DISC 2.0: INTEGRATING SELF-INJECT CONTRACEPTION **INTO AN EXPANDED METHOD MIX**

- Why self-injectable (SI) contraceptive?
- What is DISC (Delivering Innovation in Self-Care)?
- DISC's impact in numbers.
- Deep dive into DISC's interventions:
  - » Demand generation
  - » Empathy-based provider training
  - » Strengthening health system foundations
- Partnerships
- Collaborate with us!

DISC

Delivering innovation in self-care

WHY SELF-INJECTABLE (SI) CONTRACEPTIVE?

"WHO recommends self-care interventions for every country and economic setting as critical components on the path to reaching universal health coverage (UHC), promoting health, keeping the world safe and serving the vulnerable."

Subcutaneous depot medroxyprogesterone acetate (DMPA-SC) self-inject is an example of contraceptive self-care. Based on the 2022 WHO Guideline on self-care interventions for health and well-being, Ministries of Health are advised to invest in self-care as a health system strengthening strategy. A type of task-shifting, self-care can substantially increase the efficiency of strained healthcare systems while simultaneously placing greater control and agency in clients' hands.

Other key benefits of DMPA-SC self-inject include:

- Self-inject is a highly effective and convenient 3-month contraceptive option, enabling women to self-inject themselves at home and save visits to health providers.
- Self-injection has the potential to relieve over-burdened health facilities as more women can safely administer themselves.
- Injectables are already the most popular category of contraceptives in much of the world (notably, sub-Saharan Africa). Thus, SI expands method choice and empowers users with self-care options within a preferred product category.
- Evidence demonstrates a lower discontinuation rate amongst SI users, supporting FP2030 and mCPR goals[1,2,3].

Yet despite the many unique advantages that SI offers, this innovation also requires significant behavior change by users and providers. Women face a multitude of barriers along their use journey. These include a limited flow of accurate information, fear and lack of agency over the ability to inject themselves, and lack of support from providers and communities[4,5,6,7].

[1] Burke HM, Chen M, Buluzi M, Fuchs R, Wevill S, Venkatasubramanian L, Dal Santo L, Ngwira B. Effect of self-administration versus provider-administered injection of subcutaneous depot medroxyprogesterone acetate on continuation rates in Malawi: a randomised controlled trial. Lancet Glob Health. 2018 May;6(5):e568-e578. doi: 10.1016/S2214-109X(18)30061-5. Epub 2018 Mar 8. PMID: 29526707.

[2] Cover J, Ba M, Drake JK, NDiaye MD. Continuation of self-injected versus provider-administered contraception in Senegal: a nonrandomized, prospective cohort study. Contraception. 2019 Feb;99(2):137-141. doi: 10.1016/j.contraception.2018.11.001. Epub 2018 Nov 12. PMID: 30439358; PMCID: PMC6367564.

[3] Cover J., Lim J., Namagembe A., Tumusiime J., Drake J.K., Cox C.M. Acceptability of contraceptive self-injection with DMPA-SC among adolescents in Gulu District, Uganda. Int Perspect Sex Reprod Health. 2017;43(4):153–162. doi: 10.1363/43e5117

[4] PSI DISC Insight Synthesis Report (2022). Available at https://www.psi.org/project/disc/insights-synthesis-report/

[5] Bertrand JT, Bidashimwa D, Makani PB, Hernandez JH, Akilimali P, Binanga A. An observational study to test the acceptability and feasibility of using medical and nursing students to instruct clients in DMPA-SC self-injection at the community level in Kinshasa. Contraception. 2018;98(5):411–7. Epub 2018/08/16. doi: 10.1016/j.contraception.2018.08.002

[6] Burke HM, Chen M, Buluzi M, Fuchs R, Wevill S, Venkatasubramanian L, et al. Women's satisfaction, use, storage and disposal of subcutaneous depot medroxyprogesterone acetate (DMPA-SC) during a randomized trial. Contraception. 2018;98(5):418–22. doi: 10.1016/j.contraception.2018.04.018

[7] PATH. DMPA-SC self-injection supports women to use injectable contraception longer. FPOptions: 2018

