

Scaling Up Community-Based Counseling and Distribution of DMPA-SC in the DRC

USAID's Evidence to Action (E2A) Project's community-based family planning project, implemented from 2014–2020, aimed to increase access to family planning (FP) to those who need it most in rural, hard-to-reach areas of Democratic Republic of the Congo (DRC). By de-medicalizing and decentralizing FP service delivery through trained, non-clinical community health workers, E2A was able to provide more women with more methods, including depot medroxyprogesterone acetate (DMPA-SC), which is administered subcutaneously. The World Health Organization describes self-injectable DMPA-SC as a safe and effective family planning method,¹ and studies in Malawi² demonstrated improved DMPA continuation among women who self-inject, compared with women who received the injection by a trained provider. As the COVID-19 pandemic highlights gaps in access to and availability of services within the health system, the ability for women to choose and access FP counseling and methods in their own communities is more important than ever. E2A's results suggest that community-based distributors provide the opportunity to further task-shift DMPA-SC to the FP user herself—an important step on the road to universal self-injection and self-care, which increases women's ability to select and eventually administer their chosen FP method.

BACKGROUND

Data demonstrates that family planning is a key life-saving intervention for both women and their children.³ A growing body of evidence shows that one way to address geographical and financial barriers to accessing modern contraceptive commodities is to establish community-based distribution (CBD) programs. CBD helps overcome obstacles such as clients' lack of adequate access to reproductive health and family planning counseling and services, limited access to and availability of an expanded modern method mix, and the economic, social, and time constraints clients face in seeking services.⁴ Additionally, CBD agents act as supplementary providers in areas with limited human resources for health, such as DRC, where there are only 0.91 physicians per 1,000 population and 0.961 nurses and midwives per 1,000 population.⁵ The WHO-recommended ratio is 2.3 doctors, nurses, and midwives per 1,000 population.

DRC's health system is so dramatically underfunded that health workers' salaries constitute less than half of their total income—leaving health workers with no option but to supplement their earnings through user fees and other means. As a result, nurses receive up to 35% of their income from user fees, and this



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proportion increases for administrators, who get up to 48% of their revenue from user fees.⁶ The government mandates that FP services be provided free of cost to the user, but facilities often struggle to offer free FP services and provide other health services for a fee with their limited revenues. In a 2014 study that randomly sampled 1,555 facilities of all levels across the country, 33% were found to offer FP services and only 14% had at least three types of FP methods available (most commonly male condoms, combined oral contraceptive pills, and progestin-only injectable contraceptives).⁷

Limited access to services and low numbers of skilled providers are compounded by infrastructure challenges, all of which can be mitigated by bringing services closer to communities through CBD. De-medicalization and decentralization of FP in DRC by using CBD agents can provide an opportunity to bring quality information and services closer to women who need them, build linkages and referral pathways between community health systems and formal health structures, and expand individual access to trusted CBD agents.

1 World Health Organization. "WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights." (2019).

2 Burke, Holly M., Mario Chen, Mercy Buluzi, Rachael Fuchs, Silver Wevill, Lalitha Venkatasubramanian, Leila Dal Santo, and Bagrey Ngwira. "Effect of self-administration versus provider-administered injection of subcutaneous depot medroxyprogesterone acetate on continuation rates in Malawi: a randomised controlled trial." *The Lancet Global Health* 6, no. 5 (2018): e568–e578

3 World Health Organization. "Family Planning: A Health and Development Issue, A Key Intervention for the Survival of Women and Girls." Policy Brief. Geneva: WHO (2012).

4 Musila, Ruth and Eunice Mueni. "An Assessment of the Policy and Programmatic Evolution of the Community-based Distribution of Family Planning Program in Kenya and Prospects for its Sustainability." USAID/Measure Evaluation Population and Reproductive Health, Jan. 2014.

5 World Health Organization. "Global Health Observatory data repository – Health workforce aggregated data." Accessed at: <http://apps.who.int/gho/data/node.main.A1444>.

6 Bertone, Maria Paola, Grégoire Lurton, and Paulin Beya Mutombo. "Investigating the remuneration of health workers in the DR Congo: implications for the health workforce and the health system in a fragile setting." *Health policy and planning* 31, no. 9 (2016): 1143–1151.

7 Mpunga, Dieudonné, J. P. Lumbayi, Nelly Dikamba, Albert Mwembo, Mala Ali Mapatano, and Gilbert Wembodinga. "Availability and quality of family planning services in the Democratic Republic of the Congo: high potential for improvement." *Global Health: Science and Practice* 5, no. 2 (2017): 274–285.

