“Multi-Faceted Donor Support for Long Acting and Permanent Methods!”

Patricia MacDonald
Senior Technical Advisor
Long Acting and Permanent Methods

IUD

Implants

Tubal Ligation

Vasectomy
What are donors supporting for LAs and PMs?

- Safety and effectiveness of methods
- DHS, biomedical and program research, data analysis
- Informed and voluntary choice
- Access, affordability and quality
- System strengthening
Safety and Effectiveness

Develop and Improve LAPMs

- IUD → CuT380A
- Implants → Norplant
- Vaginal Ring → NES/EE 1 year
- Vasectomy → NSV, facial interposition, cautery
- Tubal Ligation → mini-laparotomy, local anesthesia
Pregnancy Rates by Method

Withdrawal
Male Condom
Standard Days Method
Oral contraceptives
Depo-Provera
LAM
IUD (TCu-380A)
Female sterilization
Vasectomy
Implants

Percentage of women pregnant in first year of use

Typical use
“Perfect” use (but humans are imperfect)
Comparing Method Effectiveness

Long-acting methods and permanent methods are the most effective of all contraceptive methods.
Containing Costs, Improving Affordability

- Price negotiation
  - Implanon reduced to $18.00
- Sino Implant II
  - $8.50/set
- Public sector pricing
  - LNG-IUS
- Consumer pricing
  - Price reduction policy, subsidy, voucher, free
## Comparison of available hormonal implants

<table>
<thead>
<tr>
<th></th>
<th>Sino-implant (II)</th>
<th>Jadelle</th>
<th>Implanon</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manufacturer</strong></td>
<td>Shanghai Dahua Pharmaceutical</td>
<td>Bayer Schering Pharma</td>
<td>Merck</td>
</tr>
<tr>
<td><strong>Formulation</strong></td>
<td>150 mg levonorgestrel in 2 rods</td>
<td>150 mg levonorgestrel in 2 rods</td>
<td>68 mg etonogestrel in 1 rod</td>
</tr>
<tr>
<td><strong>Mean Insertion &amp; Removal time</strong></td>
<td>Insertion: 2 min Removal: 4.9 min</td>
<td>Insertion: 2 min Removal: 4.9 min</td>
<td>Insertion: 1.1 min Removal: 2.6 min</td>
</tr>
<tr>
<td><strong>Labeled duration of product use</strong></td>
<td>4 years</td>
<td>5 years</td>
<td>3 years</td>
</tr>
<tr>
<td><strong>Trocars</strong></td>
<td>Disposable</td>
<td>Disposable</td>
<td>Pre-loaded disposable</td>
</tr>
<tr>
<td><strong>Cost of implant (US$)</strong></td>
<td>$7.50 - 8.50</td>
<td>$21.00 - 23.00</td>
<td>$18.00</td>
</tr>
<tr>
<td><strong>Cost per Year (if used for duration)</strong></td>
<td>$1.90 - 2.10</td>
<td>$4.20 – 4.60</td>
<td>$6.00</td>
</tr>
</tbody>
</table>

*Costs from Reproductive Health Supplies Coalition database, 2009.*
Using DHS data to Understand the Use of LA/PMs

**Spacers**

**Limiters**

- Total demand for spacing (%)
- % of total demand for spacing met by some method
- % of total demand for spacing met by LA

- Total demand for limiting (%)
- % of total demand for limiting met by some method
- % of total demand for limiting met by LAPM
Who can choose, and use LAs and PMs?

**Long Acting Methods:**
- Implants (Jadelle, Sino-Implant II, Implanon)
- IUDs (Cu T 380A, ML-375 LNG-IUS)

**Delaying first births**
- Youth
- Nulliparous

**Spacing between births**
- Postpartum
- Postabortion

**HIV+ women** can use any LAPM

**Permanent Methods:**
- Tubal Ligation
- Vasectomy

**Limiting births** after desired fertility goals are reached
- High Parity
- Low Parity
Informed and Voluntary Choice

• Expand the method mix, and offer greater choice, by including LA/PMs

• Update policies and guidelines, and remove barriers to using the method of choice

• Monitor program and provider compliance with informed and voluntary choice
Enhancing Provider Performance

