Insights and Recommendations for Facilitating DMPA-SC Self-Administration in India

POLICY BRIEF

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INTRODUCTION

Globally, injectable contraceptives are popular in the contraceptive method mix, with an estimated 42 million women using it as a method of choice[1]. This preference is even more pronounced in the Sub-Saharan African region, where injectables hold a 36% share of the contraceptive method mix[2]. The injectable contraceptive, Depot Medroxyprogesterone Acetate (DMPA) has been available in India since the early 1990s through private and social marketing channels and was introduced in the National Family Planning (FP) Program by the Government of India in 2016-17. As per the National Family and Health Survey-5 (NFHS-5), 0.6% of currently married women in India use DMPA-IM (intramuscular route), which contributes to 1.1% of the modern contraceptive prevalence rate (mCPR)[3] in the country. The other route of administering DMPA is subcutaneously (DMPA-SC), which involves injecting just under the skin. The standard dose for SC is 104 mg of medroxyprogesterone acetate per 0.65 ml, and for IM, it is 150 mg per 1 ml. DMPA-SC also uses a smaller needle size than used in DMPA-IM. Both intramuscular and subcutaneous DMPA are equally effective at preventing pregnancy when used correctly and consistently[4]. However, DMPA-SC has the additional advantage of self-administration.

Studies from African countries on the feasibility (Uganda[5], Malawi[6], Congo[7]) and acceptability (Senegal[8], Uganda[9]) of DMPA-SC show that both users as well as providers accepted self-administration of DMPA-SC (marketed as Sayana Press) over IM. The reasons stated were – fewer side effects, quick and easy administration, less pain, all-in-one design leading to lesser stock-outs, and less intimidating due to shorter needles. In addition, significantly higher continuation rates (12 months and 6 months) with training and support were reported among those who self-administered DMPA-SC as compared to those who used DMPA-IM, in studies done in Malawi[10], Senegal[11], Uganda[12], and Nepal[13]. Furthermore, self-administration of DMPA-SC was found to be cost-effective due to lower costs (direct non-medical) and higher continuation rates in studies conducted in Burkina Faso[14], Uganda[15] and Senegal[16]. Overall, these findings highlight that DMPA-SC is acceptable, cost-effective and has the potential for increasing contraceptive autonomy and access for women when accompanied by proper training and support.

In India, studies on DMPA-IM[17-19] have highlighted factors for its uptake and acceptance, which are helpful in understanding general perceptions surrounding injectable contraceptives. However, there is limited understanding around subcutaneous DMPA that may influence its adoption and self-administration. To assess the potential of DMPA-SC as a new contraceptive option in India, Institut Publique de Sondage d'Opinion Secteur (Ipsos), with technical support from Ipas Development Foundation (IDF), conducted a market research study. The goal of this study was to investigate factors influencing the acceptance of DMPA-SC and its self-administration among various stakeholders.

In April 2023, a roundtable workshop was convened with a select group of key family planning experts in India. During this event, topline findings of the market research study were presented, and global evidence on DMPA-SC was exhibited for the group's reference. The objective of the roundtable was to ideate, discuss, and develop policy recommendations based on existing evidence, which would be essential for scaling-up self-administration of DMPA-SC in India.

Understanding Self-Administration in the Context of DMPA-SC

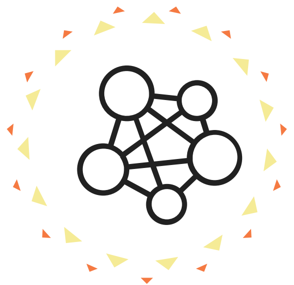
In the context of DMPA-SC in India, it is essential to establish a language of self-administration that conveys empowerment, agency, and autonomy for the client, while also emphasizing the supportive role of the health system. As the World Health Organization (WHO) views it, self-care is considered an extension of the health system 'so that while people are using self-care interventions, they can also access the health system and community support for further assistance when needed.' This understanding aligns with our approach in this document, as we use the term 'self-administration' within the broader context of self-care. This alignment underscores the inherent support of the health system in facilitating DMPA-SC self-administration.

As DMPA-SC is introduced as a contraceptive in the national FP program, it is essential to understand what needs to be done to reach the method's full potential i.e., the benefit that it offers to clients for self-administration. This brief is intended as a first step towards providing this understanding. In this brief, policy recommendations for scaling-up DMPA-SC self-administration in India, have been formulated by triangulating evidence and insights from multiple sources.

