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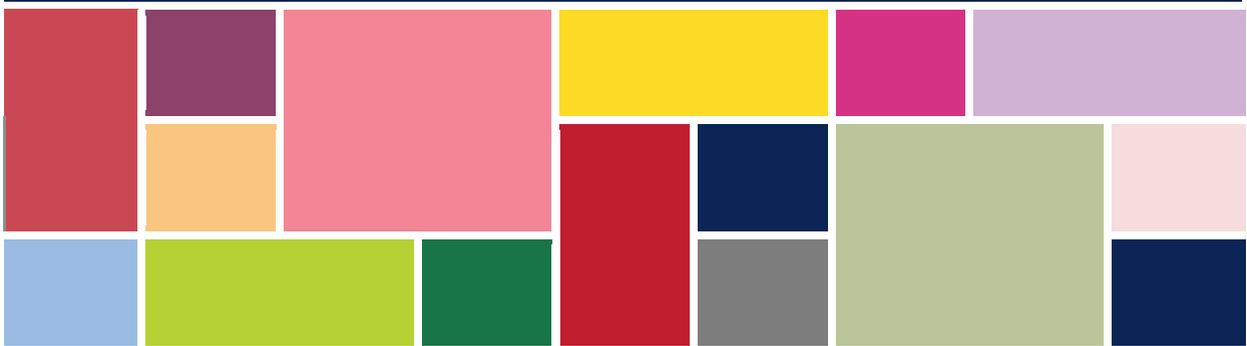
SHOPS
PLUS

Long-Acting and Permanent Methods Community of Practice

Contraceptive Implants Technical Consultation: *Addressing Barriers to Service Delivery as Implants Move to Scale*

Meeting Report

Human Rights Campaign Offices
1640 Rhode Island Avenue NW, Washington, DC
October 16, 2018



The Maternal and Child Survival Program (MCSP) is a global, \$560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries,* as well as other countries. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

* USAID's 25 high-priority countries are Afghanistan, Bangladesh, Burma, Democratic Republic of Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen and Zambia.

This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Program and do not necessarily reflect the views of USAID or the United States Government.

April 2019

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Abbreviations

ART	antiretroviral therapy
COP	community of practice
DHS	Demographic and Health Survey
FP	family planning
FP2020	Family Planning 2020
HEW	health extension worker
IAP	Implant Access Program
IUD	intrauterine contraceptive device
LARC	long-acting reversible contraceptive
LAPM COP	Long-Acting and Permanent Methods Community of Practice
MCSP	Maternal and Child Survival Program
MOH	Ministry of Health
NGO	nongovernmental organizations
NNRTI	non-nucleoside reverse transcriptase inhibitors
PSI	Population Services International
RH	reproductive health
RHSC	Reproductive Health Supplies Coalition
SHOPS	Sustaining Health Outcomes through the Private Sector Plus
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Overview

When offered in the context of voluntarism and informed choice, contraceptive implants are playing an increasingly important role in ensuring that women and couples are able to achieve their reproductive goals. The increasing availability of implants has contributed to the diversification of many countries' method mix,¹ and from 2018-2020, 18.2 million women across the Family Planning 2020 (FP2020) focus countries are expected to adopt implants.² To meet the continued demand for contraceptive implants, more attention to underutilized and nuanced service delivery channels is needed. Conservative estimates of global method mix trends, for example, demonstrate the private sector will need to be equipped to serve an additional 280,000 women who desire implants, including removals by 2020 (and over 1 million if implant uptake continues to rise).³



In light of this, on October 16, 2018, the Long-Acting and Permanent Methods Community of Practice (LAPM COP) hosted a 'deep-dive' technical consultation to explore trends, barriers and solutions to continued expansion of contraceptive implant availability, including engaging the private sector. This day-long event was hosted by the United States Agency for International Development's (USAID's) flagship Maternal and Child Survival Program (MCSP) and USAID's flagship initiative in private sector health, Sustaining Health Outcomes through the Private Sector (SHOPS) Plus. The event featured presentations from researchers and implementers, small group subject matter consultations, an information marketplace and a panel discussion on financing the future of implants.

Meeting Goal

The LAPM COP convened to provide an update on the current state of global contraceptive implant service delivery, review the evidence and explore underutilized approaches to expanding services. By sharing examples and engaging in collective problem-solving for overcoming challenges, participants highlighted potential solutions and key recommendations on service delivery expansion, including increased involvement of the private sector, both not for profit and commercial.

Meeting Objectives

The meeting objectives were for participants to:

- Gain a deeper understanding of the current state of contraceptive implant use and delivery;
- Share and explore evidence and experiences related to expanding implant service delivery through underutilized approaches, including the private sector; and
- Identify practical solutions to address challenges faced in the expansion of implant service delivery.

Participants

The 65 in-person meeting participants represented the following projects and organizations (Annex A has a complete list of in-person participants):

- Abt Associates
- Avenir Health
- The Bill and Melinda Gates Foundation

¹ FP2020 Progress Report, 2016-2017.

² Contraceptive Commodity Gap Analysis, 2018.

³ The Private Sector: Key to Achieving FP2020 Goals.

- CARE
- Clinton Health Access Initiative
- Chemonics International
- DKT International
- FHI 360
- FP2020
- Global Health Supply Chain Program-Procurement and Supply Management
- IntraHealth International
- Jhpiego
- John Snow, Inc.
- MCSP
- Packard Foundation
- PATH
- Pathfinder
- Project Concern International
- Population Council
- Population Services International (PSI)
- Reproductive Health Supplies Coalition (RHSC)
- SHOPS Plus
- The Manoff Group
- USAID

Introductory Remarks

Trish MacDonald, Senior Technical Advisor, USAID, opened the meeting.

Presentations and Plenary Discussions

Plenary I: State of the Implant(s) Address

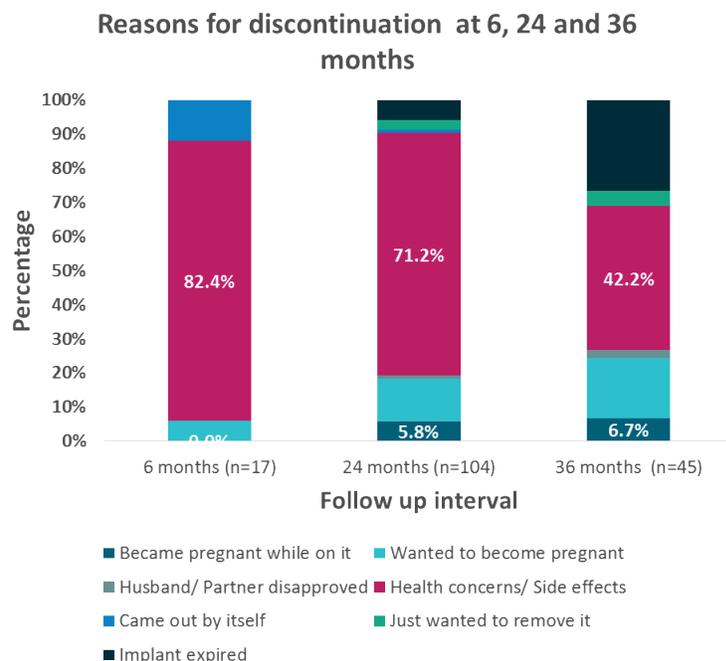
Maryjane Lacoste, Senior Program Officer for Family Planning Service Delivery, The Bill & Melinda Gates Foundation, introduced and moderated the first panel of speakers.

Overview of Contraceptive Implants

by Michael Muthamia, Senior Technical Officer, Jhpiego Kenya

Michael Muthamia presented an overview of contraceptive implants, focusing on what they are, who can and cannot use them, what it takes to provide implant services and key programmatic considerations. He began the presentation by providing a comprehensive overview of how implants work, including their mechanism of action, medical eligibility criteria, non-contraceptive benefits and a review of the various implant products on the market. Muthamia reminded us that although bleeding changes are common with implant use the majority of clients still discontinue implants due to side effects or other health concerns (see Figure 1).

Figure I. Reasons for discontinuation of contraceptive implants at 6, 24, 36 months



Service delivery considerations that negatively impact implant services include:

- Poor quality pre-insertion counseling
- Inadequate equipment and medical supplies
- Lack of capacity to provide quality removal services
- Minimal support for the private sector

Other key considerations include:

- **Medical Products:** It is important to consider strategies for broadening the method mix, as well as strategies for product introduction and product transition.
- **Measurement:** Most health management information systems lack essential indicators about implants that could improve programmatic decision-making.
- **Health Workforce:** Service provider skill gaps in providing quality implant services still exist, and there is a need to invest in effective training approaches. A key point emphasized is that removal skills are just as important as insertion skills.
- **Health Leadership and Governance:** Minimal dissemination of family planning (FP) policies and guidelines, so it is key to keep implants as an advocacy agenda
- **Client Perspective:** This needs to be a central part of programming, including addressing myths and misconceptions about implants, lack of awareness among clients about immediate postpartum provision, management of side effects and ensuring access to quality implant removal services.

(Full presentation available on the [Long-Acting and Permanent Methods Community of Practice \(LAPM COP\) website](#)).

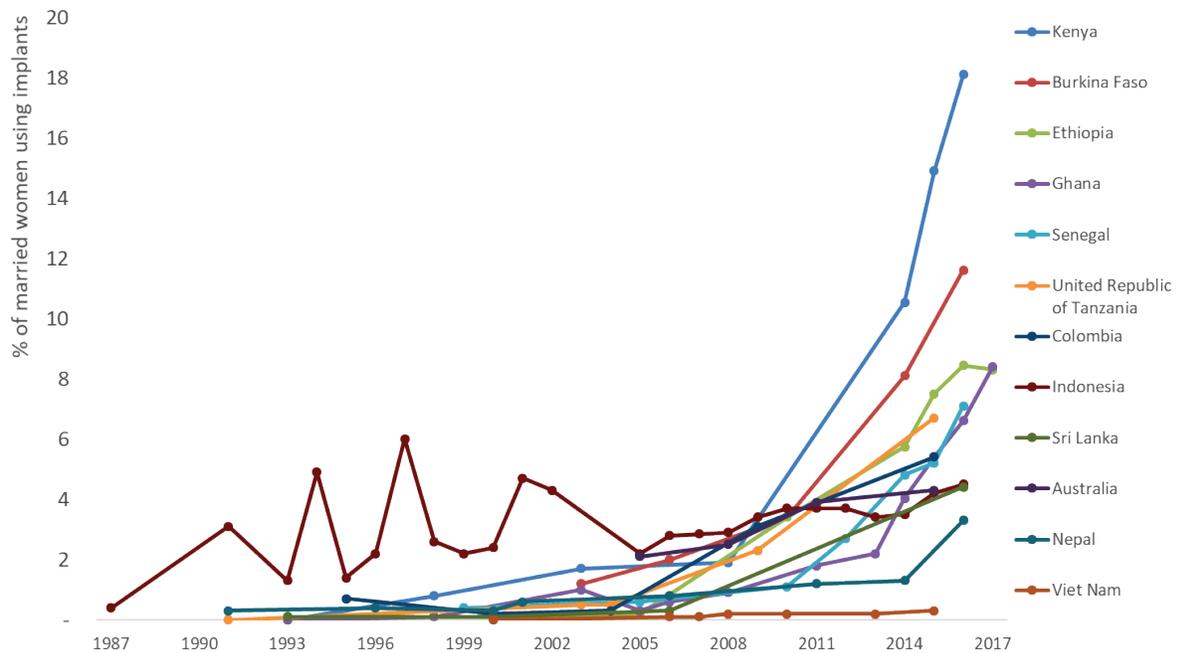
What Do the Data Tell Us about Implants?

by **Michelle Weinberger, Avenir Health**

Michelle Weinberger presented an overview of the global landscape of implant use, as well as insights on users, supply and availability. Weinberger began by presenting **long-term trends** in implant prevalence

among married women for select countries, noting the rapid increases in use in recent years is primarily coming out of sub-Saharan Africa, with the highest levels seen in Kenya, at about 18% of married women using implants, followed by Burkina Faso, Ethiopia and Ghana (see Figure 2).

