Global Trends and Considerations in Contraceptive Implant Scale-Up

October 12, 2017

Megan Christofield, MPH
Technical Advisor, Family Planning

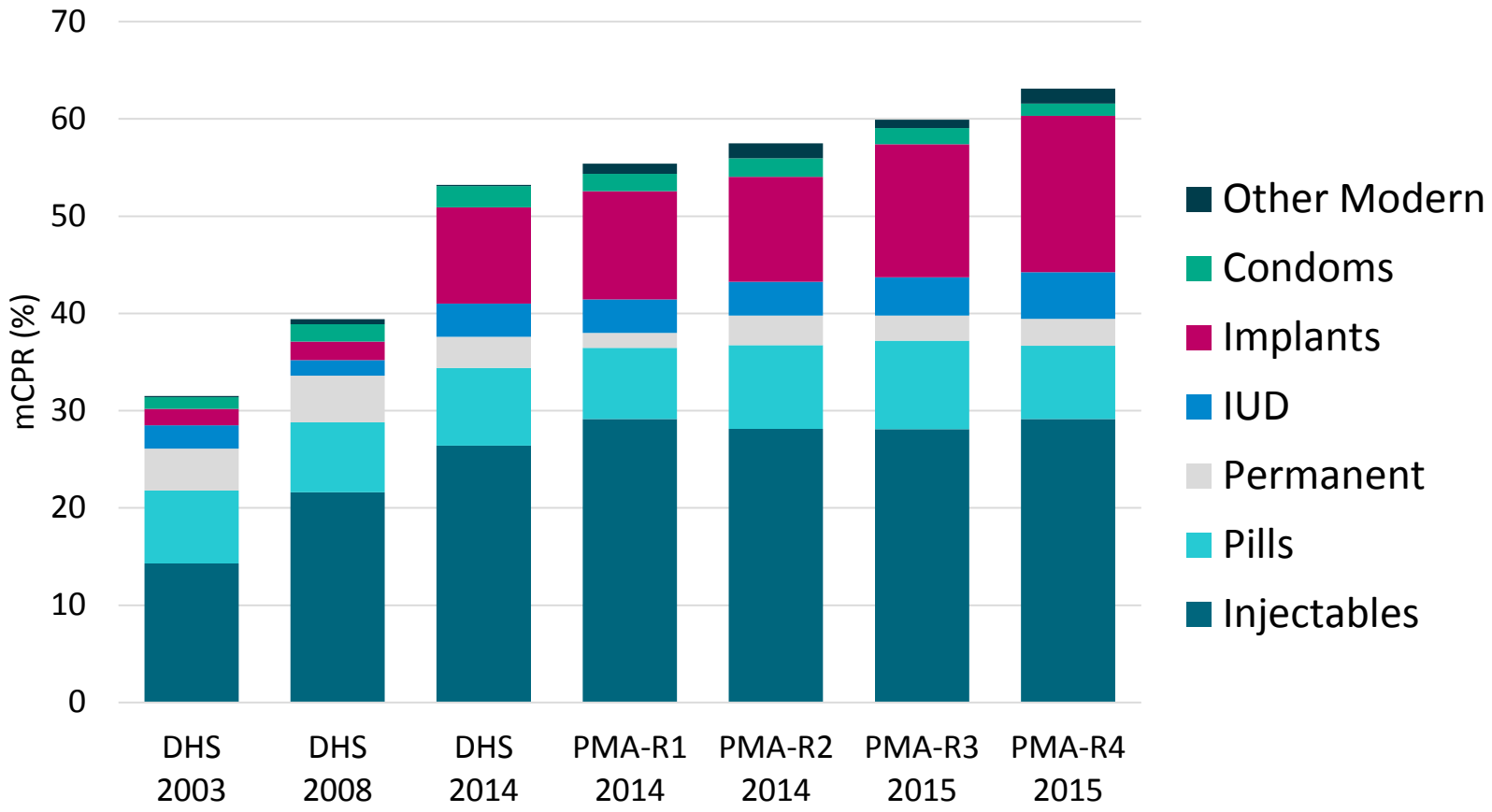
Jhpiego

jhpiego
Saving lives. Improving health. Transforming futures.