Specifically, the recommendations have been developed by:

Integrating Good Practice Statements from WHO's Self-Care Guideline: Good practice statements from WHO's guideline on self-care interventions for health and well-being were reviewed to inform critical considerations for DMPA-SC in India.

Drawing upon Global Literature on DMPA-SC: Evidence from research studies and policy documents from low and middle-income countries were reviewed and key learnings and practices were extracted.



Analyzing Data from Large Scale Research Study on DMPA-SC: Insights were drawn from a nationwide, mixed methods study conducted in 19 states of India among women, health care providers and pharmacists on acceptance of DMPA-SC and its self-administration.

Incorporating Insights from Expert Group Roundtable Workshop: Valuable insights shared during a FP expert group roundtable in April 2023 were synthesized, leading to comprehensive policy recommendations.

LEARNINGS FROM GLOBAL LITERATURE ON DMPA-SC

DMPA-SC and its self-administration has been introduced and scaled-up in many countries such as Nigeria, Uganda, Congo, and Kenya. These countries have implemented policy level strategies that encompass the total market approach, provider base expansion, and targeted engagement with high-volume service providers and distribution channels. Moreover, countries like Zambia, Senegal, Burkina Faso, Niger, and Uganda have implemented program-level measures to ensure client competency and adherence to self-administration, emphasizing task sharing, effective stock management, and proper product disposal. The valuable insights derived from these experiences can serve as a blueprint for India to adapt and tailor these approaches to its unique local context, thereby facilitating the scale-up of self-administration of DMPA-SC programs. For a more in-depth understanding of learnings from global literature, please refer to **Annexure 1**.

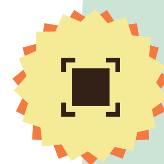
CONCEPT EVALUATION OF DMPA-SC IN INDIA

In India, a market research study was conducted by Ipsos with the goal to investigate the factors influencing the acceptance of DMPA-SC and its self-administration among various stakeholders. A mixed-method study was conducted in 19 states with 17,959 nulli and multiparous women (18 years and above), 717 health care providers (HCPs), and 1,113 pharmacists. A concept card was designed to introduce DMPA-SC to study participants (this concept card included a component on self-administration of the method).

Results from the study demonstrate a positive inclination of all participants towards self-administration of DMPA-SC. About 55% women were comfortable with the idea of self-administration with some support. The key benefits mentioned were a long period of protection, convenience (easy to use), and privacy. Fear of side-effects (48%), fear of needles (28%) (trypanophobia) and fear of not being able to manage self-administration (26%) were the major concerns reported by women. HCPs also had similar perceptions around the product concept and were supportive of the method's introduction. For prescribing DMPA-SC, HCPs considered better compliance to method (as it does not require daily consumption), option of self-administration by women, duration of effectiveness (3 months), as well as feasibility of use during crisis situations like pandemics and natural calamities to be enabling factors. On the other hand, factors such as – safety, potential side-effects, possible failure rates, and high cost – were perceived as barriers by HCPs for prescribing DMPA-SC. Pharmacists also reported the 3-month protection period, easy storage of the product, and convenience of use as positive factors for the adoption of DMPA-SC by women. For more details on the study findings please refer to **Annexure 2**.

RECOMMENDATIONS FOR SCALING-UP DMPA-SC SELF-ADMINISTRATION

Based on the study insights, learnings from other countries, knowledge from WHO self-care guidelines and the discussion with stakeholders during the roundtable workshop, below are some key recommendations for the scale-up of DMPA-SC self-administration in India.*



ADOPTING A TOTAL MARKET APPROACH TO MAXIMIZE IMPACT

In order to reach the full potential of DMPA-SC, a total market approach should be adopted by leveraging the capacities of both the public and private sectors. This approach acknowledges the role of public health facilities, private health facilities, clinics, and pharmacies in delivering healthcare services and commodities.

According to NFHS-5 data[3], there is a nearly equal proportion of households where individuals seek healthcare in the private sector compared to the public sector when they fall ill (48.2% in the former and 50.1% in the latter). Therefore, along with the public sector, it is crucial to recognize and tap into the untapped potential of the private sector. Moreover, when it comes to contraceptive sources, approximately 25% of current users of modern methods and 30% of current users of Injectable contraceptives get their chosen method from the private sector. Additionally, there are more than 8,50,000 registered pharmacies[20] (retail and online) in the country and often these are one of the first access points for communities for medication, contraceptives and healthcare care advice. Therefore, it is important to also recognize pharmacies as delivery points and pharmacists as potential facilitators of DMPA-SC self-administration. Adopting a total market approach in this way would allow us to increase accessibility of DMPA-SC by reaching clients wherever they choose to access contraceptive services.