Figure 2. Long-term trends in contraceptive implant prevalence among married women for select countries

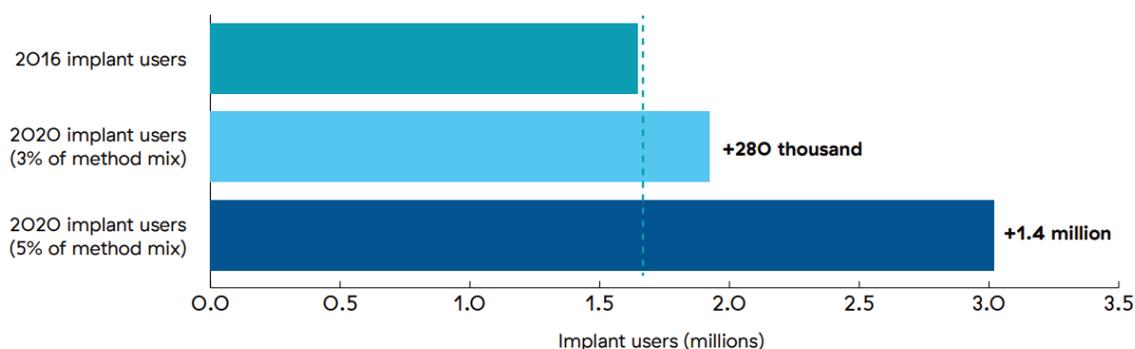


Across **FP2020 countries**, implants account for about 8 million of 300 million modern users (results for 2016). Eastern and Southern Africa FP2020 countries account for both the largest absolute number of implant users (nearly 4 million), and the highest share of implants within the method mix (14% of modern users). Southeast Asia and Oceania FP2020 countries are home to the second largest number of implant users (just under 2 million), however, in this region implants only account for a small share of the method mix (3%).

The public sector is the predominant source for implants across all regions, with Southeast Asia and Oceania having the largest percent of women receiving implants from private clinics. For the private sector to keep pace with shifts toward more implants, there is a need for additional investments in training private providers, financing service delivery and ensuring adequate implant insertion and removal supplies at private facilities (see Figure 3).

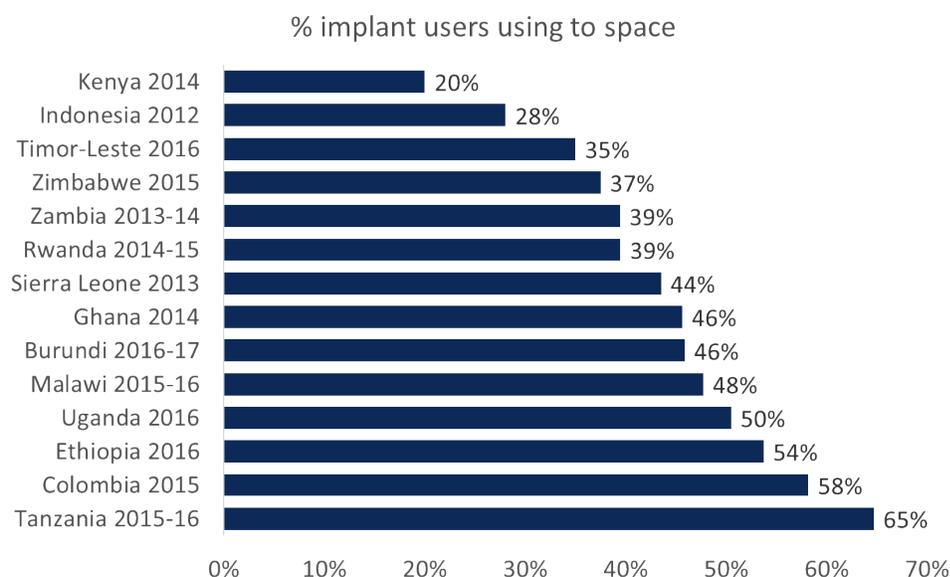
Figure 3. Private sector implant users in 2016 and 2020 under two scenarios

Private sector implant users in 2016 and 2020 under two scenarios



Using results based on the most recent Demographic and Health Survey (DHS) for 14 countries with sufficient data, Weinberger shared key **insights on users**, explaining there is a wide variation across countries between women using implants to space versus limit births. In Kenya, 20% of implant users are using them to space, compared to in Tanzania where 65% of users (see Figure 4).

Figure 4. Percentage of people using implants to space births



Generally, users aged 15-19 years old comprise a very small percent of the implant users in many countries, but in some countries, like Sierra Leone, around 1/3 of implant users are adolescents. Weinberger also noted that the prevalence of implant use varies between married and unmarried sexually active women across countries. In about half of the countries, married prevalence was higher than unmarried prevalence, but in the other half, the opposite was observed. Weinberger noted that differences in program planning and implementation are likely contributing to these different patterns across countries.

In terms of **supply and availability**, based on preliminary data from the National Composite Index on Family Planning, on average, between 2014 and 2017, there has been an increase in the extent to which the entire population has access to implants (results based on surveys on key informants in country).

Weinberger reminded the audience that there are a lot of data, and we need to think about using this rich information and bringing it into discussions. Weinberger concluded that there isn't a single story; the variation between countries is huge, so we need to program to specific contexts.

(Full presentation available on the [Long-Acting and Permanent Methods Community of Practice \(LAPM COP\) website](#)).

Key Points from Question and Answer Session

One limitation of DHS data is it does not always tell us who specifically provided the method: This is something that we may be able to get through an analysis being done for the RHSC Commodity Gap Analysis.

Relationship between women’s use of implants and level of education:

Although Weinberger has not looked specifically at this, it is doable. When analyzing other FP data that are not specific to implants and looking at education and income, women with high education/income have had lower use of hormonal methods. Roy Jacobstein, in his recent paper “Liftoff: The Blossoming of Contraceptive Implant Use in Africa,” looked at wealth quintiles and implant use and found that some countries are more equitable than others.

Most countries now collect information on implant use:

MCSP’s review of health management information system tools from 18 countries found information on implant use and about half aggregated information on removals. However, most do not record type of implant, which in some contexts may be important for procurement and program planning.

Did the cost of implants presented take into consideration cost of consumables?

The wording in the DHS is “How much did you pay?” so women may include the cost of consumables in their estimation, rather than just the implant itself.

Plenary 2: Overcoming Barriers to Implant Expansion

The second plenary consisted of a series of short “flash” presentations to precede the roundtable sessions that followed. **Elaine Menotti, Technical Advisor, USAID**, moderated this panel and highlighted that key factors for success included global market shaping and price reductions, multistakeholder commitment and attention to addressing gaps and barriers, service delivery models and approaches that reached clients, including task sharing.

As the global trends toward smaller desired family size continues, clients desire to limit at earlier ages so we can expect continued increased demand for implants. But this requires continued systems investments and support to service quality and access:

- Ensure products and supplies for insertion and removal are available: right place, right time.
- Use a range of service delivery models to facilitate equitable access.
- Ensure timely removal services are part of **continuity of care** for implants.

Key Resources Featured at the Marketplace

Weinberger M, Callahan S. 2017. [The Private Sector: Key to Achieving Family Planning 2020 Goals](#). Bethesda, MD: Sustaining Health Outcomes through the Private Sector Project, Abt Associates.

Tilahun Y, Lew C, Belayihun B, Hagos KL, Asnake M. 2017. [Improving Contraceptive Access, Use, and Method Mix by Task Sharing Implanon Insertion to Frontline Health Workers: The Experience of the Integrated Family Health Program in Ethiopia](#). *Glob Health Sci Pract*. 5(4): 592-602.

Christofield M, Lacoste M. 2016. [Accessible Contraceptive Implant Removal Services: An Essential Element of Quality Service Delivery and Scale-Up](#). *Glob Health Sci Pract*. 4(3): 366-372.

Jacobstein R, Stanley H. 2013. [Corrigendum: Jacobstein et al., Contraceptive implants: providing better choice to meet growing family planning demand](#). *Glob Health Sci Pract*. 1(2): 285.

Jacobstein R. 2018. [Liftoff: The Blossoming of Contraceptive Implant Use in Africa](#). *Glob Health: Sci Pract*. 6(1): 17-39.

Job Aids from the [LARC LRP*](#):

- One-Rod Implanon NXT Insertion
- One-Rod Implant Insertion
- Two-Rod Implant Insertion
- [Implant Standard Removal](#)
- [Deep Implant Removal](#)
- How Contraception Works
- Putting on and Removing Gloves

*Available in English, French and Spanish

- Enable country programs to be flexible and resilient by using different implant products and by considering provider and client-level needs.

Menotti explained that although task sharing to more cadres has expanded access, more countries can follow. She highlighted that to increase access, we also need to look at how we can remove barriers to broader private sector provision, including:

- Access to affordable implant products and supplies,
- Ability to charge for services/inclusion in health care financing mechanisms,
- Training and support for implant insertion and removal, and
- Use social behavior change communication to benefit and promote providers from **any sector** who can provide implant services.

Menotti concluded by reflecting on the importance of contraceptive method choice, reminding us that although collectively the global FP community has made really important strides in making implants more available in the last 8 years, it is important to remember we are working simultaneously on all of these methods to meet the diversity of client reproductive intentions, needs and lifestyles.

Community-based Distribution of Implants through Task Sharing

by **Dr. Yewondwossen Tilahun, FP/Reproductive Health (RH) Advisor, Pathfinder Ethiopia**

Before the roundtable discussion, Yewondwossen presented on Pathfinder’s experience with the Implanon scale-up program in Ethiopia from 2009-2016. Initiating and sustaining Implanon insertion services at the health post level in Ethiopia required a lot of investment and effort. Implant task shifting was conducted thorough training health extension workers (HEWs) only on Implanon insertion skills (not on removal skills), and the scale-up program required training a large number of HEWs. Although the newly trained HEWs were able to reach large numbers of clients with implant services, the readiness of the health facilities to provide removal services was limited, and in some areas, not available. The program was able to demonstrate the safety of implant provision by HEWs, was scaled up to over 10,000 HEWs and expanded to include removal services through system support interventions.

More information is available online in the notes from [“Roundtable 1: Community-based distribution through task shifting.”](#) and the full presentation is available on the [Long-Acting and Permanent Methods Community of Practice \(LAPM COP\) website](#).

Addressing the Unique Needs of Private Sector Implant Provision

by **Françoise Armand, Principal Associate, SHOPS Plus**

Before the private sector roundtables, Armand highlighted some of the challenges faced by private providers regarding implant provision. Nongovernmental organizations (NGOs) and social marketing organizations have concerns around future ability to access implants at a low cost beyond the life of the Implant Access Program (IAP). Commercial for-profit providers experience supply challenges because they are excluded from the guaranteed price. Across the board, access to timely training in particular regarding implant removal is also a challenge. Financial barriers are also a concern for private providers because national health insurance schemes do not always cover a broad range of methods or a broad range of private providers.

More detailed information is available in the notes from [“Roundtable 2: Addressing commercial private sector provider needs”](#) and [“Roundtable 3: Addressing donor-supported private provider needs”](#) and [“Roundtable 4: Addressing client financial barriers.”](#)

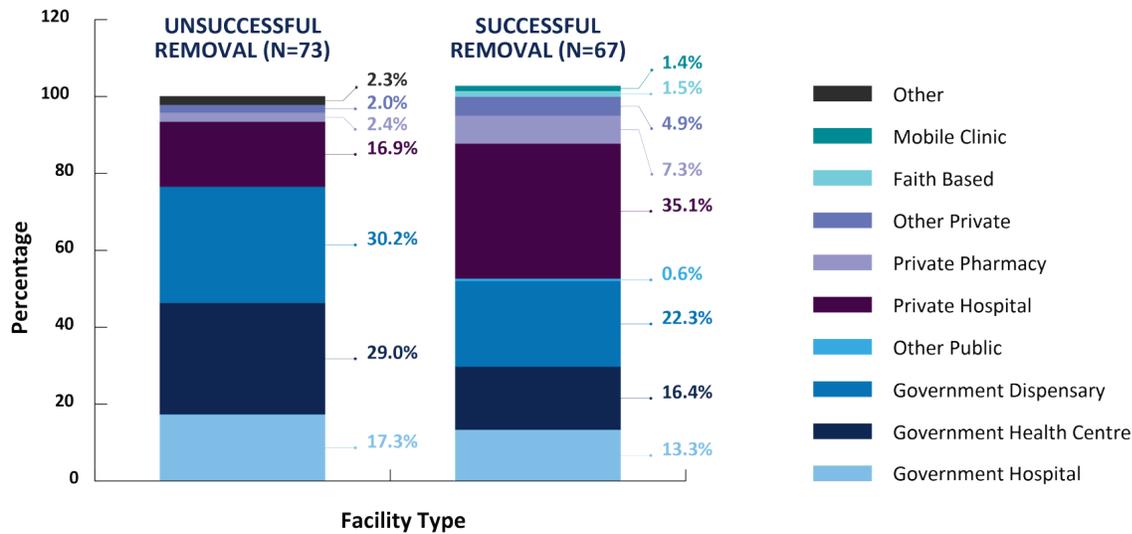
Ensuring Availability and Access to Timely, High-Quality Implant Removal Services

by **Michael Muthamia, Senior Technical Officer, Jhpiego Kenya**

To provide some background for the Implants Removal roundtable discussion, Muthamia shared data from a recent Performance Monitoring and Accountability (PMA2020) analysis that provided an overview of the location of implant removal attempt and successful removals (see Figure 5).