	AWARENESS	DECISION	INITIATION	CONTINUATION
IDEAL BEHAVIOR	Learn about self-inject from a relevant channel, peer or provider.	Use her power to choose if she wishes to try the method.	Access high quality training on self-injection at a local facility. Successfully inject herself during training and access 3 take home units.	Re-inject at home every 3 month for as long as she wishes to use the method.
BARRIERS	• Limited awareness of Self- injection as a contraceptive option provider acts as the gatekeeper (with biases about who is 'eligible' to self-inject). • Self-injection not a norm in communities.	• Lack of self-agency to inject oneself correctly - seen as something only providers can do. • Fear of pain. • Myths and misconceptions about side effects of contraceptives.	• Fear of injecting oneself incorrectly and some concern about the pain. • Lack of provider empathy to overcome client fears. Product not available at facility.	• Lack of support for re- injection at home. Limited availability of take-home doses.
MOTIVATORS	• Value proposition of convenience of 3-months protection. User-facing communications educating about the product. • Providers without bias offering SI as part of the method mix.	• Community engagement normalizing self-injection. Experienced users/peers sharing their experiences. • Providers without bias offering SI as part of the method mix.	• Empathetic providers successfully coaching women to inject themselves. Consistent supply of product at facilities providers adhering to take home unit policy.	• Experienced users and CHWs demonstrating product usage and support women during reinjection at home.

For contraceptive self-care options, the role of the provider shifts from being the sole deliverer of the product or service to playing a more supportive, secondary role. This leads to concerns over losing stature or business, biases around who is 'capable' of self-care and inadequate training.

In the past, there has been limited investment in addressing these behavioral barriers. However, evidence from the DISC project in Uganda, Nigeria and Malawi demonstrates significant increases in acceptance and adoption of self-injectable contraception when these barriers are reduced.

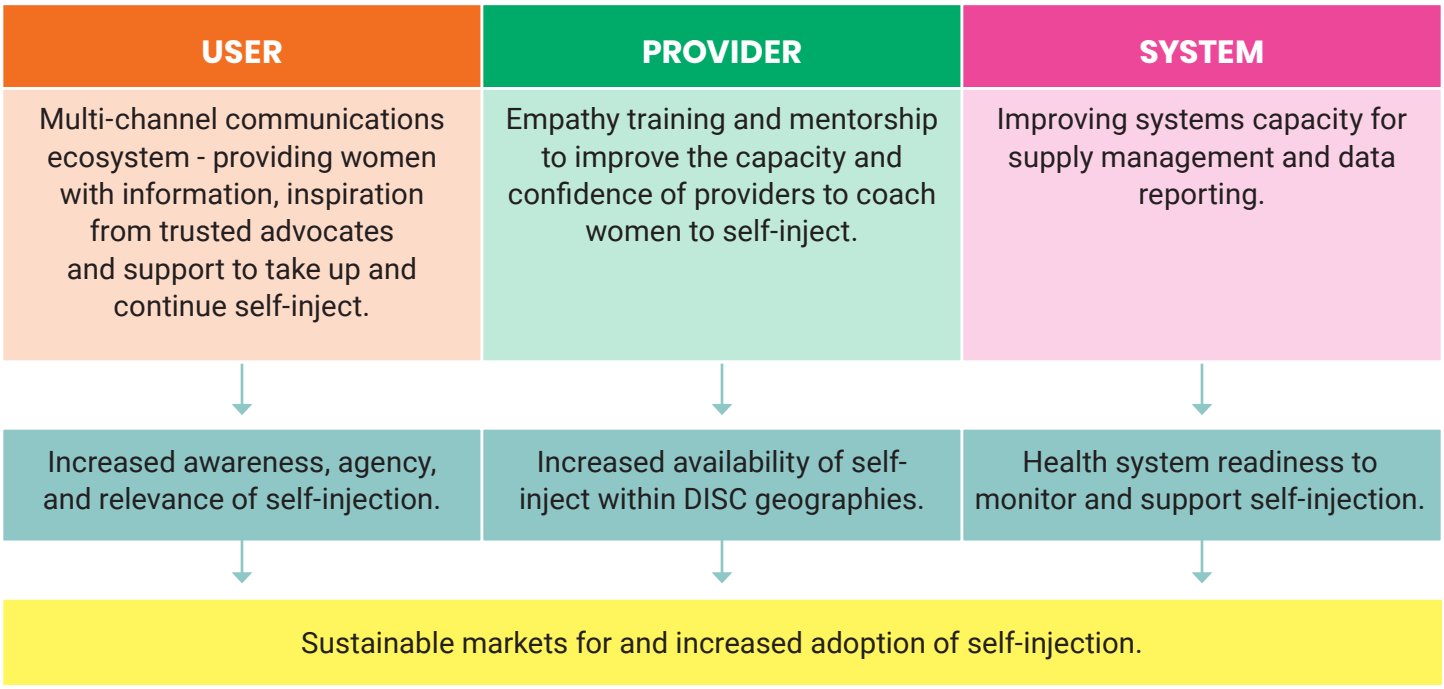
WHAT IS DISC?