COMMUNITY-BASED FAMILY PLANNING PROJECT

To help address these gaps in service access, the E2A Project, USAID's global flagship project for strengthening FP and reproductive health (RH) service delivery, received field support funding from USAID DRC to implement a community-based family planning (CBFP) project in DRC from June 2014 to June 2018 and, through an extension, from March 2019 to September 2020. The project's goal was to build upon existing systems, plans, and partnerships to implement scalable community-based FP/maternal and child health (MCH) service delivery approaches in three provinces in DRC. The intervention zones were originally chosen in conjunction with USAID and the government of DRC based on population, poor maternal and child health indices, geographic access challenges, and motivated and willing facility or health management committees. In the targeted communities, the CBFP project expanded provision of quality FP/MCH services and methods (including DMPA-SC) at community level through community-based distribution, facility outreaches, strengthened community–facility linkages, and increased awareness and demand for FP services in targeted communities, as well as health systems strengthening through training and supervision of providers, data collection and reporting, work planning and management. In the first phase of the project (2014–2018), E2A and Pathfinder International worked in 15 health zones in Kasai Central, Lomami, and Lualaba provinces. In the extension phase (2019–2020), the CBFP project continued working in Kasai Central and Lomami and also expanded to Kasai Oriental, in order to sustain gains made under the first phase and to expand to several new health zones and health areas.

From the project's inception, systematic scale-up was a guiding principle to ensure that CBD of FP was included in government and partner plans to both expand and institutionalize the practice.⁸ The DRC national government has recognized the necessity of CBD, demonstrated by the National Strategic Plan for Family Planning (2014–2020) including CBD of FP information and services as a key objective,⁹ with a plan to progressively introduce CBD and have at least three CBD agents delivering FP services in each health area. The plan envisions CBD agents distributing non-clinical methods (male and female condoms, cycle beads, and oral contraceptive pills), as well as reporting data on (1) number of new and continuing users provided with methods, (2) number of methods (by type) distributed; (3) number of households visited, (4) number of group educational sessions conducted, and (5) number of individual counseling sessions provided by division of the health system—i.e., up to health zones, which is the lowest division of the national health system. Additionally, the National Reproductive Health Program (Programme National de Santé de la Reproduction [PNSR]) produced an implementation guide for FP service delivery at community level, highlighting the role of CBD agents. Throughout the CBFP project, E2A ensured government buy-in and joint government and E2A ownership for strengthening systems and supporting institutionalization of CBD of FP. The government's commitment to CBD was reaffirmed throughout their

Key FP/RH Statistics – DRC

TOTAL FERTILITY RATE: 6.6 (7.3–8.2 in provinces covered by CBFP project)

PERCENTAGE OF MARRIED WOMEN USING MODERN METHODS OF CONTRACEPTION: 7.8% (4% in provinces covered by CBFP project)

UNMET NEED FOR FAMILY PLANNING: 27.7%

PERCENTAGE OF WOMEN, AGED 20-24, WHO GAVE BIRTH BEFORE AGE 18: 26.7%

PERCENTAGE OF WOMEN, AGED 20-24, WHO WERE MARRIED BEFORE AGE 18: 37%

USAID, The DHS Program (2018). STAT Compiler: Women currently using any modern method of contraception.

close engagement with and oversight of the CBFP project, including the scale-up strategy development workshop and project close-out meetings. Additionally, PNSR national trainers, in conjunction with facility-based providers, trained the CBDs. The facility providers conducted regular supervisory visits and meetings with CBD agents to discuss the challenges they encountered and collect their data. The systematic scale-up approach led to the inclusion of CBD family planning indicators in the national health information system and transferred full ownership of the interventions to the government with implementation support from other partners. Creating and strengthening government platforms increases the potential to sustain the interventions, and expand the services they provide, including CBD of DMPA-SC.

DMPA-SC IN DRC

In December 2014, shortly after adopting the National Strategic Plan for FP, DRC approved use of DMPA-SC, granting provisional authorization to market the contraceptive for one year and extended this authorization for another five years in 2016. This authorization allowed Tulane University to lead three pilot studies of community delivery of DMPA-SC to test the acceptability and feasibility of CBD of DMPA-SC by medical and nursing school students and non-clinical community health workers. The pilots led to several innovations in CBD of DMPA-SC, one of which was the distribution of DMPA-SC by non-clinically trained CBD agents through the E2A CBFP project.