Figure 5.

Location of Implant Removal Attempt and Successful Removal



Location of implant removal attempt and successful removal

Muthamia also provided an overview of the **Client-Centered Conditions for Ensuring Access to Quality Implant Removal:**

- Implant removal data are collected and monitored
- Service is affordable or free
- Service is available when she wants, within reasonable distance
- Woman knows where and when to go for removal
- Reassurance, counseling and reinsertion/switching are offered
- System is in place for managing difficult removals
- Provider is competent and confident
- Supplies and equipment are in place

For more information, see the notes from “[Roundtable 5: Ensuring availability and access to timely, high-quality implant removal services](#)”. The full presentation is available on the [Long-Acting and Permanent Methods Community of Practice \(LAPM COP\) website](#).

Maintaining Informed Choice in the Evolving Landscape of Contraceptive Implants

by Megan Christofield, Technical Advisor, Jhpiego

To set the stage for three separate roundtable discussions, Christofield discussed how over the past three decades, our implant products, their attributes and our evidence-based interpretation of their attributes has evolved (and continues to do so). Even for those entrenched in full-time FP/contraceptive access work, these changes are a lot to keep up with and to translate into our work. For health care providers responsible for understanding and relaying nuanced clinical guidance about implants, and the clients who seek to understand the products and how/when they can be used, how can we ensure that guidance is standardized and clear and that systems are nimble enough to incur continued updates to these evolutions? Christofield also explained how all of these changes are happening in the context of exponential growth in implant use worldwide,

leading providers and clients with a number of well-justified questions that require constant reevaluation and attention to ensure full, free and informed choice.

For more detailed information on these subjects, see the notes from “[Roundtable 6: Addressing the needs of clients living with HIV or at high-risk of HIV acquisition](#),” “[Roundtable 7: Equipping the workforce to meet the needs of implant users](#)” and “[Roundtable 8: Product evolution & the role of client and provider product-specific preference](#),” The full presentation is available on the [Long-Acting and Permanent Methods Community of Practice \(LAPM COP\) website](#).

Roundtables: Overcoming Barriers to Implant Expansion

Following the two plenaries, a series of eight concurrent roundtable sessions allowed participants and key technical experts to engage in deep-dive programmatic discussions on the key topics introduced during the plenary. Participants were able to choose three tables, and discussions focused on exploring solutions and remaining challenges. Guiding questions for each roundtable were:

- What are the drivers of this issue, and why are we seeing it as a barrier?
- How have you/are you currently dealing with addressing these barriers/drivers?
- What innovative or potential solutions should we [the FP community/implementers] be exploring?

[See Annex D](#) for detailed notes from each of the following eight roundtable discussions.

Roundtable 1: Community-based distribution through task shifting

Table Lead: Dr. Yewondwossen Tilahun, FP/RH Advisor, Pathfinder Ethiopia

This roundtable focused on strategies and solutions for availing contraceptive implants to the last mile, through community-based distribution. Participants built off of examples, like that of Ethiopia, where task shifting was implemented through skill training to frontline service providers (HEWs) to address major gaps in access and use of LARCs. From the Ministry of Health’s (MOH’s) introduction of Implanon at the community level 9 years ago, significant program gaps have been both prevented and overcome, resulting in national scale-up and established interventions for supporting and improving the health delivery system to uphold the quality of Implanon insertion and removal services at the community level.

Roundtable 2: Addressing commercial private sector provider needs

Table Lead: Françoise Armand, Principal Associate, SHOPS Plus

The success of the IAP has been made possible in part by investments in service delivery programs that have helped scale up access to the method in previously underserved areas. To date, private facilities account for only a fraction of women receiving implants, yet meeting the rapidly growing demand for this method will require significant increases in the number of private providers able to deliver it. In this roundtable, participants discussed the obstacles that prevent independent providers from offering implants to their clients and the strategies that might overcome them.

Roundtable 3: Addressing donor-supported private provider needs (through social franchising/social marketing)

Table Lead: Sarah Thurston, Sr. Technical Advisor, PSI

The private providers (clinics and pharmacies) that many of our programs support through social franchising and social marketing interventions are important conduits for FP products and services. But these providers face barriers to maximizing their ability to offer a full method mix, including contraceptive implants. This roundtable sought to identify top barriers that prevent providers, participating in donor-supported FP programs, from consistently offering implants at high-quality standards to all interested clients. From there, the table brainstormed solutions and concrete actions that the FP COP can take to increase consistent availability through these important channels.

Roundtable 4: Addressing client financial barriers

Table Lead: Susan Mitchell, Principal Associate, Abt Associates and Project Director, SHOPS Plus Implant provision has increased substantially with significant donor support and with subsidized or free provision. The challenge is how to sustain access to a low-cost product to reduce financial barriers. This roundtable explored financing options that have been used and how to continue to scale the progress that's been made.

Roundtable 5: Ensuring availability and access to timely, high-quality implant removal services

Table Lead: Elaine Charurat, Project Director, Jhpiego & Rebecca Callahan, Associate Director, FHI 360

With contraceptive implant uptake on the rise, governments, FP programs and other stakeholders (including users themselves) are eager to ensure that access to quality removal services are within reach for clients using implants. However, emerging data demonstrate that this accessibility has not been achieved. This roundtable engaged participants in a discussion of barriers and solutions for ensuring that implant users have timely, high-quality implant removal services. To ignite conversation, implementation examples from Kenya and Uganda, as well as user insights from Ghana, Ethiopia and beyond were shared.

Roundtable 6: Addressing the needs of clients living with HIV or at high-risk of HIV acquisition

Table Lead: Jack Wille, Program Officer, MCSP, and Anne Pfitzer, FP Team Lead, MCSP

New evidence has been emerging that women on certain antiretroviral therapy (ART) regimens have experienced contraceptive failure while using various types of implants. MCSP recently completed a retrospective medical chart review study that confirmed high incidence of pregnancy among Kenyan implant users on two types of ART. This roundtable looked at these findings and discussed implications for FP counseling and clinical practice in high HIV prevalence settings.

Roundtable 7: Equipping the workforce to meet the needs of implant users

Table Lead: Emma Clark, Director of Maternal, Newborn, and Child Health, HRH2030 & Neeta Bhatnagar, Sr. Technical Advisor, MCSP

The evolving landscape of implants has made implants more popular, accessible and usable but also expanded the training needs of the workforce, who must keep up with increased demand, new clinical guidelines and new/updated types of implants. Roundtable participants discussed barriers and potential solutions for ensuring that the health workforce is equipped to provide quality implant services through the entire implant cycle, including pre-placement counseling, insertion, side-effect management and removal. Sub-topics included expanding use of evidence-based training methods such as simulations, revising training curricula with updated clinical guidance, incorporating the private sector into implant capacity-building and enhancing participation from frontline cadres in implant-related planning.

Roundtable 8: Product evolution and the role of client and provider product-specific preference

Table Lead: Megan Christofield, Technical Advisor, Jhpiego

The core discussion topic for this roundtable focused on how, over the past three decades, our implant products, their attributes and our evidence-based *interpretation* of their attributes has evolved (and continues to do so). Even for those engaged in full-time FP work, there's been a lot to keep up with. Since 2012, we've incurred product renamings, changes to product effectiveness life, World Health Organization (WHO) medical eligibility criteria modifications, brand introductions and shortages and more. For health care providers responsible for understanding and relaying nuanced clinical guidance about implants, and the clients who seek to understand their product choices, these evolutions can be even harder to follow and

understand. We need urgent solutions, so that amidst these changes, informed choice is upheld in its fullest sense.

Plenary 3: Panel Discussion on Sustaining Access to Implants

To close the meeting, **Caroline Quijada**, Deputy Director of SHOPS Plus, led a dynamic panel discussion with key experts that shared lessons learned and discussed in-depth where we've been and where we are going.

Moderator: Caroline Quijada, Deputy Director, SHOPS Plus

Panelists:

- Maryjane Lacoste, Senior Program Officer for Family Planning Service Delivery and Quality, Bill & Melinda Gates Foundation
- Trish MacDonald, Senior Technical Advisor, USAID
- John Skibiak, Director, RHSC
- Rodrigo Portugues, Commercial Director, DKT WomenCare

Question for Maryjane Lacoste: Can you share a bit of the history of the Implant Access Program, Gates' role in helping to broker the partnership, and what the original thinking was in terms of how each partner would benefit?

- The IAP was born out of the 2012 London Summit.
- The IAP is a partnership that allowed two implant manufacturers (Bayer, which manufactures Jadelle; MSD, which manufactures Implanon NXT) to make these implants available to select low-income countries (e.g., FP2020 countries) at a reduced price of \$8.50/unit through 2018.
 - These manufacturers used to sell the implants at a higher price, which also included provider training on insertion/removal. The lower price no longer includes training, so the idea was that the IAP partnership would take on the training piece.
 - It is important to note that the IAP only distributes implants to governments, not to private commercial providers.
- This included a volume guarantee for the manufacturers, which has been met. Bayer and MSD have agreed (without any further volume guarantee) to continue supplying the implants at the reduced \$8.50 price for another 5 years through 2023.
- The IAP projected to have 300 million in savings through 2018, but they have already realized 405 million in savings by 2017. The plan was for these cost savings to go back into procurement, training and health system strengthening.
 - The IAP is currently going through an independent evaluation, so we will know more soon about how these cost savings have actually been allocated.
- Lacoste emphasized that despite the IAP's name, they are proponents of all methods and voluntary/rights-based FP counseling and choice. Implants are one method that was underutilized and difficult to access, so the IAP made it more accessible and helped to expand the overall method mix.
 - All training that the IAP conducts promotes method choice. For example, provider training helps refresh providers on all methods.
 - They've also found that making implants more accessible has catalyzed uptake of a variety of methods.
- The IAP also has an emphasis on growing a healthy/competitive implant manufacturing market, so they are happy about the new WHO prequalified Levoplant implant, manufactured out of Shanghai by Dahua.

Question for Trish MacDonald: Can you share a bit of USAID's history with implants and thoughts about the partnership?

- USAID’s involvement with implants dates back to the introduction of Norplant (the first implant brand).
- USAID’s role has focused on making LARCs more accessible through many of their projects and implementing partners.
- USAID has also been involved with other donors around implant price points and ways to make implant provision sustainable, particularly after the IAP ends.
- One idea worth exploring is packaging implants and intrauterine contraceptive devices (IUDs) together from a marketing perspective.

Question for John Skibiak: Tell us a bit about the RHSC and the work you are doing with the commodities financing gap (focusing on the implants market) as well as the Global Visibility and Analytics Network and how it is meant to strengthen product flows and decision-making around implants.

- RHSC was launched in 2004. It grew out of a movement that focused attention on the disparity between the growing public sector demand for contraceptive commodities and uncertainties over prospects for future donor funding. That disparity was evident in the first costed commodity gap analysis, which was carried out in 2001 and then updated in 2009. The 2016 edition of the analysis looked for the first time at consumption across the total market: public- and private-sector consumption. This analysis looks at:
 - Number of users and projected growth;
 - Anticipated changes in the method mix; and
 - Purchase price of supplies (donor price for public sector procurement; consumer price for those who pay out of pocket in the non-public sector).
- Based on the results of the Commodity Gap Analysis 2018, implant consumption will see the greatest growth, relative to all other individual methods, between 2017 and 2020 (33%) in the 135 low- and middle-income countries that RHSC analyzes. The cost of the 7.7 million implants likely to be consumed in 2020 will be \$98.7 million
 - That said, implants will remain a relatively small percentage of the overall method mix (4% in public sector, 2% in private sector)
- Due to subsidized prices from the IAP, the consumers’ willingness to pay’ for implants remains unclear.
 - This factor will be increasingly important as donor roles potentially decrease and the IAP ends.
- The RHSC manages a [Global Family Planning Visibility and Analytics Network](#), which promises to provide greater visibility into global supply chain flows and improve the efficiency and effectiveness of supply forecasts. The network aims to:
 - Streamline data collection from multiple sources and organizations to help align the currently fragmented supply chain data landscape;
 - Automate manufacturer data flows, which are currently completed manually; and
 - Help supply chain decision-makers ensure more timely and cost-effective delivery of commodities to countries.