Delivering Innovation in Self-Care (DISC) is a contraceptive self-care project funded by the Children's Investment Fund Foundation (CIFF) and Gates Foundation (GF). DISC supports women to control their own sexual and reproductive health by using DMPA-SC self-injectable contraception—which can help her to achieve her life goals by delaying or preventing pregnancy if she so chooses. In partnership with Ministries of Health, healthcare provider networks, and other key stakeholders, the DISC team is integrating self-injection into health systems and bringing care closer to consumers. Active since 2020 in Nigeria and Uganda, DISC expanded into Malawi in late 2022. DISC received follow-on grant funding from both donors in 2024, enabling further scaleup of self-injection in existing and new countries.

Our vision is to develop sustainable markets for self-injectable (SI) contraception by ensuring that all women who choose this method have frictionless access and support.

We accomplish this through a set of interdependent demand generation, workforce development and health systems strengthening interventions. DISC operates across multiple levels of the health system, with different sets of activities targeting potential users, providers and health system functions.

DISC INTERVENTION OVERVIEW



WHERE DO WE WORK, AND WHO ARE OUR PARTNERS?

DISC has a focus on scale and health system integration. To achieve this, DISC has developed an efficient partnership model. Within a country, we identify partners that already have a large footprint within the priority geographies – usually through existing family planning programs funded by other donors. DISC layers or 'bolts on' the SI interventions onto their infrastructure (within facilities, at community level and within the sub-national health system). This is a lower-cost way to maximize impact, while building the capacity of a range of players to implement SI interventions effectively.

As of June 2024, CIFF announced the DISC 2.0 expansion, which extends our implementation period through mid-2027 and expands our reach across more sub-geographies in existing DISC countries, plus the addition of Zambia as the newest CIFF-funded DISC country. Additionally, the Gates Foundation awarded a separate but parallel award to further scale up SI in a combination of existing and new DISC countries, including Pakistan, Mozambique, and the Democratic Republic of Congo (DRC), through mid-2027. Our current and planned DISC 2.0 geographies and partners are as follows:

- In **Malawi**, we will continue our broad geographic focus, with operations in 24 out of the country's 28 districts, in close partnership with Family Health Services (FHS), Amref Health Africa, and the Family Planning Association of Malawi (FPAM). With Gates funding, we will design and test scalable interventions to support women with SI continuation, via a design sprint and a multi-arm, parallel-group cluster randomized controlled trial (RCT).
- In **Nigeria**, we have plans to work in 15 out of the 36 states. With co-funding from both CIFF and Gates, we are working in collaboration with, SFH-Nigeria, MSI Reproductive Choices, and Jhpiego.
- In **Uganda** under DISC 2.0, we are operating in 46 districts, more than doubling the 21 districts that DISC 1.0 supported. This expansion is made possible through PSI Uganda's partnership with the USAID Uganda Health Activity (UHA) project implemented by FHI-360.
- In **Zambia**, we are working in 6 of the 10 provinces in close partnership with Jhpiego, who are implementing the USAID Family Health & Nutrition and Momentum MCGL projects.