** It is important to note that while these recommendations offer significant considerations, they do not form an exhaustive list. The scale-up of DMPA-SC supportive self-administration may also be subject to the necessary policy and regulatory approvals which are not covered under these recommendations.*

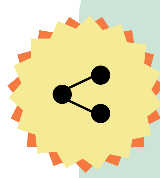
ESTABLISHING HEALTH SYSTEM LINKAGES IN METHOD INITIATION AND CONTINUED ADOPTION

The market research study, referred to above, indicates that with adequate training and support, women would be comfortable self-administering DMPA-SC. The support is a critical aspect to consider, and it is important to understand that the responsibility of self-administration between the client and the health system exists along a continuum and can shift over time depending on the needs of the client. For example, some clients could be very comfortable in self-administering at the outset while some may need greater handholding at the start, before they are able to self-administer independently, and some others may continue needing some sort of support throughout the duration of method use. The key is to have clear linkages with the health system so that the client can access need-based support.

For clients who adopt the method and are able to independently self-administer it, these linkages could be established through existing channels such as the Home-based Delivery of Contraceptives (HDC) scheme where community health workers distribute contraceptives to the doorstep of clients. This scheme could be expanded to include provision of subsequent doses of DMPA-SC, taking back used Injectables for safe disposal (as per biomedical waste management guidelines) and for checking-in on any support required. In addition to the public sector channels, the private sector, including local pharmacies and clinics, can play a pivotal role in supporting clients to self-administer DMPA-SC. Exploring partnerships between the public health system and private sector entities can also help create a seamless network for DMPA-SC users. This could enhance convenience, ensuring clients have various options for obtaining DMPA-SC doses and returning used Injectables for disposal. Moreover, digital health interventions such as helplines and telemedicine platforms (for e.g., e-Sanjeevani) can also strengthen these client and health system linkages by complementing in-person support services.

EMPHASIZING SELF-CARE IN DMPA-SC FROM THE START

While the first dose of DMPA-SC would be initiated under the supervision of a provider i.e., it would be provider-led, it is important that from the start, the messaging around the self-administration component is clear. The counselling provided to clients during this initiation needs to establish the advantages of the method i.e., convenience and privacy of self-administering as well as of reduced travel costs in accessing method. Moreover, this is where its differentiation with DMPA-IM also needs to be established. DMPA-SC should be positioned as a new method being introduced to expand contraceptive choices for clients, with its additional benefit of self-administration. It is essential to remember that self-care does not absolve the health system of its responsibility; rather, it represents another form of task sharing, emphasizing the collaborative effort needed to ensure the best outcomes for clients.

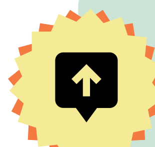


IMPLEMENTING TASK-SHARING AND SPECIALIZED TRAINING

To facilitate decentralized service provision and to reach the last mile of clients, a task-sharing approach should be adopted. This task-sharing includes authorizing community workers and pharmacists to provide supportive self-administration of DMPA-SC (with understanding and establishing distinct roles for these providers). However, task-sharing can also extend to individuals and/or caregivers and training them to self-administer, if and when they are comfortable to do so with the proper training and support. Such delegation of tasks would significantly increase accessibility of FP services and be cost-effective specially in low-resource and high caseload settings.

Additionally, just as any new method requires training, so would DMPA-SC. However, in this case, there would need to be a focus on training providers to further train individuals and/or caregivers on the self-administration technique and schedule of injecting. Based on the global evidence and the concept evaluation study, the key training domains would need to include administration of injection, orienting clients on self-administration, medical ethics, data management, counselling women, possible side effects (including menstrual changes), safe home storage, disposal practices

and product sale procedures/protocols. These training areas can be adapted as per different cadres of providers such as HCPs (doctors, nurses), community health workers (ANMs, ASHAs, AWWs) and pharmacists. Additionally, job-aids (such as tutorial videos and leaflets) and reminder mechanisms for subsequent doses (such as calendars, SMS and/or call reminders) can be set up for clients to further support their self-administration journey[11].



