FEDERAL MINISTRY OF HEALTH

NATIONAL GUIDELINES
FOR THE INTRODUCTION AND SCALE-UP OF
DMPA-SC SELF-INJECTION

January 2019

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ABBREVIATIONS/ACRONYMS

ACPN	Association of Community Pharmacists of Nigeria
AGPMPN	Association of General Private Medical Practitioners of Nigeria
AGPNP	Association of General Private Nursing Practitioners
CBD	Community Based Distributors
CP	Community Pharmacist
CHEW	Community Health Extension Worker
CHIPS	Community Health Influencers Promoters and Services
CORPS	Community Oriented Resource Persons
CPR	Contraceptive Prevalence Rate
CV	Community Volunteer
DMPA	Depo Medroxy Progesterone Acetate
DMPA-IM	Depo Medroxy Progesterone AcetateIntra-muscular
DMPA-SC	Depo Medroxy Progesterone Acetate Sub-cutaneous
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
FP	Family Planning
GON	Government of Nigeria
HE	Health Educator
HIV	Human Immuno-deficiency Virus
JCHEW	Junior Community Health Extension Worker
LGA	Local Government Area
LMIS	Logistic Management Information System
MOH	Ministry of Health
mCPR	Modern Contraceptive Prevalence Rate
NAFDAC	National Agency for Food and Drug Administration and Control
NPHCDA	National Primary Health Care Development Agency
NRHTWG	National Reproductive Health Technical Working Group
PCN	Pharmacist Council of Nigeria
PHC	Primary Health Care
PPMV	Proprietary and Patent Medicine Vendor
RH	Reproductive Health
RHTWG	Reproductive Health Technical Working Group
RIRF	Requisition, Issue and Report Form
SBC	Social and Behavioural Change
SDP	Service Delivery Point
SI	Self Injection
SMOH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
UCSF	University of California, San Francisco
VHW	Village Health Worker

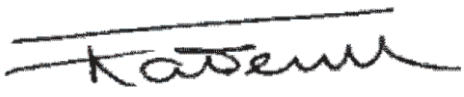
FOREWORD

The Federal Government of Nigeria through the Federal Ministry of Health in collaboration with relevant stakeholders has taken steps towards the introduction and scale up of another variety of Injectable Contraceptives, the Depot-medroxyprogesterone Acetate-Subcutaneous (DMPA-SC) into the country's family planning method mix. The steps which commenced with a programme implemented in the South West and South East Zones in 2015 was in line with the determination of Government towards finding sustainable solutions to the very poor maternal health indices in the country. The aim has been to make available a wide variety of contraceptive commodities expected to help in promoting equity of access and improve uptake of family planning services by Nigerians of reproductive age.

The success recorded in the course of piloting necessitated the convening of a Visioning Meeting in February 2017 during which stakeholders reached a consensus on the need for nationwide provision of DMPA-SC through a variety of service delivery channels including health facilities in the public and private sectors as well as community-based distribution structures. The DMPA-SC Introduction and Scale-Up Strategic Plan were subsequently developed to serve as a guide and provide necessary direction towards an effective and efficient provision of DMPA-SC alongside other existing family planning services.

The National Guidelines for the introduction and Scale – Up of DMPA-SC self injection in Nigeria 2019 is considered by the Federal Ministry of Health and other stakeholders as a very important tool in facilitating the comprehensive roll-out of the DMPA-SC Strategic Plan even to the hard-to-reach parts of the country. It is a proven fact that correct use of the National Guidelines usually enhances quality and cost-effectiveness of health service delivery. It becomes important therefore for all to see the National Guidelines for DMPA-SC as central to the successful delivery of DMPA-SC information, services and commodities to potential users in every Nigerian community. I sincerely believe that this will contribute significantly to our ability to meet and even surpass our national target of 27% modern Contraceptive Prevalence Rate by 2020.

I am convinced that proper utilization of the National Guidelines for the Scale-Up of DMPA-SC Self-Injection will go a long way in equipping service providers and other implementers at all levels of the healthcare service delivery with the skills and knowledge to adequately respond to service delivery requirements as well as issues that may arise from the implementation of DMPA-SC Strategic Plan in Nigeria. Consequently, I strongly recommend the National Guidelines for the Introduction and Scale-Up of DMPA-SC Self-Injection to all stakeholders across public, private and social marketing sectors. I assure every stakeholder that the Federal Ministry of Health will always provide the leadership in the coordination of mechanisms to promote compliance with the contents of the National Guidelines.



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ACKNOWLEDGEMENT

The development of the National Guidelines for the Introduction and Scale-UP of Depot-medroxyprogesterone Acetate-Subcutaneous (DMPA-SC) Self-Injection in Nigeria was one of the key outcomes of the coordinated efforts of the Federal Ministry of Health in collaboration with relevant stakeholders towards a further expansion of the country's family planning method mix. The Ministry takes cognizance of the understanding, zeal and determination exhibited by the numerous stakeholders in the process of developing the National Guidelines and appropriately obliged to acknowledge and appreciate them individually and collectively. We are highly appreciative of the Ministries, Departments and Agencies (MDAs) of the Federal Government of Nigeria, State Ministries of Health, Development Partners, Implementing Partners, Civil Society Organizations and Non-Governmental Organizations who made valuable inputs at different stages of the development of the National Guidelines.

The ministry's special recognition and thanks go to the Access Collaborative Project of John Snow Incorporated for the technical and financial support provided to facilitate the initiation and finalization of the SI Guideline. Our sincere commendation goes to Dr. Adewole Adefalu for the tremendous work done to ensure a successful development process. The Consultant, Dr Abiodun Hassan, is particularly recognized in a very special way for working tirelessly in providing needed technical support towards the eventual finalization of the National Guidelines.

The Ministry extends special recognition and gratitude to the staff of the Reproductive Health Division, Family Health Department in the Federal Ministry of Health under the leadership of Dr. Kayode Afolabi, Director and Head of Reproductive Health Division for effectively and efficiently coordinating the implementation of the various tasks involved in producing the National Guidelines.

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Executive Summary

This National Guideline for the Introduction and Scale-Up of DMPA-SC Self-Injection guides the implementation of the DMPA-SC self-injection program referenced in the National DMPA-SC Accelerated Introduction and Scale-up Plan 2018-2022, approved in July 2018 that focuses on a national roll out of DMPA-SC service delivery through all channels.

This self-injection scale-up Guideline builds on existing global and local DMPA-SC evidence and provides room to learn and reprogram as new research and programmatic evidence emerges. A cross-sectional interview done in Nigeria with providers, program managers and other stakeholders had shown a high level of acceptance of self-injection.Self-injection evidence to date from Uganda, Senegal, and Malawi shows that self-injection is feasible, acceptable to women and providers, and improves continuation rates, which means more women will stay on a reliable form of contraception rather than switching to a potentially less reliable method or no method.

The objectives of this Guideline are to:

- Elaborate the DMPA-SC self-injection plan from the DMPA-SC Scale-up Plan
- Provide country specific guidance and tools to roll out facility and community-initiated SI service delivery to ensure DMPA-SC reaches new users and expands access for women in hard to reach areas
- Provide guidance for adaptation of the DMPA-SC SI plan at the State level
- Outline a monitoring plan to adapt the implementation based on continuous learning

This Guideline lays out the various considerations and decisions needed to implement and scale-up a self-injection plan, including: policy, geographic area, service delivery channels, provider training, commodities, client training, demand generation, advocacy, and monitoring. It is intended to be used as a roadmap for partners to guide their SI program implementation so that it aligns with and supports the national vision as laid out in the DMPA-SC scale-up plan.