- In **Mozambique**, DISC is working in three high-population provinces (Nampula, Sofala, and Zambezia), in close partnership with Pathfinder International, who are implementing the USAID Improved Family Planning Initiative (IFPI). Complementary funding from UNFPA will further enable DISC to rollout SI across both public and private sectors.
- In **Pakistan**, the Gates Foundation is funding DISC to work in 13 priority districts within Sindh province in partnership with Pathfinder International and HANDS, given that Sindh recently approved their SI scale-up plan. DISC will 'bolt on' intervention to the USAID Building Healthy Families Activity (BHFA) implemented by Pathfinder, as well as the HANDS/BMGF project which is scaling FP via Marvi workers.
- In the **Democratic Republic of Congo (DRC)**, DISC anticipates commencing implementation in mid-2025 with co-funding from CIFF and Gates. Partnerships and provinces will be determined in the coming months.

Across all countries, we collaborate closely with Ministries of Health, local and national governments, various health worker cadres, and a wide range of other FP implementing partners.

DISC'S IMPACT TO DATE

HOW IS DISC INCREASING ACCESS AND SUPPORTING ADOPTION OF SELF-INJECTION?

1,454,200

Self-inject visits delivered through DISC partners since 2021.

SI represents

57%

of DMPA-SC across DISC facilities – demonstrating the proportion of women who are able to access the full benefits of Self-inject.

2,108

facilities supported with the empathy-based training intervention package since 2021.

HOW IS DISC FACILITATING SUSTAINABLE NATIONAL MARKET GROWTH FOR SELF-INJECTION?

Although reliable baseline data on SI vs provider-administered DMPA-SC were unavailable in Uganda, all indications show that across the three DISC 1.0 countries, both SI use and reporting of SI have majorly increased since the project's provider- and user-facing behavior change and system strengthening interventions were rolled out. DISC also measures the proportion of DMPA-SC and all injectables that is self-injected, which have also shown substantial increases.

IMPACT NUMBERS

		SI VISITS ANNUAL	SI % OF DMPA-SC	SI % OF INJECTABLES	% OF FACILITIES REPORTING INJECTABLES ALSO ACTIVE IN SI
UGANDA	**2021*** BASELINE	ND*	ND*	ND*	ND*
	Q1 2025 CURRENT	274,392	23%	15%	31%
MALAWI	**2021*** BASELINE	167,327	21%	7%	45%
	Q1 2025 CURRENT	422,657	33%	16%	82%
NIGERIA	**2021*** BASELINE	74,624	14%	3%	7%
	Q1 2025 CURRENT	933,253	56%	29%	37%

ND* Not disaggreated 2024 numbers are based on National Market numbers in countries listed.

DEEP DIVE INTO DISC INTERVENTIONS

The project designed demand generation and empathy training activities to actively address the barriers for women and providers – and geared towards increasing women's voluntary adoption of self-injectable contraception. These are supported by foundational investments to strengthen the health system for data reporting and supply management of DMPA-SC.

DEMAND GENERATION

DISC's demand generation (DG) campaign reaches women directly with informative and supportive messaging and information under the banner of Discover Your Power, which speaks to the potential for DMPA-SC self-inject (and self-care more broadly) to place greater power, control, and agency directly into her hands.

In areas where self-injectable DMPA-SC is new, awareness and acceptance of self-injection starts very low. Dedicated communications for self-injection are required to move awareness closer to that of other contraceptive methods and towards a 'tipping point' where the innovation is sufficiently established in communities. DISC's communications focus on:

- Reaching women with information about SI – avoiding the provider being the sole gatekeeper.
- Proactively addressing concerns over the fear of needle and lack of self-efficacy.
- Creating relevance for SI (and contraceptives broadly).
- Tapping into peer advocacy for word of mouth.

Our marketing messages are oriented towards behavior change by including clear calls to action to learn more about SI and seek guidance from a health worker. Our demand generation workstream has contributed to a national-level increase in women's awareness of SI and a significant uptick in the proportion of DMPA-SC that is self-injected rather than provider-administered.