Contraceptive Implants are Accelerating Growth in Contraceptive Prevalence Worldwide

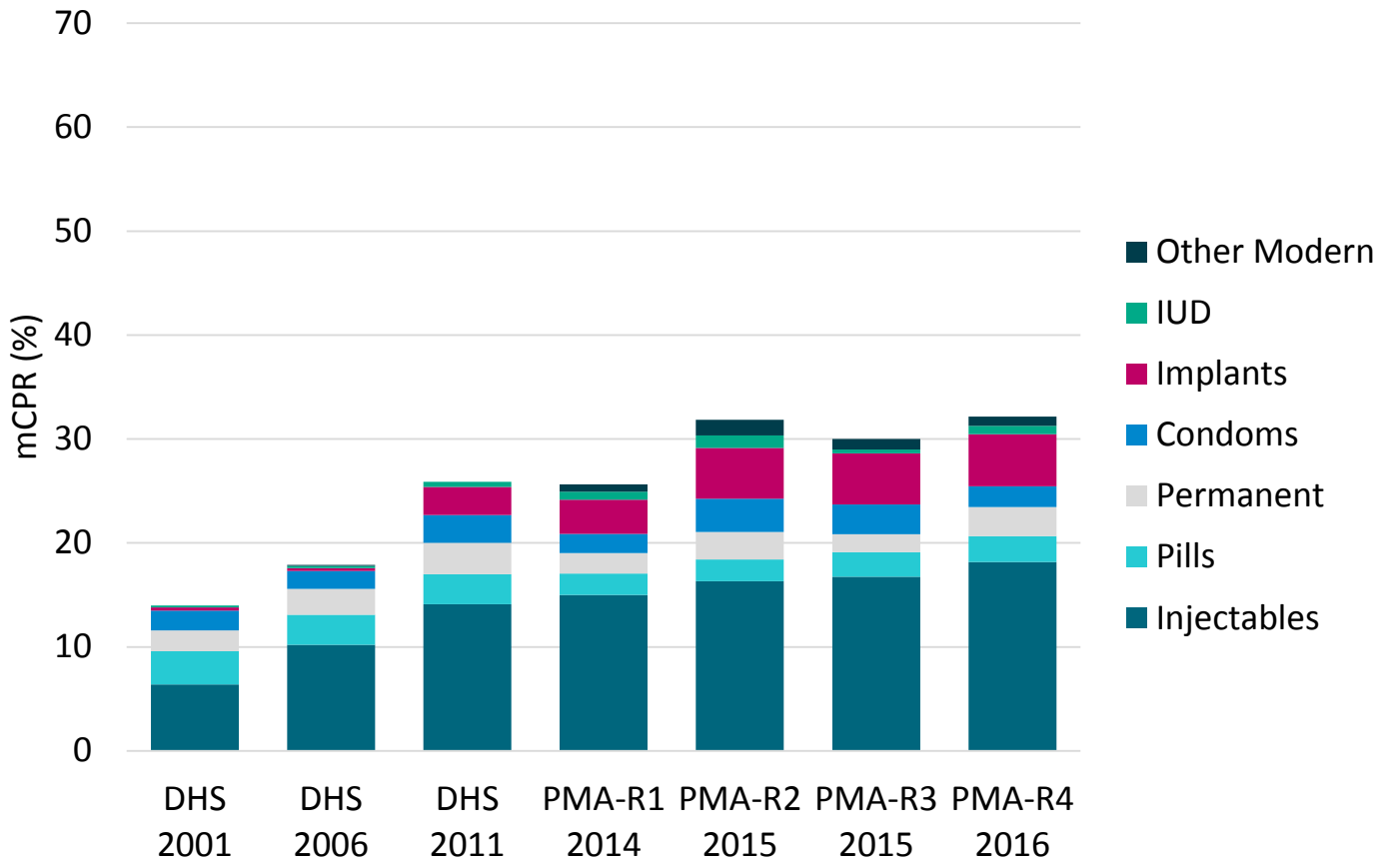
Kenya mCPR and Method Mix among Married Women, 2003–2015

