



The introduction of subcutaneous DMPA (DMPA-SC, brand name Sayana® Press) promises to expand women's access to family planning options by increasing opportunities for lower-level health workers and even clients themselves to administer injectable contraceptives. Insights from the first introductions can help inform new country experiences and transitions, whether small pilots or scaled delivery. This section discusses results and lessons learned during introduction pilots in four countries and provides recommendations to guide future efforts by ministries of health and implementing partners related to **planning the country introduction strategy**.

INTRODUCTION PLANNING PROVIDES A ROAD MAP

Introduction of DMPA-SC can increase contraceptive access for women and adolescent girls. Traditionally, injectable contraception has been most widely available in clinics. Because administration of DMPA-SC requires minimal training, it is especially suitable for use in more remote settings and community-based distribution (CBD).

At the beginning of PATH's coordinated pilot introduction efforts for the DMPA-SC product, Sayana Press, in Burkina Faso, Niger, Senegal, and Uganda, each country developed an introduction plan to harness this subcutaneous DMPA product's potential.

These plans served as road maps, providing an overview of each country's family planning goals and a corresponding approach to integrating the product into their program. The introduction plans generally included:

- Overview of the country's family planning landscape and goals.
- Country need or rationale for subcutaneous DMPA introduction.
- Description of introduction strategy, including:
 - » Service-delivery channels (e.g., public or private sector, clinics, communities, or pharmacies).
 - » Geographic area for introduction.

- » Partners and their roles.
- » Distribution plans.
- » Training plan: number of providers to be trained, approach, timeline.
- » Approach to demand generation and communications.
- » Monitoring plan: indicators, reporting system.
- Product registration status and procurement plans.
- Description of any research or evaluation activities.



INTRODUCTION TIP

The key components of a DMPA-SC introduction plan are also applicable to a scale-up plan. Some introduction plans may include budget provisions or sources of financing.

- Plans for scaling up.

Developing the DMPA-SC introduction plans with national partners and validating the plans with a broader set of national family planning stakeholders helped generate buy-in and support, as well as a common vision. Each country's coordinator was responsible for shepherding the plan to completion. National family planning partners reviewed the introduction plans in a workshop or meeting

forum, and the national ministry of health (MOH) validated the plans before introduction got under way.

The planning phase is an opportunity to carefully think through a monitoring and evaluation approach for pilot introduction. The approach should consider what results are expected or hoped for, and what systems and resources are available to measure those results. During the pilot introductions, all countries elected to initiate use of DMPA-SC in limited geographic areas, moving to scale after about a year of successful implementation. Collecting and reviewing monitoring data were essential to scale-up decisions in the pilot countries. In addition, the data can inform programmatic improvements even when scale-up is already assured (see Section 10: Monitoring and evaluation).

DESIGNING THE INTRODUCTION STRATEGY TO ACHIEVE DESIRED RESULTS

During the pilot phase, how and where each country chose to introduce DMPA-SC depended on the country's family planning program goals. All countries aimed to increase their contraceptive prevalence rate and reduce unmet need for contraception, but each strategy was also driven by more particular priorities (e.g., expanding coverage or reaching more new family planning users). Analysis





Respective roles of DMPA-SC and DMPA-IM.

When subcutaneous DMPA* (DMPA-SC) was first presented as an option to the pilot countries prior to 2013, its price per dose was higher than that of intramuscular DMPA (DMPA-IM). International donor agencies such as the United States Agency for International Development, United Nations Population Fund, and the World Bank—which often procure contraceptives on behalf of country governments—were wary of replacing DMPA-IM with a more costly presentation. Country governments were similarly hesitant to invest in a more expensive product. In November 2014, a public-private partnership made the DMPA-SC product Sayana Press available for US\$1 per dose to qualified purchasers; DMPA-IM is generally available for about US\$.70-.80 per dose. This significantly reduced donors' and countries' concerns about pricing and helped pave the way for decisions to scale up the product in the pilot countries. Given the near price comparability, concerns about replacement were largely alleviated during the past two years.

DMPA-SC was not intended to replace DMPA-IM in any pilot setting. Most countries expressed interest in enlarging their family planning method mix and envisioned DMPA-SC attracting new clients through nonclinic channels—including outreach and community-based distribution—while satisfied DMPA-IM clients would continue with this method. Some degree of switching was expected, but it was impossible to predict how much. Monitoring data reveal that, cumulatively, the share of doses administered to women switching from DMPA-IM to DMPA-SC ranged from 7 percent in Burkina Faso to 16 percent in Uganda.

In some instances, provider bias for one product or the other may have influenced DMPA-SC uptake. For example, early on in introduction, many providers across country settings misunderstood and believed that DMPA-SC was to replace DMPA-IM, which resulted in higher proportions of doses administered to women switching from DMPA-IM (ranging from 16 percent in Burkina Faso to 51 percent in Senegal). This was quickly addressed during supervision, and switching declined sharply at first and then continued to gradually decline over time. In contrast, early on at some sites in Burkina Faso, providers were hesitant to initiate women on DMPA-SC because they had surmised that “pilot project” meant a short-term or temporary offer of the method. Supervisors had to remind these providers that DMPA-SC would continue to be available long-term because the term “pilot” referred to the limited geographic area for initial introduction.