Following the studies, DMPA-SC was added to nursing and medical school curricula, and students (considered clinical CBD agents) were allowed to administer DMPA-SC to clients in their communities. In addition to Tulane, international technical and

8 Mai, Murtala, Elham Hassen, Alexis B. Ntabona, Jacqueline Bapura, Meera Sarathy, Rachel Yodi, and Zenon Mujani. "Government ownership and adaptation in scale-up: experiences from community-based family planning programme in the Democratic Republic of the Congo." *African journal of reproductive health* 23, no. 4 (2019): 35-45.

9 Programme National de Santé de la Reproduction (PNSR). "Plan de mise à échelle de DMPA-SC." Kinshasa: Ministry of Health, 2018.

financial partners including DKT, Marie Stopes International, and Population Services International used CBD agents with a clinical profile to administer FP methods including DMPA-SC. To date, E2A and Pathfinder and Association de Bien-Etre Familial (ABEF) are the only two organizations in DRC to test the feasibility and acceptability of using non-clinical CBD agents to administer DMPA-SC.

Since 2017, the Subcutaneous DMPA Access Collaborative has been working with DRC's Ministry of Health and family planning stakeholders involved in the introduction and scale-up of DMPA-SC. The Access Collaborative (funded by the Bill and Melinda Gates Foundation) is a coordination and technical assistance project led by PATH and John Snow, Inc., and implemented by Pathfinder International in DRC, to advance the long-term, sustainable availability of DMPA-SC as part of a broad contraceptive method mix.¹⁰ The CHAI-funded Catalytic Opportunity Fund (COF) has supplemented those efforts between June and December 2020 to support the MOH in finalizing the national guidelines for implementation of self-injection of DMPA-SC and roll it out to about 50% of health zones across the country.

TESTING AND SCALE-UP OF COMMUNITY-BASED COUNSELING AND DISTRIBUTION OF DMPA-SC

PILOT TESTING AND INITIAL EXPANSION: 2017–2018

In 2017, E2A and Pathfinder and Tulane University jointly developed and implemented a study to test the acceptability and feasibility of offering DMPA-SC in the community by non-clinical community-based distributors. In this pilot project, E2A and Tulane trained 34 CBD agents to provide DMPA-SC to women in their homes or at mobile outreaches in their communities in two health zones in Lualaba (Bunkeya and Fungurume).

The 34 CBD agents who were chosen for the DMPA-SC pilot study were amongst active CBD agents who had already been trained to provide other short-acting methods in their respective communities. The criteria used in their original selection was: (1) knowledge of and acceptance by the communities they served; (2) willingness and availability to volunteer; (3) ability to speak the local language; and (4) possession of literacy skills and ability to fill data collection forms.

The key criteria for the selection of CBD agents for the DMPA-SC pilot study were (1) successful performance as a CBD agent; and (2) residence in the pilot study zone. The six-day DMPA-SC training that the selected CBD agents received focused on how to provide quality counseling and inject DMPA-SC. CBD agents received refresher trainings on FP methods in general and DMPA-SC in particular. National trainers and facility-based clinical health workers conducted the training and provided ongoing support and supervision to CBD agents after the training. Upon completion of the training and

demonstration of competencies, the trained CBD agents participated in a supervised field exercise prior to providing the method to clients. Surveys and three-month follow-up interviews were conducted with acceptors to assess the acceptability and feasibility of CBD provision of DMPA-SC.

During the five-month pilot period (June to October 2017), CBD agents provided DMPA-SC to 596 new FP acceptors and 94 clients for repeat injections. A survey of 252 acceptors found that almost all (96%) were comfortable with a CBD agent administering the injection, rather than a doctor or nurse. A vast majority of acceptors (97.9%) reported that they were satisfied with the information the CBD agent provided, 93.8% reported being satisfied with the overall service, and 96.4% reported that they would prefer to continue receiving DMPA-SC from a CBD agent than from a clinic.¹¹ A follow-up study of the CBD agents found that 88% were satisfied with the experience of providing DMPA-SC, and 79.4% felt they had adequate supervision and 79.4% felt comfortable providing DMPA-SC.¹²

Following the pilot, CBD agents provided DMPA-SC to 1,060 new users of FP and 261 continuing clients from January to March 2018. The results demonstrated the feasibility of non-clinical agents to administer DMPA-SC. These results were widely disseminated in a workshop organized by Tulane University in Kinshasa and by E2A in the second general assembly conducted by the Permanent Multisectoral Technical Committee in Lualaba. Based on the results and lessons learned, the government with support from E2A, scaled up this training to 220 CBD agents in 44 health areas of three provinces of DRC in 2018, using a cascade training approach.