GENERATING DEMAND AND BUILDING MOTIVATION

Creating and sustaining demand within the community is crucial for ensuring the uptake and utilization of the product. To achieve this, it is essential to allocate sufficient resources aimed at developing comprehensive Information, Education, and Communication (IEC) materials that effectively target both potential clients and healthcare providers. Additionally, endorsements from influential champions can significantly contribute to generating demand for the method. Exploring the possibility of incentives (similar to existing incentive structures for other methods) can also prove beneficial in motivating clients to adopt DMPA-SC.

The IEC materials should encompass a wide range of essential information, including the method's effectiveness, highlighting its user-friendly nature and privacy benefits, potential side-effects, techniques for self-administration, tools or reminders for injection dates, safe storage practices at home, and proper disposal guidelines. Leveraging social media platforms and digital channels will further facilitate the dissemination of IEC material, reaching a wider audience and maximizing its impact.

MONITORING OF UPTAKE, USE AND QUALITY PARAMETERS

To enable robust monitoring, it is important to include relevant indicators in the Health Management Information System (HMIS). Additionally, exploring motivation mechanisms for private sector support staff to contribute data that can be integrated with public sector data will enhance monitoring capabilities. This approach will facilitate continuous tracking of uptake, identification of bottlenecks such as stock outs, and provision of valuable data for research and evaluation, benefiting both sectors.

As individuals are being empowered towards self-administration, it is equally important to provide them with the necessary tools to capture their own usage and experience data, enabling improvements in the program. In line with this, one of the recommendations is to leverage a technology-based solution that allows women to self-report data, including batch numbers, usage dates, and ideally, the platform could also provide reminders for the next dose. By establishing a robust monitoring framework, integrating indicators into the HMIS, and empowering individuals to report their data, the continuous improvement and success of DMPA-SC self-administration can be ensured.

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ANNEXURE 1: LEARNINGS FROM GLOBAL LITERATURE ON DMPA-SC

DMPA-SC self-administration has been introduced and scaled up in many countries, such as Nigeria, Uganda, Congo, and Kenya. Some of the policy-level learnings from the strategies adopted by these countries are summarized below:

- Reaching the last mile through a total market approach (Kenya[a]) – herein, the Ministry of Health led the public-sector introduction, while private-sector stakeholders worked closely and quickly to expand DMPA-SC to the private market. This was done to ensure that every woman is able to access DMPA-SC at every public and private service delivery point.

- Expanding the provider base through evidence-based research:
  - Revision of the National Family Planning Guidelines (Kenya[a]) to authorize pharmacists and pharmaceutical technologists to administer injectable contraceptives facilitated Kenya's total market approach.
  - Leveraging medical and nursing students as community-level distributors (Congo[b]) of DMPA-SC led to the incorporation of community-based product distribution in their National Plan for Scale Up of DMPA-SC.

- Targeting high-volume contraceptive service providers and leveraging existing wholesale distribution channels (Nigeria[c]) – helped catalyze product distribution.

With the increasing evidence base of studies on the acceptability and continuation of self-administration of DMPA-SC from other countries, it is important to understand and document learnings for implementing and operationalizing programs on self-administration in India. Some important learnings from existing literature on implementation are provided below.

Training of clients

The WHO guidelines on self-care states educating individuals to self-administer as an important strategy to ensure its proper use. Thus, training of clients by a diverse group of health care providers is one of the essential components in implementing self-administration of DMPA-SC. Such trainings can be conducted using different methods and formats. Studies done in Senegal and Uganda used a multi-page client booklet along with hands-on practice of the injection technique to conduct one-on-one training of clients by licensed nurses and midwives. But, due to provider time constraints and supply costs (approx. US$ 2 per client) these methods were not perceived to be feasible especially in low-resource settings. Consequently, approaches in Uganda have shifted to training women in small groups (while still ensuring some time for one-on-one interaction), substituting injection demonstrations by health workers for client practice, and replacing the booklet with a one-page client training aid and in some cases, a training video. However, countries like Nigeria and Zambia, continue use of expensive client training methods. Therefore, it is crucial that training methods and materials are contextually relevant and feasible for implementation.

Continuity, follow-up, and adherence

The acceptability and continuity studies in Senegal and Uganda on DMPA-SC self-administration show that majority clients discontinue DMPA-SC since they forget to track and comply with the injection dates which is a similar hurdle observed for other contraceptives. Addressing this is crucial to ensure continuity and adherence. Evidence from Uganda shows that providing clients with a calendar to take home along with an injection job aid led to significantly more compliance and injection competence.