The approach to introduction depends on each country's goals, which may include co-delivery of both injectable presentations, eventual replacement of DMPA-IM, or targeted offering of DMPA-SC in specific channels. If volumes of DMPA-SC administered continue to increase in the coming years across geographies, and if and when self-injection becomes more widely available, conversations among international family planning donors, ministries of health, implementing agencies, and the product manufacturer about these two products will undoubtedly continue and evolve.

**DMPA: depot medroxyprogesterone acetate*

of pilot introduction monitoring data from Burkina Faso, Niger, Senegal, and Uganda helps to illustrate how different DMPA-SC introduction strategies may achieve varied family planning outcomes, as outlined below.

Introducing DMPA-SC at many delivery points and higher levels of the health system achieves large volumes.

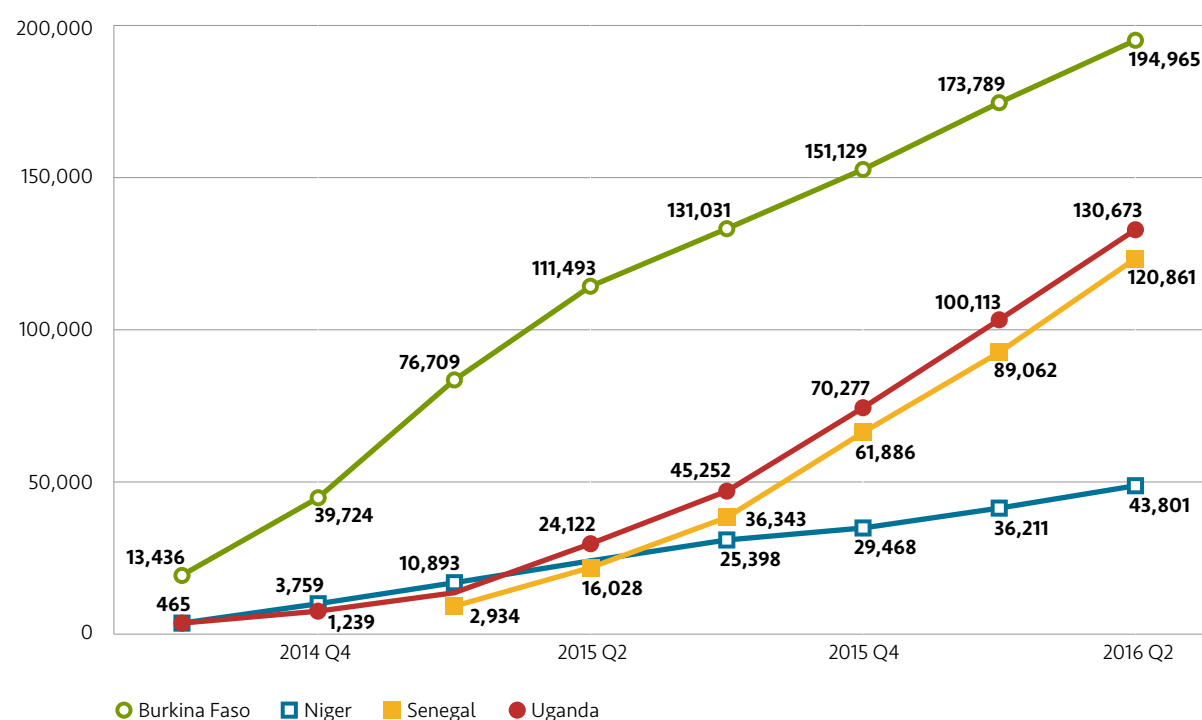
- **Approach:** Senegal and Burkina Faso introduced DMPA-SC through delivery points at all levels of the health system, alongside DMPA-IM. They also implemented the pilots in four regions with the greatest population and highest rates of intention to use family planning, based on data from national Demographic and Health Surveys.
- **Results:** Volumes of DMPA-SC distributed and administered were high in both countries, because the product was

available in every type of health facility—including clinics (see graph). Higher volumes of DMPA-SC distributed can help inform global conversations about product supply and demand. Ideally, higher demand will result in more supply and more availability of the product for women—including those with an unmet need for family planning.

Introducing DMPA-SC in more peripheral channels reaches higher proportions of new family planning users.