INSTITUTIONALIZATION: 2018

At the end of the CBFP project in June 2018, E2A and ExpandNet (a member of the E2A consortium) facilitated a workshop in collaboration with the National Reproductive Health Program, various government entities, and partners to develop a scale-up strategy for CBFP. Following ExpandNet's nine-step systematic scale-up process, the group created a "resource team" for CBFP and made recommendations for scale-up. The group identified priority recommendations for scaling up CBFP, including continuing and expanding community-based provision of DMPA-SC and advocating for adoption of the CBD of DMPA-SC approach in government plans and policies. The group recommended expanding FP access in areas of DRC that are served by community-based workers, rather than health facilities, thereby increasing service availability in remote areas of the country. Based on these recommendations, CBD of DMPA-SC was included as a core program element supported by E2A during the extension period (2019-2020), as well as within the USAID-funded Integrated Health Project Plus (IHP+).

In 2018, PNSR, with the Access Collaborative, developed a plan to guide the sustainable scale-up of DMPA-SC in DRC. This plan complemented the 2014–2020 National Strategic Plan for FP and

10 PATH. "DMPA-SC Access Collaborative." Accessed at: <https://www.path.org/articles/dmpa-sc-collaborative/>.

11 Mwembo, Albert, Rebecca Emel, Tesky Koba, Jacqueline Bapura Sankoko, Aben Ngay, Rianne Gay, and Jane T. Bertrand. "Acceptability of the distribution of DMPA-SC by community health workers among acceptors in the rural province of Lualaba in the Democratic Republic of the Congo: a pilot study." *Contraception* 98, no. 5 (2018): 454-459.

12 Hernandez, Julie H., Pierre Akilimali, Annie Glover, Rebecca Emel, Albert Mwembo, and Jane Bertrand. "Task-shifting the provision of DMPA-SC in the DR Congo: perspectives from two different groups of providers." *Contraception* 98, no. 5 (2018): 449-453.