- Preservice education and inservice training
  - Curriculum, TOT
  - Knowledge & skills
- Job aides
- Toolkits
- Data monitoring
- Publications
FOUR CORNERSTONES

• Medical Eligibility Criteria
• Standard Practice Recommendations
• Family Planning Handbook
• Decision Making Took
Testing and Scaling-up Service Approaches to Expand Access

- Integrated services
  - Postpartum
  - Postabortion
  - HIV
- Mobile outreach
- Community-based information, referrals
- Facility-based
  - routine
  - scheduled days/visits
- Private Sector
- Social marketing
- Event days
- Urban & peri-urban

Photo: MCHIP
Strengthening Systems for LA/PMs

- Commodity Security
  - Forecasting and Quantification
  - Logistics Management Information System
  - Supply chain management
  - LA/PM instruments, consumable supplies
  - RH Supplies Coalition and RH Interchange
  - SPARHCS, job aides, toolkits
• Human Resources
  – Task sharing
  – Preservice and inservice training
  – Dedicated providers

• Policies, Leadership, Management
  – Reduce barriers to access
  – Planning, budgeting, programming

• Service Delivery
  – Innovative approaches tested, scaled-up
  – Institutionalize and sustain LA and PM services
When LA/PMs are made available, people choose them and like them [this fact under-known]

<table>
<thead>
<tr>
<th>Country/Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya focuses on IUDs, in context of full choice, and “FP revitalization”</td>
<td>More than 200,000 women use an IUD. Satisfaction is high.</td>
</tr>
<tr>
<td>Rwanda’s CPR increased from 27 to 45% and expands access to implants</td>
<td>CPR for implants is 6.3%, roughly one in every 7 modern FP users (2010)</td>
</tr>
<tr>
<td>Ethiopia makes greater commitment to FP services</td>
<td>Procurement of implants rises from 31,000 to 830,000 units (2005-2009)</td>
</tr>
<tr>
<td>Malawi’s clinical officers allowed to perform female sterilization</td>
<td>CPR for female sterilization rises to 9.7% and equitable across residence, income and education</td>
</tr>
<tr>
<td>FP access high for all methods in South Africa; modern CPR: 58%</td>
<td>1 of every 4 women in union (14%) relies on sterilization.</td>
</tr>
<tr>
<td>In United Kingdom, few access barriers, wide range of methods, CPR 75%</td>
<td>14% rely on vasectomy; 8% female sterilization, 2% implants; 7% IUD</td>
</tr>
</tbody>
</table>

Sources: DHS; Reproductive Health Supplies Coalition
• We look forward to supporting your efforts to include, expand, and sustain the availability of Long-Acting and Permanent Methods in your programs!

• Thank You!
Provision of Long Acting Reversible Contraceptive (LARC) Services through the Use of Health Extension Workers (HEWs) in Ethiopia

Mengistu Asnake, MD, MPH
Integrated Family Health Program
International Conference on Family Planning, November 30, 2011
Presentation Outline

• Background
• Genesis of the Health Extension Program
• Program description
• Results and achievements to-date
• Challenges and lessons learned
• The way forward
Background: Ethiopia

- Total population = 80 million
- Population growth rate = 2.6%
- Rural population = 83%
- Population under 15 = 44%
- Unmet need = 25% (34% in 2005)
- Contraceptive Prevalence Rate (CPR) = 28.7% (27.3% modern FP)

Data Sources: DHS 2011 and Census 2007
**CONCLUSION:**

*Cannot do business as usual!*
Health Extension Program (HEP)

16 HEP Packages

- HIV/TB, Malaria First Aid
- MCH, FP, Immunization, Nutrition, Adol Health
- Health Education and Communication (1)
- Personal hygiene; water & sanitation, latrine; solid & liquid waste; housing construction; insects & rodent control

34,000 HEWs (98% female) with one year of training, paid by government (2/5000 people).
Program Description

• FMOH decision on the inclusion of Implant services at Health Extension Worker (HEW) level

• Joint planning and development of training materials by FP Technical Working Group (TWG)

• Selection of initial learning sites and scale up based on the lessons
  – TOT, rollout training, and follow up activities
  – Task shifting
  – Backup support within the Primary Health Care Unit (PHCU)
Results: Training Coverage

• 154 operational woredas/districts of IFHP covered during the period of July 2009 –September 2011

• 611 HEW supervisors and 572 clinical providers completed a 1-week TOT on Implanon insertion.