Question for Rodrigo Portugues: How does DKT view the implants market currently? Tell us a little bit about DKT’s efforts to get Levoplant introduced and some of the challenges faced?

- Levoplant is a new product for DKT, which in and of itself shows our interest and commitment in this new market and expanding access to LARCs.
 - Levoplant (prequalified by WHO in June 2017) is manufactured by Shanghai Dahua Pharmaceutical company

- Sustainability is a key objective for DKT; they are encouraging the governments with which they are working to take a greater role in implant procurement, shifting away the responsibility of multilateral partners/donors. We recognize and appreciate the work that partners have done so far to get government involved and accountable and would very much like to continue seeing that work intensify at senior levels over the next couple of years.
- DKT will sell this product for \$6.90/unit to FP2020 markets.
 - They recently lowered to this price from \$7.50 & entered into a long-term agreement with United Nations Population Fund (UNFPA) and a service agreement with USAID to supply Levoplant at this price to all FP2020 markets.
 - This includes a high-level training of trainers model. The expectation is then that the government or other partners will take over the actual training.
- Levoplant is registered in a total of 22 countries (including Angola and Papua New Guinea that don't require registration). Registration submitted and expected soon for an additional 13 countries and dossier is under preparation for further 30 countries. They are also working with non-FP2020 countries. However, the \$6.90 price will not extend to these countries. (The price will still be relatively lower than other implants, though).
 - Sales revenue from these countries will use a cross-subsidization/cost-recovery approach to cover training of trainer costs.
- They are selling the implant to anyone interested: governments, private providers, NGOs, etc.

Key Points from Question & Answer with the Audience

The IAP announced that, as a result of higher than expected demand for Implanon NXT in early 2018, MSD would not be able to meet all 2019 requests for the one-rod implant. MSD had reached its production capacity. Shortages will be felt in 2019 and may extend into 2020.

- Countries that plan to introduce Implanon NXT in 2019 will be delayed.
- Current supply is prioritized to go to countries with:
 - Existing Implanon NXT implant programs
 - Self-funded programs
 - Programs solely reliant on Implanon NXT for implant supply (e.g., no two-rod)
- IAP is looking for solutions and talking to various partners, but it seems likely that this constraint won't be fully resolved until 2020 at the earliest.

Potential financing solutions: The Bridge Funding Mechanism provides UNFPA with the means to procure commodities, even if pending donor funding commitments have not yet been disbursed. Through a partnership with Bill & Melinda Gates Foundation and United Kingdom's Department for International Development, the Bridge mechanism offers UNFPA a revolving fund they can tap when needed and then replenish when donor disbursements occur.

- Panelists shared their hope that DKT's pricing structure would keep pressure on other manufacturers to keep prices low even after 2023.
- Even after the IAP ends, the Bill & Melinda Gates Foundation will remain committed to improving access to an expanded method mix, including ensuring availability of quality implant removal services.

Future support for training: The effort to reduce commodity prices has undoubtedly increased product access. But it has also come at a price. Support services (e.g., provider training) that once figured into the price of goods now require separate financing.

- For those who can secure such separate support, the lower prices are an advantage. But for those who cannot or who find it inconvenient to make separate arrangements for support, the attractiveness of the new volume guarantee prices is mixed.

- Many middle-income countries are now asking for something in-between: a slightly higher price but one that includes the support services that were once part of the package. Have manufacturers or the IAP partnership considered variable pricing options that would allow governments to access necessary support services?
- DKT is trying to do this to some extent by including the training of trainers, but it's difficult to provide the comprehensive package unless donor funds are available and demand is stable and growing.
- Lacoste noted that there has been one recent instance in which one of the manufacturers sold the implant at a slightly higher price, and it did include some degree of training as requested from the host government (Philippines).

Reflections on Community of Practice and Closing

Trish MacDonald, Senior Technical Advisor at USAID, stressed that when offered in the context of voluntarism and informed choice, contraceptive implants are playing an increasingly important role in ensuring that women and couples are able to achieve their reproductive goals. MacDonald also noted that coming together and sharing across our various projects/organizations via technical consultations like this is what will continue to move the FP community forward.

MacDonald also explained that there has been discussion at USAID and within the broader LAPM COP about expanding to a broader Method Choice COP. After group discussion with the audience on the strengths and weakness of this idea, a vote was taken with participants deciding that transitioning to a broader Method Choice COP made the most sense. MCSP, who currently chairs the COP, will reach out in 2019 to hold a deep-dive discussion on how to operationalize this change. If you would like to be engaged in that discussion, please e-mail LA_PM_CoP@my.ibpinitiative.org.

On December 4th, 2019, the LAPM COP will host a technical meeting focused on information sharing around the current global efforts to increase access to the levonorgestrel intrauterine system (LNG-IUS). This meeting will be hosted at MCSP offices and invitations will be sent out via the COP.

Annex A: List of In-Person Attendees

1. Adrienne Allison, Independent
2. Afeefa Abdur-Rahman, USAID
3. Alexandra Angel, PSI
4. Anita Gibson, Jhpiego
5. Anne Pfitzer, MCSP
6. Aparna Jain, Population Council
7. Brandon Hugueley, Project Concern International
8. Caitlin Gillespie, MCSP
9. Caroline Quijada, Abt Associates
10. Chidude Osakwe, Pathfinder
11. Chris Farrell, USAID Global Health Supply Chain Program-Procurement and Supply Management
12. Coley Gray, Packard
13. Deborah Sitrin, MCSP
14. Devon Cain, CHAI
15. Edward Kenyi, Jhpiego
16. Elaine Charurat, Jhpiego
17. Elaine Menotti, USAID
18. Elizabeth Smith, DKT International
19. Ellen Tompsett, USAID Global Health Supply Chain Program-Procurement and Supply Management
20. Ellen Starbird, USAID
21. Emma Clark, Chemonics International
22. Erin Mohebbi, Abt Associates
23. Erin Mielke, USAID
24. Fariyal Fikree, PATH
25. Françoise Armand, Abt Associates
26. Intissar Sarker, Abt Associates
27. Jacqueline Wille, MCSP
28. Jessica Turner, Intrahealth International
29. Jessica Wabara Baker, MCSP
30. John Skibiak, RHSC
31. Julianne Weis, USAID
32. Kaitlin Christenson, PATH
33. Kamlesh Giri, CARE
34. Kelly Peuquet, JSI
35. Kendal Danna, PSI

36. Kuyosh Kadirov, USAID
37. Laila Akhlaghi, JSI
38. Laura Raney, FP2020
39. Laurie Krieger, The Manoff Group
40. Leah Elliott, MCSP
41. Marguerite Farrell, USAID
42. Martyn Smith, FP2020
43. Maryjane Lacoste, Bill & Melinda Gate Foundations
44. Maureen Norton, USAID
45. Megan Christofield, Jhpiego
46. Melissa Freeman, USAID
47. Michael Muthamia*, Jhpiego Kenya
48. Michelle Weinberger, Avenir Health
49. Mohamed ElFeraly, Independent
50. Naomi Bouchard-Gordon, Jhpiego
51. Neeta Bhatnagar, MCSP
52. Ojaswi Adhikari, USAID
53. Rebecca Callahan, FHI 360
54. Rodrigo Portugues*, DKT International
55. Saadi Abdulmumin, USAID
56. Sarah Kashef, Intrahealth International
57. Sarah Thurston, PSI
58. Shana Finkel, PSI
59. Susan Mitchell, Abt Associates
60. Susan Otchere, World Vision
61. Tembi Mugore, Intrahealth International
62. Tess Shiras, Abt Associates
63. Tilahun Yewondwossen, Pathfinder
64. Tishina Okegbe, FHI 360
65. Trish MacDonald, USAID

*remote participant

Annex B: Speaker Biographies

Françoise Armand is a Principal Associate at Abt Associates with 18 years of experience in commodity distribution systems, social marketing and market-based approaches to improving health outcomes. She has served as private sector advisor on four consecutive USAID global private health projects and as US-based technical director for the USAID Uganda Health Initiatives for the Private Sector, the United States Center for Disease Control and Prevention's Public-Private Partnerships in the President's Emergency Plan for AIDS Relief Countries project, and the UK Department for International Development-funded Zambia Scaling up Family Planning Program. She currently oversees Abt-managed system strengthening bilateral projects in Tanzania and serves as a Senior Private Sector Advisor on SHOPS Plus where she focuses on Total Market Approaches for health. She holds a master's in business administration from the University of Miami.

Neeta Bhatnagar, MD, is a Senior Technical Advisor in Family Planning at MCSP. She has 23 years of experience as an obstetrician and gynecologist and 18 years of progressive experience as a public health and technical expert in RH and FP. While with USAID's Maternal and Child Health Integrated Program and MCSP, she has contributed to introduction, implementation and scale-up of newer contraceptives such as postpartum intrauterine contraceptive device, LARCs and revitalizing minilaparotomy under local anesthesia. Before this, she worked as the Technical Advisor with PSI, Ipas and Engender Health in India. Being a qualified instructional designer, she has led efforts in designing FP training materials on the principles of low-dose, high-frequency and use of alternate and evidence-based training approaches to build a confident and competent workforce.

Rebecca Callahan, PhD, MPH, is a public health scientist with more than 15 years of experience in the field of global RH. Dr. Callahan serves as Associate Director for FHI 360's Contraceptive Technology Innovation Department where she leads research activities focused on user preferences for new contraceptives in development, as well as studies assessing access to implant removal services in several countries. She previously worked as Family Planning Technical Advisor with USAID and served as a Peace Corps volunteer in Nepal. She obtained her doctorate in public health from the Johns Hopkins Bloomberg School of Public Health.

Emma Clark, MHS, MSN, CNM, is a public health professional and certified nurse-midwife. She is currently the Director of Maternal, Newborn and Child Health at Chemonics International. Before coming to Chemonics, she worked as a midwife at Community of Hope Family Health and Birth Center in Washington, DC, where she continues to practice on a per diem basis. Before that, she developed and managed health and nutrition programs in some of the world's most challenging environments, including Iraq, Haiti, Somalia, Jordan, Kenya and South Sudan, for International Medical Corps. Ms. Clark was a Fulbright Fellow in Botswana and a 2016-2017 Duke-Johnson & Johnson Nurse Leadership Fellow. She also teaches in the nurse-midwifery program at Georgetown University. She is on the board of the Partnership for Maternal, Newborn and Child Health. She holds bachelor's degrees in economics and nursing, a master's degrees in global disease epidemiology and control from Johns Hopkins Bloomberg School of Public Health and a certified nurse-midwifery degree from Frontier Nursing University.

Elaine Charurat currently serves as the Project Director for Jhpiego's Family Planning Special Projects. She has more than 15 years of experience in program implementation in FP/RH, HIV/AIDS and cervical cancer prevention in Africa, Asia, the Caribbean region and Eastern Europe. She holds master's degrees in public health and business administration from Johns Hopkins University.

Megan Christofield is a Technical Advisor, FP at Jhpiego with over a decade of global health experience. She supports Jhpiego's global FP portfolio, particularly in the areas of program design, advocacy and innovation. Since 2013, she has supported contraceptive implant introduction and scale-up efforts in 10 countries, was the managing editor of the Contraceptive Implants Learning Resource Package and a founding member of the Implant Removals Task Force. She holds a master's in public health in women's and RH from the Johns Hopkins Bloomberg School of Public Health and is a returned Peace Corps volunteer (Uganda).

Maryjane Lacoste joined The Bill & Melinda Gates Foundation in May 2014, working with the FP Team as the Senior Program Officer for FP Service Delivery and Quality. As such, she leads and manages implementation of the IAP, ensuring that the strategy focuses on expanding access to method choice and strengthens quality of care including counseling, interpersonal communications, clinical training, service delivery and performance monitoring. She also oversees the FP portfolios in Indonesia and Ethiopia. Before joining the Foundation, she worked with Jhpiego for over 20 years, spending the last 15 years in the field as country/regional director in Tanzania, Indonesia and Malawi. She has worked with MOHs, donors and other stakeholders to develop and manage implementation of large RH, maternal, newborn and child health and HIV projects in many countries in sub-Saharan Africa, as well as in Indonesia. She holds a master's of arts degree from University of Maryland and a bachelor of arts degree from Loyola University.