This document is targeted for use by national and state family planning focal persons, partners and others supporting the Federal and State Ministries of Health, public and private sector family planning providers, and community stakeholders.

1 DMPA-SC Self-injection in Nigeria

·On July 11, 2017, the Federal Government of Nigeria (FGoN) updated the country's FP2020 commitment at the Family Planning Summit in London with the goal of increasing the modern Contraceptive Prevalence Rate (mCPR) to 27% among all women by 2020. The Federal Ministry of Health (FMOH) recently launched its five-year National DMPA-SC Accelerated Introduction and Scale-up Plan 2018-2022 ("the DMPA-SC scale-up plan") that focuses on a national roll out of DMPA-SC service delivery through all channels.

Nigeria FP2020 Commitments

- Expand task-shifting policy implementation to include Patent Medicine Vendors and Community Resource Persons to expand access to sexual and reproductive health services in difficult to reach areas and amongst disadvantaged populations.
- Deliberate efforts targeted at scaling up access to new contraceptive methods including DMPA-SC injection in the public and private sectors, and removal of regulatory barriers that impede access.

The DMPA-SC scale-up plan provides a 5-year vision and roadmap required for the systematic and sustainable integration of DMPA-SC into the Nigerian health system as part of the full basket of family planning methods. The plan's intent is to help the country accelerate progress towards achieving its CPR goals in recognition of the potential of DMPA-SC to rapidly increase the number of family planning users and reach previous non-users. Furthermore, the plan articulates the FGON's intent to optimally leverage the total market -- the public and private sectors -- to maximize the complementary effects of these markets to expand access and equity. To help achieve this vision, the government will make DMPA-SC widely available at all levels of the health care system – at public and private facilities as well as at the community level. This includes rolling out facility and community initiated self-injection service delivery to ensure DMPA-SC reaches new users and expands access for women in hard to reach areas as well as to address unmet need by helping to increase continuation.

This National Guideline for the Introduction and Scale-Up of DMPA-SC Self-Injection ("the self-injection implementationplan") is meant to provide a national direction on programmatic and service delivery decisions related to implementation of the self-injection (SI) component of the DMPA-SC scale-up plan. The purpose of this document is to outline the progressive roll out strategy for SI in sufficient detail to ensure a common understanding and 'vision' by all partners and to guide implementation and ensure SI implementation approaches are in alignment with this vision.

This self-injection implementation Guidelinebuilds on existing global and local DMPA-SC evidence and provides room to learn and reprogram as new research and programmatic evidence emerges. Self-injection evidence to date from Uganda, Senegal, and Malawi shows that self-injection is feasible, acceptable to women and providers, and improves continuation rates, which means more women will stay on a reliable form of contraception rather than switching to a potentially less reliable method or no method.

2 Self-injection introduction strategy

This National Guideline for the Introduction and Scale-Up of DMPA-SC Self-Injection is an addendum to the recently developed National DMPA-SC Accelerated Introduction and Scale-up Plan 2018-2022. It lays out the steps needed to plan and implement a DMPA-SC self-injection program in Nigeria and scale up at the state level.

The national roll-out of DMPA-SC, including self-injection, is planned with the roll of capacity building at facility level over a span of five years, with scale-up to all planned facilities and providers as laid out in the DMPA-SC scale-up plan achieved by 2022. With 36 states and the Federal Capital Territory, the scope of scale-up in Nigeria is very large and includes a wide range of contexts.

The FMOH has developed set targets for the roll out plan which incorporate expansion to both public and private sectors and the community stakeholders. This bold vision of the FGON, is to be supported by the State governments and the implementing partners providing technical and financial support for the implementation of DMPA-SC in the country. In each state, the State Ministry of Health (SMOH) will provide leadership and coordination for stakeholders' meetings and activities. The stakeholders' forum shall be all-inclusive and ensuring active participation and engagement of relevant stakeholders, partners, and bilateral organizations working in the respective states.

The objectives of this Guideline are to:

- Elaborate the DMPA-SC self-injection implementation plan from the DMPA-SC Scale-up Plan

DMPA-SC is a lower-dose presentation of the three-month injectable contraceptive Depo-Provera® in the Uniject™ injection system-a prefilled auto-disable device originally developed by PATH. DMPA-SC contains depot medroxyprogesterone acetate (DMPA) and is administered via subcutaneous injection.

DMPA-SC is small and easy to transport and administer. DMPA-SC is approved for use by drug regulatory authorities in the European Union, United States and NAFDAC in Nigeria.

The World Health Organization (WHO) recommends self-administration of DMPA-SC "in contexts where mechanisms to provide the woman with appropriate information and training exist, referral linkages to a healthcare provider are strong, and where monitoring and follow-up can be ensured."

Source: PATH, 2017. Sayana Press (DMPA-SC in Uniject) Self-Injection research

- Provide country specific guidance and tools to roll out facility and community-initiated SI service delivery to ensure DMPA-SC reaches new users and expands access for women in hard to reach areas
- Provide guidance for adaptation of the DMPA-SC SI plan at the state level
- Outline a monitoring plan to adapt the implementation based on continuous learning

This Guideline lays out the various considerations and decisions needed to implement and scale-up a self-injection plan, including:

- DMPA-SC Self-Injection Roll-out
- Provider training
- Client training
- Supply chain
- Waste disposal
- Demand generation/advocacy
- SI provider supervision, client follow-up, data reporting
- Monitoring, reporting and supervision

2.1 DMPA-SC Self-Injection Roll-out

This document lays out the implementation guidelines for DMPA-SC self-injection program implementation based on decisions made by the FMOH. The Reproductive Health (RH) Division of the Family Health Department in the Federal Ministry of Health led the development of this self-injection scale-up Guideline and will be the lead authority to oversee the national roll-out and implementation of DMPA-SC self-injection services, in coordination with the State Ministries of Health. There are many international donors, local and international implementing partners who are also involved in the scale-up of DMPA-SC and will likewise be involved in the scale-up of self-injection. All implementing partners are encouraged to include DMPA-SC SI in their package of service delivery and trainings. Refer to the DMPA-SC scale-up plan for more detail on the role of each implementing partner in DMPA-SC scale up.

The National Reproductive Health Technical Working Group (NRHTWG) is an existing source of coordination and decision-making for RH programming. The NRHTWG, which consists of government, donors, and implementing partners, is already involved in coordination of the scale-up of DMPA-SC programming (i.e. validation of the DMPA-SC scale-up plan). Integration of self-injection into this coordination mechanism is a natural fit. A DMPA-SC subgroup is being planned to focus specifically on coordination and funding issues related to DMPA-SC and self-injection. This subgroup will provide their recommendations to the NRHTWG who will make final decisions.

2.1.1 Self-injection enabling environment

In 2016, theNational Agency for Food and Drug Administration and Control (NAFDAC) in Nigeria approved the self-injection label for DMPA-SC. This is a first step in rolling out a self-injection program. In Nigeria, those providers who are already legally allowed to administer DMPA-IM will be able to provide DMPA-SC, including for self-injection. However, one of the goals of self-injection is to increase access to women who may not have easy access to a health facility or to higher cadre medical providers. For this reason, the Federal Ministry of

Health is planning to expand the national Task-Shifting and Task Sharing Policy for Essential Health Care Services in Nigeria which was approved in October 2014. The pending update to the policy has the potential to include a wider range of cadre in the provision of DMPA-SC and self-injection, including to those who are often a first point of contact for medical care in their communities.

