients.
- **Some women continue on DMPA-SC but do not transition from provider-initiated injection to actual SI.** This is likely related to women's trust and confidence in providers, a lack of proactive support to transition them to full self-administered injection, and the fact that the facility is a confidential place outside of the home.
- **Lack of supportive key influencers, stigma, supply chain issues such as stock outs, and dislike of side effects can result in discontinuation.** Users value support to continue use, and many women continue to require full confidentiality (visible, auditory, or otherwise). Tracking and follow up needs to go beyond the first three months and via formats (physical or digital) that women prefer.
- **Safe storage and disposal are considerations in women's experience at the 'Continuation' stage.** Some women can manage this need, but others require a place outside of their home or community where they can safely store and dispose. These users may purchase only one unit at a time and inject at the place of purchase (whether self- or provider- administered).

Women are generally satisfied with the concept of SI, the convenience aspects of SI, and the training they receive to self-inject, but discontinuation factors such as a wish to get pregnant, problems with resupply (due to stock outs), side effects, and being 'caught' by unsupportive partners remain. Young women have higher risk of contraceptive discontinuation while still in need than do older

women. Few service providers see their role as continuing beyond counselling, training, and supply of DMPA-SC. Focused support to key cadres is thus required to bolster their motivation and ability to support clients through this portion of the user journey. This may take the form of training and engaging experienced SI users as 'expert clients' who can help fill gaps in support to new users.

COMPETENCE AND CONFIDENCE

Fear of pain and needles, lack of confidence and competence, underpinned by a lack of support are common reasons for not self-injecting, a desire that may override the benefits of reduced travel and inconvenience. Fear of not doing SI right—and therefore not being protected from pregnancy—and worries about risk of exposure when injecting at home are also concerns.

Early adopters and service providers both indicate that face-to-face time is necessary to monitor clients' health and injection technique, and in case something goes wrong. There is a tension between service providers reporting that they are short of time and FP/SI counselling taking too much of their time, and the desire among some to be present during or to provide the injection. Training may be improved by more supervised self-injects, more information, a video, more opportunity to practice on dummies, and more reassurance from the providers or other women.

SIDE EFFECTS

While a perception of reduced side effects is a key motivation for many women to adopt and continue with SI, side effects are also a leading reason for discontinuation. Understanding side effects is critical throughout the user journey, but clear information about side effects, and support and reassurance to manage them, are particularly important in the first three months after initiation. Several respondents indicated that they would be willing to tolerate side effects if they were short-lived and if they had a prior understanding. UYs said that enduring side effects for three months would be too long, especially when contrasted with STM side effects, which can be halted almost immediately. Reduced monthly bleeding or loss of periods was highlighted several times as an undesirable side effect, with women preferring monthly confirmation that they are not pregnant, as well as fearing that these changes may be noted by key influencers in their lives.

SUPPORT MECHANISMS FOR CONTINUATION

Support provided to current self-injectors is not standardized, and often dependent upon the individual provider, some of whom do not see support for continuation as being in their scope of work. Respondents desired ongoing support at the appropriate three-month intervals, including reminders for timely reinjections, reinforcement of key information, response to queries, and reassurance regarding side effects, as well as support to switch methods rather than discontinue, if needed. Some women, however, would refuse reminders for fear of the messages being seen by others, and require channels that can be used discretely.

MOTIVATION TO CONTINUE

Early adopters were mainly motivated to continue to use SI by its convenience, especially how conducive the product is to discretion. Women often still do not have agency to openly use DMPA-SC or to discuss with their partners. Partners' disapproval or destruction of supplies can lead to women discontinuing.

STORAGE AND DISPOSAL

Safe and effective storage and disposal are significant factors in a woman's decisions about using SI. Benefits of SI include the ability to store multiple units at home, supporting more effective use of time, fewer travel costs and less interaction with providers or risk of being observed by others. However, covert users do not want SI units in their homes for fear of being found, and retaining the units to return to the provider is unrealistic, due to risk of detection. The lengths women described going to keep their secret suggest that the consequences of women being 'found out' while disposing units are significant.

"In case I'm using a dustbin to dispose, my partner, friend, or parents see that thing, then will say 'Who is using that product? Why are you using the product?'"

Urban Youth, Uganda

AVAILABILITY

Stockouts are a barrier which have the potential to undermine any convenience gains for users and influence the motivation of the service providers to promote DMPA-SC. Some women reported having to visit multiple sites to access supplies, delaying until stock was available, or switching methods. Some subsegments of UY (e.g., university students) prefer outlets close to their university, but there are women across youth and mums who intentionally seek out service outlets far from home and associate outlets at a distance from home as more confidential and trustworthy.

Users needing privacy may also purchase from a generic location, such as a pharmacist, which may be expensive, but is associated with other valid reasons for being there (e.g., pretending they were buying a different product) in the event that someone sees them. Early adopters show some appetite for an expanded range of channels, although many were unaware of what alternative channels are available.