Trish MacDonald is a registered nurse and public health specialist in FP and RH. Over the last three decades, she has lived and worked in several countries in Africa and Asia to train clinical providers, strengthen quality of care and health systems, design and conduct programmatic research and manage maternal and RH projects. As a Senior Technical Advisor in the Office of Population and Reproductive Health in USAID's Bureau for Global Health, she provides leadership in areas of contraceptive method choice, LARCs /PMs, FP integration with maternal and child health, service communication and scaling up evidence-based high-impact practices. Ms. MacDonald has a master's in public health in health behavior and health education from the University of Michigan.

Elaine Menotti is a Technical Advisor at USAID's Office of Population and Reproductive Health where she works on the Private Sector team, manages FP/RH and other health service delivery programming and engages in strategic efforts to expand method choice and access globally. Previously, she worked in USAID's Nutrition division on community-based maternal and child health programming. Prior to USAID, Ms. Menotti worked at Futures Group (now Palladium) to strengthen FP and RH policies and programs in multiple countries. She worked in Central America with local and international NGOs, as well as domestically, to design, implement and monitor community-based maternal and child health, FP and nutrition programs. She has a master's in public health in health behavior and health education and a certificate in reproductive and women's health from the University of Michigan and a bachelor of arts in anthropology from Duke University.

Susan Mitchell is a Principal Associate at Abt Associates and the Project Director for the SHOPS Plus project. She has more than 25 years of experience in the design, implementation, management and evaluation of private health sector programs. Susan has an master's in business administration from New York University Stern School of Business and a bachelor of arts in social studies from Hampshire College.

Michael Muthamia works as a Senior Technical Officer at the Jhpiego Kenya Office. For the last 7 years, he has been providing technical guidance for the implementation of RH programs, including supporting the national transition from Implanon to Implanon NXT, the Accelerated Scale up of Implants Project, The Implant Removal Best Practices Project and Post Pregnancy Family Planning Project. Before this, he was a key player in the implementation of the multicounty urban RH initiative that was very successful in increasing the modern contraceptive prevalence rate among the urban poor. Before joining Jhpiego, he worked with PSI for 4 years where he played a key role in the strengthening quality of RH services within the private sector through the Tunza Family Health Network.

Anne Pfitzer is the Family Planning Technical Team Leader for MCSP. Before this, she was Deputy Director for Save the Children's Saving Newborn Lives program, funded by the Bill & Melinda Gates Foundation. She has also served as Country Director in Ethiopia for Jhpiego and as Performance Improvement Advisor for a FP USAID bilateral program, called STARH in Indonesia.

Rodrigo Portugues is the Commercial Director at DKT WomenCare Global, where he leads global sales and distribution efforts in over 90 countries, including for the recent WHO prequalified contraceptive implant, Levoplant. He has over 12 years of project management and international public health experience with proven strategy development and implementation, business management, social marketing, sales, service

delivery, social franchise, proposal writing and donor relations experience in the Americas, Africa and Asia. He has a postgraduate certificate in health promotion and education from the Universidade de Brasília and a master's of business administration from the Bradford University School of Management.

Caroline Quijada is a private health sector expert with over 20 years of experience working on international public health programs. She is currently the Deputy Director of Abt's Sustaining Health Outcomes through the SHOPS Plus project –USAID's flagship program to increase the role of the private sector in the sustainable provision and use of quality health information, products and services. She has served as Deputy Project Director on two predecessor private health sector projects led by Abt Associates – Strengthening Health Outcomes through the Private Sector (\$95m) and Private Sector Partnerships One (\$65m). Ms. Quijada bridges core knowledge in RH/FP with a strong understanding of the commercial and social enterprise market for health. She supported the design and led execution of Abt's HANSHEP Health Enterprise Fund which supported 16 social enterprises focused on delivering health services to the poor sustainably. She has experience working with the private health sector across Latin America, Africa and Asia in areas such as total market approaches, corporate partnerships, private provider networks and base of the pyramid approaches. Ms. Quijada has a master's in population and family health sciences from Johns Hopkins Bloomberg School of Public Health. She is a native Spanish speaker and is proficient in French.

John Skibiak brings more than 30 years of experience in the development field, most of it spent developing, implementing and managing RH programs in Africa, Asia and Latin America. He currently serves as the Director for the RHSC, a global partnership of public, private and NGOs dedicated to ensuring that all people in low- and middle-income countries can access and use affordable, high-quality RH supplies. Before joining the Coalition in 2006, he was Director of the Population Council's Africa Program to Expand Contraceptive Choice and founder of ECafrique, a bilingual network of health care professionals seeking to mainstream quality emergency contraception services in Africa. An anthropologist by training, Skibiak brings skills and professional experience in such areas as appropriate technology and micro-enterprise development—experience that has enabled him to forge multi-sectoral partnerships across the health field.

Sarah Thurston is a senior technical advisor for FP at PSI, working on the PSI-Support for International Family Planning Organizations 2 project. She works closely with PSI country programs to improve and scale FP awareness, counseling and service delivery with a focus on ensuring voluntary LARCs are part of a broad method offering through PSI's FP programs. Sarah has been working in FP, RH and maternal health for 14 years, most recently with Marie Stopes International. She brings expertise in service delivery models including social franchising and social marketing as well as in public-private partnerships for health services delivery.

Yewondwossen Tilahun, MD, is a gynecologist and obstetrician who has worked in the field for more than 15 years, and since 2009, specializing as a public health expert with Pathfinder International as a senior FP/RH Advisor. During his time with Pathfinder, he organized implant and intrauterine contraceptive device, including the postpartum FP, national scale-up programs as a partner to the MOH of Ethiopia.

Michelle Weinberger is a Senior Associate with Avenir Health. She works across a range of projects including Track20, SHOPS Plus and Health Policy Plus. Her work focuses on data analysis and modelling that informs strategic policy and programmatic decisions related to FP and RH. Ms. Weinberger serves as the technical lead for RHSC's annual Commodity Gap Analysis (2016), is the modelling lead for HP+, and serves on the High Impact Practices Technical Advisory Group. Before joining Avenir Health, Ms. Weinberger headed the Impact Analysis team at Marie Stopes International where she oversaw the development of impact models and metrics. This included developing the Impact 2 model, which estimates the health impact of RH service provision. Before that, she worked for FHI 360 in Tanzania on RH and HIV prevention programs. She has a master's in science in population and development from the London School of Economics.

Jacqueline Wille is a Program Officer with MCSP where she provides programmatic support for the MCSP Family Planning, Monitoring and Evaluation and Executive Management Teams; coordinates the annual and quarterly reporting process; and has contributed to the data analysis and write-up of studies on FP-

immunization service integration and the interaction of antiretroviral therapy and contraceptive implants. Prior to joining Jhpiego in 2016, she served as a Peace Corps volunteer at the Embangweni Mission Hospital in Malawi. She earned her master's in public health from Boston University and a bachelor of arts from the University of Minnesota.

Annex C: Meeting Agenda



Long-Acting & Permanent Methods Community of Practice

Contraceptive Implants Technical Consultation:

Addressing Barriers to Service Delivery as Implants Move to Scale

Date & Time: Tuesday, October 16th from 9:00am – 4:30pm

Venue: Human Rights Campaign Offices
1640 Rhode Island Ave., NW
Washington, DC 20036-3278

Goal:

The LAPM COP will convene to provide an update on the current state of global contraceptive implant service delivery, review the evidence and explore underutilized approaches to expanding services. By sharing examples and engaging in collective problem-solving for overcoming challenges, participants will highlight potential solutions and key recommendations on service delivery expansion, including increased involvement of the private sector, both not for profit and commercial.

Objectives:

Participants will:

- Gain a deeper understanding of the current state of contraceptive implant use and delivery;
- Share and explore evidence and experiences related to expanding implant service delivery through underutilized approaches, including the private sector; and
- Identify practical solutions to address challenges faced in the expansion of implant service delivery.

Agenda:

Time	Session	Presenter
8:30-9:00 – Breakfast & Registration		
Opening		
9:00 - 9:05	Meeting logistics	Leah Elliott, MCSP
9:05 - 9:30	Opening remarks & introductions	Trish MacDonald, USAID & Anne Pfitzer, MCSP

Time	Session	Presenter
Plenary 1 – State of the Implant(s) Address		
9:30 - 9:40	Panel opening remarks	Moderator: Maryjane Lacoste, Bill & Melinda Gates Foundation
9:40 - 10:00	Overview of contraceptive implants	Michael Muthamia, Jhpiego Kenya
10:00 - 10:30	What do the data tell us?	Michelle Weinberger, Avenir Health
10:30 - 10:50	Question and Answer	
10:50–11:15 Break & Marketplace		
Plenary 2 – Overcoming Barriers to Implant Expansion		
11:15- 11:25	Panel opening remarks	Moderator: Elaine Menotti, USAID
11:25- 11:30	Community-based distribution of implants through task sharing	Yewondwossen Tilahun, Pathfinder Ethiopia
11:30- 11:35	Addressing the unique needs of private sector implant provision	Françoise Armand, SHOPS Plus
11:35-11:40	Ensuring availability and access to timely, high-quality implant removal services	Michael Muthamia, Jhpiego Kenya
11:40-11:45	What do clients and providers need to know in the evolving landscape of contraceptive implants	Megan Christofield, Jhpiego
11:45-11:55	Closing Thoughts & Roundtable Introductions	Moderator: Elaine Menotti, USAID
Roundtables: Overcoming Barriers to Implant Expansion		
Topics:		
1	Community-based distribution through task shifting	Yewondwossen Tilahun, Pathfinder Ethiopia
2	Addressing commercial private sector provider needs	Françoise Armand, SHOPS Plus
3	Addressing donor-supported private provider needs (through social franchising/ social marketing)	Sarah Thurston, PSI
4	Addressing client financial barriers	Susan Mitchell, SHOPS Plus
5	Ensuring availability and access to timely, high-quality implant removal services	Elaine Charurat, Jhpiego & Rebecca Callahan, FHI 360
6	Addressing the needs of clients living with HIV or at high-risk of HIV acquisition	Jack Wille & Anne Pfitzer, MCSP
7	Equipping the workforce to meet the needs of implant users	Emma Clark, HRH2030 & Neeta Bhatnagar, MCSP
8	Product evolution & the role of client and provider product-specific preference	Megan Christofield, Jhpiego
11:55-12:30	Roundtable Rotation 1	
12:30-1:15 Lunch & Marketplace		
Roundtables Continued		
1:15-1:50	Roundtable Rotation 2	
1:50-2:25	Roundtable Rotation 3	
2:25-2:45 Break		

Time	Session	Presenter
Plenary 3 – Sustaining Access to Implants		
2:45-2:55	Panel introduction	Moderator: Caroline Quijada, SHOPS Plus
2:55-3:40	Panel Discussion on Lessons Learned: Where we've been and where we are going	<ul style="list-style-type: none"> • Maryjane Lacoste, Bill & Melinda Gates Foundation • Trish MacDonald, USAID • John Skibiak, RHSC • Rodrigo Portugues, DKT WomenCare
3:40-4:00	Question and Answer	
Reflections on COP & Closing		
4:00-4:20	Discussion on expanding the LAPM COP to a Contraceptive Method Choice COP	Trish MacDonald, USAID
4:20-4:30	Closing thoughts	

Annex D: Notes from Roundtable Sessions

Roundtable I: Community-based distribution through task shifting

Table Lead: Dr. Yewondwossen Tilahun, FP/RH Advisor, Pathfinder Ethiopia

This roundtable focused on strategies and solutions for availing contraceptive implants to the last mile, through community-based distribution. Participants built off of examples like that of Ethiopia, where task shifting was implemented through skill training to frontline service providers (HEWs) to address major gaps in access and use of LARCs. From the MOH's introduction of Implanon at the community level 9 years ago, significant program gaps have been both prevented and overcome, resulting in national scale-up and established interventions for supporting and improving the health delivery system to uphold the quality of Implanon insertion and removal services at the community level.

Question 1: What are the drivers of this issue, and why are we seeing it as a barrier?

Poor access to LARC services at the community level. Traditionally most community health workers provide only short-acting methods of FP, such as condoms, pills and injectables.

Resources/investments and technical assistance do not always keep pace with the real-time needs generated by training large numbers of health workers under task-shifting efforts. In Ethiopia, it was a struggle to keep up with the large number of HEWs trained on implant insertion (Pathfinder alone trained 10,000 HEWs & implants services by HEWs were rolled out in more than 5,000 health posts without adequate planning for resources, investments and technical assistance).

