CONNECTING THE DOTS BETWEEN EVIDENCE AND EXPERIENCE

Photo credit : JSI, Inc.

Remote Supervision Allows for Continuity of FP Services for Providers in Madagascar

PROGRAM ADAPTATION CASE STUDY - JANUARY 2022

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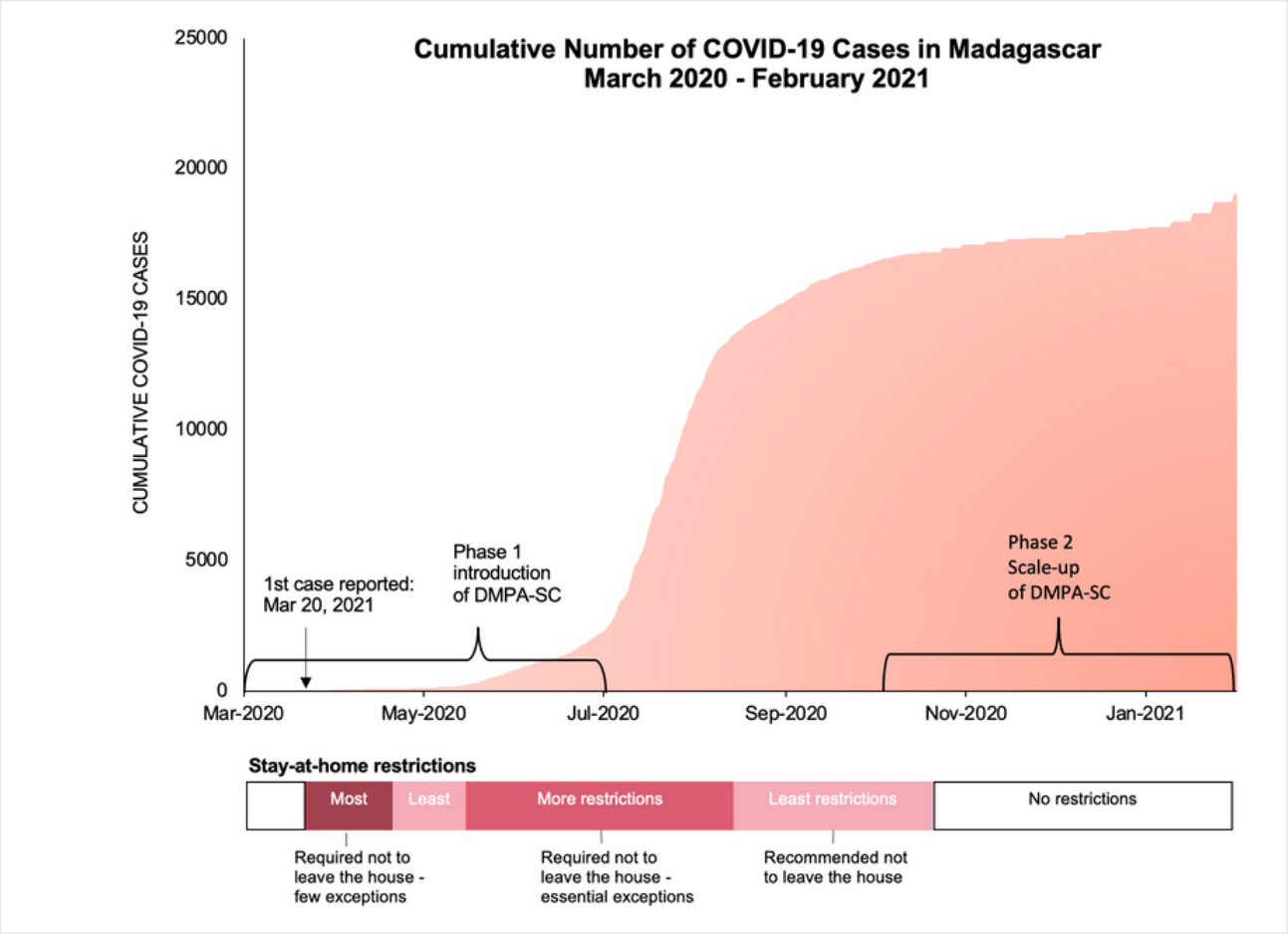
Key Takeaway:
Remote supervision of providers enabled successful introduction and scale-up of DMPA-SC self-injection during the COVID-19 pandemic. Remote supervision reached more providers than in-person supervision.

Background COVID-19 Context



DMPA-SC self-injection introduction started in March 2020, when the most restrictive stay-at-home measures were put in place. The evaluation took place in December 2020 when no restrictions were in place but the cumulative number of COVID-19 cases was high and slowly increasing.

Program Description

As of June 2021, about 26 countries around the world have either introduced or plan to introduce self-injection of DMPA-SC, a three-month contraceptive injectable. Most countries that offer DMPA-SC self-injection train women to self-inject and offer them enough units to last one year to take home. This makes it an especially useful contraceptive method during pandemics such as COVID-19 or epidemics like Ebola. The DMPA-SC Access Collaborative (AC) conducted a policy scan from October to November 2020 of 19 countries and found that 5 of these countries had DMPA-SC self-injection as part of their COVID-19 response—DRC, Madagascar, Malawi, Niger, Uganda—and Nigeria's policy had DMPA-SC self-injection in a draft.