• Nearly 4,000 HEWs have successfully completed the roll out Implanon insertion

• Each trainee were able to provide service to 7-10 clients during the training activity
Results: FP Service Delivery by Methods during TOT and Rollout Training, July 2009-September 2011

<table>
<thead>
<tr>
<th>Training</th>
<th>Number of clients receiving services, by FP type</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Implanon I</td>
<td>Implanon R</td>
<td>Jadelle I</td>
<td>Jadelle R</td>
<td>Norplant I</td>
<td>Norplant R</td>
<td>IUCD I</td>
<td>IUCD R</td>
<td>Pills</td>
<td>Depo</td>
<td></td>
</tr>
<tr>
<td>TOT</td>
<td>9,398</td>
<td>1</td>
<td>791</td>
<td>15</td>
<td>0</td>
<td>47</td>
<td>6</td>
<td>0</td>
<td>72</td>
<td>229</td>
<td>10,559</td>
</tr>
<tr>
<td>Roll out</td>
<td>27,866</td>
<td>3</td>
<td>1766</td>
<td>59</td>
<td>0</td>
<td>187</td>
<td>2</td>
<td>0</td>
<td>91</td>
<td>344</td>
<td>30,318</td>
</tr>
<tr>
<td>Total</td>
<td>37,264</td>
<td>4</td>
<td>2557</td>
<td>74</td>
<td>0</td>
<td>234</td>
<td>8</td>
<td>0</td>
<td>163</td>
<td>573</td>
<td>40,877</td>
</tr>
</tbody>
</table>


Results: Task Shifting and Backup support

Hospital and health center level services by nurses or other higher level health professional

Task Shifting

Referral & Back-up support

Health post level service delivery at the village level by HEWs
## Results: FP Service Delivery by Methods during Backup Services

<table>
<thead>
<tr>
<th>Year</th>
<th>Sessions</th>
<th>Number of clients receiving services, by FP type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Implanon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I</td>
</tr>
<tr>
<td>2009</td>
<td>62</td>
<td>3,006</td>
</tr>
<tr>
<td>2010</td>
<td>83</td>
<td>8,684</td>
</tr>
<tr>
<td>2011</td>
<td>122</td>
<td>3,519</td>
</tr>
<tr>
<td>Total</td>
<td>267</td>
<td>15,209</td>
</tr>
</tbody>
</table>
Practice on arm model

Clients waiting for services

Counseling clients using displayed methods

Implanon insertion by HEW
Results: Client Characteristics

Data from initial training (7,000 clients):

- Over 50% below age 30
- Over 55% had 4 or less children
- 67% were on Depo-Provera and 26% new users
- 42% used a method over a year period
Results: Monitoring and Evaluation

• Pre- and post-test

• Daily session evaluation

• Evaluation of trainees on:
  – Counseling clients
  – Implanon insertion procedure
  – Ensuring infection prevention
  – Recording and analysis of client information and characteristics

• Follow up mechanisms with checklist and review meetings

• External M&E by FHI-Ethiopia
Results: External Evaluation during Training (FHI)

Trainee scores on medical eligibility screening of the client (n=62/116)

Percent scores of trainees on following correct insertion procedures (n=62/116)
Challenges

• Too short time for initial planning

• Absence of materials in local language for the rollout training during the learning phase

• Limited time for model practices (from 5 to 6 days)

• Shortage of consumable supplies

• Fee for FP related services at some Health Centers (Free FP policy)
Lessons Learned

• Existence of huge demand for LAFP

• With proper follow up and TA, HEWs can manage the Implanon insertion without difficulty

• The need for availing a wide range of FP services during training

• It is an opportunity for providing integrated MCH services
The Way Forward

• Continue follow-up visits by integrating with supportive supervision

• Strengthen linkage with nearby HCs for removal services and other technical support through the back-up support

• Scale up to more woredas

• Document lessons (OR on exploring the reach and the nationwide scale-up of Implanon in Ethiopia and assessing discontinuation)
For more information contact:
Dr. Mengistu Asnake

MAsnake@pathfinder.org

Thank You
A Non-Starter?