Taking inspiration from the Diffusion of Innovation Theory and early insights from the DISC program design phase, DISC's awareness-building campaign tackles the primary barriers to adoption of SI—namely, lack of awareness / information about SI; fear of the act of self-injection, and a low sense self-efficacy to self-administer unfamiliar medical projects. The project's DG messaging encourages women to learn more about SI by visiting a nearby clinic, connecting with a provider, and/or attending a DISC event.

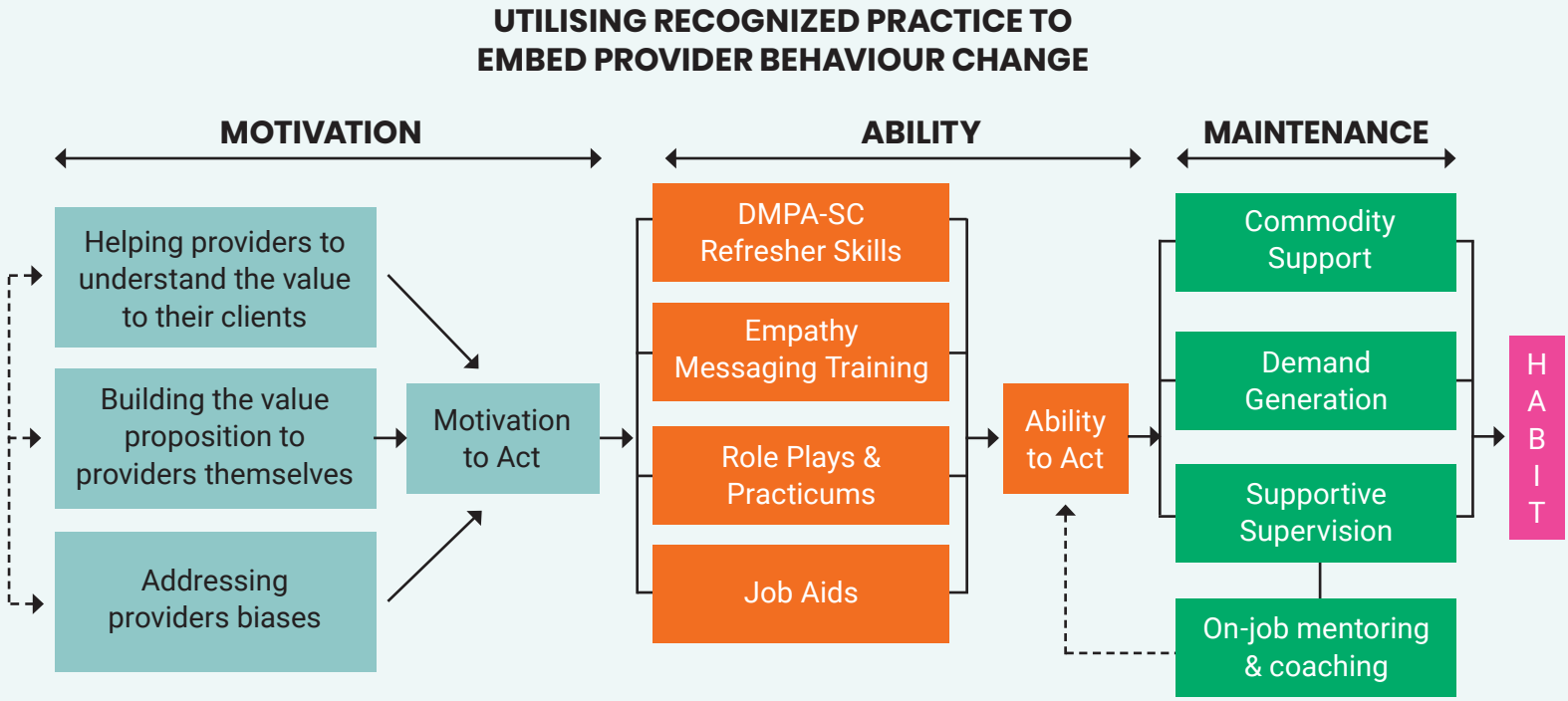
We facilitate communication and information-sharing with women using digital and phone-based tools such as interactive voice response (IVR), call-centers, SMS automated reminders, and country-specific digital platforms such as DiscoverYourPower websites.