- **Approach:** Given Niger's high fertility rate (6.5 percent) and low level of unmet need (20 percent) due to the desire for large families, the MOH wanted to reach and attract new users of family planning and expand geographic access for women living in remote or rural areas. They elected to introduce DMPA-SC as the first offer of

Total cumulative number of DMPA-SC doses administered by quarter, by country (2014–2016)



injectables only at the most peripheral facilities in two districts, and through CBD of socially marketed product at the village level in two districts. In other words, women in Niger who previously only had access to pills and condoms were provided with an entirely new contraceptive option. Given how new the injectable offer was at these outlets, Niger elected to pilot in only four districts, with the intention to move swiftly to national scale if the first year of the pilot was successful.

- **Results:** Of the four countries, Niger reached the highest cumulative proportion of new users (42 percent of doses were administered to new users overall for the entire pilot period). From the beginning, demand among new users was clear: in the first full quarter of introduction in Niger (October through December 2014), the percentage of DMPA-SC doses administered to new family planning users was an astounding 70 percent. The proportion of all doses administered to new users decreased and leveled off

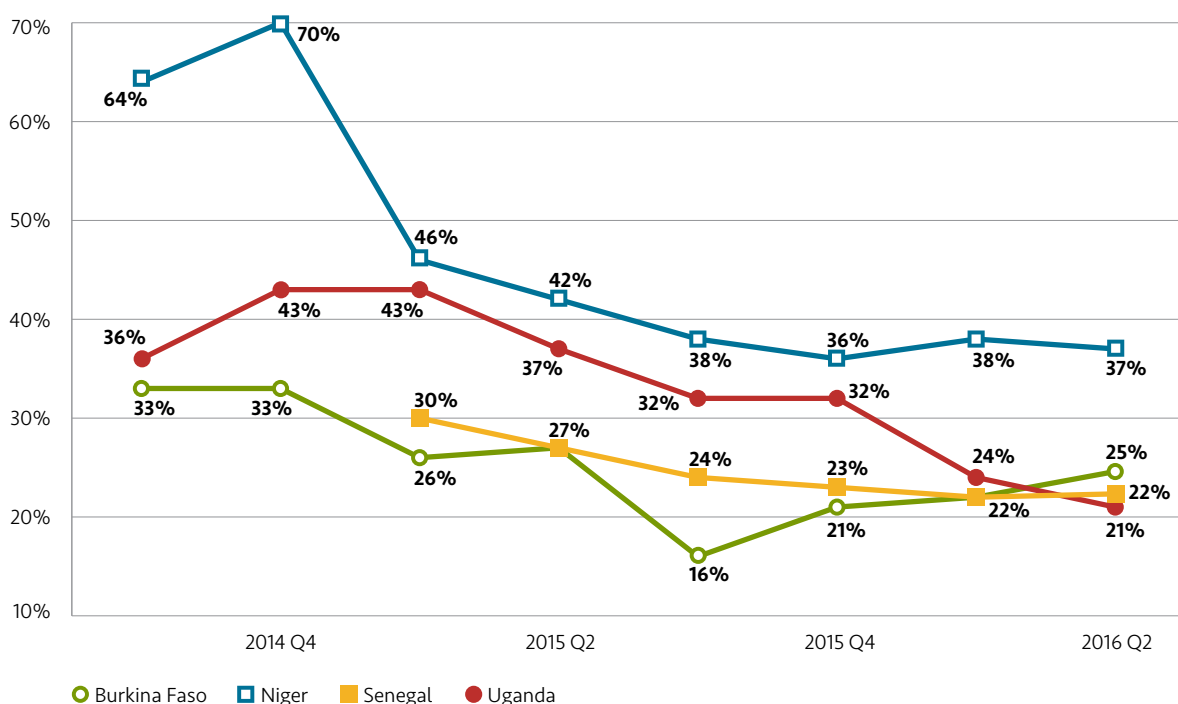
over time as more clients came back for reinjections (see graph).

Introducing DMPA-SC through community-based distribution will likely result in the product outpacing DMPA-IM in these channels (see graph on page 37).

- **Approach:** Planning for DMPA-SC introduction in Senegal was concurrent with a successful pilot study of CBD of DMPA-IM. A full policy shift at the outset of Senegal's introduction enabled community health workers (CHWs) called *matrones* to offer both DMPA-SC and DMPA-IM.

Uganda was the only pilot introduction country that already had a policy supporting CBD of DMPA-IM when DMPA-SC introduction began. The Uganda MOH and implementing partners desired to expand task-sharing through community-based service provision, selecting 28 districts where Village Health Teams (VHTs) were functional but not offering

Proportion of DMPA-SC administered to new users by country, by quarter (2014–2016)



injectables consistently. The pilot trained VHTs in family planning, including administration of both DMPA-SC and DMPA-IM.

- **Results:** When offered side-by-side at the community level in both countries, DMPA-SC volumes far outpaced DMPA-IM volumes. CHWs and their clients may be more comfortable with DMPA-SC due to its ease of use or may prefer subcutaneous injection over intramuscular injections. For example, in Senegal, the proportion of DMPA-SC administered relative to DMPA-IM was 72 percent at rural community health huts compared to only 14 percent at upper-level facilities. Similarly, in Uganda, DMPA-SC constituted 75 percent of injectables administered by VHTs where both methods were available.