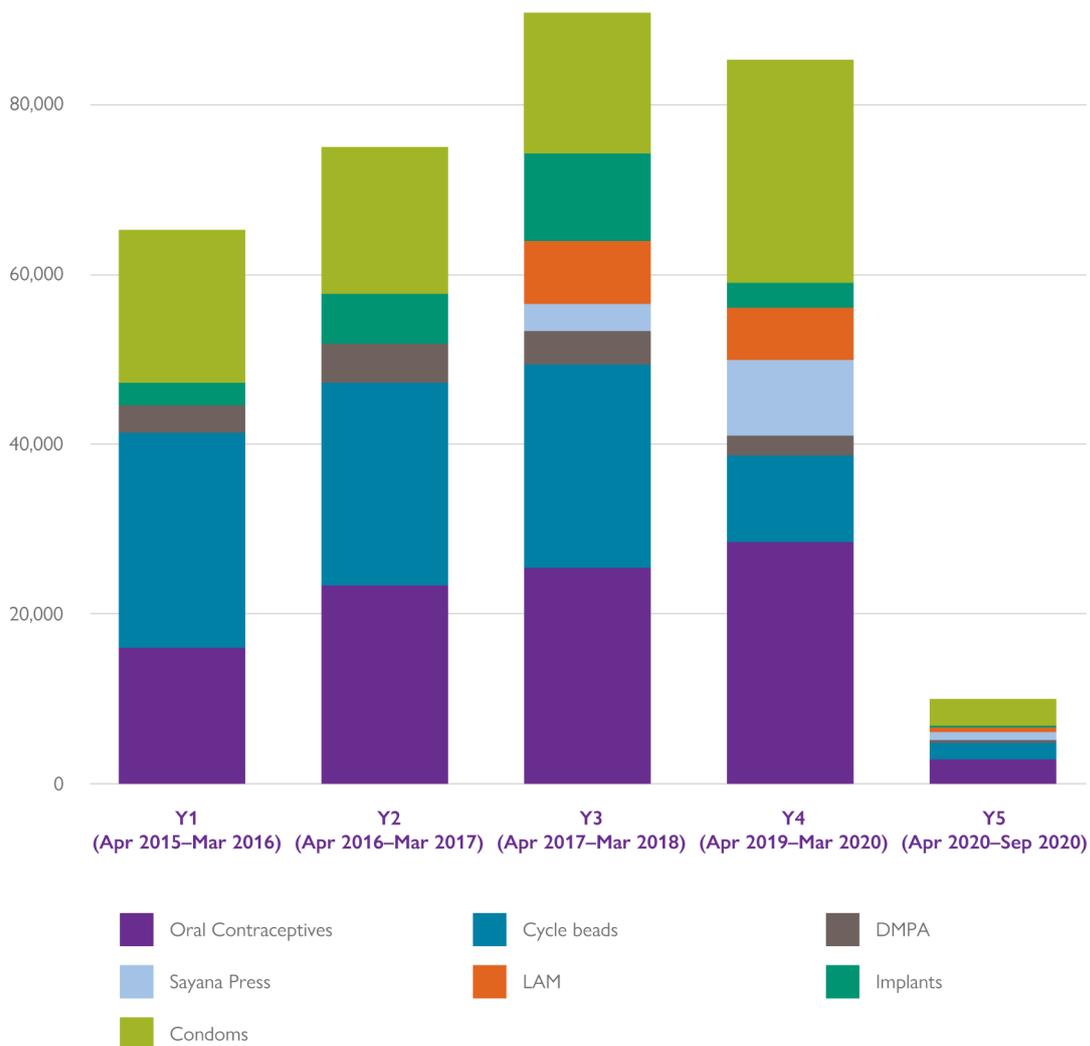
defined an implementation process to ensure that DMPA-SC was available to FP clients throughout DRC as part of a full range of methods in order to offer expanded contraceptive choice to all clients. The strategy advocated for the provision of DMPA-SC at the facility level, distribution at the community level by both clinical and non-clinical providers and self-injection by the user after being trained by a skilled community level clinical or non-clinical provider like a CBD.¹³ A specific goal was to train at least half of all active CBD agents to offer DMPA-SC at the community level. At the time of the mid-term evaluation of the National Strategic Plan for FP in July 2017, the government found that, out of the 493 health zones offering FP, 150 zones had DMPA-SC available (30.4% coverage) and only 430 of the 8,517 facilities that offer FP had DMPA-SC (5% coverage).¹⁴ The low availability of DMPA-SC at facility level, in addition to evidence of the feasibility and acceptability of community-based distribution of DMPA-SC produced by E2A and Tulane, led the government to include CBD in the national DMPA-SC scale-up strategy, thereby institutionalizing within national policy.

EXPANSION: 2019–2020

In March 2019, E2A was extended through September 2020 to continue and expand the CBD approach to several new health zones and areas. In this extension phase, known as CBFP+, E2A trained a total of 400 CBD agents in 51 health areas in three provinces to provide DMPA-SC. These trainings followed the same approach as the previous trainings: CBD agents received refresher trainings on FP methods in general, and DMPA-SC in particular, from local health departments and nurse supervisors. From April 2019 to March 2020, CBD agents distributed DMPA-SC to 6,693 new acceptors of FP and 3,897 repeat injections to continuing users. DMPA-SC constituted about 10% of the methods distributed by CBD agents (in addition to oral contraceptive pills, CycleBeads®, and male and female condoms).

Over the life of the project, 397,421 women were new acceptors of family planning.

Figure 1: New FP Acceptors, disaggregated by method, April 2015–Sept 2020



13 Programme National de Santé de la Reproduction (PNSR). "Plan de mise à échelle de DMPA-SC." Kinshasa: Ministry of Health, 2018.

14 Ibid.

THE ROAD AHEAD

DMPA-SC AND SELF-CARE

The World Health Organization's Consolidated Guidelines for Self-Care include self-injectable DMPA-SC as a safe and effective family planning method.¹⁵ DMPA-SC is being produced and marketed as a pre-filled needle and drug combination, which has regulatory approval for self-injection in 54 countries, including the United Kingdom, several European countries, and more than 20 FP2020 countries.¹⁶ Injectable contraceptives are a popular family planning method, but in many rural or remote settings clients have trouble accessing clinics where injectable contraceptives are offered.¹⁷ Providing the option to self-inject DMPA may improve DMPA continuation by removing barriers, such as the need to return to a healthcare facility every three months for a repeat injection. By introducing DMPA-SC as a self-care method option in communities, and by using CBD agents as the midway point to further task-shift injection to the FP user herself, it enhances autonomous care seeking for preferred FP method choice.