The AC has been supporting the Ministry of Health in Madagascar to introduce and scale up DMPA-SC and self-injection, using a three-phase approach:

- **Phase 1: i**ntroduction in 22 districts (one district per region) from January-July 2020
- **Phase 2:** scale up to other districts, which started in October 2020 and will last approximately 18 months
- **Phase 3:** expansion to the community level

COVID-19 Adaptations

Following the authorization of DMPA-SC self-injection in late 2019, Madagascar risked losing momentum when the COVID-19 pandemic and resulting movement restrictions took hold in early 2020. Drops in facility-based SRH services and contraceptive use during crisis situations are well-documented from previous outbreaks such as Ebola and Zika. As the COVID-19 pandemic shut down in-person contact with health care providers, the Ministry of Health and the AC rapidly developed a remote supervision approach and adapted materials and protocols to train providers to give DMPA-SC injections to women and counsel women on how to self-inject.

Photo credit : JSI, Inc.

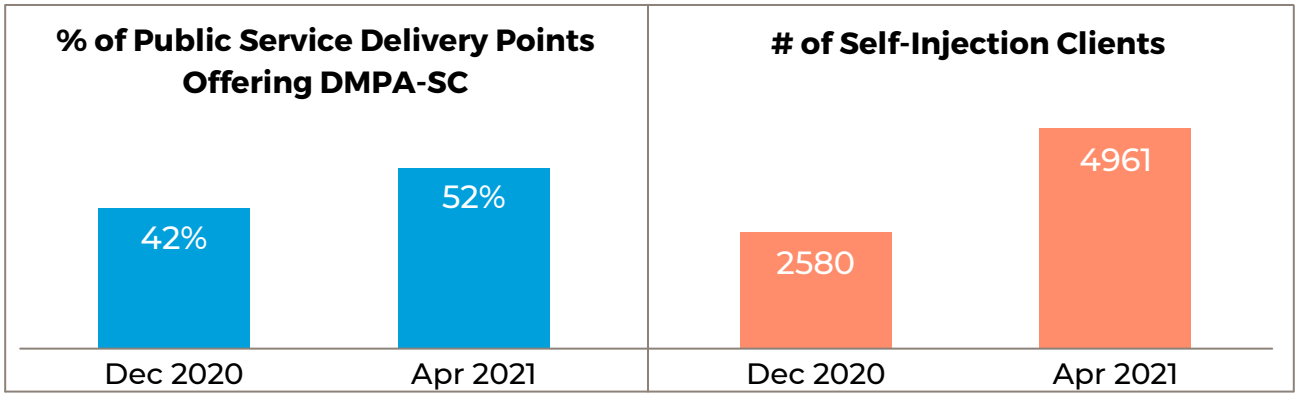
The 4 key steps for self-injecting are:

1. Mix the liquid by shaking device for 30 seconds.
2. Push the needle cap and port together to close the gap, activating the device.
3. Pinch the skin to form a "tent" and insert the needle.
4. Press the reservoir slowly to inject for about 7 seconds.

Beginning in March 2020, health care providers who had been trained to offer DMPA-SC and self-injection in Phase 1's 22 districts were remotely supervised by the phone. A supervisor would call a provider on the phone and the provider would simulate training a client to self-inject, demonstrate the steps using a condom filled with salt, and answer questions. This approach is also being used in Phase 2.

Impact

- Between March and December 2020:
  - **100% of providers (496) were successfully supervised remotely.** Despite best efforts, in-person supervision prior to COVID-19 reached only 40%-60% of those who needed it, mainly due to resource constraints (e.g., time, budget, shortage of staffing, difficulty with travel).
  - **100% of facilities offering DMPA-SC were supervised.** Prior to COVID-19, only 50%-60% of facilities had been planned for in-person supervision.
  - **Almost all (93%) providers highlighted the key steps for self-injecting.**
- As of April 2021:
  - **52% of public service delivery points were offering DMPA-SC,** up from 42% in December 2020 and exceeding the goal of 50% by July 2021.
  - There were **4,961 self-injection clients** across 55 districts (of a total of 114 districts), an increase from 2,580 self-injection clients in 40 districts in December 2020.



Lessons for Other Programs

The innovative remote supervision model using phone simulations in Madagascar was feasible and enabled supervisors to oversee providers' counseling skills. Compared to in-person supervision, remote supervision reached more providers and saved time and resources. Nonetheless, some supervisors would prefer to return to in-person supervision when travel normalizes as they feel they can better assess the performance of specific providers in person. In Phase 2 rollout, 100% of facilities that offer DMPA-SC are planned to be supervised remotely with additional in-person supervision available for priority facilities. This approach has also been applied to other health programs in Madagascar, and Uganda is planning to use both remote and in-person supervision approaches for DMPA-SC.

> *"Remote supervision has allowed us to limit travel during this period of confinement in the context of the COVID-19 pandemic. Moreover, the [district management team] was able to do these daily tasks while carrying out a supervision... In a week we carried out supervisions for thirty-one [health facilities]."*
>
> —Supervisor, Andramasina district, Madagascar, Source: DMPA-SC Access Collaborative Insights: Looking back, thinking forward, and scaling up

For more information:

- DMPA-SC Access Collaborative - Looking back, thinking forward, and scaling up
- Seizing opportunities in Madagascar to expand access to contraceptives - Protect Global Gains (protectingglobalgains.org)

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