Source: DHS and PMA2020



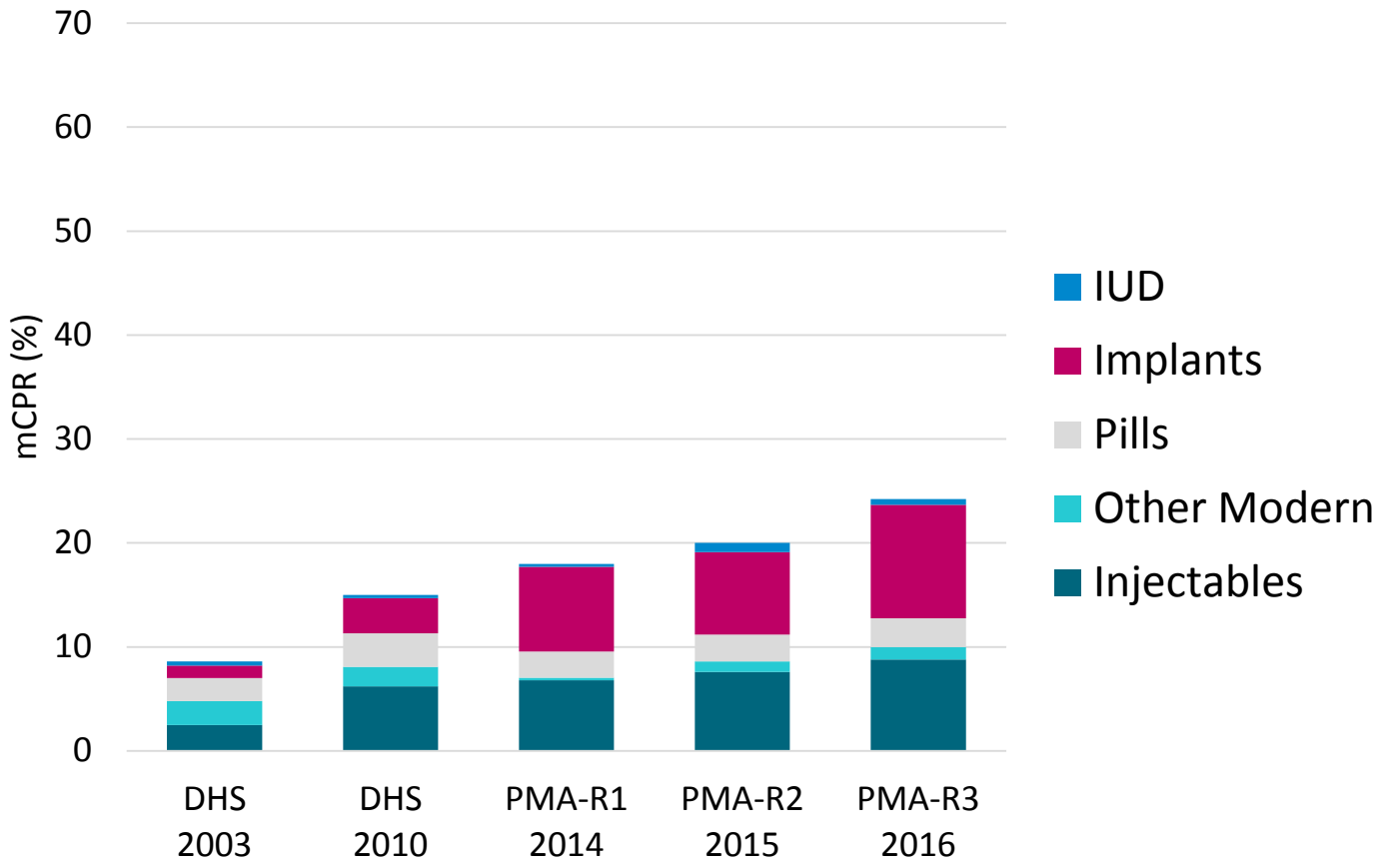
Uganda mCPR and Method Mix among Married Women, 2001–2016

Source: DHS and PMA2020



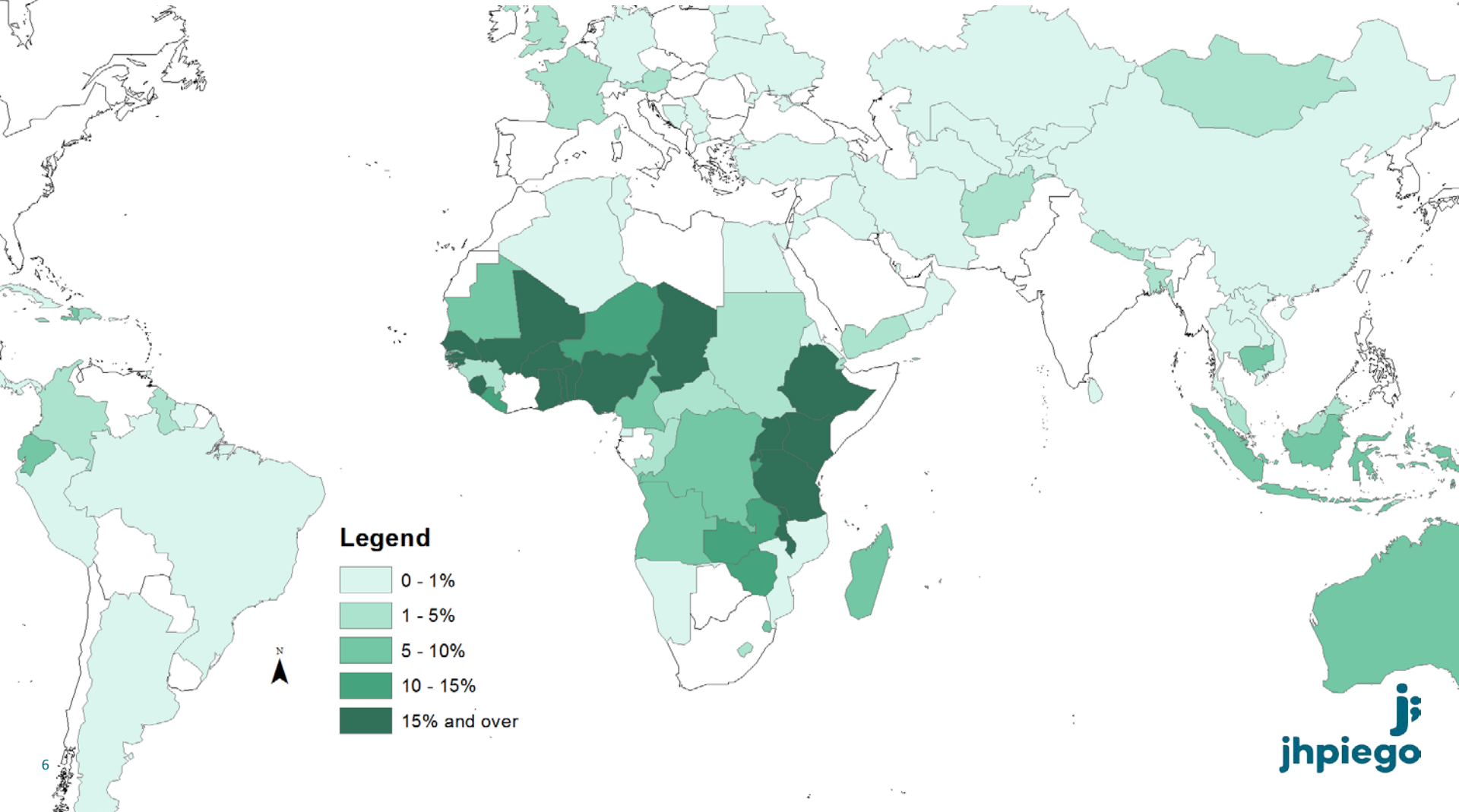
Burkina Faso mCPR and Method Mix among Married Women, 2003–2016