"There are some people who speak out the information like, 'someone's wife comes here and gets medication, someone's wife comes and gets injected from here.' So this makes one want to go to a distant hospital where she is not known or you buy from a distant drug shop not from the one near your home."

Mum, Uganda

OTHER BARRIERS TO CONTINUATION

The number of reported barriers among current self-injectors is low. Not being free of charge (as per government FP policy) was referred to quite frequently but was not identified as a barrier. Other potential barriers include loss of sexual appetite, HCW discrimination against young people, and family disapproval (which underpins the need to not be discovered as using a method of FP).

DISCONTINUATION

Measuring continuation remains a significant challenge, limiting ability to manage performance in supporting women's improved continuation outcomes. Some providers did report sending text message reminders about appointments, though only one PPMV included a provision of continuous support as part of their role. Interestingly, service providers appear to stay in touch with STM users (e.g., monthly reminders) more than with long-acting and reversible method users.

"My role is to encourage them, like those that are afraid of the side effect and the rest and are afraid of taking an option. My role is to guide them, encourage them and let them to see the different method and the one that will be suitable them."

Community Extension Healthcare Worker/Pharmacist, Urban Edo, Private Clinic

Some providers continue to inject women and therefore are providing some ongoing care outside of self-care parameters. Some service providers in Nigeria even reported travelling to the client's home to inject them, which was striking, given that the reported cost to travel to clients' homes is identified as a challenge elsewhere.

"In our society, most of the men don't allow their women to go out, it's an advantage because if she were to be planning to come back for more, the husband may not allow her but, she can self-inject herself at the comfort of her home without the husband necessarily knowing."

Community Extension Healthcare Worker, Rural Kano/Urban Kano, Private Hospital in Urban Area/Public Hospital in Rural Area

Low reported levels of post-initiation support provided to clients may result from a lack of clarity around expectations, and a general lack of guidance. Providers reported high levels of interest in using technologies to reach clients, which may indicate a higher than reported role in providing ongoing care. However, issues such as connectivity and cost (of data and travelling to clients' homes) are a challenge for the majority.

"In our society, most of the men don't allow their women to go out, it's an advantage because if she were to be planning to come back for more, the husband may not allow her but, she can self-inject herself at the comfort of her home without the husband necessarily knowing."

*Community Extension Healthcare Worker, Rural Kano/
Urban Kano, Private Hospital in Urban Area/Public
Hospital in Rural Area*

Over 50% of the community-based distribution agents, pharmacists, PMMVs, and PPVs indicated a concern about women injecting incorrectly, particularly forgetting the date (despite the majority

stating that they are sending reminders), sharing with other women, complications and side effects, storage and disposal concerns, and women's health not being monitored. This may indicate providers do not fully understand the concept of self-care and fear being held accountable if women do not SI correctly, or lack of confidence in the training they are providing. Only a very small number of providers reported knowledge of something (minor) going wrong, though this low level of incidents may be due to the providers continuing to inject rather than supporting or allowing women to self-inject SI.

Service providers in Uganda showed a high level of awareness of the need to counsel women and to provide support with side effects at the 'Decision' stage, but there was less discussion about providing support throughout the user's journey. Some refer women to clinics for further support with side effects. Stated interest in improved customer services skills and increasing convenience for clients appears to be motivated by profit and accessing/retaining clients eligible for services elsewhere.

"My responsibility is counselling on the method of family planning she has to use. Second, elaborating on the side effects of the family planning method she is going to use. Third, using the correct method and giving her the service cheaply."

Drug Store Worker, Uganda

Across all geographical contexts service providers were concerned about accountability and liability, which may have an impact on their behaviors and decisions. In Uganda it is illegal for drug store owners to inject; some are injecting their clients and willing to risk National Drugs Authority penalties to do so, noting their lack of confidence in women self-injecting. Nigerian service providers expressed less concern around liability, though for some the approval of a husband is a pre-requisite for providing contraception.



ADVOCACY



COLLECTIVIZATION

Women self-identify as potential advocates and educators, especially in the context of supporting younger, poorer, and/or rural women.



VOICE AND AGENCY

Women's existing voice and agency to demand accountability from health system actors to support SRH self-care, cannot be assumed.

The sensitive nature of using DMPA-SC and/or SI and the need for absolute privacy for some youth and women may preclude them from using their voices to advocate for self-care publicly.