2.1.2 Geographic area for introduction

The FMOH is planning for a phased national roll-out and scale-up of DMPA-SC, including self-injection. This plan should be adapted to each state context as appropriate through consultation with state and local governments, implementers, FP service providers, and clients (as appropriate) to ensure successful scale-up, while adhering to the core components of the plan.

As per the DMPA-SC scale-up plan, the self-injection scale-up Guideline intends for all states and LGAs to offer DMPA-SC, including self-injection, side by side with DMPA-IM by 2020 in facilities with providers authorized to provide DMPA-IM.

2.1.3 Service delivery channels

The FMOH understands the importance of a total market introduction plan, hence self-injection being introduced in both the public and private sectors from the beginning. This will help to ensure that the geographic spread of DMPA-SC availability is as broad as possible, and self-injection will ensure even greater access by limiting the need to access a health facility.

All newly trained providers will receive training in both DMPA-SC administration and self-injection training at once. As laid out in the DMPA-SC scale-up plan, training will begin at the highest public facility levels (selected tertiary and general hospitals) to develop a cadre of master trainers and supervisors of lower cadres. Once there are sufficient numbers of master trainers, state level cascaded trainings will be rolled out. This state level trainings will incorporate public and private sector health facilities and other health workers of lower cadres in both sectors, including community-based workers who will be trained in self-injection. A brief description of the self-injection scope of practice for each cadre is highlighted in the table below (see Table 1).

Table 1: Authorized providers of DMPA-SC self-injection in Nigeria (in line with TSTS Table of Signal functions)

Title	Role	Facility affiliation
Doctor (public)	• Serve as and train master trainers (select from existing pool) • Monitor lower cadres; • Initiate self -injection • Provide refill and follow up	Public health sector (Tertiary centers, General Hospitals, PHC)
Doctor (private)	• Serve as master trainers (select from existing pool) • Monitor lower cadres in private sector in catchment area • Initiate self -injection • Provide refill and follow up	Private health sector (hospital or clinic)
Nurse (public)	• Serve as master trainers (select from existing pool) • Monitor lower cadres; • Initiate self -injection • Provide refill and follow up	Public health sector (Tertiary centers, General Hospitals, PHC)
Nurse (private)	• Serve as master trainers (select from existing pool) • Monitor lower cadre • Initiate self -injection • Provide refill and follow up	Private health sector (hospital or clinic)
Midwife	• Serve as master trainers (select from existing pool) • Monitor lower cadre • Initiate self -injection • Provide refil l and follow up	Public or private hospital or clinic
Community pharmacist	• Initiate self -injection • Refill • Follow up	Community pharmacy
CHEW	• Initiate self-injection • Refill • Follow up	Public or private clinic
JCHEW	• Initiate self-injection • Refill • Follow up	Public or Private health sector
CORPS	• Refill • Referral • Community mobilization • Follow up	Community level
PPMV *	• Refill • Follow up • Community mobilization • Counselling • Referral	Community level

*-This cadre will only be allowed to initiate SI when the tiered accreditation is passed into law

2.2 Provider Training

With the July 2018 approval of the DMPA-SC scale-up plan, systematic roll-out of DMPA-SC training will begin at all levels of the health system, and the training includes a module on self-injection so that administration and self-injection will be taught at the same time, making self-injection available immediately. In year two of the roll-out plan, DMPA-SC and self-injection will be incorporated into pre-service training curricula for providers to enhance sustainability and cost-effectiveness. This document complements existing Federal Government of Nigeria (FGoN) documents on family planning.

2.2.1 Mode of training

Provider training can take several forms depending on the category of the providers to be trained and the training context:

· Experience in Uganda and other countries indicate that on-site training can save time and funds on provider transport, ensure that multiple individuals at a site are trained, and promote program buy-in among all staff at a facility—not just the few who participate in centralized training. This approach also enables the trainers to conduct general site visits and check in on issues such as product inventory, recording of monitoring data, as well as encouraging a team-based approach where everyone in the facility understands their role and the roles of others in supporting SI.

- Centralized training can be time saving because multiple providers from different clinics are trained at the same time.
- On-site trainings can provide a cost savings as trainees do not need to be transported and housed at a centralized location. It also allows less time away from the facility and more people at the facility to be trained and to understand their role in providing DMPA-SC self-injection.
- Hybrid training is a combination of centralized and on-site training. This can take advantage of the benefits of each of these training methods.
- Refresher training that includes self-injection can be provided to those already trained on DMPA-SC administration.

Experience in Uganda and other countries indicate that on-site training can save time and funds on provider transport, ensure that multiple individuals at a site are trained, and promote program buy-in among all staff at a facility—not just the few who participate in centralized training. This approach also enables the trainers to conduct general site visits and check in on issues such as product inventory, recording of monitoring data, as well as encouraging a team-based approach where everyone in the facility understands their role and the roles of others in supporting SI.

As the program rolls out, the Federal Ministry of Health will continue to monitor and explore new and efficient training approaches that have the potential to contain costs and/or time. This could rapidly increase the pool of SI providers, such as e-learning adaptations of DMPA-SC training materials combined with practical sessions. An example of this is a SI training video, downloadable onto a mobile phone or other devices,which could be used by the provider or client to review the self-injection steps. This video should be adapted in-country into local languages.

2.2.2 Cascade training at state level

In each state, training on DMPA-SC will be organized in a cascade manner starting with the master trainers, then FP service providers at the tertiary, secondary and health facilities. It is expected that in each state, at least 10 master trainers will be identified from the pool of already trained master trainers for FP services. The master trainers will cascade the training within each state as exemplified in figure 1 below.

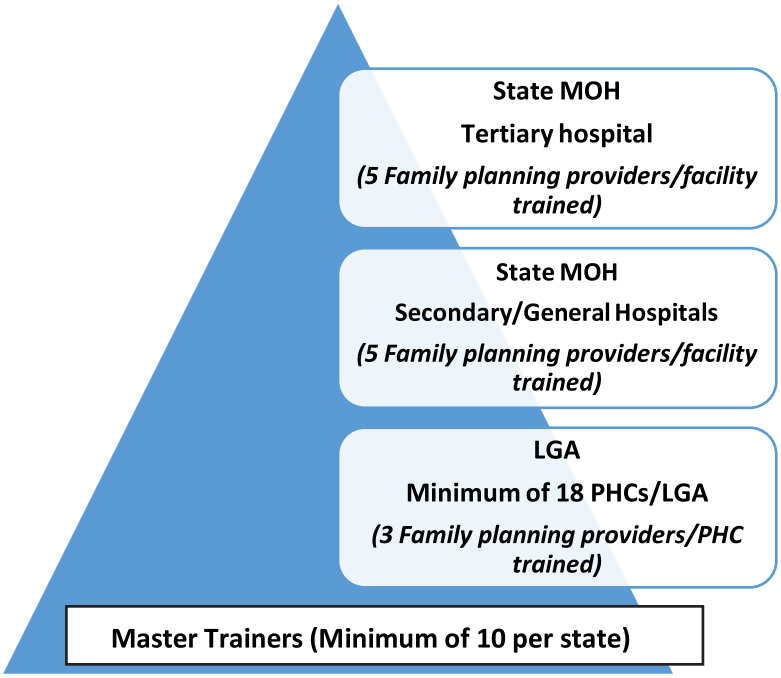


Figure 1: Cascade map for Provider training in 36 states and FCT

Initial training of trainers will take place across the geopolitical zones and involve state FP coordinators and identified FP state master trainers from all the 36 states plus FCT, covering all 774 local government areas (LGAs) in Nigeria.

