

Pia: Greetings and welcome to today's webinar on Injectable Contraceptives. My name is Pia Kochhar, and I am the Knowledge Management Coordinator for the Advancing Partners & Communities project. Before we begin today's presentations, I'd like to quickly review the Adobe Connect environment and set a few norms for today's webinar. Today's webinar has three presentations, followed by a discussion period, during which our speakers will address your questions. Within the webinar environment, please make use of the Q&A box on the bottom right side of your screen to share your thoughts, note your questions, or ask for help with sound during the presentation. Questions you ask are only visible to you, our presenters, and technical support.

If you are experiencing difficulties, our technical support will respond to your question privately. We will collect your questions for our speakers and will save them for the discussion period. It is great that we are able to connect people from so many places today, but your experience may vary based on your internet connection and computer equipment. I will briefly go over a few troubleshooting steps if you have technology challenges today. A few troubleshooting tips. If you lose connectivity or cannot hear, close the webinar. Re-enter the meeting room in a browser other than Google Chrome by clicking on the webinar link provided. Use the Q&A box to ask APC Tech for assistance.

If the troubleshooting steps are not successful, please rest assured, the webinar is being recorded and you will receive an email with a link to the recording following today's event. Questions that don't get answered during the Q&A sessions will be compiled after the webinar, shared with presenters, and responses from presenters will be shared with participants. To get us started, I will now turn it over to our moderator, Kimberly Cole.

Kimberly: I would like to welcome and thank everyone for joining us today. My name is Kimberly Cole. I'm a technical advisor at USAID. Today's webinar is organized by the USAID Advancing Partners & Communities project, and this webinar on injectable contraceptives is the third in a series of webinars that will highlight several family planning methods. This webinar series is designed to highlight a range of family planning methods and each webinar will provide details on a single method. Our target audience includes Ministries of Health, policymakers, donors and program managers.

The series will provide information on family planning methods, including how to use them, their effectiveness, how they work,

medical eligibility criteria and hot topics specific to each method, as well as country case studies and family planning method service delivery channels. Our objectives for all the webinar in the series are to provide technical information and updates on a broad range of family planning methods, engage a global audience to discuss emerging trends, highlight programmatic successes and challenges, and answer questions specific to each method. Finally, a reflection on volunteerism and informed choice.

In programs and in practice, we always expect that clients have access to a broad range of methods, clients receive client-centered counseling on a range of contraceptive methods, including a discussion about lifestyle, reproductive intentions and preferences, and they can ask questions, clients freely choose their method without coercion, clients also receive detailed information on the chosen method and can further discuss the method with the provider and ask questions, and providers are able to offer and counsel clients on a range of methods, even those they do not offer themselves but might be available via other providers or sources, such as through referrals. I would now like to introduce our first speaker, Jeff Spieler, who is an independent consultant. Hi, Jeff, are you there?

Jeff: Good morning, good afternoon, and good evening to all the participants. Can you hear me?

Kimberly: Yes, we can hear you.

Jeff: It's my pleasure to be presenting the overview on injectable contraceptives and this overview will cover the following topics shown on this slide, including mechanism of action, side effects, medical eligibility criteria, effectiveness, and service delivery components, some of the service delivery components of injectables. Injectable contraceptives are hormone-containing injections that are injected into the muscle, that's called intramuscular, or IM, usually in the buttocks or the upper arm, or just under the skin, and that's called subcutaneous, or SC or sub-Q. Injectables are not visible. They can be used discreetly and I'll mention more about that later.

They're considered a short-term contraceptive method. They're easy to use and quick to administer, and highly effective with perfect use, that means the reinjection window is always followed, and in typical use, they're still highly effective at 94 percent. How do they work? For the most part, injectable contraceptives prevent ovulation. The progestin only, particularly, also thickens the

cervical mucus, which prevents sperm penetration, and hence, there could be no fertilization, even if ovulation occurred, but ovulation usually does not occur when using injectable contraceptives. This slide shows an overview of the five major injectable contraceptive. The first is Depo-Provera. That's DEPO-IM, intramuscular. It's three months.

You can see on the slide all the details of that method. I won't go through every item on this slide but I want to mention that the reinjection window for Depo is two weeks before and up to after four weeks after the three-month mark. The subcutaneous Depo, also known as Sayana Press but more known as SC, also at three months and it has the same injection window. The product called Noristerat, or enantate, is a two-monthly injectable, but the company Bayer Health says that after the first three injections at two-month intervals, you can then move to a three interval similar to Depo. Cyclofem is a one-month contraceptive, a combined contraceptive that has a shorter window of reinjection. It contains an estrogen and a progestin, and that's for one month.