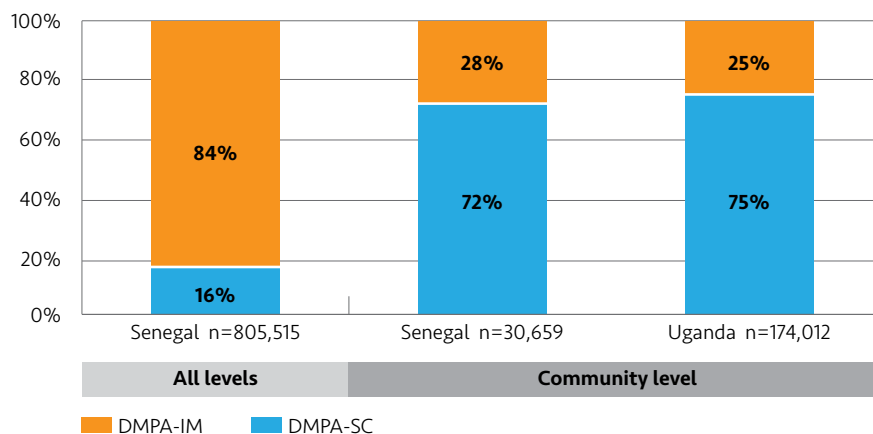
INTRODUCTION TIP

DMPA-SC seems to be highly preferred by community health workers and their clients, and may help advance task-shifting and task-sharing.

Introducing DMPA-SC may help reach more young women with contraception.

- **Approach:** Uganda expressly aimed to reach young women and adolescent girls through the pilot introduction of DMPA-SC, and it revised the national training curriculum and developed communication strategies accordingly. The training curriculum includes specific sessions designed to reduce resistance to provision of family planning to adolescents, and radio spots targeted to a younger audience were developed.
- **Results:** In Uganda, monitoring data from the second quarter of 2015 showed that 41 percent of DMPA-SC clients were under the age of 25 years. By way of comparison, the Demographic and Health Survey (2011) found that only 26 percent of injectable users were under the age of 25 years. Because the Demographic and Health Survey data on injectable users were collected prior to DMPA-SC introduction, they represent DMPA-IM clients. Although the Demographic and Health Survey data are several years old, it is encouraging to see that a higher proportion of women under age 25 years accessed DMPA-SC compared to the previously available DMPA-IM. This may indicate that DMPA-SC is an attractive option for younger women. It is not possible

Relative proportions of DMPA-IM and DMPA-SC administered by country, by level—Senegal and Uganda (2014–2016)



to conclude whether the product itself, specific training and communication approaches, the community-based delivery channel, or the demographics of the pilot areas may have driven these results.

DISTRIBUTION THROUGH THE PRIVATE SECTOR

DMPA-SC introduction in these first four countries primarily took place in the public sector, where most women access contraception (particularly injectable contraception). In each country, private, nonprofit implementers also introduced DMPA-SC in a small number of outlets. In Burkina Faso, for example, PATH's monitoring data from the first 18 months of pilot introduction reveal that while the relatively small-scale nongovernmental organization (NGO)-sector distribution represented only 6 percent of overall doses administered, it reached a higher proportion of new users (39 percent) compared with the public sector (25 percent). Additionally, fewer doses were

administered to women switching from DMPA-IM and other methods in the private sector. This may be partly attributable to NGO delivery channels like mobile outreach, community distribution, youth centers, and pharmacies. Much remains to be learned from settings where DMPA-SC is distributed through the private commercial sector. In some of the pilot countries, private-sector implementers faced delays getting started because of procurement challenges and the need to obtain permission to overbrand the product for social marketing. Examples of private-sector introductions are outlined below:

- **Association Nigérienne de Marketing Social (ANIMAS-SUTURA).** A local social marketing agency, ANIMAS-SUTURA, was contracted by the United Nations Population Fund (UNFPA) to distribute an overbranded product called “SUTURA Press” at the community level through a network of 100 trained community health agents in Madarounfa and Mayahi, two districts of Maradi Region that have distributed

Marie Stopes complements public-sector introduction in Burkina Faso.

Marie Stopes Burkina Faso (MSBF) integrated DMPA-SC into its package of family planning services at various service-delivery points, including three clinics, five mobile teams, and one youth counseling center in the four pilot regions. MSBF trained 31 health providers as well as 32 social marketing agents who provide information and refer clients to MSBF's service-delivery points. In collaboration with health district management teams, MSBF conducted behavior change communications and media activities (such as radio talk shows and spots, and referral education) that reached an estimated 223,000 people. One unique activity was the engagement of women's and men's associations, such as hair dressers and taxi drivers, to serve as client referral networks. MSBF also trained 140 cotton-farming group leaders to refer family planning clients to MSBF's service-delivery points. During the project, MSBF administered more than 3,500 doses of DMPA-SC, including approximately half of these to first-time users of modern contraception.