Trainings should be rolled out in both public and private sectors under the Public-Private-Partnership (PPP) arrangement. Where possible, trainees could be drawn from both sectors to be trained together.

2.2.3 Selection of master trainers

Many states already have a pool of master trainers in family planning who train other cadres of health workers. The basic criteria for the selection of master trainers:

1. Knowledge of family planning procedures and management of side effects, (especially on IM and SC injections); and
2. Number of trainings conducted (minimum of three (3) trainings in the last two (2) years)

The state family planning coordinator should be responsible for the selection of master trainers for SI.

2.2.4 Selection of trainees

At the facility level, criteria for selection of trainees should include:

1. Availability of staff and
2. Priority should be given to the staff currently providing family planning services.

Cadres to be trained on DMPA-SC self-injection initiation and resupply will include doctors, nurses, midwives, Community pharmacist, CHEWS and JCHEWS while other staff including PPMVs and CORPS will be trained on community mobilization, health education & counseling, refill, follow up and referral.

In the private sector, eligible service providers should be selected in collaboration with the regulatory bodies of the private sector and all relevant associations.Selection in the private sector should be based on willingness of the private facilities to participate in the training and provision of family planning services. The highest cadre of health care providers in the private sector (doctors or nurses) should be involved in these trainings and can cascade training to their staff. A set of criteria will be used to guide selection of participants to be trained on self-injection, this includes selecting trainees who already provide a range of family planning products (to encourage informed choice) and be willing to include DMPA-SC in the range of FP services delivered in their facilities and outlets. Participants to be trained must also be willing to document and submit this data to the LGA M&E personnel or contact persons.

2.2.5 Training curriculum

The FMOH has adapted evidence-based DMPA-SC self-injection training materials for use in Nigeria, including accompanying job aids and client tools. There are two versions of the curriculum, one shorter version for health care providers and another version for non-healthcare providers. While all providers will be trained on DMPA-SC administration, including how to counsel clients for self-injection, those with limited medical training will spend additional time training on DMPA-SC, client eligibility, management of complications, its administration, and how to teach self-injection skills and reinjection timing, and FP counseling (on a wide range of available contraceptive methods) and referral for those who choose an option other than DMPA-SC or another method they are legally permitted to administer or sell.

The training curriculum of the public sector should be modified for the private sector. This includes recommendations that at private facilities, the first injection should not be self-injected in order to allow the providers demonstrate effectively how DMPA-SC is administered without wasting one (paid-for) injection.

The training curriculum for private sector should also cover information about any regulatory permissions in terms of scope of practice e.g. Community Pharmacies (CPs) initiation of a DMPA-SC, or hospitals allowing only trained personnel to teach self-injection and not passing the responsibility to any available personnel.

- Injection models: Condoms filled with salt can be used to make demonstration and practice models (assume 4-5 injections per condom model for group trainings before the model becomes inelastic)
- One DMPA-SC unit for demonstration at group trainings
- Video demonstration
- Instruction sheet/job aid for providers and self-injecting clients
- Calendar for client re-injection dates for all the injections provided to them to take-home
- Puncture proof containers for storage of used DMPA-SC units

Figure 2: Supplies needed during training for Providers and Clients on Self-injection

All providers trained in DMPA-SC will also be trained to teach self-injection, as it is part of the full training curriculum. Table 2 (taken from the DMPA-SC scale-up plan) shows a national summary of providers to be trained in DMPA-SC (and self-injection) from 2018-2022.

Table 2: Cumulative Service Provider Projection by facility type 2018 – 2022 among all 36 states and the FCT

SDP Type	No. of providers				
	2018	2019	2020	2021	2022
Tertiary Hospital	185	185	185	185	185
General Hospital	1,850	3,870	3,870	3,870	3,870
PHCs	21,000	41,796	41,796	41,796	41,796
Private Hospital	9,990	19,980	19,980	19,980	19,980
Total Facility -based providers	**33,025**	**65,831**	**65,831**	**65,831**	**65,831**
CBD (Public)	35,000	69,570	69,570	69,570	69,570
CBD (Private)	2,500	7,500	10,000	10,000	10,000
PPMVs	74,000	148,000	148,000	148,000	148,000
Community Pharmacies	2,775	5,550	5,550	5,550	5,550
Total community-based providers	**114,275**	**230,620**	**233,120**	**233,120**	**233,120**

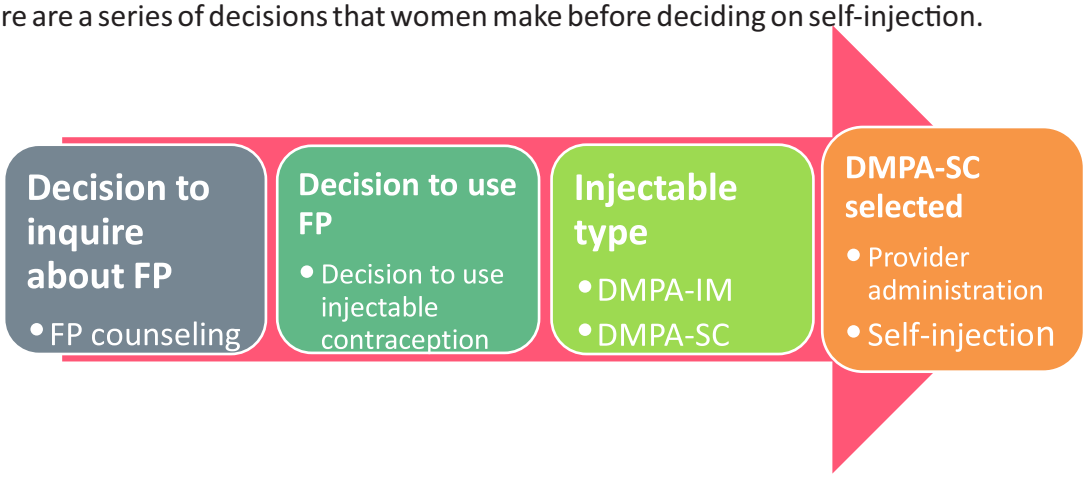
2.3 Client self-injection journey

Figure 3 contains three journey maps of the continuum of the self-injection client's experience in three different provider contexts (public health center, community pharmacists and CORPs), from training to resupply. Journey maps are user centered design visual frameworks that help designers/implementers understand and address client and provider experiences, perspectives, and needs by walking through every step of a program. As self-injection enters new states, there could be benefit in repeating this exercise for each state context.

The goal of DMPA-SC self-injection is to increase women's control over whether and when to have children, and to decrease the time and cost associated with frequent trips to a clinic by allowing her to administer contraception on herself in the privacy of her home.

2.3.1 Client training

There are a series of decisions that women make before deciding on self-injection.



Women can be trained on self-injection individually or in small groups depending on the ability and capacity of the facility or community provider. If there is a low client flow, then individual training sessions are recommended. However, if there are many clients awaiting self-injection training in a high-volume facility and the providers have limited time, then small group (not more than 10 women) training may be acceptable with extra thought put into ensuring quality services for women including one-on-one time for FP counseling.

PATH is conducting a study in Uganda to evaluate if women can learn the self-injection steps through provider demonstration only, with no practice. The results will be available in quarter one of 2019. This can save training costs and wastage of DMPA-SC units if practice injections are not required to develop client self-injection

During the training session, the service provider will demonstrate to the client(s) steps that have to be followed for a successful DMPA-SC self-injection.The client(s) should be asked to service provider demonstrates.