CBD AS A ROUTE TO SELF-INJECTION

Several countries, most notably Senegal, Malawi, and Uganda, have seen successful in DMPA-SC self-injection and are looking to scale up the practice. The government of Senegal began training providers to teach women to self-inject in September 2018 and is currently integrating self-injection into the national FP program.¹⁸ In both Senegal and Uganda, a survey on stakeholder perspectives on scaling up self-injection revealed that multiple informants thought that community-based health workers were the appropriate agents to train women to self-inject. This was due to their close links with communities in rural areas and the likelihood that they would be able to relate to the experiences of the women they were serving.¹⁹

In Malawi, a randomized controlled trial compared continuation rates of women who self-injected DMPA-SC at home and women who received DMPA-SC from a facility-based provider or a salaried community health worker (Health Surveillance Assistant). It showed that women who self-injected had a 73% continuation rate over 12 months, as compared to a 45% continuation rate among women who received the provider-administered injection.²⁰ The findings provided the evidence to support the rollout of DMPA-SC self-injection by trained community health workers. This strategy also points to the potential for cost savings through self-administration, which could decrease operational costs and resources, such as provider time, as well as decrease costs to the user, such as those related to travel to facilities to seek care.²¹

Recognizing the potential impact of self-injection of DMPA-SC, and in line with the DRC government's goal to roll out self-injection of DMPA-SC, in the CBFP+ extension phase, E2A facilitated trainings on DMPA-SC self-injection, in conjunction with the Access Collaborative. The government's strategy for DMPA-SC scale-up is based on progressive implementation of self-injection through cascade trainings to increase the pool of clinical and non-clinical providers around the country who can provide DMPA-SC, and teach women to self-inject. Following finalization of the national guidelines for self-injection of DMPA-SC and the establishment of a central pool of FP trainers, PNSR pretested the curriculum in May 2020, with E2A's support, by training five nurse supervisors at the health zone level in Kasai Central. Through the Access Collaborative project, Pathfinder continued to support the MOH to conduct cascade orientations to trainers and health care providers on self-injection of DMPA-SC, covering 257 Health Zones in 15 of the country's 26 provinces.

The five trained nurse supervisors, in turn, trained 17 health area providers, who, in turn, trained 85 CBD agents (42 women and 43 men) in June 2020. This training cascade approach was first tested in E2A-supported zones before it was extended to other health zones. In July, newly-trained CBD agents supported 17 women who sought DMPA-SC self-injection. Supervisors who conducted post-training follow-up indicated that CBD agents were able to train women to successfully self-inject. During the training, several clients said they had waited a long time for a method that would make them autonomous, while some clinical providers expressed fear of losing clients if they knew how to self-inject. Even so, it was determined that using existing, trained CBD agents would be a viable strategy to generate demand and fulfill women's stated self-care desires while still ensuring women were linked to the health system to provide proper training and support to self-inject.

This adaptation represented an opportunity to leverage the presence of trained CBD agents, who were already active in communities and accepted by community members, to task-shift the provision of DMPA-SC—not only to the CBD agents but to the clients themselves. By teaching women to self-inject DMPA-SC, CBD agents are uniquely positioned to help empower women with the skills and confidence they need to obtain and administer the DMPA-SC if it is the method they choose.

15 World Health Organization. "WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights." Geneva: 2019.

16 PATH. "The power to prevent pregnancy in women's hands: DMPA-SC injectable contraception." *Advancing Partners. SELF-INJECTION OF DMPA-SC LEADS TO IMPROVED CONTINUATION RATES.* September 2017.

17 *Advancing Partners and Communities.* "Self-injection of DMPA-SC leads to improved continuation rates." Sept 2017.

18 PATH. "Self-injection of DMPA-SC in Ghana, Malawi, DRC, Senegal, and Uganda: increasing access, improving continuation, and empowering women." Seattle: 2019.

19 PATH. "Stakeholder views on self-injection of DMPA-SC in Senegal and Uganda." (Seattle: 2016).

20 Burke, Holly M., Mario Chen, Mercy Buluzi, Rachael Fuchs, Silver Wevill, Lalitha Venkatasubramanian, Leila Dal Santo, and Bagrey Ngwira. "Effect of self-administration versus provider-administered injection of subcutaneous depot medroxyprogesterone acetate on continuation rates in Malawi: a randomised controlled trial." *The Lancet Global Health* 6, no. 5 (2018): e568-e578.