Taking Long-Acting Reversible Contraceptive Provision to Scale in Sub-Saharan Africa

Jully Chilambwe
Society for Family Health (PSI) - Zambia
30 November, 2011 - ICFP Dakar, Senegal
Low IUD use in Sub Saharan Africa – 0.5%
Many barriers to LARCs

- Poor reputation of older models
- Lack of competent and confident providers
- Myths and misconceptions
- Cost of services
- Provider bias and inadequate knowledge
- Lack of training, equipment, and supplies
- Pelvic exams and vaginal contact (IUD)
- Relative complexity compared to other FP methods
Solutions to improve informed use of LARCs

- Training of service providers
- Ongoing supportive supervision
- Counseling & Education
- Improving affordability and financial viability
- Sustainable changes to healthcare system
- Generating demand
• There are no Magic Bullets to improve access and increase informed use of LARC.

• Successful strategies include a combination of approaches to address both the supply side and demand side.
Mali Dedicated Providers – Integrating LARCs with Immunization Days in Public Clinics
Franchising Private and Public Sector Providers
Clinic Service Days
Maintaining Quality

- Training and clinical practice
- On-going supportive supervision
- Clinic support days
- Infection prevention training for clinic staff/community workers
- Internal and external audits
IUD and Implant Service Delivery in Sub-Saharan Africa

Services: 526,894 IUDs and 306,993 implants

LARC Service Provision Jan 10 - Jul 11

- Benin
- Cameroon
- DRC
- Kenya
- Madagascar
- Mali
- Togo
- Tanzania
- Uganda
- Zambia
- Zimbabwe

Legend:
- IUDs
- Implants
Challenges

- Delays in ammending FP policies, protocols and training materials that are in line with international best practices
- Service provider motivation to maintain high performance
- Geographical coverage and effective provider supervision
- Linking demand and supply (services)
Lessons Learned

• Match models to local context
• They will come: address access, cost, information barriers
• Create efficiencies of scale: outreach services or dedicated service provision
• Ensure providers have adequate clientele to maintain competence and confidence
psi
Healthy lives. Measurable results.
Strengthening Mobile FP Service Evaluation Approaches: A Peer Review Approach

Presenter: Adrienne C. Testa
Authors: Adrienne C. Testa\textsuperscript{1}, Kenzo Fry\textsuperscript{1}, Nomi Fuchs-Montgomery\textsuperscript{2}

\textsuperscript{1} Marie Stopes International, United Kingdom
\textsuperscript{2} Marie Stopes, United States of America
Overview

1. Background
2. Method
3. An Example – Adverse Events
4. Conclusions
Background

- Marie Stopes International (MSI) is a global leader providing long-acting and permanent methods (LAPM) of family planning, as part of a comprehensive method mix.
Background

- In 2010 MSI delivered in excess of 21 million CYPs
- 12.5 million CYPs delivered through 6,000 outreach sites in 26 countries.
Background

- MSI conducted a 5 country retrospective evaluation of mobile services in 2010 to determine if:
  1) mobile services were meeting the FP needs of underserved women
  2) quality services and follow-up were provided
Background

• Results were directly programme relevant and stimulated the adoption of prospective evaluations in other country programmes

• MSI is increasing the number of mobile service evaluations, and aims to develop current methodologies.

• Currently prospective outreach evaluations are in preparation or implementation in:
  – Cambodia, India, Tanzania, Vietnam, Zimbabwe
Method

- To strengthen the technical rigour and comparability of MSI mobile service evaluations we are in the process of conducting:

1) internal review among MSI international researchers and managers of outreach programmes

2) external review of our tools by research organisations, donors, FP service delivery organisations
Methods

Currently evaluations aims are to ensure MSI:

1) meets FP needs of underserved women, particularly in communities with few or no alternative providers

2) ensure quality of care

3) ensure client satisfaction
Method

- The principal indicators MSI evaluations currently measure are:

  1) complication rates by method

  2) discontinuation rates of IUDs and implants (ideally up to 12 months)

  3) method failure rate

  4) client satisfaction
Method

- Some indicators common among some research and service delivery organisations
- MSI is keen to foster shared learning among stakeholders through reviews
An Example – Adverse Events