And Mesigyna or Norigynon, is also a one-month. It contains a slightly different progestin and estrogen and it also has a shorter injection window. And the unit cost of these products, except for Cyclofem, which is not really available widely right now, are shown on this slide, and they all – all products except for Sayana Press at this point has a shelf life of five years and hopefully, the SC Sayana Press will also have a five year – eventually – shelf life. This slide gives you the major differences between the IM and the subcutaneous formulations, and you can see that the sub-Q, SC, that DMPA-SC, has about 30 percent less progestin. It comes in a prefilled Unject system and Jen Drake, the next speaker, will speak about that later. And the IM comes with a syringe and a vial.

The needle is larger for the IM than it is for the SC product and there is sometimes a bit of irritation at the injection site with the SC delivery, but that's very transient and doesn't create a problem. And the last item I mentioned is that there are generic equivalents for Depo, DMPA-IM, but there are no other manufacturers at this time for the SC product. The advantages of injectable use are shown on this slide and I'd like to mention that, in addition to being highly effective, injectables like DMPA which is a three-month, is not considered a long-acting method, but it is certainly longer acting than oral contraceptives that have to be taken daily.

They're easy to use and they're private. And this is really important for some women, their partner cannot tell that a woman

is using injectables, particularly if there is resistance on the part of the partner to use contraception or the partner's family. The progestin-only injectables are safe for breastfeeding women and they have many non-contraceptive effects. Oral contraceptives also have the same non-contraceptive effects by reducing to risk of endometrial and ovarian cancer and protection from uterine fibroids, ectopic pregnancy, and symptomatic pelvic inflammatory disease. And these injectables also have special advantages for certain kinds of women. Women who have sickle cell anemia, it may reduce the crisis of sickle cell, and also, it prevents seizures in epileptics and prevents iron deficiency anemia.

Potential side effects, perhaps one of the most concerning is the delay in return to fertility for some women, and there's an average of ten months from the last inject and that's understandable because, as I said earlier, DMPA actually lasts for four months. Once you have an injection, you've got four months of contraceptive protection and then that slowly wanes off.

And studies have shown that after a year, most women have returned to fertility. Injectables may cause some weight gain, headaches, and nausea. Headaches and nausea are common with hormonal contraceptives, and there are some issues related to HIV, STIs, and bone loss, and I'll mention a little bit more about that in a moment. And then there's changes in menstrual bleeding, which I'll talk about in our last slide, and those are the changes that could be problematic for some women and I'll deal with that again.

I'm sure all of you know about the medical eligibility criteria created by WHO, also called the MEC. It is broken into four categories. Category one and two basically mean use the method, and category three and four says be careful with using it or don't use it at all. A perfect example of a category four is a woman who is 35 years or older, smokes, and wants to use oral contraceptives.

Last year, the WHO changed to medical eligibility criteria for the progestin-only injectables from a one to a two. A two means still use, that the use – women should not be denied use but this is primarily for women at high risk of HIV because there's some continuing concern about the possible association between the acquisition of HIV and the use of DMPA. They moved it to a two, but again, no woman should be denied the use of injectables, even those who are at a high risk, but women at a high risk should be informed that they need to use condoms to prevent acquisition of HIV.

There is ongoing research to resolve this problematic issue, and there's a trial called the ECHO trial. It's Evidence for Contraceptives and HIV Outcomes. It's a randomized trial between DMPA, the implants Jadelle, which contains levonorgestrel in a copper IUD, and more information can be obtained about this trial at the website identified on this slide. And everybody is hopeful that maybe there will be a resolution to the issue of whether or not there is an association between DMPA and the acquisition of HIV, but one can never assume that the study results will be unambiguous. This slide shows the comparative effectiveness of the typical use of all methods and you can see that injectables are sort of in the middle of highly effective methods.

This is the number of women who would become pregnant when using the method typically amongst 1,000 women in one year. You can see that injectables are quite a bit more effective than the pill and condoms, and certainly, so much more effective than no method at all, but not as effective as the long-acting reversible method, the implants or the IUD, or as effective as female and male sterilization, but they're still highly effective.