Community mobilization and clinic activations are conducted in the 'catchment areas' of clinics where the flow of SI clients is low. After client flow reaches critical mass (on par with other common methods), then community activation resources are shifted to areas with lower client flow. To ensure sustainability, we collaborate with Ministries of Health, local governments, and health worker cadres like Community Health Workers (CHWs) to integrate ongoing Demand Generation into broader FP programming.

PROVIDER WORKFORCE DEVELOPING USING EMPATHY-BASED TRAINING

Early evidence from DISC and partners' insight research found that prior to DISC, a large proportion of women did not go on to use SI even after receiving training. We found that providers' own clinical training was not building the skills necessary to effectively support women to overcome their fear. Beyond that, provider biases around who was 'capable' of using SI were contributing to low SI adoption and continuation rates. DISC's analysis led to the finding that empathy was the main missing component in the previous provider training modules—which did not sufficiently address women's reasons for hesitating to use SI.

Using insights from providers and early adopters of SI, DISC developed an empathy-based training and follow-up supportive supervision (SSV) curriculum, which, following piloting and a study period, has been subsequently scaled up throughout the three DISC 1.0 countries and officially integrated into national providers' training curricula. Beyond empathy and skills-building to address the most common barriers, key elements of the curriculum include role plays, a practicum, and job aids to support providers as much as possible while they build their skills in teaching self-care. DISC further enables ongoing provider capacity-building via post-training supportive supervision (SSV), which is critical for reinforcing behavior change.



In Nigeria, the SI Empathy-Based Counseling (EBC) has been incorporated into the revised National DMPASC & SI Strategy Document (2024–2030). The EBC is recognized as key in increasing self-injection uptake, improving provider attitudes, reducing fears of needles/pain, and boosting provider confidence. The training model is being integrated into the national DMPASC & SI curriculum and planned for inclusion in pre-service training for PPMVs. Additionally, MoHs have incorporated EBC into their Annual Operational Plans and training programs.

In August 2023, Uganda's Ministry of Health integrated a module on empathetic counseling for DMPA-SC self-injection clients into the Comprehensive Family Planning Clinical Skills Training Manual. This manual, used for all future family planning training, aims to improve client-provider interactions by equipping healthcare workers with skills to offer supportive, empathetic care. The move reflects Uganda's commitment to enhancing the quality of family planning services, focusing on both technical expertise and building trust with clients.

In Malawi, the MOH have played a collaborative role in executing our plans to deliver SI empathy training across public, private and CHW cadres.

SUPPORT FOR CONTINUATION

As cited above, numerous studies have found that DMPA-SC SI users tend to have higher continuation rates compared to users of other injectables. Yet now that more and more women are adopting SI, finding innovative, effective, and scalable means of supporting women with continuation is vital for ensuring that clients receive high-quality FP services throughout their 'user journey' and not just at the initial adoption stage. Improving client's experience with various aspects of service – ranging from the number of take- home units she receives, consistent access to refills, availability of 'refresher' support after first-time training, and establishing channels for ongoing learning and engagement (such as chatbots)—can all make a big difference in how well supported and enabled a client feels, in order to comfortably and confidently go on using SI outside of the facility. We are thus continuing to apply a user-centered design approach and thinking creatively about additional 'support systems' to further develop, pilot, and scale, using an adaptive implementation approach.

DATA REPORTING

The SRH self-care space presents an interesting conundrum for monitoring and measurement: the very nature and appeal of self-care—the unique user journey—is what also makes it difficult to capture in traditional reporting systems. With provider-administered FP methods, the provider is responsible for reporting on uptake and the frequency of engagement with a client is generally equivalent to the frequency of administration of the method. Self-injection defies this norm by giving women the choice to administer her method herself, at a time and place of her choosing and convenience.