A high number of implant clients now require removals. In Ethiopia, HEWs were only trained on insertion so removals became a serious challenge. Clients returning for removals were referred from the health post to the health center level, however, health center staff were not well equipped with the resources and skills to do removals.

Question 2: How have you/are you currently dealing with addressing these barriers/drivers?

Poor access to LARC services at the community level:

- In Ethiopia, the government decided to address this issue by using the existing HEW structure at the community level. Previously, HEWs provided short-acting FP methods only, but in 2009, the government trained them on Implanon insertion and the task-sharing program commenced.
- Post-training supplies and consumable packages were provided to HEWs immediately after training to ensure they were equipped to initiate implant insertion services at the community level.
- Training providers on proper counseling of clients and what to expect after implant insertion made implants more acceptable to women.

Lack of sufficient resources/investments and technical assistance:

- Gap filling by NGOs to ensure consumables and commodities are in place: To address these gaps, many NGOs provided "gap filling" support in Ethiopia at both the health post and health center levels. For example, Pathfinder provided consumables and FP commodities to ensure continuity of both implant insertion and removal services.
- Ensuring logistic organization and sustainability for FP commodities: Where possible, integrate identified needs into existing health care financing structures of the health system so that they can be adequately addressed.
- Ensure technical assistance is available to providers recently trained in new skills: In Ethiopia, the focus was on building capacity of health center staff to provide routine support to health posts. Pathfinder organized teams of providers from the health center level, trained them and provided them with implant and IUD kits and consumables. These providers routinely go to health posts to provide technical assistance to HEWs on implant and IUD insertions and removals, as well as other FP services.
- Monitor progress: One-year data were collected from 142 primary health care units (PHCUs) that were randomly sampled after 3 years of the above-mentioned interventions. Results showed that a significant amount of service delivery was done through these interventions: 38,000 clients were served with back-up services; more than 15,000 through static implant removal support, more than 8,000 through outreach

services; including 100,000 potential clients who received implant insertions through the post-training supply package provisions.

Ensuring Access to removal services:

- a. Provide implant removal training and supplies: In Ethiopia, static implant removal services at the health center level were ensured by providing implant removal training, consumables, removal kits and other technical assistance.
- b. Community sensitization on availability of outreach services: In Ethiopia, Pathfinder organized outreach on implant removal services in the program catchment area.
- c. Monitor progress: In 2016, Pathfinder conducted operations research on the Implanon scale-up program in the pilot districts to assess if clients had their removals done in supported facilities. Results showed that 95% of clients received Implanon removals at sites where the system support interventions were implemented. Of these removals, 14% were done at health posts during the training sessions and through back-up support from health centers.

Question 3: What innovative or potential solutions should we [the FP community/Implementers] be exploring?

Sustainability/Government Ownership: In Ethiopia, the government has now taken over the implant task-shifting activity and currently funds it.

Identify additional gaps that can be addressed by task shifting: In Ethiopia, HEWs who are promoted/upgraded to Level IV are now being trained on comprehensive FP methods and service provision at the health post level. This includes implant and IUD insertion and removals, among other FP methods. The government intends to do a phased approach for training the promoted HEWs. Last year, 3,000 HEWs were trained and 3,000 will be trained this year.

Look at alternate human capacity development approaches: To ensure sustainability of implant insertion training for HEWs, a pilot looked at the benefits of onsite training vs. offsite training models. See Table 1 for early preliminary descriptive results from 13 PHCUs.

Table 1: Assumed advantages of onsite Implanon insertion training of HEWs at the primary health care unit level compared to offsite Implanon training (from Pathfinder Ethiopia)

Variables	Training approach		Assumption: offsite vs. onsite
	Offsite (at district level)	Onsite (at PHCU level)	
Number of days HEW is away from work place for training	8	3	The HP is closed for only 37% of the time during the training.
Average cost required to train one HEW	4,200 ETB	1,614 ETB	62% less cost through the onsite at the PHCU training approach.
Number of clinical practice days required for HEWs to insert Implanon for an average of five clients	Required a minimum of three clinical practice days	Completed in the first day of the clinical practice day	33% of the clinical practical days was enough to complete the required number of Implanon insertion through the onsite approach.
Personnel organizing and conducting the training	People outside the PHCU	Providers who are responsible for the technical and administrative issues at the PHCU	Trainers involved in onsite training are the same people responsible for service planning, follow-up, monitoring health posts, promoting ownership and sustainability.

Variables	Training approach		Assumption: offsite vs. onsite
	Offsite (at district level)	Onsite (at PHCU level)	
Possible number of HEWs that can be trained in one session at district level	25	42	Through the onsite training approach, a PHCU can train the HEWs under PHCU. At a district level large number of HEWs can be trained.

Roundtable 2: Addressing commercial private sector provider needs

Table Lead: Françoise Armand, Principal Associate, SHOPS Plus

The success of the IAP has been made possible in part by investments in service delivery programs that have helped scale up access to the method in previously underserved areas. To date, private facilities account for only a fraction of women receiving implants, yet meeting the rapidly growing demand for this method will require significant increases in the number of private providers able to deliver it. In this roundtable, participants discussed the obstacles that prevent independent providers from offering implants to their clients and the strategies that might overcome them.

Question 1: What are the drivers of this issue, and why are we seeing it as a barrier?

Independently operating, non-networked providers cannot commercially procure contraceptive implants. This is because the manufacturer requires training and quality assurance, and there are currently no mechanisms to provide these to independent providers outside franchises or NGO networks. This is an issue because they make up a significant portion of the private sector and could meet a lot of the future demand for implants by serving women who are already in or can afford to seek services in the private sector. We can't make progress without these providers, but we also don't know to what extent independent facilities and providers might have an interest in providing this method. These providers do not necessarily cater to the typical target group as donor-funded franchises and this model may not serve their business model well, nor do they necessarily need to receive free commodities.

Some faith-based providers (e.g., mission hospitals) also seem to have trouble accessing implants and training in administering/removing the method so this issue is not limited to for-profit providers.

The IAP is currently the only source of affordable implants in most developing countries but is only available to donors, governments and NGOs. Independent for-profit providers cannot access these products at the reduced price of \$8.50 unless they are somehow affiliated with these program partners.

Even if private providers are provided access to implants at this lower price it does not automatically translate into increased access or quality services to end user.

Giving implants free of charge to private providers comes with conditions, such as not being able to charge for the method. When the public sector (through the national medical store) provides the method, they tend to see private providers as an extension of the government, subject to the same rules. For-profit providers are not necessarily interested, especially if they can earn more on other methods or services.

All of these issues are linked to a greater issue relating to **who is responsible for reaching and engaging the private sector.** None of the above issues can effectively be addressed without some form of stewardship.

Question 2: How have you/are you currently dealing with addressing these barriers/drivers?

DKT has an agreement with Dahua to **distribute and market Levoplant through the DKT woman care platform (nonprofit).** Through this platform, they provide products to UNFPA, USAID, as well as commercial distributors. Where DKT has a local affiliate, it will be able to sell Levoplant (cost: approximately \$6.90) to private providers and possibly commercial distributors.

Although private providers cannot directly procure implants, there are **work arounds**. For example, in some countries private facilities have been able to procure from central medical stores like Kenya Medical Supplies Authority in Kenya. In others, providers working in hospitals and clinics who are also employed in the MOH are known to bring supplies procured through the public sector. However, these workarounds are not sustainable solutions nor do they address the need for training and quality assurance in the private sector.

Question 3: What innovative or potential solutions should we [the FP community/Implementers] be exploring?

The consensus was that **product access, training and quality assurance should be addressed concurrently to ensure and sustain quality services.**

Including FP in benefits packages of national health insurance schemes Insurance programs are scaling up and FP is not always included in the benefits packages of many countries. In countries like the Philippines and Indonesia, however, there has been success in including FP and contracting independent providers, particularly those belonging to professional associations (midwives in the example of Indonesia). Insurance payments that make it worthwhile to obtain certification and maintain it are a strong incentive for independent providers looking to add a specialty through LARC provision.

Some national medical stores (e.g., KEMSA in Kenya) are able to sell to the private sector, which may be a sustainable solution because it does not involve a subsidy.

Including implant insertion and removal training in pre- and in-service training for a wide range of cadre (nurse/midwives, GPs, gynecologists).

Work with strong professional associations (e.g., Uganda Private Midwives Association) to provide training and quality assurance that could support provider certification in implant and other LARC services. This may be facilitated by having the MOH accredit teaching/training institutions.

Engage DKT in developing an inclusive and scalable model of private sector provision of implants.

Work with manufacturers on third-tier pricing that would make it possible to have a “middle” price for implants delivered through independent providers that includes training and technical support.

Allow private providers to purchase implants from public health facilities (e.g., district hospitals) or receive them free of charge if they operate in underserved communities and have received training from the MOH.

Roundtable 3: Addressing donor-supported private provider needs (through social franchising/social marketing)

by Sarah Thurston, Sr. Technical Advisor, PSI

The private providers (clinics and pharmacies) that many of our programs support through social franchising and social marketing interventions are important conduits for FP products and services. But these providers face barriers to maximizing their ability to offer a full method mix, including contraceptive implants. This roundtable sought to identify top barriers that prevent providers, participating in donor-supported FP programs, from consistently offering implants at high-quality standards to all interested clients. From there, the table brainstormed solutions and concrete actions that the FP community of practice can take to increase consistent availability through these important channels.

Question 1: What are the drivers of this issue, and why are we seeing it as a barrier?

Drivers of these barriers include the **high cost of implants** (which results in a high service cost for client, low provider profit margin or both). This may be exacerbated by difficulty for private providers to procure implants in small quantities on their own.

As independent private providers, many providers feel professional isolation, a lack of opportunity to hone their skills and improve their quality and little opportunity to meet with other providers to share

experiences and problem solve. The franchisor can play this role of ‘connector’ and facilitate problem-solving and comradery among providers.

Demand generation can pose challenges, both around building awareness for voluntary LARC methods in communities where they are less known and building community awareness that a franchise facility has capacity to offer high-quality voluntary LARC services as part of a broad range of FP methods.

Regulatory barriers may limit the cadre of medical professional permitted to insert or remove implants, decreasing opportunity for nurses or lower level cadres to expand method choice to include implants.

Social franchising programs seek to address these barriers; however, the support provided by franchising programs may differ by country or by franchisor. A comprehensive social franchising package of support would include training and supportive supervision, demand generation, branding and provision or support obtaining implant commodities, and in some cases, associated consumables. However, the specific support package can vary by context and available resources.

Question 2: How have you/are you currently dealing with addressing these barriers/drivers?

Include private providers in social franchise networks that enable them to access implant commodities, training, quality assurance and demand generation support. Private providers need to see the value of participation in the network as it relates to offering better services to their clients, more FP options and helping their business grow.

Support approaches to build franchisee sustainability of implant access. Typically, social franchise networks provide LARC commodities to franchisee facilities for free or at subsidized prices. To support long-term sustainability of implant access, franchisees can be encouraged to offer sliding scale fees for FP services so that clients able to contribute to their cost of implant (or other) service can do so and subsidy can be better targeted at lower income quintile clients.

Match new social franchise network members with a veteran provider who can mentor them. PSI franchisees often rank “being part of a network” where they have access to and a forum to meet other providers as the most valuable element of franchise participation. Additionally, in some countries, formal mentoring relationships are set up between new franchisee and established one.

Demand generation and awareness building support is often most useful when focused in local catchment areas rather than approaches that focus on marketing specific products to a larger, wider population area.

Working with franchisees on their business plans can help set them up to sustainably provide voluntary LARC methods in the context of broad method choice. As existing private facilities, franchisees are already sustainable as a clinic before engagement with the social franchise network. Through social franchising’s introduction of implants (and IUDs), franchisees begin offering additional FP services that are often not financially profitable for the clinic. Many franchisors offer support to franchisee clinics to help them devise sliding scale pricing, cross-selling of FP services with other health services and other approaches to help bring voluntary LARC services closer to cost recovery and ultimately support their sustainable provision at the franchise facility.

Question 3: What innovative or potential solutions should we [the FP community/Implementers] be exploring?

Help private providers gain accreditation into public/ national health insurance programs to broaden their base of clients able to access voluntary LARC services in a manner that is cost recoverable or profitable for the clinic.

Supporting direct-to-consumer FP campaigns that include implants among the methods introduced.

Collaboration with the MOH and, as feasible, the manufacturers of implants would be beneficial.

Message testing and inclusion of evidence in FP awareness raising campaigns. What marketing messages are being used and which ones resonate with consumers?