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nearly 4,000 doses (9 percent of total doses administered in pilot introduction in Niger). In addition, in March 2015, the project trained 151 staff from private pharmacies and clinics in Niamey in promotion and sales (no distribution data available).

- **Agence pour le Développement du Marketing Social (ADEMAS) in Senegal.** Promoting an overbranded product called “Securil Press,” the social marketing agency ADEMAS trained 164 pharmacists in the pilot regions to counsel clients about injectable contraception and sell the product. Clients needed to take the product to a different trained provider for the actual injection. More than 9,000 doses were sold to pharmacies through June 2016.
- **Marie Stopes Burkina Faso (MSBF).** MSBF integrated DMPA-SC into its package of family planning services at fixed and mobile clinics, trained health providers and social marketing agents, and led behavior change communications activities (see text box on page 37).
- **Marie Stopes Senegal (MSS).** After overcoming significant challenges in product procurement, MSS trained staff and began offering DMPA-SC through a clinic and a youth center in Dakar in May 2016. By June, MSS began offering the product

through all their distribution channels nationwide except in one region; these distribution channels included mobile outreach teams, social marketing agents called “MS Ladies”, youth centers, and a social marketing franchise network of 55 affiliated private health centers.

- **National affiliates of International Planned Parenthood Federation (IPPF) in Burkina Faso** (Association Burkinabe pour le Bien-Être Familial, or ABBEF), Senegal (Association Sénégalaise pour le Bien-Être Familial, or ASBEF), and Uganda (Reproductive Health Uganda, or RHU). ABBEF introduced DMPA-SC through 11 clinics, 3 mobile clinics, 2 youth counseling centers, and more than 600 community-based health distribution agents. In fact, the first four women in Africa to receive DMPA-SC in a normal clinic delivery setting were clients at an ABBEF clinic in Burkina Faso in June 2014. In Senegal, ASBEF introduced DMPA-SC nationwide in 8 clinics and through CBD programs in 17 cities and towns across the country. In Uganda, RHU integrated DMPA-SC into one of its urban clinics in Gulu District. Two years later, RHU is integrating DMPA-SC into its contraceptive offerings across the country.

EXPANDING INJECTABLE ACCESS IN: **BURKINA FASO**

BURKINA FASO PILOT INTRODUCTION BY THE NUMBERS: JUNE 2014–JUNE 2016

1,908

Number of providers trained in pilot

194,965

Doses administered during pilot

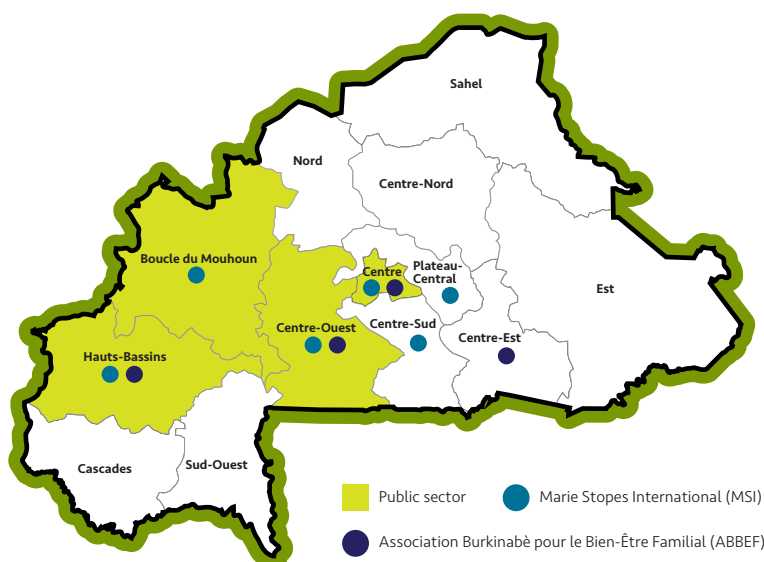
25%

Proportion of doses administered to new users



COUNTRY OVERVIEW

- Contraceptive prevalence rate, modern methods, all women: 21.5%
- Injectables as proportion of method mix, married women: 31%
- Most widely-used method: implants (45%)
- Population: 19 million



GEOGRAPHIC SCOPE OF PILOT

Over 680 public-sector facilities across the 4 most populous regions and 23 districts participated in the pilot. DMPA-SC was offered alongside DMPA-IM at all levels of the health system. Clinic and mobile outreach was offered by nongovernmental organization partners.



INNOVATIVE DELIVERY

DMPA-SC pilot introduction represents the first time injectables are offered through outreach directly in communities. Outreach workers based at the most peripheral health centers—already active in routine vaccination campaigns—offer DMPA-SC during monthly community visits.



SCALE-UP

Decision to move to scale made in November 2015. National pool of 35 master trainers from 9 regions trained in May 2016, followed by simultaneous cascade training of providers across 9 additional regions and 47 districts by end June 2016.