21 *Advancing Partners and Communities.* "Self-injection of DMPA-SC leads to improved continuation rates." Sept 2017.

SUSTAINABILITY

The use of CBD agents to scale up provision of DMPA-SC, as well as to train women to self-inject DMPA-SC, is an effective, intermediary step on the road to universal self-injection, expanded family planning method choice and access, and ensuring reproductive and family planning goals are met for individuals and couples. As governments begin to scale up self-injection, they will need to address familiar constraints such as shortages in human and financial resources, as well as supply chain distribution directly to consumers. Currently, DMPA-SC is available at pharmacies or through social marketers in the DRC, but at a cost to the client, whereas DMPA-SC is free at health facilities and through CBD agents. While E2A's CBFP and CBFP+ project addressed health systems strengthening through provider training and supervision, quality data collection and reporting, supply chain support, and work planning and management, lack of adequate human and financial resources remain a challenge to scaling up CBD and other task-sharing approaches. As providers are diverted to focus on urgent needs, such as the COVID-19 response, and community members are hesitant to go to health facilities for care during a pandemic,²² it would be beneficial to shift the task of providing DMPA-SC to CBD agents who can provide the injection at the community level and also train women to self-inject in the comfort of their own homes. This would reduce the burden on highly-trained medical providers and health care facilities while ensuring essential family planning services are not disrupted.

E2A is working with the USAID-funded Integrated Health Project (IHP+) to adopt and scale the CBD approach. As E2A's CBFP+ ended in September 2020, this transition to IHP+ is expected to expand CBD of DMPA-SC to a total of nine provinces in DRC. The IHP+ presents an opportunity to continue CBD of DMPA-SC, as well as task-shifting self-injection training to CBD agents, and therefore build toward sustainable self-injection programs throughout DRC. While the national DMPA-SC scale-up strategy shows significant government commitment to sustainability, the lack of budget lines dedicated to funding these plans remain a barrier to true sustainable scale-up.

CONCLUSION

In rural areas of DRC, access to health facilities and qualified health personnel is often limited. Given that these challenges have been exacerbated by the COVID-19 pandemic and women face increasing difficulties in accessing quality services at health facilities, making quality community-based family planning available and accessible is more important than ever.

Through training and supervision of non-clinical community health workers, the project was able to offer a wider contraceptive method mix to more women and enabled 13,303 new family planning acceptors to access DMPA-SC. E2A's experience showed that competent, non-clinical community health workers were able to both safely provide DMPA-SC to women and also to train women to self-inject it. Clients are increasingly selecting this self-care option and are reporting satisfaction with the services they have received from CBD agents. E2A worked with the government and other key stakeholders to scale-up the cascade training approach of facility providers and CBD agents to 51 rural health areas in four provinces, showing the feasibility of scaling up community-based FP that includes DMPA-SC in the method mix and offering a greater choice of methods to women at the community level.

The inclusion of DMPA-SC provision by non-clinical CBD agents in the national DMPA-SC scale-up strategy indicates that the government recognizes the potential impact of this approach. CBD agents have strong community ties and a demonstrated record of effective service delivery and counseling. Their expertise should be leveraged to further task-shift DMPA-SC provision to clients, by training women to self-inject DMPA-SC. Practical implications for introducing and scaling-up community-based distribution of FP, introducing DMPA-SC into the method mix, task-sharing the provision of DMPA to CBD agents, and further task-sharing CBD agents to teach clients to self-inject are demonstrated through the E2A program in DRC, and support global FP goals of expanding method mix, informed and voluntary choice, and increased access to quality community-based FP counseling, services, and self-care. Additionally, training and support of non-clinical CBD agents augments the health workforce by filling gaps in service provision in hard-to-reach areas and reinforces linkages between communities and health systems. Policy makers and donors should strongly consider making commitments towards CBD and self-injection of DMPA-SC as part of national level family planning policies and decentralization programs as a critical step on the road to self-care, de-medicalization, and women's control of their contraceptive choice.

²² Médecins sans Frontières. "DRC: COVID-19 continues to spread, with potentially deadly secondary impacts." 15 June 2020.

The Evidence to Action (E2A) Project is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services. The project is led by Pathfinder International and will end on March 31, 2021.

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