Coordinate with MOH commodity supplies to support/enable franchisee providers to access implant (and other) commodities directly from MOH, rather than current system whereby franchisor often accesses through MOH or international procurement and provides on to each franchisee individually.

Engage stakeholders to support private sector wholesalers and quality assurance processes for products and systems that can be used across both private and public sectors.

Address professional isolation by including networking and mentorship as key part of social franchise network. This allows providers to communicate with each other, gather of their own accord (without the direction of the franchisor) and discuss common challenges and collectively problem solve.

Roundtable 4: Addressing client financial barriers

by Susan Mitchell, Principal Associate, Abt Associates and Project Director, SHOPS Plus

Implant provision has increased substantially with significant donor support and subsidized or free provision. The challenge is how to sustain access to a low-cost product to reduce financial barriers. This roundtable explored financing options that have been used and how to continue to scale the progress that's been made.

Question 1: What are the drivers of this issue, and why are we seeing it as a barrier?

There are no comprehensive data on client cost actually paid for implants across countries. PMA2020 does collect this, but these samples aren't nationally representative. FPWatch surveys in select countries have these data, too.

- Some data show implant use is higher among higher socioeconomic groups.
- We have anecdotal evidence that women from low socioeconomic levels get implants when they are distributed for free from NGOs (e.g., very long lines to get implants on “free insertion” days).
- Because implants are so highly subsidized, it's difficult to gauge if clients are willing to pay for this product.

Subsidized cost can still be too expensive: Even though the \$8.50 is very cost effective for a product that lasts 3-5 years, this may be expensive for some women with low incomes to pay all at once. Some clients may also have to pay a service fee or the cost of associated consumables.

In 2023, the price guarantee from IAP goes away, at which time client financial barriers could be much larger.

Some groups face higher financial barriers than others: Unmarried and young women likely have higher financial barriers to implants, and very poor clients who have difficult/complicated removals likely face higher financial barriers as the client needs a tertiary level facility if there are removal complications.

Additional financial barriers to removals: Although the government could contract this to the private sector, there could be ethical considerations—if the client got the implant inserted for free, it should probably be removed for free, as well.

Lack of global data about removals including cost, the number of removals and where women go for removals. PMA2020's data on this are not nationally representative.

- PMA2020 data from Kenya shows women might be disproportionately likely to go to the private sector for removal than insertion (small sample size, though). This could be because the removal cost from the private sector is low, so women are willing to pay this.

Clients who do have the ability to pay for implants are often unable to get it from the private sector: as obtaining implant commodities in the private sector is very difficult (see additional roundtable discussions on this topic).

Private providers are not included in health financing: Private sector may not be included in the health financing/insurance scheme and likely not included in reimbursement.

Barriers to financial sustainability of implants: Will donors and governments be able to sustain the demand for implants – what happens after 2023?

- Although UNFPA and USAID will continue to supply implants, UNFPA budget is going down because some European governments have switched to donating to the Bill & Melinda Gates Foundation and the World Bank.

Question 2: How have you/are you currently dealing with addressing these barriers/drivers?

Vouchers: Vouchers help to subsidize products and reduce client financial barriers and can also help to generate demand. However, vouchers may not cover the consumable and service costs, so this is still not a completely proven practice. Research studies continue to evaluate voucher programs to examine how effective they are. Ultimately, someone still has to pay for the voucher, so this is not a sustainable solution to reducing client financial barriers.

Free MOH commodities for the private sector: In some countries (like Nigeria), the MOH provides free implants to the private sector and then private facilities charge a service fee to those willing to pay. This is a mechanism to allow the private sector to enter into and participate in the implant market. When the private sector serves implant users who are willing to pay, public sector can allocate its limited resources to serving women most in need.

Integration into insurance schemes: A handful of countries, such as the Philippines, has implants included in its national health insurance scheme. However, not many countries have implants included in their health insurance scheme, if FP services are included at all.

Question 3: What innovative or potential solutions should we [the FP community/Implementers] be exploring?

Tie contraceptives to micro-loans/savings groups: This has not been tested before to the group's knowledge.

Explore feasibility of formalizing government provision of free product to private sector under IAP: coupled with private providers charging a service fee.

Support providers to introduce fluctuating price scales so that the provider would charge more if a woman is able to pay and reduce the price if she isn't able to pay.

- Planned Parenthood does that in the US using a sliding scale based on income criteria.
- This is not easy to implement, though. It's burdensome, can be discriminatory and is difficult to provide oversight for.
- Include implant insertion/removal in national or private insurance schemes: This could also include employer-based insurance schemes.
 - Postpartum FP is sometimes only reimbursed from an insurance scheme if it's within a specific time frame, so it incentivizes and de-incentivizes FP services at key time points. Insurance schemes should not include these time-bound postpartum FP limitations.

Increased domestic resource mobilization: focus more on government contribution to commodity supply as well as government resource allocation to implant insertion/removal training, capacity-building and health system strengthening.

- Data on government expenditure for FP comes from: (1) WHO Spending Health Account System but is not by specific commodity and (2) UNFPA has government expenditure tracking in select countries. So, we know which governments are buying FP commodities, but it may be difficult to tease out whether those are implants.

Increased availability of LARCs in private sector: As a first step to better target limited resources, LARCs should be available in the private sector so that women who are able and willing to pay can purchase the method. As a result, there will be more resources available for those most in need via the public sector.

- If we focus on people who are willing to pay for implants, then we can increase the acceptance rate. This is the opportunity for the private sector. Many of the women in the top two wealth quintiles are using implants, so there is an opportunity to move these clients from public to private sources (Lowenstein, 2018).

Explore implant provision via drug stores: We know that many people go to pharmacies for contraceptives, especially in sub-Saharan Africa. Drug shop operators in many countries may have more skills than CHWs, and many drug shops are owned by midwives or nurses (like in Nigeria).

- These types of facilities have the potential for training for implant insertion/removal; need to ensure that there is oversight at that level.
- This intervention could focus on the Implanon NXT because it's just one rod and it comes pre-assembled, so it's easier to insert.

Explore Implant provision through a private-sector CHW program: For example, Bangladesh has private CHWs who are linked to private clinical providers. This is similar to a mini-franchise, but the private CHWs go to the community level to advertise products and then refer clients to a clinical provider.

- Need oversight for this model to work, so it might work better under a social franchise, so there is a network of providers and a supervision mechanism in place.
- Could have incentives in place for the private CHW to refer to the private clinics.
- Could look at the Ethiopia HEW task-shifting model and try to translate that to private sector CHWs and clinics.
- World Health Partners in India also has a tiered model for task shifting and incentives so that CHWs refer up when it makes sense. This could be another example that could be adapted for private sector CHW implant provision.

Roundtable 5: Ensuring availability and access to timely, high-quality implant removal services

by Elaine Charurat, Project Director, Jhpiego & Rebecca Callahan, Associate Director, FHI 360

With contraceptive implant uptake on the rise, governments, FP programs and other stakeholders (including users themselves) are eager to ensure that access to quality removal services are within reach for clients using implants. However, emerging data demonstrate that this accessibility has not been achieved. This roundtable engaged participants in a discussion of barriers and solutions for ensuring that implant users are availed timely, high-quality implant removal services. To ignite conversation, implementation examples from Kenya and Uganda, as well as user insights from Ghana, Ethiopia and beyond were shared.

Question 1: What are the drivers of this issue, and why are we seeing it as a barrier?

Lack of adequate training for providers on removals: Implant removal is more clinically difficult than implant insertion. Training often focuses more on implant insertion than removals, and when included, removal training is usually done on arm models and not actual clients. Meaning even providers who may have some training on removals are not comfortable providing the service. Also, not all cadres of health providers who support implant insertions are allowed to provide removal services.

Volume of removal demand is not enough for sufficient provider practice/maintaining skills: Implant removal is a skill that must be maintained, which requires ongoing practice on clients and/or models. In many settings, there are not enough removal clients to give providers sufficient client load to practice skills.

Lack of equipment and supplies: Insufficient resources available to support removal services, like gloves and forceps.

National policies don't necessarily emphasize quality implant removals and/or provide guidance on it: Although many countries put administering implants into their national policy, removals are rarely featured. There is lack of MOH and policymaker buy in on the importance of removal.

Removal services may not be readily available This may be particularly true when clients receive an implant from an outreach service provider and removal services may not be available in the area the client resides.

Lack of readily available clinical guidance on implant removals: There is not always very detailed clinical guidelines on implant removal readily available at the service delivery level (most focuses on implantation).

Provider bias toward removal depending on clients' reason for seeking removal. Some providers may encourage women to keep their implant or refuse to remove if the implant has not reached its expiry date.

Question 2: How have you/are you currently dealing with addressing these barriers/drivers?

Expand the cadre of health care providers who can conduct implant removals: Implant removal is doable by nurses, midwives and doctors. Some programs are also exploring via CHWs.

Support fixed-day removal services: Accumulate removal clients and schedule them all on the same day to ensure clients will have access to services and also to provide clinicians an opportunity to practice.

Bring providers to higher-volume facilities or centers of excellence: To help providers practice implant removals, rotate providers between facilities so those in low-volume facilities can spend time at higher-volume facilities to practice, and in turn, providers at high-volume sites can supervise removals in lower volume sites. In Kenya, Jhpiego has capacitated Implant Removal Centers of Excellence in select counties, where providers can receive targeted mentorship on multiple skills, including implant removals.

Support training for remote providers: Marie Stopes International outreach trainers train providers in farther to reach public facilities.

Support revision of country guidelines so that training on insertion and removal must take place at the same time.

Question 3: What innovative or potential solutions should we [the FP community/Implementers] be exploring?

Implement mobile removal services by deploying a team of roving mobile removal specialists that have specific dates they go to each region (must also consider how much time is reasonable).

Continue development of biodegradable implants that do not need to be removed and that can just disintegrate in the body (but will still emit hormones in the 6 months it's disintegrating).

Invent a device that makes removal easier so that less skilled health workers can provide removal services. (e.g., RemoveAid).

More programming that acknowledges the importance of gender dynamics for both implant use and removals is needed: A study by FHI 360 in Ghana collected data from qualitative interviews, and the consistent finding was that if a husband wanted the implant removed, this was one of the most valid and urgent reasons a provider would remove an implant (vs. women wanting a removal herself). There are also stories of husbands forcing their wives to remove implants, and even some who will forcibly pull out an

implant or IUD because they did not want their wives to be on contraception. Most providers are not be trained on gender-based violence and how to recognize it or what to do when they see it.

Roundtable 6: Addressing the needs of clients living with HIV or at high-risk of HIV acquisition

by Jack Wille, Program Officer, MCSP, and Anne Pfitzer, FP Team Lead, MCSP

New evidence has been emerging that women on certain ART regimens have experienced contraceptive failure while using various types of implants. MCSP recently completed a retrospective medical chart review study which confirmed high incidence of pregnancy among Kenyan implant users on two types of ART. This roundtable looked at these findings and discussed implications for FP counseling and clinical practice in high HIV prevalence settings.

Question 1: What are the drivers of this issue, and why are we seeing it as a barrier?

Lack of clear guidelines for counseling women living with HIV: providers in country do not have access to clear guidelines on this subject. Emphasizing volunteerism and informed choice is key.

Providers are concerned about the burden of counseling on this topic: During MCSP's study findings dissemination event in Western Kenya last year, we found that midwives pushed back on all of the counseling job aids, saying that we are putting too much on them and that they lack time for in-depth counseling. They also worry about the burden of explaining this risk to women living with HIV.

Many FP providers currently do not ask about use of concurrent medications (for ART or TB): especially if the clinic is not integrated. This represents a big provider behavior change challenge in terms of screening as well as counseling.

Client counseling should not be one-size fits all: The ability of clients to understand risk may need to inform the counseling, as well as her intention for using FP (spacing vs limiting).

Remaining questions around recommending dolutegravir as alternate first-line regimen: Though the question around possible drug interactions between efavirenz and implants is not new, its resolution became less urgent while WHO was exploring the use of dolutegravir—which has not been associated with implant failures—as the recommended first-line regimen. However, concerns over the possibility of neural tube defects among the children of women who became pregnant on dolutegravir have caused

Additional Background Information

Growing evidence has shown that women using some forms of ART—particularly non-nucleoside reverse transcriptase inhibitors (NNRTI), such as efavirenz—may experience contraceptive implant failures at rates greater than the general population. To assess this concern, MCSP conducted a retrospective chart review among women 15–49 years old who concurrently used an implant and ART in Kenya between January 2011 and December 2015. Analysis of 1,152 women revealed 115 pregnancies, giving a pregnancy incidence rate of 6.32 pregnancies/100 person-years. The pregnancy incidence rates of women on efavirenz and those using nevirapine (another NNRTI) were both significantly higher than among women using protease inhibitors, among whom no pregnancies were identified. There was also a statistically significant difference in the pregnancy incidence rates of women using levonorgestrel (4.74) and etonogestrel implants (9.26). These trends extended to the analysis by specific combination of ART and implant, with pregnancy incidence rates ranging from 4.78–9.84 among women whose combination included a NNRTI.