There are many service delivery considerations. First, I'd like to mention that there are somewhere around 40 million women using DMPA and three million women using other injectables, that injectables are one of the most commonly used methods in many countries like Kenya and account for about half the methods in other countries listed on this slide. Jen Drake and her presentation will give more details about injectable use around the world. The monthly injectables are primarily used in Latin America and there's at least one injectable available in all service delivery sites in most low and middle income countries through fixed services, community health workers, pharmacies, and drug shops. And again, Jen Drake will speak about this in the next presentation.

Related to the major service delivery requirement is the need for providers counseling women on the side effects of injectable contraceptives, particularly the progestin-only injectable contraceptives, and a job aid mentioned on this mentioned on this slide with the acronym, NORMAL, was developed by FHI 360 and psi. It is a simple set of counseling messages about menstrual bleeding changes that that healthcare providers can easily incorporate into counseling sessions without requiring substantial increase in time and effort.

The tool's primary goals are to prompt providers to educate women on bleeding changes associated with contraceptive use,

address most of the common misconceptions and fears about menstrual changes and increase women's awareness of the potential advantages of reduced menstrual bleeding and/or amenorrhea. I'm now gonna turn the speaker back to our moderator, Kimberly.

Kimberly: Thanks, Jeff. And to our audience, please do go ahead and add your questions for Jeff to the Q&A box for our discussion section. And the next presentation is from Jennifer Drake of PATH.

Jennifer: Great. Thanks, Kimberly. Hi, everyone. I'm really pleased today to have the opportunity to talk to you about global priorities and hot topics for injectable contraception. As you can see here, the proportion of global contraceptive use that's represented by injectable contraception has more than tripled over the past two decades. It's a relatively large order of magnitude relative to most other methods during the same period. Jeff has already talked about why injectables are a preferred option for some women. For example, it's easy to use them without a partner's knowledge.

This figure is from FP2020's most recent progress report and it shows that injectables are the most common method in several countries. The boxes with orange blocks show countries where injectable contraception is the most common method. As you can see, that's the case in several FP2020 countries, in sub-Saharan Africa, and a few in South and Southeast Asia. In Liberia and Ethiopia where the boxes have a dark border around them, injectables represent more than 60 percent of the method mix, so those are classified as cases of method skew.

PMA2020 sent us some data so that we could consider how DMPA injectable users specifically compare to modern contraceptive users overall. They actually shared survey data with us from nine countries and we've highlighted a few here that reflect the general trends. What you can see is that relative to overall modern contraceptive users, more DMPA users are married or in union, fewer DMPA users are in urban areas, and fewer have completed primary school. Now, of course, in Uganda, for example, the difference between the two groups is not as great. I'd also like to point out that in most countries, it seems that the majority, or even most women, receive their injectable contraceptives from the public sector. Again, this is slightly different in Uganda and DRC.

I'd like to talk today about a few different priorities for programs offering injectable contraception that would enable them to expand contraceptive access and options for women. First, investing in

delivery channels and approaches across the total market, including options for task-sharing, such as community-based access to injectables, also known as CBA2I, and administration through pharmacies and drug shops. Just to clarify, when we talk about task-sharing, we mean specific tasks like administration of injectable contraception being shared across different levels and types of health workers, not task shifting where we're taking the task of administration and moving it from one health worker to another. Injectables are and remain a great option to include in facility-based programming, as well as more peripheral options like community-based access.

There are many opportunities to make them more accessible to more women through various delivery points and approaches. The second priority we'll talk about today is providing women full and accurate information on all contraceptive options, including injectable contraception. And the final priority in considering the potential for the novel injectable DMPA-SC, or subcutaneous DMPA, the branded product Sayana Press, to expand access, reach new users of modern family planning, and improved continuation, especially through self-injection, which you might think of as the ultimate task-sharing strategy, and we'll talk more about that in a bit.

First, investing in delivery channels across the total market. Benefits of task-sharing include enabling access and availability for women by offering contraception through a wide range of providers, and there is strong evidence on the effectiveness and impact of task-sharing strategies. I'd like to highlight, in particular, a few high impact practices, which are evidence-based practices that when scaled up and institutionalized can support family planning programs and maximize investments and effort to improve reproductive health.

The core conveners of these high impact practices, or HIPs, are USAID, UNFPA, WHO, IPPF, and FP2020. A proven HIP is equipping community health workers to provide a wide range of family planning methods, including injectable contraception. The evidence based on this is very robust. A promising HIP is training and supporting drug shop and pharmacy staff to provide a wider variety of family planning methods, including injectable contraception.