Ensuring enough units are provided to the client for facilitating continuity and adherence to self-administration is also important. One of the strategies used in Nigeria and Senegal involves providing extra units during the second supervised self-administration at which point clients both confirm their intention and capability to continue self-administration. Similarly, in Uganda, during the initial program guidance from the Ministry of Health, it was observed that clients preferred to have three rather than two units to take home as the three units gave them a year of continuous contraceptive coverage. Thus, authorizing women to take three units post demonstrated competency in self-administration, may be feasible.

Another core component of service delivery which is even more essential in the context of self-care is- follow-up. The emerging evidence from Uganda shows that women majorly preferred to reach out to the health system

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[a] *PATH-JSI. Kenya's journey to DMPA-SC and self-injection scale-up. DMPA-SC ACCESS COLLABORATIVE COUNTRY BRIEF, 2021*

[b] *PATH-JSI. Democratic Republic of the Congo's journey to DMPA-SC and self-injection scale-up, 2021.*

[c] *Plus HP. DMPA-SC Introduction and Scale-Up in Nigeria: Future Benefits for Contraceptive Use and Savings: Health Policy Plus, 2018.*

for support as per their need instead of a regular follow-up. This was for either injection technique or overall method issues (e.g., side effects). However, the follow-up needs might be different for clients who have never used injectable contraception, are unfamiliar with the side-effects or face challenges due to irregular menstrual cycles (owing to cultural and social reasons) and thus may require support through regular follow-ups. Therefore, such processes should be designed based on client requirements/preferences. (Refer to Box 1 for an overview of strategies adopted to ensure compliance with DMPA-SC usage.)

BOX 1: KEY STRATEGIES TO ENSURE COMPLIANCE

- **Injection schedule management:** Implementing reminders to help clients track and comply with injection dates.
- **Supportive tools:** Providing take-home resources such as calendars and job aids to improve injection competence.
- **Take-home units:** Ensuring a consistent DMPA-SC supply and providing extra take-home units during the second supervised session.
- **Tailored client support:** Developing personalized follow-up systems based on individual needs, especially for new users of Injectable contraceptives or those with unique challenges such as menstrual cycle irregularities.

Task-sharing and expansion of provider base

Expanding the provider base for administering DMPA-SC and providing support to clients is required, especially in low resource settings, to reach every woman. A study conducted in Democratic Republic of Congo (DRC)[d] shows possibility of expanding the provider base since women choose to continue receiving DMPA-SC from a community health worker rather than from a health facility. In addition to this, evidence from Zambia[e] demonstrates the potential for task-sharing of contraceptive self-administration training with private health providers. Also, early experience in training private providers in Uganda, and specifically a small number of pharmacists and accredited drug shop operators, has shown that it is important to equip these commercial providers to integrate appropriate client training and education into their workload. Learnings from Kenya also demonstrate that task sharing and expanding provider base is key in increasing delivery points and reaching every woman.

Stock management

In low-resource settings, it is crucial that wastage and stock-outs are prevented. Evidence from pilot introductions of DMPA-SC in four countries – Burkina Faso, Niger, Senegal, and Uganda[f]- highlighted stock-outs in two countries which hindered product uptake. The reasons for stock-out were large quantities of product expiring and poor stock surveillance. Strengthening systems for better stock management is hence crucial to ensure uptake.

Product disposal

The current WHO guidance advises against needle recapping, yet the safety risk from recapping may be lower (than an exposed needle) in the context of self-administration, especially in settings with poor waste disposal systems. Guidelines specific to household-level sharps disposal are still a lacuna in many countries. The self-administration studies in low-resource settings have shown that women do not find it challenging to store products safely at home, but disposal is more complicated. In Uganda[g], women were advised to store their devices at home in an impermeable container and return them to a health worker for safe disposal at a convenient time, and most clients complied with these instructions. In such cases, community, and other health workers (e.g., those in pharmacies) who may not be authorized or trained to provide DMPA-SC, but who have access to medical waste receptacles, should be briefed on waste-disposal practices for self-administered Injectables. It may even be possible to set up formal medical-waste disposal sites. Additionally, providers need to be advised on how to best manage the transfer of waste from the individual to the health system.

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ANNEXURE 2: CONCEPT EVALUATION OF DMPA-SC IN INDIA

A market research study was conducted by Ipsos with technical support from the Ipas Development Foundation (IDF). The aim of the study was to investigate the factors influencing the acceptance of the concept of DMPA-SC and its self-administration among various stakeholders. For the study design and participant details, refer to Box 2 and Box 3, respectively.