STATUS OF SELF-INJECTION

Label change pending. No self-injection research currently under way. Interest in self-injection pilot emerging.



PARTNERS

Ministry of Health, United Nations Population Fund (UNFPA), Marie Stopes Burkina Faso (MSBF), Association Burkinabè pour le Bien-Être Familial (ABBEF), Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)

Sources: Population Reference Bureau 2016 World Population Data Sheet, Performance Monitoring and Accountability 2020 (PMA2020) Burkina Faso-R3 (2016), PATH's Monitoring Sayana Press Pilot Introduction: Final Pilot Project Results

EXPANDING INJECTABLE ACCESS IN: **NIGER**

NIGER PILOT INTRODUCTION BY THE NUMBERS: SEPTEMBER 2014–JUNE 2016

371

Number of providers trained in pilot

43,801

Doses administered during pilot

42%

Proportion of doses administered to new users

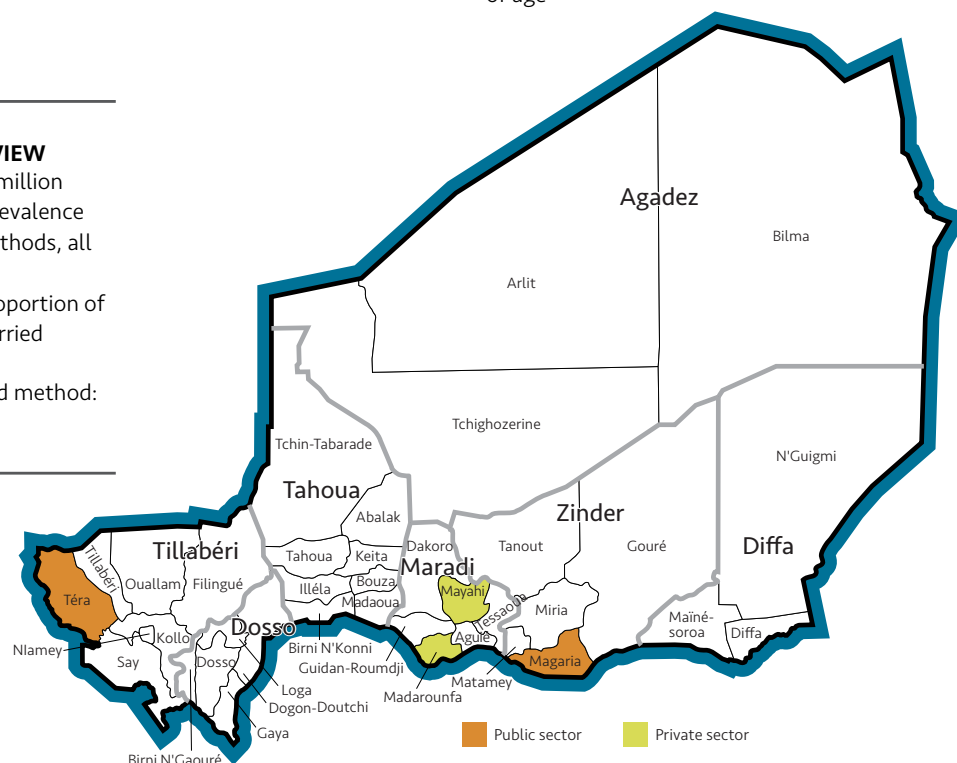
50%

Proportion of doses administered to users under 25 years of age



COUNTRY OVERVIEW

- Population: 19.7 million
- Contraceptive prevalence rate, modern methods, all women: 12.6%
- Injectables as proportion of method mix, married women: 35%
- Most widely-used method: pills (47%)



GEOGRAPHIC SCOPE OF PILOT

211 public-sector community health huts in 2 districts (Téra and Magaria) of 2 regions (Tillabéri and Zinder). ANIMAS-SUTURA distributed socially marketed brand SUTRA Press through community-based distribution in 50 villages of 2 districts (Madarounfa and Mayahi) of Maradi Region and in pharmacies and private clinics around Niamey.

INNOVATIVE DELIVERY

DMPA-SC pilot introduction represents the first offer of injectables in public-sector health huts, the most peripheral level of Niger's health system.

SCALE-UP

Decision to move to scale was made in June 2015. Partners, including Pathfinder and EngenderHealth, trained health workers in an additional 661 health huts beyond the 211 huts involved in the pilot introduction, out of 2,500 total across the country.



STATUS OF SELF-INJECTION

Label change was approved to indicate self-injection in June 2016. The status of future introduction or research is unknown.