Aligned with the HIP is a recent brief that WHO released on task-sharing and modern contraception. Evidence and experience support that various types of providers can safely and effectively

provide injectable contraception. What you can see here in the yellow box is that most providers can safely and effectively provide hormonal injectables. You can also see that community health workers can safely and effectively provide injectable contraception under targeted monitoring and evaluation. And similarly, operators of retail outlets such as drug shops and pharmacies can safely and effectively provide injectable contraception according to their clinical qualifications.

Finally, I just want to highlight this excellent map from FHI 360 on community-based access to injectables sub-Saharan Africa, and note that over the past decade or so, this practice has gained enormous momentum as the evidence base has grown and countries have begun to focus on expanding to family planning at the community level. As you can see here, as of this month, a total of 12 countries have adopted policies or practices that support community-based access to injectables. There's a similar map from 2005 and the only country that had color filled in was Uganda for 2005.

Moving to the second priority, I want to talk for a moment about the importance of providing full and accurate information on all contraceptive options. One of the best tools for providers is WHO's global family planning handbook, and there was actually an update to the Family Planning handbook released just a few days ago. You can access it at the link shown here. This 2018 edition includes information about available and new methods and I wanna highlight that it includes new selected practice recommendations for DMPA-SC, how to give those injections, and also how to train clients to self-inject. Referring back to Jeff's discussion about medical eligibility criteria and potential association with HIV acquisition, there is a new job aid on counseling women at high risk of HIV who want to use a progestin-only injectable.

Finally, I'd like to talk today about the potential value of the novel injectable subcutaneous DMPA, or DMPA-SC, for family planning programs. The product's features and benefits make it a great option in all service delivery points across health systems. As Jeff noted, it has equivalent efficacy and safety to DMPA-IM, as well as, now, the price of the product to qualified purchasers. It also has a shorter needle, a lower dose, and as Jeff noted, is presented in an all-in-one device, which means that the drug, DMPA, comes pre-filled in the Uniject injection system, unlike the DMP-IM where the vial and syringe are packaged separately and delivered separately.

The features and benefits lead to the opportunities of increased acceptability. What we have seen consistently is a preference for DMPA-SC among users and providers when both injectable options are available. For example, in 2012, FHI 360 conducted a study in Uganda, and in that study, all community health workers and 84 percent of women preferred DMPA-SC over DMPA-IM if both products were available. This same finding has been borne out in pilot introductions of the product, as well. The product's features and benefits also make it well-suited for community based distribution in drug shops and pharmacy provision, which we've already discussed, and the product is uniquely suited to self-injection.

All of this translates to expanded access and more new users of family planning, as well. Reaching new users of family planning can help countries achieve FP2020 goals. What we've seen across several countries, including Mozambique, Nigeria, Senegal, Uganda, and Niger, is that when DMPA-SC is newly introduced in a program, about one third of the doses that are administered are to first time users of family planning who have never used modern contraception before. The next slides are going to focus on self-injection and continuation.

Before I get into some new findings on continuation and self-injection, I want to talk briefly about the evidence behind the practice. First, it's important to know that in September of 2015, Pfizer announced the approval of self-injection from its stringent regulatory authority in the UK, the UK Medicines and Healthcare Products Regulatory Agency, or MHRA. Pfizer is applying for the same label change in additional countries and self-injection label change has already been approved in Ethiopia, Ghana, Guinea, Myanmar, Niger, Nigeria, Uganda, Vietnam, and Zambia, among other countries.

I want to also review some findings from studies in Senegal and Uganda that helped establish that self-injection is feasible and acceptable. In 2015, 2016, PATH and Ministries of Health conducted two separate studies. In each country, nearly 400 women who had decided to use injectable contraception were invited to try self-injection. They were trained one-on-one at a facility to self-inject and three months later, they were asked to self-inject independently without coaching from a provider, but following a visual aid. What we saw in both countries was that nearly 90 percent of women were proficient at self-injection three months after their training. Almost all of them, when asked at the

end of the study, said that they would like to continue self-injecting in the future.

It's worth noting that although all study participants were 18 and older, women younger than 25 in the study were able to self-inject as capably as older women. It's also worth noting that women with less education, particularly those who had never attended any amount of school, had a more challenging time learning to self-inject, and so, programs may need to offer additional support for those women during training. Finally, I just want to highlight that we also learned in these studies that most women who self-injected could store DMPA-SC securely in their homes, almost all the women in both countries.