BOX 2: STUDY DESIGN

- **Mixed methods design** was adopted to understand – perceptions around DMPA-SC, intention of using/recommending the product and its acceptability among stakeholders (women, healthcare providers, and pharmacists)
- **Concept card** was designed to introduce DMPA-SC to study participants (this concept card included a component on self-administration of the method)
- **19 major states of India covered** – Assam, Andhra Pradesh, Bihar, Delhi, Gujarat, Haryana, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Mizoram, Nagaland, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, and West Bengal; both urban (73%) and rural (27%) areas were covered.

BOX 3: STUDY PARTICIPANTS

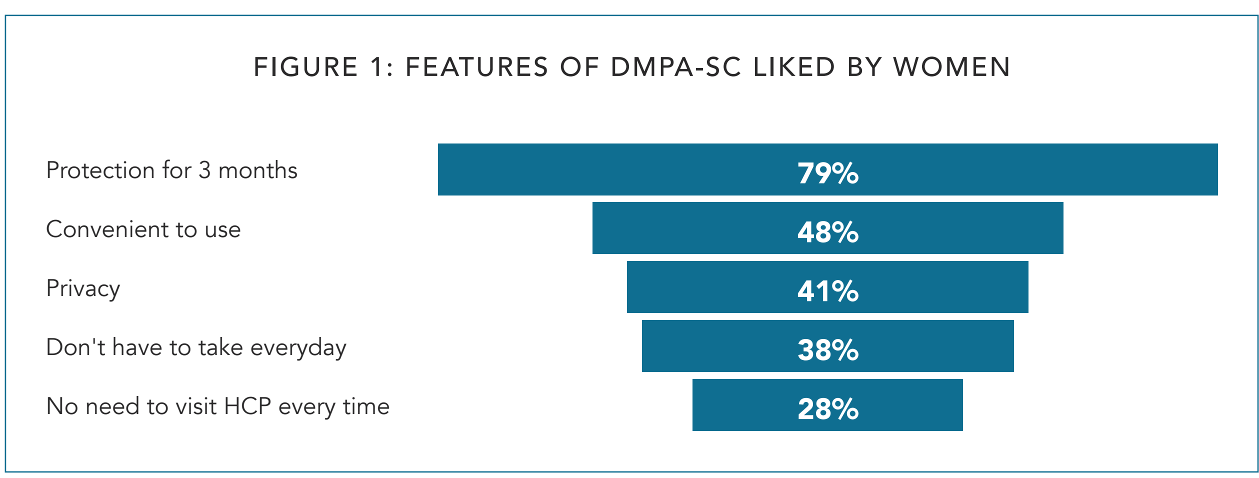
Quantitative data collection (via interviews):
- Women (18-45 years): 17,959
- Healthcare Providers (HCPs): 717
- Pharmacists: 1,113

Qualitative data collection:
- Women (18-45 years): 90 FGDs
- HCPs: 28 IDIs

Perceptions around DMPA-SC

The concept of DMPA-SC was presented to **women** and about 55% were comfortable with the idea of self-administration with some support. The key benefits mentioned were a long period of protection, convenience (easy to use), and privacy (as shown in Fig 1).

FIGURE 1: FEATURES OF DMPA-SC LIKED BY WOMEN



Fear of side-effects (48%), needles (28%) (trypanophobia) and fear of not being able to manage (26%) were the major concerns reported by women. However, women also reported that confidence would be built in the product with training for its self-administration, more information on side-effects and their management along with recommendation from HCPs (Refer to Box 4 for quotes from FGDs with women).

HCPs also had similar perceptions around the product concept. A largely positive perception of DMPA-SC self-administration was found, with HCPs being supportive of its introduction. Aspects of greater independence, autonomy, and privacy for use of this product were mentioned as attractive propositions for women (Refer to Box 4 for quotes from HCPs). In addition, convenience in terms of use (once in 3 months) and storage, as well as ease of reversibility, and minimal pain were the other facilitators for women's use, as reported by HCPs. The perceived barriers stated by HCPs for self-administration of DMPA-SC were trypanophobia, lack of awareness about injectables, potential cost, and doubts/concerns around self-administration.