Source: DHS and PMA2020



Where do implants comprise larger proportions of overall contraceptive use?

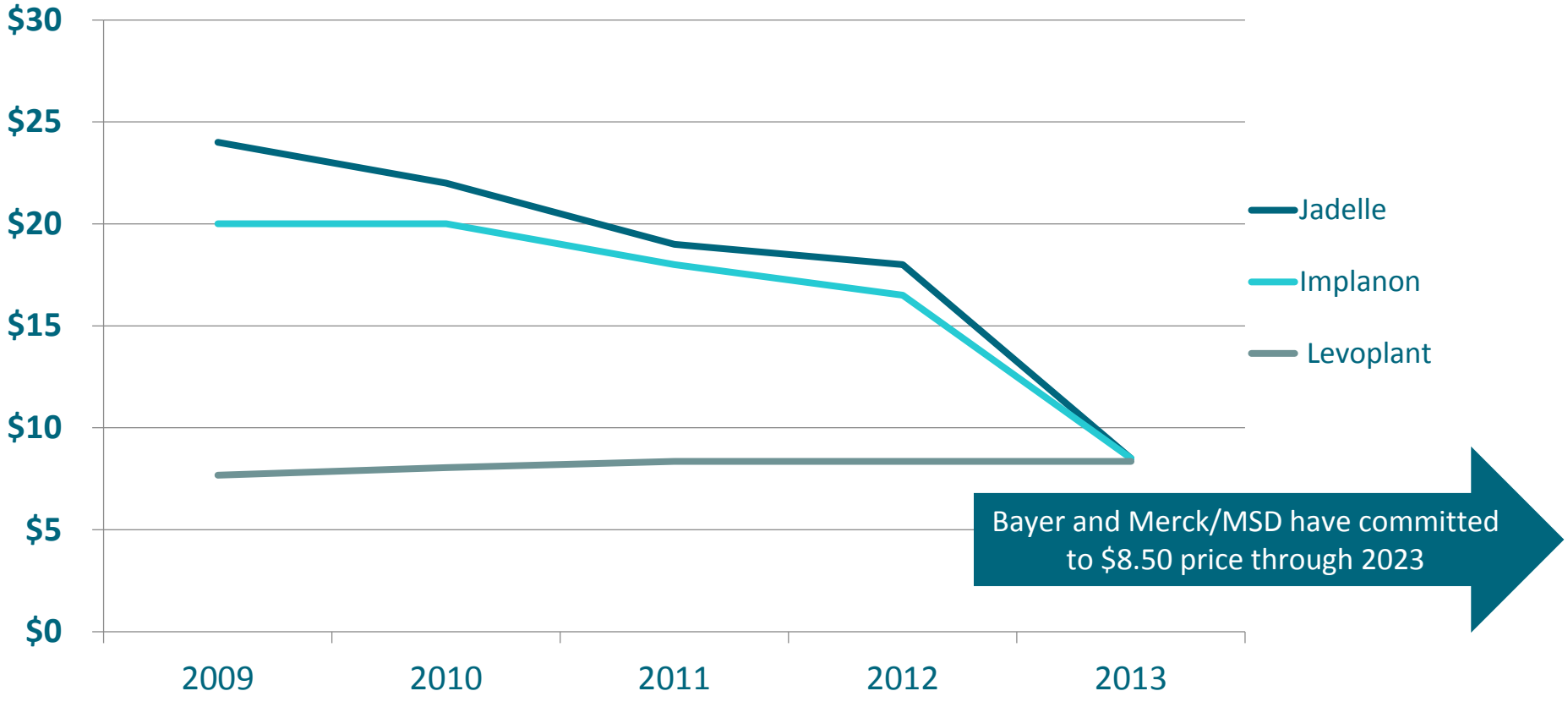
Source: UN Contraceptive Use, Demographic and Health Surveys