We've also seen that waste disposal is more challenging, but given these positive findings on storage, what we're now actually working to assess in Uganda in an initial rollout of self-injection in a few districts is whether it's also feasible for women to store used units at their homes safely and securely until their next trip to a health worker or a clinic, when they can return the units for safe disposal at their convenience. Other innovations for waste disposal would also be very welcome.

Finally, as I mentioned, self-injection of DMPA-SC can help improve contraceptive continuation, which has been a persistent challenge for injectable contraception. As you can see here in this table, the median duration of injectable use is lower than most other contraceptive methods. New results have been published or are forthcoming that have found self-injection seems to enable significantly more women in three different country settings to continue using the method at 12 months. Studies led by FHI 360 in Malawi, PATH in Uganda, and the Planned Parenthood Federation of America in the United States have found these consistent results.

I also want to point out that in Uganda, we saw significant increase in continuation for women between the ages of 18 and 25 particularly, so self-injection seems to be especially promising for younger women who face particular challenges to contraceptive continuation. And as noted, some of these results have not yet been published so keep an eye out. They should be forthcoming in the next few months.

I want to just close today with a few lessons learned for addressing key challenges when it comes to expanding access and options through programming. First, it's important to consider all delivery

channels and approaches across the total market to maximize access and options for women, including task-sharing and self-injection. Second, mechanisms for ongoing supervision and support are critical parts on and task-sharing initiative to ensure that programs are high quality and work for women.

Relatedly, informed choice is always a priority in health worker training and supervision, even or especially in the context of initiatives that are focused on a specific product or practice. Informed choice enables women to identify the best method for them at the time, to continue and manage their use, and to transition to other methods as needed. Relatedly, supply chain is key to making informed choice a reality. Finally, it's critical that we support health management information systems to capture contributions of new delivery channels and approaches and alternative practices. Data on the impact of these options are needed to make the case for scale up of innovative products and practices.

Thank you very much. If you need more information, there are lots of resources from different partners featured throughout the slides. I do want to flag that the PATH and JSI DMPA-SC Access Collaborative is a great resource working with lots of country leaders and partners to scale up DMPA-SC across context so please reach out to us if you have more questions about that product. Thank you.

Kimberly: Thanks, Jen. As a reminder to everyone, please continue adding your questions for Jen and Jeff to the Q&A box for our discussion later. The next presentation is from Fred Mubiru from FHI 360. Thank you. Fred, we can't hear you if you're still on mute. Fred, we still can't hear you.

Fred: I hope you can hear me now.

Kimberly: Yes, we can. Thank you.

Fred: Thank you very much. Hi, do you hear me?

Kimberly: Yes, we hear you. Thank you.

Fred: The previous presenters gave the global perspective on DMPA-IM and DMPA-SC utilization and Jennifer, in her just most recent presentation just talked about some of the statistics for Africa [inaudible] [00:35:18] I'll tell you about [inaudible] of injectable

contraception through community-based family planning in Uganda. Next slide, please.

Kimberly: Fred has moved ahead, for the audience, if you would like to go ahead –

Fred: Do you hear me now?

Kimberly: Yes.

Fred: Do you hear me now. Hello, do you hear me now?

Kimberly: Fred, we can hear you. You can go ahead.

Fred: **[Inaudible]** [00:36:26] giving you an overview, Uganda has a population of about 35 million as of the most recent census of 2014, and it has a high fertility rate of about 5.4 percent. The contraceptive prevalence rate has increased to about 35 percent of married women. Unmet need has gone down to about 28 percent. However, at the current rate, we will not be able to meet our Family Planning 2020 goals, which we committed through our Costed Implementation Plan for family planning, which is a contraceptive prevalence rate of 50 percent and to reduce the unmet need to ten percent. Currently, about 2.6 million women are using modern contraception in Uganda. Next slide, please.

If you can hear me, I'm now talking about the current method mix in Uganda. Right now, injectables are the most utilized method at about 43.8 percent as per the PMA2020 round five results, and of course, DMPA-IM is the most utilized, followed by the implants. The DMPA-SC, Sayana Press, comes in at about sixth. You can see the slide now that I just talked about, that injectables are the most preferred and most utilized methods in Uganda, both according to the DHS and PMA2020.