In a self-injection pilot study in Uganda, women attempted to self-inject during their first training, and if deemed competent, they were sent home with DMPA-SC units to self-inject on their own. In a Senegal pilot, women also self-injected under provider supervision during their first training, but then were instructed to return to the provider to again self-inject under provider supervision. However self-injection competence rates 3-months post-provider supervised injection training were higher in Uganda (88%) than in Senegal (87%).

In order to avoid unnecessary wastage of the product, women will be supported to learn the injection steps by use of clear visual/written instructions and a video demonstration of self-injection techniques. The service provider may also demonstrate the self- injection steps on a model during training but void activating the device, so that one unit can be used several times.

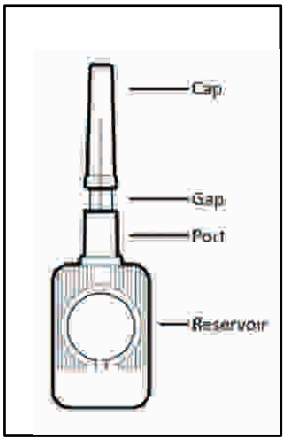
The supplies needed for group client self-injection training are the same as those for provider training and are listed in Figure 2.

Training of client for self-injection should emphasize competency-based learning. At first visit, once the client shows willingness to self-inject, she should be allowed to administer DMPA-SC on herself under supervision of the FP provider. Clients will only be supplied doses of DMPA-SC to administer at home only after the second visit to health facility. During the second visit, the client will be observed to conduct self-injection and if she is assessed as competent, the Provider will supply two doses of DMPA-SC, a calendar and Job aid.

2.3.2 First injection

1st Injection

After the demonstration of the self- injection steps, facility or community-based provider will then ask the woman (if ready) to follow the Job aid and give herself the first self-injection .The service provider should remember to ensure privacy and confidentiality, for example, if the clients were trained in a group it may be necessary to call one at a time to a private injection room. The service provider will supervise and immediately correct any errors on any of the steps as the woman first-injects herself to ensure a correct and safe injection. The provider will then assess, using clinical judgement, client competency at self-injection, which is assessed based on correct performance of the four critical steps to self-injection. Missing any of these four critical steps could lead to an



ineffective injection. A visual step-by-step job aid will be used to help the provider decide if the client is competent and has correctly performed the four critical steps. The steps are:

- ***Mix the solution by shaking vigorously for 30 seconds.***
- ***Push the needle cap and port together to activate the device.***
- ***Pinch the skin to form a "tent" and insert the needle.***
- ***Squeeze the reservoir slowly, for 5 to 7 seconds, to inject the contraceptive***

- If the client is classified as competent by the provider, she is given an appointment for the second injection which is due after three months. During the next visit, the service provider should review the self- injection steps with the client(s). The client should be asked to self-inject under supervision of the service provider. The client can now be given (or sold in the private sector) two units of DMPA-SC for the subsequent re-injections, the illustrated self-injection Job aid and a calendar marked with her reinjection dates, and either given or told where she can obtain an impermeable container for safe disposal of used DMPA-SC units. In addition, if she has a mobile phone with android device, a self-injection demonstration video could be sent to her mobile phone, for use as a self-injection guide at reinjection and reminder calls can be set up to prompt the clients a week before the next injection/refill, and on the day of the next injection/refill. The reminder call system is a toll-free line and is designed to aid client compliance. The provider should also discuss with the client her options forwhat to do in case she needs follow-up care after self-injection. Client follow-up and support should be consistent with the usual health system practices in Nigeria

Skin preparation of patient before injection.

"Although skin that is visibly soiled or dirty must be washed, swabbing the clean skin of a patient before giving an injection is unnecessary. Studies suggest that there is no increased risk of infection when injections were given in the absence of skin preparation. Bacteria from the skin flora might be introduced through skin piercing. However, most of these bacteria are non-pathogenic and the number introduced is lower than the minimal infectious dose for pus formation. Skin-preparation protocols traditionally used, including wiping with 70% alcohol, may be insufficient to eliminate the skin flora because of a limited contact time. While the benefit of skin preparation is unclear, unsafe skin preparation protocols may be harmful".
Therefore, sterilizing injection site may not be necessary prior to self-injection, rather if the skin is visibly dirty, the woman is advised to take a bath or simply wash the skin area before self-administering the injection.

Hutin, Y., Hauri, A., Chiarello, L., Catlin, M., Stilwell, B., Ghebrehiwet, T., & Garner, J. (2003). Best infection control practices for intradermal, subcutaneous, and intramuscular needle injections. *Bulletin of the World Health Organization, 81*, pp 491-500.

- If the client is evaluated as not proficient, she should be advised to return to the clinic in three months for retraining (if she wants to try self-injection again) and not given product

[1]Provider supportive supervision is very important to ensure that client training is being done correctly and that self-injection clients are being recorded in the client registry.

to take home. The provider should administer DMPA-SC again on the client. If she opts for another method, she should be given an alternate family planning option of her choice in the meantime (e.g., provider injection).

2.3.3 Client device storage at home

Women should be advised to store extra DMPA-SC devices at home safely, at room temperature, out of the sun, and out of reach of children and animals. Evidence shows that popular storage locations for women include her handbag, dresser, and luggage.

2.3.4 Client follow-up support (if needed)

Clients should be instructed that, if needed, follow-up support should be sought from a facility provider or community-based provider trained in DMPA-SC. Clients could reach out to the trained PPMVs, community pharmacists and CORPs working in the community for follow up assistance, counseling, clarifying doubts and reporting adverse effects or complications they might notice. Client follow-up and support should be consistent with the usual health system practices in Nigeria.

2.3.5 Reinjection

The client should use the calendar provided at her initial self-injection training to determine her next injection date, or an appointment card if this is what she is given by her provider. The National DMPA-SC Accelerated Implementation and Scale-up Plan also references the development of a mobile-based reminder system for injections that will be developed for DMPA-SC. The client's next injection is on her own using the client instruction sheet/illustrated Job aid as a guide; if she is not confident or decides she does not want to self-inject, she should return to the facility or community-based provider for retraining, reinjection or a different FP method.

There is a grace period or “window” of two weeks before and four weeks after the specific reinjection date during which contraceptive coverage will be continuous. It is important to tell women that if they are more than four weeks late, they should use alternate contraceptive protection and return to the health facility for counseling and pregnancy screening. They can either restart DMPA-SC or switch to a method that may work better for their particular circumstances.

Note: if women give themselves a reinjection within the window but different from the initial reinjection dates calculated with the provider, she will need to independently recalculate her NEXT injection dates (depending on how many units she's given). She should also be encouraged to seek help from available resources (PPMVs, CORPs, CHEWs, health facility) if needed.

2.3.6 At-home waste disposal

Evidence shows that an effective, safe, and acceptable way to dispose of used DMPA-SC units (which are medical waste) is to place the used device in the puncture-proof container with the needle pointing down. The client then stores the container with the used devices out of reach of children. She then returns the container with the used devices to a health facility or community health worker at her convenience. Proper disposal practices remove the used sharps from circulation and reduce the risk of needle stick injuries and infection.

Training on waste disposal should include emphasis that clients should store used injections at home in plastic puncture-proof containers until they return to a provider or until a CORPs/CHW can pick up the units. Clients will be instructed to return used units to the health facility or other outlets such as the CP. The global evidence on waste disposal of self-injected DMPA-SC units is still being generated, so different contexts may require different solutions. If evidence and lessons can be gathered from different methods of waste disposal then the evidence base will be enriched. Linking with any other initiatives on medical waste in the country may also be helpful.