jhpiego

Contraceptive Implant Prices 2009-2013

Source: RHInterchange and RHSC Press Releases



Slide adapted from M. Steiner, FHI360

jhpiego

How do implant users compare to contraceptive users overall?

Source: PMA2020 Special Surveys in Burkina Faso, Ethiopia, and Kenya

They are on average more married, higher parity, and less educated

	Contraceptive Users Married	**Implant** Users Married	**Contraceptive** Users Parity 2+	**Implant** Users Parity 2+	**Contraceptive** Users w/No Education	**Implant** Users w/No Education
Burkina Faso	85%	90%	74%	80%	56%	64%
Ethiopia	9%	10%	75%	74%	42%	48%
Kenya	78%	89%	65%	72%	45%	53%

They receive their method from public health facilities

	Contraceptive Users Receiving Method from Public Facility	**Implant** Users Receiving Method from Public Facility
Burkina Faso	85%	90%
Ethiopia	9%	10%
Kenya	78%	89%

jhpiego

Special Considerations for Introducing and Scaling-up Contraceptive Implants

Lessons Learned from Implant Programming:

From Jhpiego's experience in the Accelerating Scale-up of Implants Project

- Develop implant introduction and scale-up plans with stakeholders
- National implant programming should factor-in product evolutions
- Consider the needs of implant users not only at initiation, but for follow-up care and removal as well
- Consider the provision of implants outside family planning wards (e.g. community provision, or in maternity settings for postpartum clients)
- Avail necessary equipment and consumables to insert and remove contraceptive implants
- Work with communities and clients to dispel myths and misconceptions

jhpiego

Product Evolution

Implanon NXT

Merck/MSD has developed an improved device for inserting Implanon, and countries around the world are transitioning from the previous version to the newer Implanon NXT.

K4Health Resource: ***Implanon NXT: On-the-Job Training Course for Current Implant Providers***