For prescribing DMPA-SC, HCPs considered better compliance to method (as it does not require daily consumption), option of self-administration by women, duration of effectiveness (3 months), as well as feasibility of use during crisis situations like pandemics and natural calamities to be enabling factors. On the other hand, factors such as – safety, potential side-effects, possible failure rates, and high cost – were perceived as barriers by HCPs for prescribing DMPA-SC.

Pharmacists also reported the 3-month protection period, easy storage of the product, and convenience of use as positive factors for the adoption of DMPA-SC by women. Pharmacists were certain that women would need training for self-administration of DMPA-SC, and they felt that HCPs, followed by front-line workers (FLWs), were best to provide this training support to women.

Facilitators for supportive self-administration

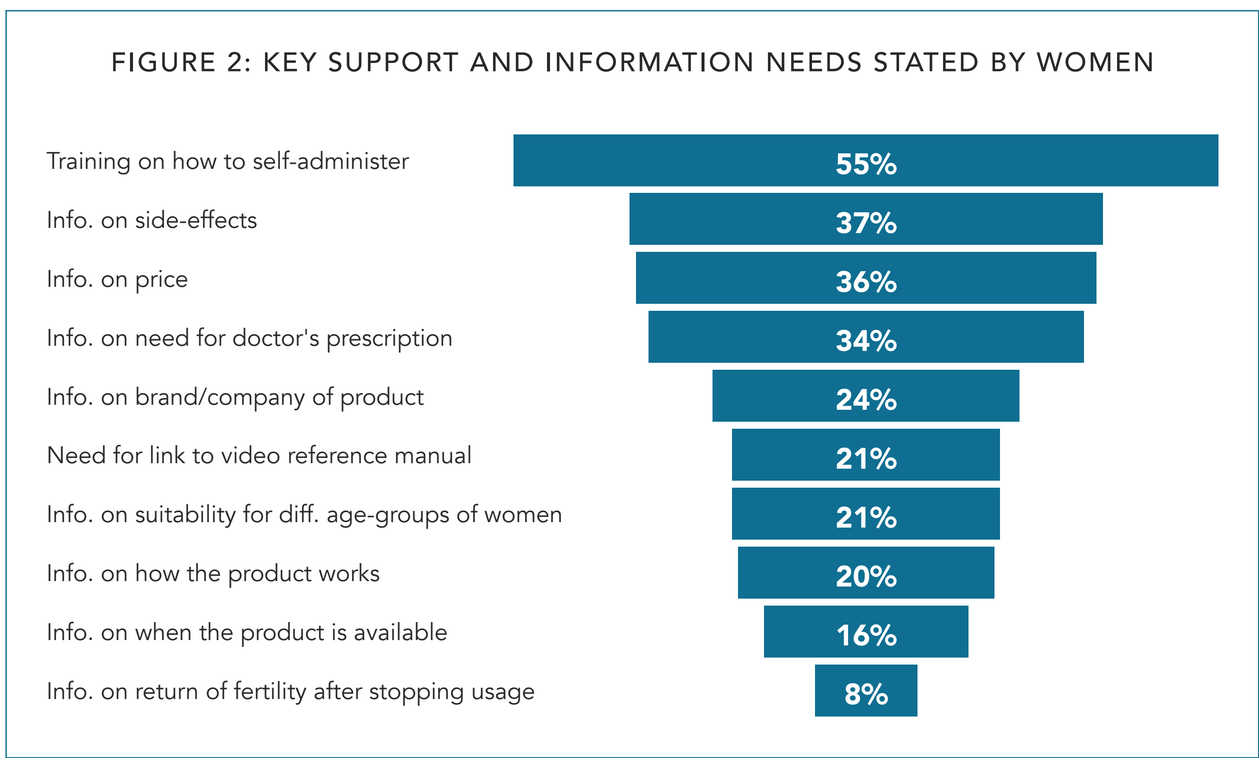
In alignment with the WHO self-care guidelines[h], the findings of this study also indicate that the pathway of self-administration of DMPA-SC is with support from doctors and other health care providers.

Key support needs stated by women (refer to Figure 2) were training on how to self-administer (55%), information on side-effects of the product (37%), requirement of doctor's prescription (34%) and information on price (36%) and brand of the product (24%). Similar support needs were mentioned by pharmacists for selling DMPA-SC such as adequate information on side effects, and protocol for selling DMPA-SC like the requirement of a doctor's prescription.