The introduction of DMPA-SC SI has required countries to rethink how data is captured on key 'source' documents like the FP register, and how this data flows into national databases such as HMIS. Most notably, amendments have to be made to distinguish between the provider-administered visit and the self-injection visit, with considerations for each country's specific guidelines on client training and provision for take home doses.

Scaling up self-injection also requires a shift in provider and health system reporting behavior as the mode of administration (provider/self) and the units dispensed become key data points for supply chain management and general oversight of the FP services provided by the health system. Like any behavior change, the shift in provider reporting behavior also takes time, during which, the reporting system is likely to have more representative data of provider administered visits (normal reporting behavior) than self-injected visits and additional doses dispensed for take home use. It is during this transition period that we typically see a growing gap between the number of SI visits reported and the actual number of women who are self-injecting.

Within a given country, seeing a sustained increase SI visits over the long term is not an indicator of 'success'. Over time, and in countries where mCPR is high and SI has become fully integrated within the health system, we should actually see the volumes of SI visits decrease. This is because as more women feel confident self-injecting outside of the health facility, the frequency of their visits is more likely to align with refill schedules (once a year for clients who are able to take the recommended 3 units home).

HOW IS DISC SUPPORTING SI DATA REPORTING?

During the first phase of the project, DISC gained valuable insights and took concrete actions towards improving data availability, quality, and use within our implementation geographies. Under the second phase, and in close partnership with Ministries of Health, the Access Collaborative, and key partners and stakeholders, DISC will be supporting national data systems and data for decision-making by:

- Advocating for the inclusion of key SI data elements in country health management information systems (HMIS): DMPA-SC disaggregated by PA and SI, total units dispensed, and client category by method, captured on both the family planning (FP) register and the HMIS monthly summary form (MSF). These elements are critical for understanding trends in self-care uptake, as well as whether expanding the method choice is drawing in new and lapsed users.
- Advocating for the use of HMIS service statistics along with LMIS consumption data when planning for commodity supply at the national and subnational levels.
- Accounting for the maximum allowable (per individual country policy) take home units for each SI visit during national quantification and supply planning meetings.
- Training and mentorship of key government personnel (FP and M&E coordinators) to strengthen data quality and ensure that commodity consumption data feed into supply forecasting. These skills are reinforced during routine SSV, DQA, and mentorship visits.
- Training and mentorship of providers on the uniqueness and value of SI data and how best to use the data to plan for service provision.
- Working with LGA and District health teams to support routine data review processes for the purposes of targeting mentorship, managing supply and facilitating redistribution exercises, and integrating SI into routine FP service touchpoints.

SUPPLY CHAIN MANAGEMENT

Ensuring consistent DMPA-SC commodity availability is crucial for both practical and ethical reasons. Women are understandably hesitant to adopt self-inject if its availability is unreliable—thus inhibiting scaleup progress. More importantly, commodity shortages and stockouts infringe choice by limiting women's options. Although DISC was not originally intended as a supply chain management program, we are integrated within the health systems in which we operate, and accordingly have a role to play as SRH advocates, advisors, and managers who work in lockstep with Ministries of Health with a shared goal of maximizing women's contraceptive options.

The fact that workforce development is such an integral component of our work has afforded DISC the opportunity to 'layer on' supply chain management training for multiple cadres of health workers. For example, in Malawi under DISC 1, we trained 240 FP providers, health surveillance assistants (HSAs), pharmacy staff, and data / HMIS officers on enhanced commodity management. DISC training also builds capacity on using stock management systems like FHIN and GFPVAN.

Inherently, effective supply chain management hinges upon robust stakeholder coordination, thus this is the main area where DISC has 'moved the needle' to rectify shortages both on an ad hoc basis and as part of a concerted sustainability strategy. Key coordination actions that we have taken, and continue to support with, include:

- Establishing and facilitating commodity tracking committees in partnership with Ministries of health
- Advise national quantification exercises, feeding in both DMPA-SC consumption data and projected need based on DISC's scale-up plans
- Coordinate between national and subnational levels of health systems to facilitate commodity redistribution efforts
- Advocacy at national and global levels in close partnership with the Access Collaborative, Elevating arising needs for additional orders via donors.

PARTNERSHIPS