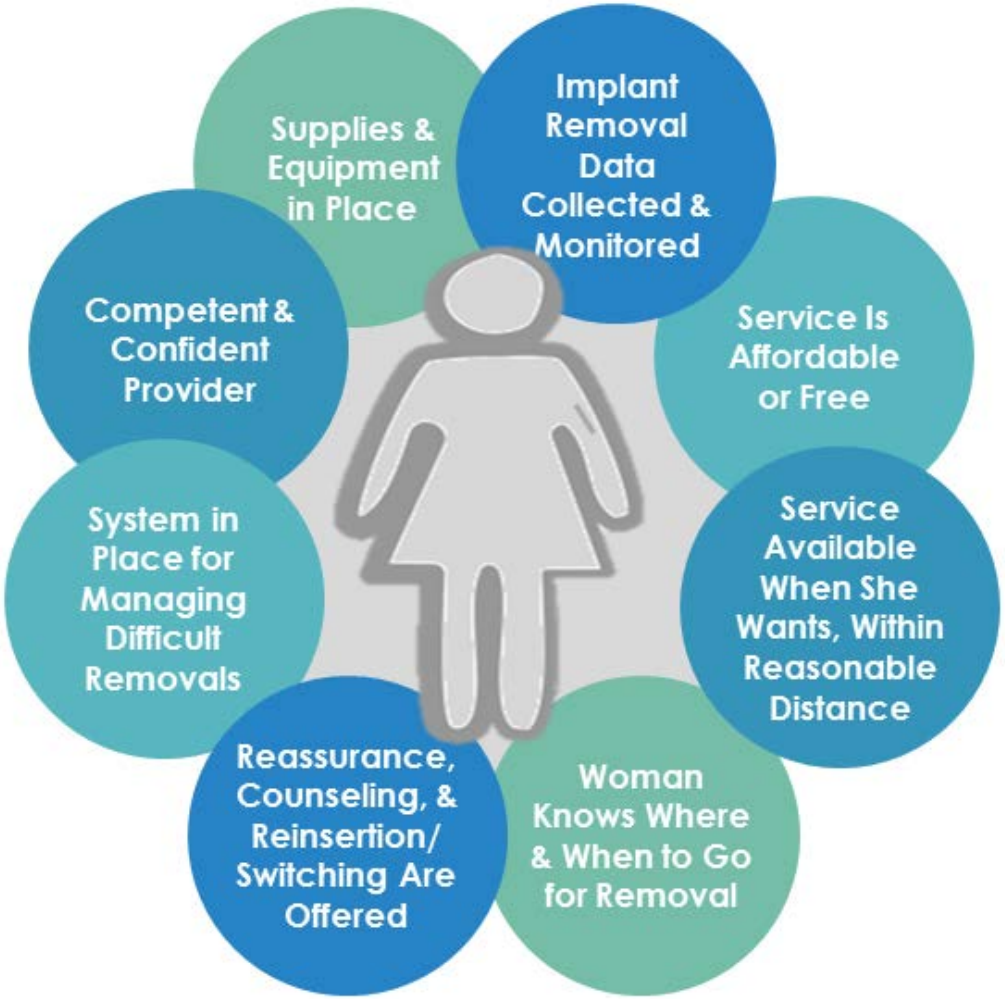
Levoplant

In June 2017, Sino-implant (II) received WHO pre-qualification and updated the global brand name to Levoplant. Now pre-qualified, Levoplant can be procured by most donors and procurers.

K4Health Resource: ***Levoplant/Sino-implant (II) Reference Guide for Healthcare Providers & Sino-implant (II)/Levoplant Overview***

jhpiego

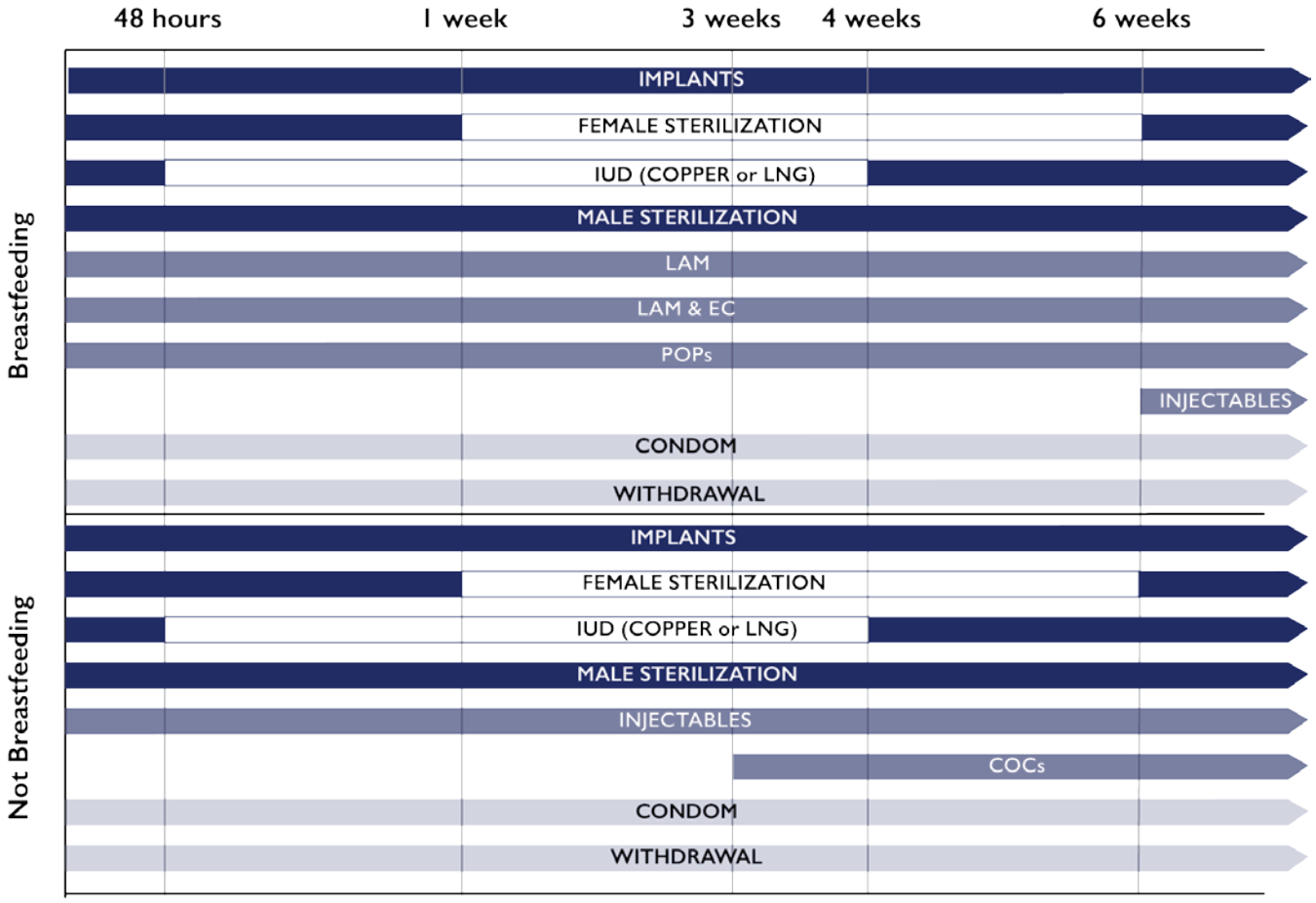
Conditions for Quality Implant Removal Services