PARTNERS

Ministry of Health, United Nations Population Fund (UNFPA), Association Nigérienne pour le Bien-Etre Familial (ANBEF), Association Nigérienne de Marketing Social (ANIMAS-SUTURA)

Sources: Population Reference Bureau 2016 World Population Data Sheet, Performance Monitoring and Accountability 2020 (PMA2020) Niger-R1 (2016), PATH's Monitoring Sayana Press Pilot Introduction: Final Pilot Project Results

EXPANDING INJECTABLE ACCESS IN:

SENEGAL

SENEGAL PILOT INTRODUCTION BY THE NUMBERS: JANUARY 2015–JUNE 2016

2,023

Number of providers trained in pilot

120,861

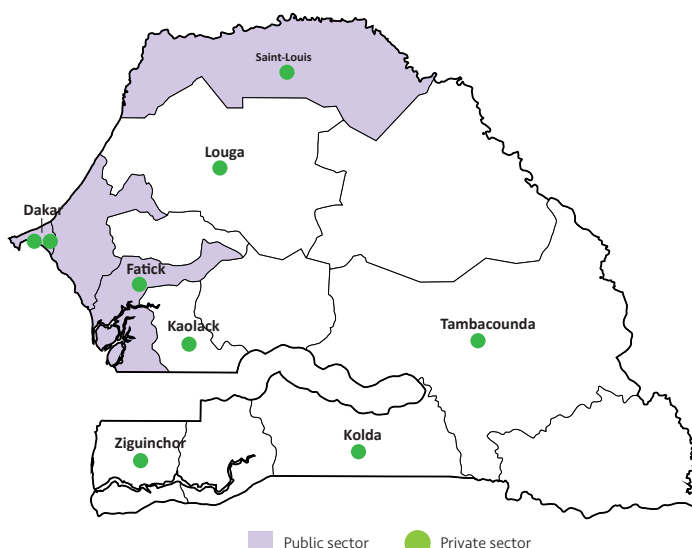
Doses administered during pilot

24%

Proportion of doses administered to new users

35%

Proportion of doses administered to users under 25 years of age



COUNTRY OVERVIEW

- Population: 15 million
- Contraceptive prevalence rate, modern methods, married women: 20.3%
- Injectables as proportion of method mix, married women: 39% (most widely-used method)



GEOGRAPHIC SCOPE OF PILOT

268 facilities and 637 health huts across the 4 most populous regions, across all levels of the public sector and alongside DMPA-IM. Marie Stopes Senegal offered DMPA-SC through a network of 55 clinics and mobile outreach teams in pilot areas, and Association Sénégalaise pour le Bien-Etre Familial (ASBEF) worked through 8 clinics and community distribution in 17 towns and cities nationwide. Agence pour le Développement du Marketing Social (ADEMAS) distributed an overbranded product, Securil Press, for sale in pharmacies.



INNOVATIVE DELIVERY

Both DMPA-SC and DMPA-IM were introduced at the health-hut level for the first time during the pilot.



SCALE-UP

Decision to move to scale was made in March 2016. Regional supervision teams were trained in May and June 2016. Progressive rollout of provider training in 10 nonpilot regions began in June 2016, continuing into early 2017.



STATUS OF SELF-INJECTION

A self-injection operational feasibility study was completed in June 2016. Continuation/cost-effectiveness studies will be completed in 2017. Label change is pending. Clear intention to pilot self-injection.



PARTNERS

Ministry of Health and Social Action, ChildFund International, IntraHealth International, Agence pour le Développement du Marketing Social (ADEMAS), Marie Stopes Senegal (MSS), Agence Sénégalaise pour le Bien-Etre Familial (ASBEF).

Sources: Population Reference Bureau 2016 World Population Data Sheet, Demographic and Health Surveys (2014), PATH's Monitoring Sayana Press Pilot Introduction: Final Pilot Project Results