2.3.7 Client resupply

After the client has used her supply of DMPA-SC units and before her next injection date, she should return to the provider for resupply (assuming she wishes to continue self-injecting). After confirming that she is still eligible and intends to continue withDMPA-SC and self-injection., the provider should ask if the client had problems reinjecting, if she reinjected on time, and how she stored/disposed of device. This is also a time for the client to return used units stored in the impermeable container.

Before providing more DMPA-SC units, the provider should check the client's eligibility to continue DMPA. The provider also assists with scheduling and provides supplies for next injections, and records relevant data in the registry.

Some women will want to continue with SI and some won't. For women who choose not to continue with self-injection, they should be counseled on all methods again, including provider-administered DMPA-SC, so that they can choose a method that is more appropriate for them.

Though DMPA-SC has a lower dose and shorter needle than DMPA-IM, they are interchangeable as the core contraceptive benefits are the same. This means if a woman starts on DMPA-IM, then changes to DMPA-SC in hopes of self-injecting, but finds that she does not prefer this, she can change back to DMPA-SC or DMPA-IM injections from a provider.

This is also important because if there is a stockout of IM or SC, the other can be provided to clients to ensure continuity of contraceptive coverage.

2.4 Advocacy, Demand Generation and Communication

The DMPA-SC scale-up plan includes a demand generation plan (Table 6 of DMPA-SC Scale-up plan), and self-injection should be incorporated into that plan. This national strategic plan also emphasizes the importance of targeted social behavior change communication as a means to orienting, informing and educating the public on vital information related to DMPSC-SC to improve awareness, visibility, access and mitigate misconceptions. This strategic approach will also be useful in promoting family planning and contraceptive practices by both men and women, adolescent and married women. DMPA-SC requires a clinician's prescription before initiation, even if self-injection is desired after DMPA-SC initiation. Thus, providers play an important role in creating awareness and in client education to promote access and demand for DMPA-SC. Beyond the health facility, mass media and other avenues will be used to broaden information dissemination on DMPA-SC as part of the FP method mix to educate the public and policy makers on its benefits and opportunities.

However, some providers could restrict access based on personal bias or disincentives to provide a product that requires fewer clinic visits and in the case of the private sector, reduces consultation fees in the aggregate. Recent research from Nigeria suggests that some providers restrict method choice for their adolescent clients, with a reduced propensity to discuss hormonal products, including injectable contraception. Programs may want to consider integrating adolescent RH modules into the DMPA-SC training to counteract provider bias. Potential client education through mass media campaigns that create general awareness for contraception use and also go into appropriate detail about each method in the FP method mix, can also help to overcome challenges with provider bias by empowering potential clients/clients to better understand their family planning options. Providers may appreciate that reduced clinic visits by self-injection clients will reduce the burden on the health system and allow providers more time and resources for more complex conditions.

Implementers should tailor some messages to specific groups who may benefit from the self-injection option (unmarried women, young mothers, different religious contexts, etc…). This could help to overcome provider bias, which may restrict access to SI to underserved populations such as adolescents, and poor/less educated women.
The FMOH and NPHCDA would leverage on the existing National Communication Plan that would drive the demand generation component of SI at both the national and community level. Each state is expected to adapt the national communication plan to their specific needs and operationalize at the community level. The communication plan has details of implementation plans for the national level that could be adapted at the state level and the plan should beexecuted with support from the state FP coordinator. At the LGA levels, there are also HEs who would support the process at community level.

The Health Educator with support from the state FP coordinatorshould integrate DMPA-SC SI demand generation activities in their states and LGAs. The Social and Behaviour Change (SBC) communication materials in the national communication plan would then be adapted for each state's unique culture, language and religious diversities. The LGA Health Educator is expected to provide orientation on how to use each SBC materials at their levels to generate demand for DMPA-SC SI. At the community level, Community Health Influencers Promoters

[2]Taken from UCSF's report on “Preparing to implement self-injection of DMPA-SC in Nigeria: Possibilities, realities, and potential challenges”

and Services (CHIPS) and Community Volunteers (CVs) would be recruited for mobilization at the community level.

2.4.1 Private Sector

It is important for private sector providers to be engaged in the national communication plan so that they are in line with approved national messages. The FGoN can also leverage the corporate social responsibility of some private sector organizations and this support could be in the form of sponsorship of mass media messages, digital media messaging, radio/television drama or playlets among others.

2.4.2 Traditional Mass Media

Traditional mass media such as newspapers, radio, television, or digital outlets, in many settings, are well-respected influencers of public debates. Media engagement can be an effective tool for advocacy and could be used to inform clients as well as policymakers and health decision-makers about DMPA SC and other FP products and the potential for deployment of DMPA-SC self-injection, to expand contraceptive access and increase choice. At the same time, mass media can help inform women about contraception and encourage them to speak out when visiting their health providers for greater access to a broad range of quality methods.

The national communication plan can be used to design mass media materials, and these could be adapted for each state and similarly modified for relevance in the private sector, and disseminated by the local mass media channels (radio and TV stations) in the country. Community radio, where available, can be very effective in this regard and town announcers could also be employed where appropriate. In addition, clients should be allowed to have access to SBC materials through the use of printed educational pamphlets that capture DMPA SC and self-injection as part of the FP method mix and this should include educational materials that are tailored towards adolescent and youth.

2.4.3 Digital Media

Digital media, which includes all forms of communications on all digital media platforms can be a powerful tool for advancing advocacy efforts to increase contraceptive choice and access among potential clients, with more chance of success among adolescents and youth. It can help to reach a broad young audience and amplify a message quickly. Devolving from the national communication plan, digital media would be appropriately deployed to meet the needs of local populations. These digital media channels would be used to reach the priority audiences for DMPA-SC SI. The digital media platforms of international and local implementing partners and community-based organizations can be used to promote messages around the introduction, availability and accessibility of DMPA SC and around the provision of self-injection in different settings.

2.4.4 Community Based Approaches

Based on the needs of each state and communities, the State Ministry of Health (SMoH) personnel would employ the most appropriate community-based approaches to reach the priority audiences. There are:

- **Community dialogues:** This is a gathering of community members to discuss health and social issues for which intervention is being made. It entails questions and answer session. This would be very useful in introducing FP methods with community members. It is good to have a HW along with facilitators to build confidence in the community members
- **Community meeting:** This occurs when the whole community needs to take a decision on any health and social issues. It requires a skilled facilitator to arrive at a consensus
- **House to house visit:** This is more personalized to each family and gives room for one-on-one interaction. It helps more reserved community members to ask burning questions which ordinarily would not be asked at community dialogue
- **Compound meeting:** This is usually for different gender, specifically the female gender in communities where they are not allowed to go out or mix with other gender. Questions could also be asked and answered without much inhibitions
- **Age grade meetings:** Peer support could be very helpful in shaping behaviour and if properly facilitated could be employed is selling DMPA-SC SI to potential users. This is especially important for young mothers, youth and adolescent groups that DMPA-SC SI is being targeted
- **August meeting:** Usually in south-east and some south-south states. It is a potent avenue to real large female audiences at the same time with messages around health and social issues
- **Community theatre (Drama):** This is actually a tool that could be employed in all of the forums earlier discussed above

(Refer to the National FP communication plan for more community-based approaches)

2.4.5 Facility Approaches

Health information and education are critical to behaviour change and are best provided by the service providers at the health facilities. To be effective, service providers must be well informed themselves and have relevant skill, good disposition and attitude to communicate and disseminate useful information that will guide clients to make informed choices. These approaches will include:

- **Inter personal communication (Counselling):** Authorized health workers would be expected to counsel potential clients on the full range of available methods, including DMPA-SC and the option for self-injection. However, service providers should be encouraged to acquaint themselves with key messages about family planning and family planning methods so that they are able to precisely and clearly provide useful information to the clients within the available and short time opportunity.
- **Job aids for authorized health workers:** Deriving from the national communication plan, all necessary materials needed by these health workers to carry out their duties effectively and efficiently should be produced and disseminated to facilities by the FGoN with support of implementing partners, the private sector and donor organizations.