K4Health Resource: *Implant Removal Resources*

jhpiego

Availing Implants Immediately After Delivery



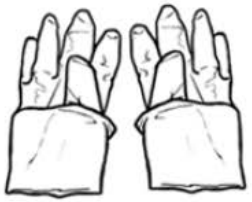
COCs should not be initiated by breastfeeding women until at least 6 months postpartum. In addition, fertility awareness methods, such as Standard Days Method (CycleBeads), require women to chart 4 regular menstrual cycles before beginning this method, so timing varies from one woman to the next.

jhpiego

Equipment and Consumable Needs for Implants:

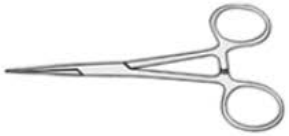
Insertion and Removal

Antiseptic solution with bowl



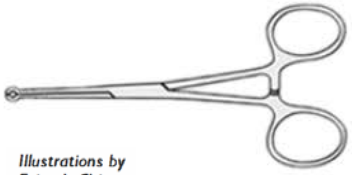
Sterile gloves

Sterile drape



Sharp dissecting forceps

Local anesthetic (1% concentration with or without epinephrine)



2.2 mm ringed forceps *(modified NSV clamp)*

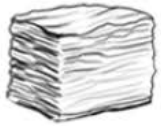
Illustrations by Erica L. Chin

Scalpel

Syringe

Curved mosquito forceps

Straight mosquito forceps



Sterile gauze

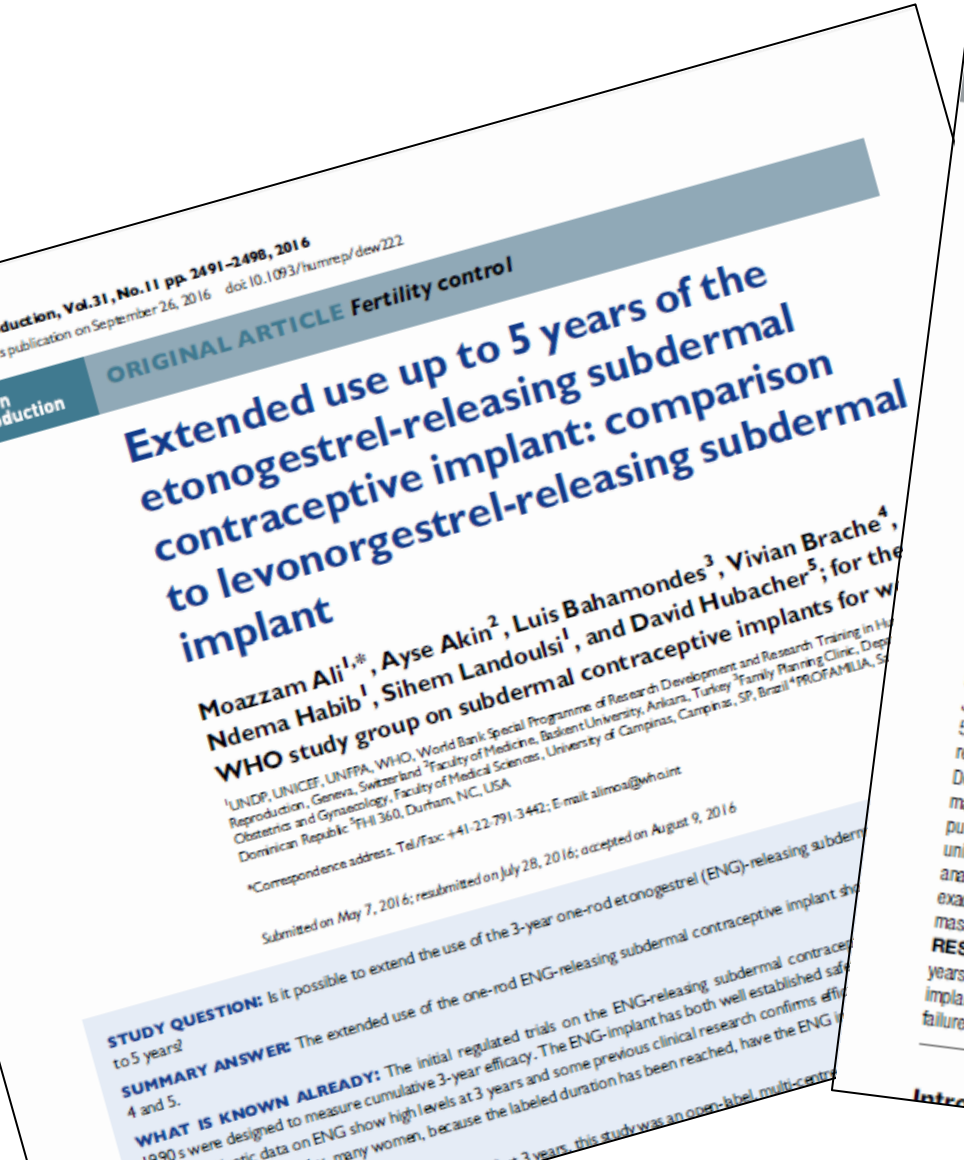
Steri-Strips or sterile skin closure

Pressure bandage

jhpiego

On the Horizon

Possible Duration Changes?



duction, Vol.31, No.11 pp. 2491–2498, 2016
s publication on September 26, 2016 doi:10.1093/humrep/dew222

n
duction

ORIGINAL ARTICLE Fertility control

Extended use up to 5 years of the etonogestrel-releasing subdermal contraceptive implant: comparison to levonorgestrel-releasing subdermal implant

Moazzam Ali[1,*], Ayse Akin[2], Luis Bahamondes[3], Vivian Brache[4], Ndema Habib[1], Sihem Landoulsi[1], and David Hubacher[5]; for the WHO study group on subdermal contraceptive implants for w

[1]UNDP, UNICEF, UNFPA, WHO, World Bank Special Programme of Research Development and Research Training in Hu Reproduction, Geneva, Switzerland [2]Faculty of Medicine, Baskent University, Ankara, Turkey [3]Family Planning Clinic, Depa Obstetrics and Gynaecology, Faculty of Medical Sciences, University of Campinas, Campinas, SP, Brazil [4]PROFAMILIA, S Dominican Republic [5]FHI 360, Durham, NC, USA

*Correspondence address. Tel/Fax: +41-22-791-3442; E-mail: alimos@who.int

Submitted on May 7, 2016; resubmitted on July 28, 2016; accepted on August 9, 2016

STUDY QUESTION: Is it possible to extend the use of the 3-year one-rod etonogestrel (ENG)-releasing subderm to 5 years?