These findings may negatively influence how implants are perceived in settings with high HIV prevalence and have implications for FP counseling for women living with HIV. Women on non-nucleoside reverse transcriptase inhibitors need information in simple yet accurate language about the drug interaction and the possibility of method failure to allow them to make informed decisions about their contraceptive method. Despite the challenge of developing service delivery recommendations, the much higher incidence of pregnancy among women using short-acting methods due to discontinuation makes it premature to systematically discourage women on ART from adopting implants. Holistic care that addresses both the FP and HIV care of clients may be required to ensure that health care workers identify, counsel on, and address the potential for drug interaction in relation to clients' reproductive intentions and FP needs.

debate around its use among women of reproductive age. Until that is resolved, it can be assumed that women will remain on efavirenz and thus the global community will need clear answers and guidelines around this group's use of contraceptive implants.

Question 2: How have you/are you currently dealing with addressing these barriers/drivers?

Developing new counseling tools:

- MCSP developed prototype counseling tools, including mocking up a new version of the [FHI 360 screening tool for women who want to initiate implants](#), to add a question about ART use and prompt the provider to explain the results.
- USAID is also working with FHI 360 to update the [Medical Eligibility Criteria Quick Reference Chart](#) to include both ART and TB data. USAID will also look into the possibility of updating FHI 360's method-specific screening checklists.

Question 3: What innovative or potential solutions should we [the FP community/Implementers] be exploring?

There is need for a prospective study that looks deeper at interactions given the conflicting evidence about which implants interact with which NNRTIs and to what degree.

Further explore the emergence of dolutegravir as an opportunity for implant users: Concern about possible neural tube defects among women using dolutegravir at the time of conception have led to some countries to recommend against its use, particularly among women of reproductive age. Though women who are on implants should be able to use dolutegravir safely because they are protected from pregnancy, development of clear recommendations for policymakers and guidelines for providers would be critical to ensure that women do not feel as though use of a LARC or PM would be a prerequisite to using dolutegravir.

Self-inject DMPA-SC or tying DMPA injection to ART resupply may help increase adherence, and therefore help increase injectables' effectiveness above the level for implant-ART users.

Explore possibility of promoting earlier replacement of the implant among women on NNRTIs (e.g., at 1 year) if that would help improve effectiveness. However, this may reduce the "set it and forget it" benefit of implants and would require further evidence on the timing of implant failures.

Look at lessons learned from fistula work: One lesson from the fistula work is that partnerships with local groups like religious organizations, first ladies, etc. can help spread information and ensure that all women are able to make informed choices.

Hotlines/Interactive Voice Response may also be an option to disseminate accurate information.

Consider ART choice being informed by contraceptive type: where possible, women may want to choose their ART based on the contraceptive method they want to use. (However, many women do not select their contraceptive option based on effectiveness; often, their choice is more related to peer recommendation, side effects, discreteness, etc.)

Roundtable 7: Equipping the workforce to meet the needs of implant users

by Emma Clark, Director of Maternal, Newborn and Child Health, HRH2030, and Neeta Bhatnagar, Senior Technical Advisor, MCSP

The evolving landscape of implants has made implants more popular, accessible and usable but also expanded the training needs of the workforce, who must keep up with increased demand, new clinical guidelines and new/updated types of implants. This topic engaged roundtable participants in a discussion of barriers and potential solutions for ensuring that the health workforce is equipped to provide quality implant services through the entire implant cycle, including pre-placement counseling, insertion, side-effect management and removal. Sub-topics included expanded use of evidence-based training methods such as simulations, revision

of training curricula with updated clinical guidance, incorporating the private sector into implant capacity-building and enhancing participation from frontline cadres in implant-related planning.

Question 1: What are the drivers of this issue, and why are we seeing it as a barrier?

Barriers to expanding the number of providers: Often country governments cannot pay salaries for all existing public providers, let alone hire enough additional staff to meet demand. Unemployed providers may go into private practice as they wait for government employment, though they often lack the capital to set up a full practice capable of providing a range of contraceptive methods. Additionally, many government providers may be underperforming in their government jobs due to additional private practice work they do on the site to compensate for low/delayed/absent government salary.

Difficult for private providers to get certified to provide methods: Public system may make certification process more difficult for private providers because they feel threatened and/or that private providers lack accountability.

Insufficient training and follow-up: traditional, classroom-based training techniques have proven less effective and there is commonly insufficient post-training follow-up and supervision. Providers also do not get sufficient client practice during training and tend to lose skills without practice or supervision. Traditional, intermittent, outside supervision often doesn't happen.

Many methods and constantly changing guidelines can lead to provider biases: If providers are not confident in the medical eligibility criteria for implants or other new methods, they will direct clients toward methods they know.

Humanitarian context often is not considered: There is always a provider shortage in these settings. CARE is working on a 3-day LARC refresher training for this context but requires providers to have some previous background in FP.

Technology solutions are not always accessible: Although technology may help with self-directed training, it is not always available or feasible for providers. Offline options are needed.

Gender-based violence issues are often not addressed adequately in existing training materials or service delivery approaches.

Question 2: How have you/are you currently dealing with addressing these barriers/drivers?

Develop evidence-based capacity-building tools: Based on evidence for effective in-service training, MCSP developed a [LARC Learning Resource Package](#) to provide trainers, facilitators and program staff with a comprehensive resource for high-quality LARC services using a modular, facility-based approach for training, capacity-building and mentorship. These resources are available in English, French and Spanish.

Support quality improvement collaboratives: The University Research Co. improvement collaborative model enables small facilities to work together and have healthy competition.

Developed gender competency tools: HRH2030 has released [gender competencies](#), which can help with gender-based violence issues. But hard to do it all, so falls on providers to look for red flags.

Question 3: What innovative or potential solutions should we [the FP community/Implementers] be exploring?

Explore supporting unemployed providers to build a private practice that includes FP/implant services: Consider helping these providers access micro-loans so they can enter the market.

Help facilities become self-sufficient in training/supervision via on-the-job training models (e.g., MCSP's LARC LRP) to ensure all providers are trained and certified competent on a rolling basis and development of quality improvement collaboratives (e.g., University Research Co. improvement collaborative model) to ensure availability of high-quality services.

Explore feasibility of self-instructional training, which has worked in Malawi.

Use the Hub-and-Spoke Model that invests in equipping large facilities to support capacity-building and supervision of smaller facilities, rather than equipping and training staff at small facilities directly.

- Support providers in low-volume facilities for rotation in high-volume facilities and vice versa.

Roundtable 8: Product evolution and the role of client and provider product-specific preference

by **Megan Christofield, Technical Advisor, Jhpiego**

Over the past three decades, our implant products, their attributes and our evidence-based *interpretation* of their attributes has evolved (and continues to do so). Even for those entrenched in full-time FP work, there's been a lot to keep up with. Since 2012, we've incurred product renamings, changes to product effectiveness life, WHO medical eligibility criteria modifications, brand introductions and shortages and more. For health care providers responsible for understanding and relaying nuanced clinical guidance about implants and the clients who seek to understand their product choices, these evolutions can be even harder to follow and understand. We are in need of urgent solutions, so that amidst these evolutions, informed choice is upheld in its fullest sense – the core discussion topic for this roundtable.

Question 1: What are the drivers of this issue, and why are we seeing it as a barrier?

Many product changes in a short amount of time and changes are often not communicated well to the vast array of stakeholders. Unclear communication roles between those who make the changes (manufacturers and guideline-developing bodies like WHO) and those expected to implement the changes.

Achieving clarity on the extent of information necessary to share. How do we help prepare countries for a perceived inundation of information? Where does the line of “too much” information start? To what extent do clients seek implant brand-specific information and comparisons?

Challenging to update thousands of trainers/providers who were already trained. Countries often rely on existing, relatively slow, bureaucratic structures to get information to providers. However, in the HIV field, providers expect updates every 1-2 years to prevention and treatment guidelines, and learning/disseminating these changes is a norm in that community. The FP field does not have this same expectation.

FP providers lack materials to communicate differences about the implant products to use when meeting with clients, and the need for these materials is not well understood. Clients themselves are not necessarily distinguishing between implant method choices: “I have an implant” vs. “I have the Implanon implant” (though this varies across settings).

Health management information systems don't capture which implant products are being used so supply is decided in part by anecdotal evidence on demand and MOHs have little insight into patterns of use disaggregated by product, when assessing service statistics.

Implant product/brand preferences can affect uptake: Some clients prefer certain implant products and when their preferred product isn't available, would rather go home with another FP method altogether and wait for the implant of their choice to be available.

- For example, there is an Implanon NXT shortage in Kenya, but it is the strongly preferred method among clients. Some clients prefer to take injectables as a “filler method” instead of getting a different implant choice (Jadelle).
- How are these decisions informed? Would the client make the same choice if they knew when to expect their implant of choice to be stocked (might not be for long time), or better understood the differences between implant methods?

Gaps in global coordination of product evolution messaging: For example, WHO study showing 5-year effectiveness of Implanon was published in 2016, but there has been no official follow-up so far. In the HIV

space, programs are being prepared on new guidelines even before WHO publishes. But there doesn't seem to be the same sense of urgency in the FP world to stay on top of new guidance.

Question 2: How have you/are you currently dealing with addressing these barriers/drivers?

Continued work on improving counseling, including more, relevant information on brand differences where of interest. Counseling tools like the Balanced Counseling Strategy organize methods by effectiveness, so for implants combines the two and makes a distinction about their different length of effectiveness. Other approaches recognize client preference can be driven by other factors besides effectiveness, like bodily effects, interactions with other drugs, bleeding patterns, etc. PSI is conducting research on “counseling for choice,” to survey clients **before** they're counseled and see if the things they care about are being reflected in the method choice they walk away with.

Preparation for the anticipated results of the Evidence for Contraceptive Options and HIV Outcomes Study, including scenario planning. Information on the study is readily available at the [trial website](#), include frequently asked questions and additional resources. In this case, having the time available to plan for possible results affords stakeholders the ability to determine dissemination plans and more.

International convening's have supported various guidelines changes, for example when WHO's 2015 Medical Eligibility Criteria were updated to reflect new guidance for the use of implants among postpartum breastfeeding women, multiple large-scale dissemination opportunities were capitalized upon (e.g., the Chiang Mai global postpartum FP meeting, International Conference on Family Planning and other fora). The medical eligibility criteria were also well disseminated within countries with the support of local WHO office representatives who often stewarded this process.

Question 3: What innovative or potential solutions should we [the FP community/Implementers] be exploring?

Promote choice while using more generic terms to refer to the various implant products: Remove the brand name distinction and discuss only in terms of 1 and 2 rods so as to better show they are the same family of contraceptives.

- Highlight brand distinctions where necessary and honor client's interest or desires for certain brands over others.
- However, removing the marketing capacity for each brand comes with its own issues as marketing is useful to make method choices known (among other reasons).
- Also calling methods by a different name does not necessarily remove the client preference factor for one type of implant over the other (and this is not a problem in itself, except in cases of supply shortages).

Share tools and resources for helping MOHs, providers and clients to interpret new information that arises around contraceptive implants (e.g., method duration, drug-drug interactions, clinical insertion or removal guidance, etc.).

Identify social behavior change opportunities at the facility/service delivery level:

- What tools can be used and adapted to different contexts to ensure the service providers get the information and opportune times to communicate to their clients?
- How much are we interacting with clients who have limited time and have already made a selection out of various methods? Will clients want to sit through more information about different implant options, or changes to their product (e.g., if she starts using a method under the impression it will work for 3 years, then is updated to hear it will work for 5 years)?
- Clients themselves may be fatigued with all their options and may want the provider to suggest which implant to choose, to consider all the products features for them.
- How might we change the “norm” around frequency of product updates? Would providers ever welcome regular changes?

Use a human-centered design approach to identify better opportunities for product evolution – are the changes that are taking place the ones that clients and providers want? How can we make product updates worthwhile?