SUMMARY HIGHLIGHTS

- **The governments of Uganda and Nigeria have demonstrated their commitment to regulating self-care**, as evidenced by their recent efforts to enshrine WHO self-care guidelines as national policy, but public sector policy does not automatically translate into private sector accountability. Further inquiry is needed to understand how to ensure that all key health system actors are willing to be held accountable for provision of self-care products as a core element of SRH services.
- **Women's existing voice and agency to demand accountability from health system actors to support SRH self-care cannot be assumed.** With the exception of university-based UY in Uganda, respondents do not tend to expect accountability of their providers or policymakers. Women client advocates can play a vital role in improving quality of care through their demands and actions.
- **Effective movement building and systems change is possible.** Though difficult, movement building that includes women's ability and agency to act on their own SRH needs and preferences is possible.
- **Women self-identify as potential advocates and educators**, especially in the context of supporting younger, poorer, and/or rural women, in both Nigeria and Uganda.
- **Women's degree of willingness to recommend SI to others is complex.** The two main enabling factors are whether she had a positive experience with SI herself, and whether she felt the potential user matched the 'profile' of an SI user.
- **FP2020 data and commitments from both Uganda and Nigeria to nationalize WHO self-care guidelines demonstrate governments' commitment** to task-shifting and fostering a self-care movement, increasing access to SI. Nigeria's Strategic Plan for DMPA-SC Introduction and Scale-Up aspires to fully scale DMPA-SC by 2021, but the full extent of this commitment is still unclear, with few women having the agency required to hold health sector actors and policy makers accountable.

The sensitive nature of using DMPA-SC and/or SI and the need for absolute privacy for some youth and women may preclude them from using their voices to advocate for self-care publicly. Supporting women and youth to advocate for their SRH and rights, and work to hold health system actors and leadership accountable to support them, may help to remove these barriers. Without building enabling environments, discontinuation, hampered voice and agency, and social risk to girls and women remains a factor in their experience.

While some current SI users indicated that they are already actively referring other women, most women would not discuss SI with other women for fear of information getting back to their partners, fear of stigma, and not wanting others to know about their contraception. Some indicated that they may be open to conversations about the product, rather than their personal behaviors. Some respondents do not recommend SI to minors, or to women whose religions forbid FP. Unsurprisingly, there was a strong relationship between side effects and recommending SI to others.

"There are some religions that do not actually support family planning. So when I am telling people in society, I need to consider the aspect of religion."

Mum, Uganda

When discussing what it would take to advocate to support other women's use of SI, UYs in Uganda displayed an intrinsic motivation to come together with other UYs to provide support. Examples of support include:

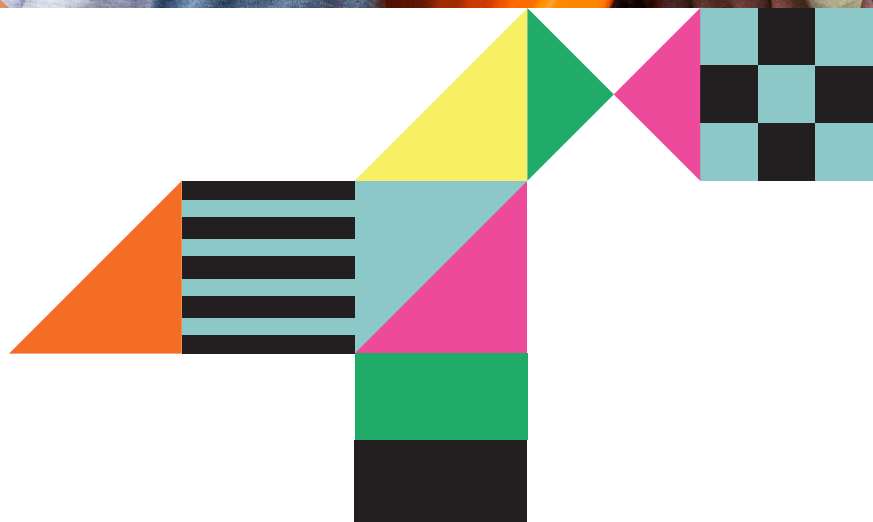
- Teaching others how to administer SI, based on personal experience
- Supporting collective purchasing to reduce costs and to ensure privacy for those who prefer not to visit a provider
- Calling new users for feedback and information on how the SI process works
- Asking new users about their fears so that they can offer solutions where possible
- Physical accompaniment of other UYs to meet with providers or for training

"Makes it easier to (tell another woman to) purchase especially if they go with another woman. If I know about the side effects, then I can tell another woman about how to manage them."







Urban Youth, Uganda

CONCLUSION AND NEXT STEPS

With DISC's evidence-based research and design phase concluded, our hope is that this summary report demonstrates the importance of considering each stage of the user journey in design, such that other actors in the self-care and evidence-based design space can use it to inform work in future contexts. DISC aims to be a proactive thought partner to a considerable global community of actors working to foster change and speed health impact for women through innovations in self-care, and will continue to pursue transparency and proactive knowledge sharing throughout its project lifecycle.



A comprehensive, long-form version of the Insight Synthesis Report is available upon request. Please email disc.info@psi.org.

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