The community-based family planning in Uganda, if we are to go to the next slide, is a result of evidence and advocacy that took quite a long time, and in 2010, there was a vision to the National Policy Guidelines and Service Standards that included an addendum that allowed village health teams, who are the community health workers in Uganda, to be able to provide injectable contraception in the communities through the task-sharing framework.

[Inaudible] by June of 2017, at least 28 districts supported by different partners were offering community-based family planning

services. The next slide, we talk about the CBF – the community-based family planning in Uganda and it is really overseen by the Ministry of Health, and like I mentioned earlier, it is implemented by several partners. The trainings for the VHTs, who are [inaudible] [00:40:06] the health center one of the Ministry of Health and usually have primary seven level education, is done by different organizations and last between seven to ten days, depending on who is doing the training, but the curriculum is standard and approved by the Ministry of Health.

The first week of the training normally covers theory, the second week, they do practicum, and then this post-training supervision follow up, which is conducted usually by a midwife at the facility where they are tasked. She will support them to make sure that they're comfortable with injecting, following the training, but as well that they're doing the screening properly, the counseling and, as well, doing the records accurately.

Following that, the VHTs do visit the facility to submit their reports and to receive resupplies. And then, the reports are then entered into the health management information system by a records assistant, who submits to the district so that the data goes into the district health information system, the DHIs, too. Refresher training often happens three to six months post-training, of the initial training.

The next slide will show, then, the sources of methods for all women in Uganda, mainly is through the public sector. And if you look at the slide, you'll see that the Sayana Press users, the DMPA-SC users, almost 70 percent get their services through the public sector, and the DMPA-IM, about 45 percent. And, again, these results are from the Performance Monitoring and Accountability Round 5. Next slide please.

I will now talk about the APC Uganda program. The APC, the Advancing Partners & Communities is supported by [inaudible]. It was principally designed to increase access to family planning services through community-based family planning. In Uganda, we've reached up to 22 districts. As of September, 2017, we have [inaudible] 22 districts, and we did do an assessment which showed that – we did a comparison to see how the districts who implemented the community-based family planning fared against those where this [inaudible] family planning wasn't done, and what we learned was that there was an over 11.3 percent increment in mCPR for the districts where the community-based family

planning wasn't done, compared to just 5.1 percent for the non-community-based family planning districts.

As well, within the districts, the sub-counties in which the community-based family planning was done showed a higher increment in mCPR compared to those where it wasn't done. For the APC program in Uganda, we've also qualitative, collaborative quality improvement in some of the districts and sub-counties, and we learned that where the quality improvement was done, we saw a higher increment in mCPR than in the other areas, and as well, a [inaudible] [00:44:16] uptake of services by [inaudible]. Next slide, please.

The next slide shows you kind of the distribution of the districts where we worked. I mentioned 22 districts. This map will show you the district spread but it doesn't include the six additional districts in 2017 that make it 22. You will then see a chart on this slide which kind of lends credence [inaudible] Jennifer mentioned earlier about the preference of DMPA sub-Q or the Sayana Press [inaudible] from several studies.

In 2015, when we started getting results from the community-based family planning program, you can see that DMPA sub-Q was only at 21 percent, while the IM was at 62 percent in terms of service numbers, but it quickly caught up in 2016 and in 2017, Sayana Press had already exceeded DMPA-IM in terms of the number of clients who are preferring to take up that method versus the other.

This is, of course, further justified by the fact that we also participated in a study with PATH and [inaudible] of public health that assessed the effectiveness of DMPA-SC compared to that of IM when distributed by community health workers as it regards continuity of use. It looked at over 600 women in both categories and we found that the continuation rates for DMPA sub-Q were higher than that of DMPA-IM, although not very significantly higher. But, as well, we found that the continuation rates were higher than the national average, which kind of might mean that community-based family planning is an effective channel for this particular method. Next slide, please.

Now, I will talk about DMPA-IM and SC provision through drug shops. There's been a lot of reports through research and pilots by FHI 360, the Ministry of Health and a number of partners in Uganda between 2007 and 2013, and a lot of evidence was gathered and this was collaborated with international evidence on

the same. In June, 2015, a task force was set up to lead consultations with a number of stakeholders but also to engage with the Ministry of Health [inaudible] [00:47:50] and the National Drug Authority to see that injected was approved to be provided through drug shops.

The efforts bear fruit in September of 2017, just last year, and the NDA did provide approval for the provision of injectables through drug shops, but only an initial 20 districts and [inaudible] limitation science kind of approach, such that we would go back after a year and share evidence that will guide eventual scale up. This also got a nod by the Ministry of Health senior management committee, and as I speak, we have started implementation. We just had a national stakeholder meeting this week on Tuesday and the field work is already going to start.