BOX 4: QUOTES FROM STUDY PARTICIPANTS

- *"We like the single-dose use, self-administration; also, we see that there is no dependence on a doctor visit. It ensures privacy for 3 months for us."* – Woman, rural area
- *"How can we use this without knowing much about the product? There could be some side effects on our health. If someone has used it before or a doctor suggests it, we can think."* – Woman, rural area
- *"Highly persuading for me is self-using means that after 3 months also they need not come back to us. They can buy and they can use that is the main thing."* – General Practitioner, urban area
- *"This is the era where people like to be independent, they do not like to be dependent on anyone else and also the reliability and easy usage of the product, this fits right well."* – General Practitioner, urban area
- *"Most of us may need the first time to be administered by doctor and then we will self-inject. We will get better idea and some confidence after some guidance."* – Woman, urban area
- *"It is not about fear - even if we give it to ourselves, we will be scared, if it is a needle and if we give it ourselves, obviously we will be scared, but once you get habituated to it then there will be no fear, but nevertheless you have to bear a little if you want its benefit."* – Woman, rural area
- *"Insulin they are using daily, they know how to do it. Once you teach them, they are comfortable."* – Gynaecologist, urban area

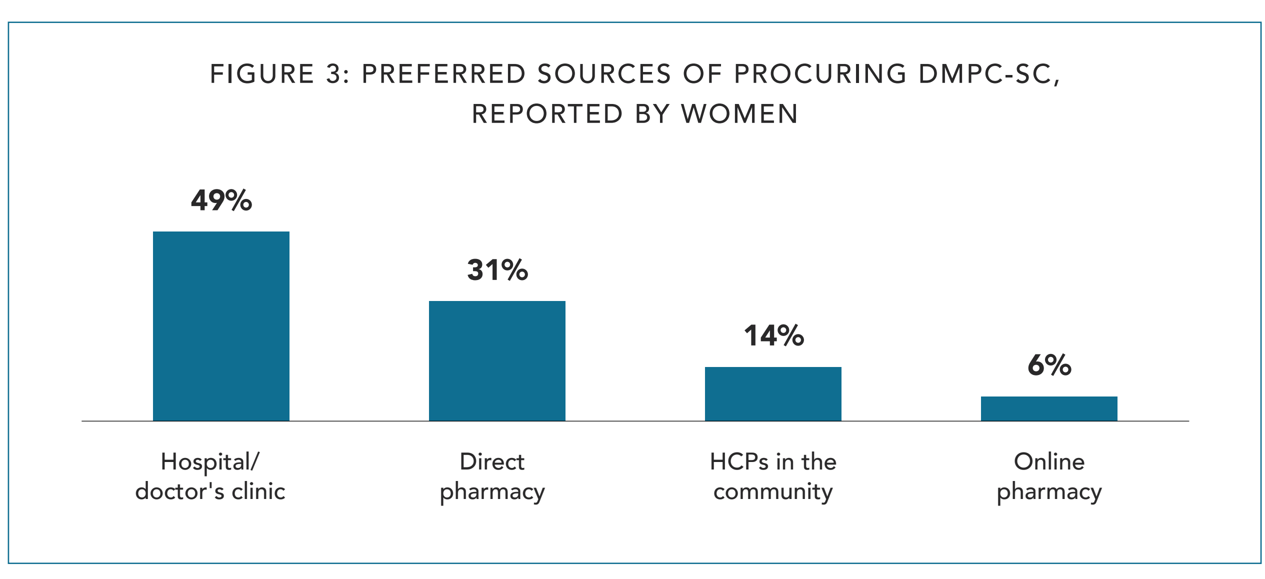
[h] *WHO guideline on self-care interventions for health and well-being, 2022 revision. Geneva: World Health Organization, 2022*



In addition, pharmacists reported that gynecologists (53%) followed by community health intermediaries (25%) and media campaigns (13%) would be vital in influencing demand of DMPA-SC. Moreover, responses from both women and HCPs indicate that confidence building will be a key aspect in being able to self-administer. HCPs linked DMPA-SC with insulin injections and stated that similar to this, women will become habitual to DMPA-SC and will find it easy to use with proper support in the form of training and guidance (Refer to Box 4 for quotes on support needs).

Preferences on information source and product procurement

The most preferred sources of information on the product reported were doctors and other health care providers (like nurses, ANMs, ASHAs and pharmacists), followed by social media platforms (like Facebook, Instagram, WhatsApp, and YouTube) and television. The sources of product procurement are shown in Figure 3, with hospitals/doctors' clinics and pharmacies featuring as the top preferences.



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