EXPANDING INJECTABLE ACCESS IN: UGANDA

UGANDA PILOT INTRODUCTION BY THE NUMBERS: OCTOBER 2014–JUNE 2016

2,284

Number of providers trained in pilot

130,673

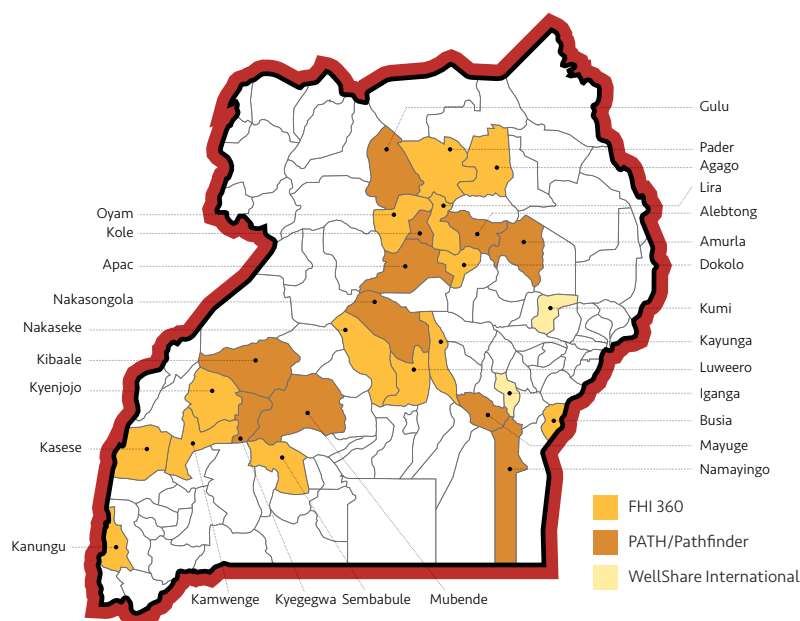
Doses administered during pilot

29%

Proportion of doses administered to new users

44%

Proportion of doses administered to users under 25 years of age



COUNTRY OVERVIEW

- Population: 36.6 million
- Contraceptive prevalence rate, modern methods, all women: 27.5%
- Injectables as proportion of the method mix, married women: 56.4%



GEOGRAPHIC SCOPE OF PILOT

Community-based distribution by Village Health Teams in 28 out of 112 districts: 10 were managed by PATH and Pathfinder, 16 by FHI 360; and 2 by WellShare International. Reproductive Health Uganda (RHU) reached youth through their nongovernmental organization clinic site in Gulu, northern Uganda.



INNOVATIVE DELIVERY

The pilot introduction expanded on Uganda's commitment to task-sharing by training many community health workers, Village Health Teams, to administer DMPA-SC and DMPA-IM.



SCALE-UP

In April 2016, the Ministry of Health signaled its commitment to national coverage of DMPA-SC. By the end of the year, several implementers had launched training in more districts and a coordinated national plan was under development.



STATUS OF SELF-INJECTION

Self-injection operational feasibility studies were completed in December 2016. Continuation/cost-effectiveness studies will be completed in mid-2017. In late 2016, self-injection of the DMPA-SC product Sayana Press was piloted in Uganda's Mubende District—the first time the practice has been available in sub-Saharan Africa outside of a research setting. Label change is pending.



PARTNERS

Ministry of Health, Pathfinder International, WellShare International, FHI 360, Uganda Health Marketing Group (UHMG), Communication for Development Foundation Uganda (CDFU), Reproductive Health Uganda (RHU), Makerere University

Sources: Population Reference Bureau 2016 World Population Data Sheet, Performance Monitoring and Accountability 2020 (PMA2020) Uganda-R4 (2016), PATH's Monitoring Sayana Press Pilot Introduction: Final Pilot Project Results

RECOMMENDATIONS: PLANNING THE COUNTRY INTRODUCTION STRATEGY

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- **To reach large volumes, introduce DMPA-SC at all levels of the public sector (or public-private) in large geographies.** Do not discount the potential for more remote and community-level channels to achieve large volumes as well.
- **To reach the largest number of new users, prioritize community-level delivery and offer injectables where previously unavailable.** Increasing the number of new family planning users can contribute to reducing unmet need and increasing contraceptive prevalence.
- **Expect high volumes of DMPA-SC compared to DMPA-IM in community-level delivery channels.** Data from the pilot introduction reinforce early research data on acceptability of and preference for DMPA-SC among community-level providers and their clients.
- **Consider opportunities for DMPA-SC to increase access for young women.** Explore a variety of public and private delivery channels and consider what additional training, supervision, and communications activities are needed to support and sustain access for young women and adolescent girls.
- **Invest in total market introduction from the origins of introduction planning and beyond.** There are still limited data on DMPA-SC introduction in private-sector channels, but the limited data available indicate that private-sector outlets hold great potential to increase access.



Uganda Sayana Press Introduction Plan Summary. Available at sites.path.org/rh/recent-reproductive-health-projects/sayanapress/sayanapress-resources/#uganda. This executive summary outlines the core elements of Uganda's pilot introduction plan, including the country's family planning goals, product registration process, DMPA-SC partners and their roles, geographic coverage, and plans for training, end-user communications, and monitoring.



Provision of Injectable Contraception Services through Community-Based Distribution. Available at www.fhi360.org/resource/provision-injectable-contraception-services-through-community-based-distribution. Produced by FHI 360 and Save the Children USA, this step-by-step guide explains how to introduce injectable contraceptives—such as DMPA-SC—into an existing community-based distribution program.



Community-Based Access to Injectable Contraceptives Toolkit. Available at www.k4health.org/toolkits/cba2i. This comprehensive resource is a platform for agencies and organizations working to plan, implement, evaluate, promote, and scale up programs for community-based access to injectables and to advocate for changes to national policy and service-delivery guidelines.



Community-Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives: Conclusions from a Technical Consultation. Available at www.who.int/reproductivehealth/publications/family_planning/WHO_CBD_brief.pdf. This four-page summary presents the conclusions of a technical consultation of technical experts in 2009. The group reviewed extensive evidence and recommended that community-based provision of injectable contraceptives by trained community health workers is safe and effective. The document highlights program guidance and operational issues as well as priorities for new research.