- Review of literature for standardising definitions and measurement of Adverse Events (AE) for Long Acting and Permanent Methods of FP
- Frequent incompatible definitions of:
  - ‘Adverse events’ versus ‘side effects’
  - ‘Minor’ versus ‘major’ adverse events
  - Measurement of bleeding
  - Measurement of pain
An Example – Adverse Events


- Assess the severity of the symptom on scale of 1-5 to determine consequence score

- Five levels of severity preferred for more precision of reporting – usual three scale (mild, moderate and severe)

- AE determined by measurement of:
  - Level of intervention required
  - Level of ability to perform normal daily activities
### AE Definitions

#### General Definitions
- **NEGLIGIBLE**
  - Symptom as a result of the procedure or drug that is generally not a sign of a health problem, nor related to the skill of the provider, and requires resting or no medical intervention or treatment.
  - Aware of the problem all the time but able to do normal daily activities (i.e. work, child care).
- **MINOR**
  - Minor injury or illness that requires minimal level of intervention such as taking pain medication (symptoms are managed at home).
  - Unable to return to normal daily activities (i.e. work, child care) for 1-2 days.
- **MODERATE**
  - Moderate injury that requires attention from medical personnel to conduct a medical intervention (managed by MSI provider).
  - Unable to return to normal daily activities (i.e. work, child care) for up to 2 weeks.
  - An event which impacts on a small number of clients ($\leq$ X number / percentage).
- **MAJOR**
  - Major injury leading to long-term incapacity / disability, and requires hospitalisation.
  - Unable to return to normal daily activities (i.e. work, child care) for more than 2 weeks.
  - Exposure to infections, e.g. HIV, Hepatitis B virus.
  - Failed procedure (MSL, MSV).
  - An event which impacts on a small number of clients ($\leq$ X number / percentage).
- **CRITICAL**
  - Incident leading to death.
  - Multiple permanent injuries or irreversible health effects.
  - Incapacitated and unable to perform some or all normal daily activities altogether.
  - An event which impacts on a small number of clients ($\leq$ X number / percentage).
### AE Questionnaire Template

#### 1. INTRA-UTERINE DEVICE (IUD)

**Complications at time of procedure**

1. Were there any complications experienced by the client during insertion of IUD?
   - [ ] No → Skip to question X
   - [ ] Yes → Specify complications:

2. **Type of complication**
   - Report all complications observed
   - [ ] Pain
   - [ ] Perforation of uterus
   - [ ] Damage to cervix
   - [ ] Other → Specify: ____________

3. **Severity of complication**
   - Report level of severity for all complications reported

<table>
<thead>
<tr>
<th>1 Negligible</th>
<th>2 Minor</th>
<th>3 Moderate</th>
<th>4 Severe</th>
<th>5 Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires no medical intervention or treatment</td>
<td>Requires minimal level of medical intervention / can self manage at home, such as take pain medication / unable to return to normal daily activities for 1-2 days</td>
<td>Requires attention from medical personnel to conduct a medical intervention / unable to return to normal daily activities for up to 2 weeks</td>
<td>Requires hospitalisation due to life threatening condition / persistent or significant incapacity or disability / unable to return to normal daily activities for more than 2 weeks</td>
<td>Permanent injury or irreversible health effects or death / incapacitated and unable to perform some or all normal daily activities altogether</td>
</tr>
</tbody>
</table>

- **Pain**
  - Sharp pain during insertion is normal, client may also feel nauseous and / or light headed
  - More than usual discomfort experienced by client requiring more than one stoppage in the surgical local and procedure
  - Client experiences pain that is not improved by any intervention by the team and cannot continue the procedure

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**INTERNATIONAL CONFERENCE ON FAMILY PLANNING**

SLIDE 14
Results

Specifically we aim to move toward consensus-building on:

1) definitions of indicators
2) measurement of ‘underserved’
3) sampling approach/es
4) follow-up intervals by method

Encourage sharing of tools and definitions related to outreach evaluations
Conclusions

- We favour a collaborative approach to sharing and reviewing mobile services tools to:

  1) promote dialogue between implementers, researchers and donors to develop relevant methods and tools

  2) promote comparability of results between organisations and country programmes by developing common indicators

  3) promote a capacity building and sharing environment among FP researchers.
To find out more about how we are addressing unmet need by reaching the most underserved, please visit www.mariestopes.org

For more information contact adrienne.testa@mariestopes.org