- SBC materials like banners, posters and infographic fliers explaining the general features of DMPA SC and the procedure for self-injection should also be available within health facilities to make it easier for Health workers to describe self-injection to all potential DMPA SC clients. Clients who show interest in self-injection will also be given appropriate SBC materials as reminders by the health workers.

2.4.6 Advocacy

Most DMPA-SC advocacy needs in Nigeria are general, not SI specific, so are laid out in the National DMPA-SC Accelerated Implementation and Scale-up Plan. The UCSF report on "Preparing to implement self-injection of DMPA-SC in Nigeria: Possibilities, realities, and potential challenges" notes that there could be a potential disincentive for certain providers (such as some private providers) to encourage self-injection. The MOH may want to consider temporary measures (e.g., monetary or non-monetary rewards, peer competition) to address disincentives to SI service provision among some private providers. In addition, it could help to incorporate SI guidelines into professional practice guidelines and training curricula.

As part of the total market approach, government should ensure that policies are available to support the private sector in the provision of contraceptive products and services and in the dissemination of potential client communication via mass media and digital media while ensuring compliance with FGoN public health standards and guidelines. Advocacy efforts to the private sector should incorporate the need for equity, affordability and quality services to women who seek care and family planning services in private sector. Advocates should also take into consideration establishment of workplace and youth-friendly policies that promote access to FP information, products and services

2.4.7 Champions

Influential people such as community heads, influencers, and opinion leaders who are supporters of self-injection can become champions. Champions can facilitate and enhance efforts for advocacy, demand generation, and other activities to increase access to and use of DMPA-SC and self-injection.

2.4.8 Youth Friendly Family Life and HIV Education (FLHE)

Youth Friendly services such as Family Life and HIV Education (FLHE) curriculum should be incorporated into in-school and out-of school programs. In-school education could be carried out as a short course and also provided to parents during PTA meetings. This will require collaboration between Ministry of education and Ministry of youth to ensure that age-appropriate SRH information is provided to young people. Youth friendly services will be provided in traditional and non- traditional outlets as well.

2.5 SI Provider Supervision, Client follow-up and Data reporting

For data collection from facilities in the private sector that do not regularly report into the National Health Management Information System (NHMIS), M&E officers from the LGAs

[3]Family Planning Evidence Brief. Available at http//apps.who.int/iris/bitstream/handle/10665/255860/WHO-RHR-17.08-eng.pdf?sequence=1. Accessed on 26th November, 2018.

should be tasked with carrying out monitoring at these private sector facilities. However, to improve the ease of collecting the data records, FMOH will leverage existing partnerships with private implementing partners (e.g. social marketers in supply chain) to assist with collecting and transferring data recorded by the facilities to the LGA M&E officers who would then enter this data unto the national DHIS-2 and FP Dashboard.The FMOH will also ensure that all the respective facilities represented at trainings are mapped out and captured on the national DHIS-2 and FP Dashboard.

For supervision, FMOH will create a supervision checklist tailored to private providers' activities. For community pharmacies and PPMVs, FMOH will also partner with Pharmacists Council of Nigeria (PCN) to include the use of this checklist when visiting the premises of DMPA-SC trained providers. LGA FP Coordinators will extend their supervisory responsibilities beyond the public sector, to include private DMPA-SC providers at hospitals, CPs and PPMVs working in the communities.

Referral processes for all sectors need to be strengthened for self-injection, but in particular for PPMVs and CPs who will be new to injectable contraceptives and issues such as management of side effects. The FMOH, working with the State MOH and implementing partners, will provide regular supportive supervision to these community structures to ensure effective linkages and referral networks are established between them and the health facilities. The network system will be arranged in a “hub and spoke pattern” such that CPs, PPMVs and CBD agents are aligned to specific health facilities within their catchment area and this will aid data collection and reporting.

For private sector facilities, critical linkages with the public sector will be identified and strengthened for supervision, data collection and regulation at the LGA level by the implementing partner supporting the SMOH.

Supportive supervision will be carried out by the LGA and State level focal persons to health facilities, CPs, PPMVs and CORPS/VHWs to mentor, guide and assess their performance with a view to ensuring compliance to the national implementation guideline for DMPA-SC. Feedback on data gaps, none or incomplete reporting will be followed up and addressed.

Regulation of these facilities should be implemented by the responsible parties i.e. PCN for CPs/PPMVs, the Medical and Dental Council of Nigeria and State Hospital Management Boardsfor hospitals. Regulations should emphasize that:

- Training of clients to self-inject should be done only by the trained private sector providers
- Providers should commit to pharmacovigilance (report of adverse events)
- Quantity of DMPA-SC that is dispensed to clients for self-injection should be limited to two units only
- Facilitate prompt and accurate reporting of DMPA-SC utilization/consumption

2.6 Monitoring, Reporting and Supervision

There are existing systems for data management, monitoring and evaluation in the country for tracking progress on family planning interventions. This data management system shall be

strengthened through capacity building of users, availability of data collection tools (NHMIS tools) at the SDPs, LGA and State levels and improving quality of reporting by all implementers and users. The Federal Ministry of Health has developed NHMIS tools which include family planning (FP) registers, client records and monthly summary forms at the health facilities. These registers are completed by the facility FP focal person with individual client's information.This is then summarized at end of every month into the summary report template for uploading to the DHIS-2 platform by the LGA M&E officer with support of the LGA FP person. At the state level, data validation takes place and training report on Family planning (including DMPA-SC) are uploaded into the FP Dashboard. Data from the public and private sectors will come from routine national systems, such as the LMIS and NHMIS, user surveys and the FP Dashboard. Routine systems already in place channel data generated at delivery points through the state level and eventually into the federal level data sources. Thus, DMPA-SC data from indicators already available at the federal level will be extracted from the federal data sources such as the District Health Information System (DHIS), the FP Dashboard and periodic surveys such as the National Demographic and Health Survey (NDHS).

The frequency of data collection will vary with indicator and data source. Some of the data sources such as the FP Dashboard and the DHIS-2 are updated on a monthly basis while the PMA 2020 is a biannual survey. The NDHS occurs once every 5 years. Program reports from implementing partners also follow varying timelines.

The private facilities will also be supplied with NHMIS tools for recording and reporting of FP services including DMPA-SC. Another source of data from the private sector will depend on program reports, sales forecasts and other summary reports from social marketing organizations and partners implementing programs in the private sector. However, for PPMVs and Community Pharmacists (CPs), data flow in-country already require for them to be linked to a health facility in the public sector. Thus, it is anticipated that DMPA-SC data among this segment of the private sector will flow into the public sector health data systems.