As you realize, Jennifer mentioned that this is one of the promising [inaudible] in her presentation, and so we are really excited in Uganda that we have this endorsement to move forward with this particular channel of providing injectable contraceptive. In this particular activity, we are also working with PATH, who intends to pilot self-injection within drug shops in at least one district. Next slide, please.

I will now finally share with you some key lessons from our experience for successful community-based family planning, access to injectables. And of course, on top of the list is the political will and the ministry to support the activity, so we really had good buy-in for community-based family planning at the Ministry of Health level and among the different stakeholders. And of course, this worked because we also had champions within the ministry itself that were very interested in [inaudible] service channel.

We've also worked with a different ministry [inaudible], as well as, you realize, oh, yeah, I mentioned that there was some revision of policies like [inaudible] guidelines so that the community of workers could be able to provide [inaudible]. Of course, when you go down to the community, we make sure that we do get district buy-in at the district level. We always do stakeholder meetings before implementations, that and we engage – both on this [inaudible] and political structures so that we get buy-in up to that level before we commence implementation.

We make sure we implement with the existing structures. The VHTs that we work with have to be linked to a facility and

supervised a midwife, and we also do support the midwives to be able to supervise the VHTs. The channel really requires, just like any other family-planning program, a steady supply of commodities and so we collaborate very closely with the Ministry of Health to ensure that where we are going to implement, the supplies are available.

And we also work through the different strategies to ensure supply availability, such as alternative distribution and the redistribution strategy at the local level such that if one facility is lacking commodities and the other has excess but doesn't have a community-based program, they can move the commodities to the area where there is community-based provision. And of course, monitoring the evaluation is important, and then the collaborations and partnerships, really, are very important.

Some of the key practice accommodations include, of course, [inaudible] [00:52:14] supervision, home visits, observations, collaborative quality improvement has done, really, wonders for us in terms of ensuring continuity of use, on job trainings, and integrating the service provision and trainings with other methods provision, for instance, the roll out of implant NXT in Uganda. Thank you very much for listening to me.

Kimberly:

Thanks a lot, Fred. And I apologize for any technical difficulties that folks experienced on the presenter and the audience side. We do have time for a few questions. I'm gonna start with one that came in asking about further elaboration on the HIV risk with injectables usage. I'll go ahead and answer this one with some information that my colleagues who focus on this area have shared with me. Based on the WHO 2017 MEC guidance, DMPA is a Category 2, as Jeff mentioned, for women at high risk for HIV because of increasing concern around potential risk of HIV acquisition among women at high risk of HIV using DMPA-IM, SC, and NET-EN, but uncertainty still remains about the risk. Evidence is inconclusive.

MEC indicates that the benefits of using the method outweigh proven or theoretical risk. Women at high risk of HIV should not be denied use of a method if that's the method that they choose. Women at high risk of HIV or all women choosing progestin-only injectables, if HIV risk cannot be assessed, should be counseled on the potential HIV acquisition and advised on HIV prevention strategies, including condom use, initiation of an HIV-positive partner on treatment and PrEP, if it's available in the country. More information is available in the WHO 2017 updated guidance

on HC HIV and the USA 2017 updated HC HIV brief, and these links will be provided after the webinar.

And now I'm going to pass on a question to Jen Drake on stock availability. The question is, are injectables at higher risk of stockout with procurement issues associated with unreliable international development assistance?

Jennifer: Thanks, Kimberly, for that question. I did look at the FP2020 progress report 2016, 2017 to check on this and actually, indicators ten through 11 in the FP2020 framework track contraceptive stockouts and availability. And to keep it quick, there really isn't much evidence that shows that injectables are stocked out with any level of higher frequency than other modern methods.

Kimberly: And staying on this topic of stock and the commodity itself, I do have a question about disposal of the Uniject device. In terms of self-injection, there has been some discussion about the issue of sharps disposal. Are there further details on how the Senegal and Uganda studies and programs addressed this?

Jennifer: Sure. Yeah, thanks, Kimberly, and thanks for the question. Yeah, it's been a hot topic, for sure. The way that women were advised to deal with their devices in the studies in Senegal and Uganda, and I believe this was the case in the FHI 360 Malawi study, as well, although we can clarify that and include it in the written responses, women were given permission to dispose of their used device in a latrine.