Forums for updating progress on DMPA-SC implementation include the National Reproductive Health Technical Working Group, DMPA-SC steering committee, and other ad hoc meetings with partners. Data will be validated during these stakeholders' meetings and triangulated between partners to the extent possible. The Research, Data Monitoring and Evaluation subcommittee of the NRHTWG is responsible for data triangulation, for use and decision-making on FP programming in Nigeria. The subcommittee, led by the FMOH, collates data and progress reports from all partners that contribute to RH and FP and advises the larger NRHTWG. The subcommittee has revised the Family Planning register, the major tool that is used to track client-related information on FP at the SDPs. The committee recently worked with partners to disaggregate injectables, so as to provide clearer insight into the proportion of women who use each of the injectable methods, inclusive of DMPA-SC. The committee included an indicator to track the demographics of women who opt to self-inject. The Monthly Summary Forms (MSFs) are used to report the SDPs level information to the LMCUs at the LGA level. Data entry is done at the LGA levels into the NHMIS. The NHMIS/DHIS-2 has also been updated to include SI. Subsequently, other data platforms like the FP Dashboard which derive information from the DHIS-2 will be updated to include information of women who opt to self-inject for DMPA-SC.

Figure 3: Self-Injection Journey Map

Primary Health Care centers (PHCs)

Demand generation	Client training	First self-Injection	Storage at home	Follow-up	Re-injection	Waste disposal	Resupply
PHC facilities and other selected service delivery points offer DMPA-SC and self-injection services Providers at selected service delivery points are trained in DMPA-SC and self-injection and FP counseling skills Providers conduct health talks addressing potential client perceptions about injecting DMPA-SC, fear of injection, and encourage good provider client relationships Providers offer IEC materials on FP Providers offer sessions on male involvement in FP Current users recruited to share their positive experiences with FP and DMPA-SC	After counselling on all FP methods, client chooses DMPA-SC Depending on client load, provider decides if training should be one-on-one or group training Provider assesses client's literacy level to select appropriate training materials Provider trains client using job aid, self-injection video, and other available training materials as appropriate/demonstration	Provider ensures that client is confident and competent to self-inject Provider enquires about spousal consent and support Provider talks to client about where and how to store unused DMPA-SC Provider talks to client about how to store and dispose of used DMPA-SC devices Client is given a job aid, calendar, and a container in which to dispose of used devices OR instructed on how to find an appropriate container Client selects the reminder/follow-up option they prefer from messages/phone calls/SMS, if available and desired	Client identifies a discrete location for storage of the DMPA-SC units that is out of reach of children and animals If appropriate, the client can disclose the use of the DMPA-SC to her spouse	Client decides if she wants to follow up at the clinic with the provider Reminder messages/ phone calls/SMS from the provider are an option if available and desired by the client	Client decides if she wants to continue with DMPA-SC and/or self-injection or switch to a different method She visits facility for reinjection (second supervised self-injection during training) or reinjects at home if approved to independently self-inject	Client identifies an appropriate storage container for used DMPA-SC devices Client stores used devices in the container until she can return them to a service provider. Client brings used DMPA-SC devices back to PHC as evidence of used commodity in order to obtain more units of DMPA-SC; PHCs have appropriate waste disposal available at the facility	CHW or provider at other refill location asks if client had problems reinjecting, if she reinjected on time, and how she stored/ disposed of device Client's eligibility to continue DMPA is assessed Provider confirms that client wishes to continue self-injection Provider assists with scheduling and provides supplies for next injection. Client pays for more devices (free in some facilities?) at the resupply location

Community Pharmacists (CPs)

Demand generation	Client training	First self-injection	Storage at home	Follow-up	Re-injection	Waste disposal	Resupply
Potential clients are reached with messages on DMPA-SC, self-injection, and family planning through digital media, radio, and posters and fliers Potential clients are reached with messages on DMPA-SC, self-injection, and family planning through interpersonal communication, peer education, and a community-based house-to-house approach CPs stock and provide educational materials on DMPA-SC and self-injection for client education. Possible materials include a pictorial job aid, a self-injection video	After counselling on all FP methods, client chooses DMPA-SC (CP refers client if she selects a method the CP is not able to provide) Depending on client load, PPMV decides if training should be one-on-one or group training PPMV assesses client's literacy level to select appropriate training materials CP trains client using job aid, self-injection video, and other available training materials as appropriate/demonstration	CP ensures that client is confident and competent to self-inject CP enquires about spousal consent and support CP talks to client about where and how to store unused DMPA-SC CP talks to client about how to store and dispose of used DMPA-SC devices Client is given a job aid and calendar, and is instructed on how to find an appropriate container for storage of used DMPA-SC units before disposal Client selects the reminder/follow-up option they prefer from messages/phone calls/SMS, if available and desired	Client identifies a discrete location for storage of the DMPA-SC units that is out of reach of children and animals If appropriate, the client can disclose the use of the DMPA-SC to her spouse	Client decides if she wants to follow up with the CP Reminder messages/ phone calls/SMS from the CP are an option if available and desired by the client	Client decides if she wants to continue self-injecting with DMPA-SC or to switch to a different method She visits CP for reinjection (second supervised self-injection during training) or reinjects at home if approved to independently self-inject	CPs advise women on how to store and dispose of used DMPA-SC units at home, out of reach of children and animals If clients return used DMPA-SC devices to the PPMV, they dispose of them safely	Clients return to the CP for a resupply of DMPA-SC CPs stock and sell DMPA-SC CPs purchase DMPA-SC at an affordable price and sell at an affordable price that still allows them to make a profit

Community Health Workers (CHWs)/Community Oriented Resource Persons (CORPs)

Demand generation	Client training	First self-injection	Storage at Home	Follow-up	Re-injection	Waste disposal	Resupply
CHWs are trained on DMPA-SC and other FP methods and provided with IEC materials CHWs generate demand for DMPA-SC and self-injection through sensitization talks at women's groups, child welfare and antenatal clinics, and health centers in their communities CHWs hold community sessions to increase male involvement in FP	After counseling on all FP options, client expresses interest in DMPA-SC CHW refers client to health facility or clinic FP provider assesses client eligibility for the injectable contraceptive using the Medical Eligibility Criteria (MEC) wheel and provides FP counselling FP provider train clients using the pictorial job aid, self-injection video, and/or practical demonstration on a model FP provider provides client with self-injection aid and calendar	FP provider provides a private space for the first self-injection FP provider provides information on possible side effects FP provider coaches the client during the first injection FP provider uses the pictorial job aid to assess client competence in self-injection CHW tells clients how to store unused DMPA-SC devices at home and how to properly dispose of them; asks client for ideas on where she can store the devices in her home Client chooses a reminder/follow-up option for her next injection (appointment card or SMS/text reminder)	Client identifies an appropriate storage location at home out of reach of children and animals If appropriate, the client can disclose the use of the DMPA-SC to her spouse	CHW uses agreed-upon option for client follow-up and ask the client about side effects	Client decides if she wants to continue self-injecting with DMPA-SC or to switch to a different method She visits facility for reinjection (second supervised self-injection during training) or reinjects at home if approved to independently self-inject	Client stores used DMPA-SC unit in an impermeable container out of reach of children and animals until disposal Client gives container to CHW for return to a health facility for disposal OR brings the container to a health facility for disposal at her convenience	CHW assists clientsto refill, asks if client had problems reinjecting, if she reinjected on time, and how she stored/ disposed of device Client's eligibility to continue DMPA is assessed Provider confirms that client wishes to continue self-injection Provider assists with scheduling and provides supplies for next injection. Keep record on consumption Fill SOP RIRF Collect supply from LGA store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