Since the ends of those studies, at least in the case of the Senegal and Uganda, we've been in contact with the Ministry of Health and I think there is limited appetite to have that be an ongoing standard practice for reasons that I think are probably pretty understandable, even though it's highly convenient for women to dispose of the product that way, and of course it takes it out of circulation and reduces the risk of injection sticks.

As I mentioned, we've been working on a program in Uganda to try to figure out how to sustainably offer self-injection at scale, and the approach we've been taking, we identified a very low-cost, impermeable household container, so basically, a typical petroleum jelly jar that's commonly available and that women would have in their households anyway. When they're given their units for self-injection, they're given one of those containers and they use that to store their units after they give an injection until they can return to a facility or a community health worker, and we hope eventually

maybe a drug shop or pharmacy and they can then give their used units to the health workers to put in the sharps disposal box.

We'll see. We'll have some results towards the end of this year in terms of how well that worked in the Uganda experience, outside of a research context.

Kimberly: Thanks a lot, Jen. On self-injection, we have a question that asks, what proportion of women using FP outside of a study context choose self-injection currently.

Jennifer: Yeah, thanks for that, too. That's a great question. Self-injection is not widely available in most FP2020 countries outside of a research context. The only data I have on hand to answer this question are from a very small soft launch of self-injection in Uganda. It was implemented around last year in one district, Mubende District, and self-injection was offered at facilities only, and what we saw was that roughly 20 percent of the women who were using injectable contraception ended up self-injecting.

Now, we're not sure how that might change if we begin to see self-injection offered, not only at facilities, but potentially through community health workers, through pharmacies and drug shops, etcetera. Those data are from a very early phase of the program and I think we'll be tracking that issue very closely as more countries begin to offer the practice.

Kimberly: Thanks. Jeff, did you have anything to add to that?

Jeff: There is – can you hear me?

Kimberly: Yep.

Jeff: Bonnie Keith, used to be with PATH and maybe she's back, wrote a wonderful review of all the work done previously on self-injection when it was available, for instance, in Brazil, and I think, from my take of reading what's been done, that it will be a choice taken by probably two thirds of women who are exposed to the possibility of self-injection. It won't be accepted by everybody but I think the majority would accept it. Thank you.

Kimberly: Thanks. I think we have time for one more question. Fred, I'd really like to ask you a question. Would you share how you were able to achieve refresher trainings every three to six months? It's been a challenge in other settings.

Fred: Yeah, sure. Basically, we actually did six months, so probably maybe some other partners did three months but we do six months. And what would happen is we would plan basically for the entire year. When we we're planning with the district, we would plan for the entire period. We would ensure that by the time the first training is done, all the logistics are ready to ensure that we would be able to do the training at six months.

I'm not sure what the challenge in the other setting is exactly, whether that it logistical or otherwise, but normally, because we would be working very closely with the facility providers, we are tracking the VHTs because we also get a copy of their report that they submit at the district meeting, we would know which VHTs were able to continue to provide and work through the district to invite them for the refresher training. We'd start planning for the refresher as soon as they start implementing. The other, I think, is – the other question I've seen is related to – sorry.

Kimberly: Method mix and community versus facility program.

Fred: Yeah, so of course, the community program has a limitation in terms of the methods they can provide. By policy, the VHTs can only provide condoms **[inaudible]** **[01:02:22]** and of course, since 2010, the injectables. However, during the counseling, they do provide counseling on the whole range of methods to ensure that the client has a chance to know about the other methods, and if it is a method that the VHTs can provide, for instance, the implants, then they will fill out a referral card to the facility or to any other outreach tem that might be in the area. Yeah, so, probably, that is how it works. But, at the facility, depending on the level of facility, they should have a broader range of methods. So, for instance, most of the VHTs that **[inaudible]** a trained midwife. If the midwife has been trained in a certain IUD or implant, then that will also be available. But, most of the facilities cannot provide **[inaudible]** that is normally done through outreaches supported by different agencies like Mary Stopes or PACE.

Kimberly: Thanks a lot, Fred. We have actually reached our end time so I want to thank our participants again for giving their time and expertise today. In the next few days, you will be receiving an email with a link to today's recording. Before we close the room, I wanted to encourage you to take a moment to fill out the poll questions below as the feedback helps us improve future webinars. Thank you all, once again.

Fred: Thank you.

[End of Audio]

Duration: 65 Minutes