SUMMARY ANSWER: The extended use of the one-rod ENG-releasing subdermal contraceptive implant sh 4 and 5.

WHAT IS KNOWN ALREADY: The initial regulated trials on the ENG-releasing subdermal contracep 1990 s were designed to measure cumulative 3-year efficacy. The ENG-implant has both well established safe tric data on ENG show high levels at 3 years and some previous clinical research confirms effi many women, because the labeled duration has been reached, have the ENG i

3 years, this study was an open-label, multi-centre

Original Research

GYNECOLOGY

Prolonged use of the etonogestrel implant and levonorgestrel intrauterine device: 2 years beyond Food and Drug Administration—approved duration

Colleen McNicholas, DO, MSCI; Erin Swor, MD; Leping Wan, MPH; Jeffrey F. Peipert, MD, PhD

BACKGROUND: The subdermal contraceptive implant and the 52-mg levonorgestrel intrauterine device are currently Food and Drug Administration approved for 3 and 5 years of use, respectively. Limited available data suggested both of these methods are effective beyond that time. Demonstration of prolonged effectiveness will improve the cost-effectiveness of the device, and potentially patient continuation and satisfaction.

OBJECTIVE: We sought to evaluate the effectiveness of the contraceptive implant and the 52-mg hormonal intrauterine device in women using the method for 2 years beyond the current Food and Drug Administration—approved duration.

STUDY DESIGN: We initiated this ongoing prospective cohort study in January 2012. We are enrolling women using the contraceptive implant or 52-mg levonorgestrel intrauterine device for a minimum of 3 and 5 years, respectively (started intrauterine device in ≥2007 or implant in ≥2009). Demographic and reproductive health histories, as well as objective body mass index, were collected. Implant users were offered periodic venipuncture for analysis of serum etonogestrel levels. The primary outcome, unintended pregnancy rate, was calculated per 100 woman-years. We analyzed baseline demographic characteristics using χ^2 test and Fisher exact test, and compared serum etonogestrel levels stratified by body mass index using the Kruskal-Wallis test.

RESULTS: Implant users ($n = 291$) have contributed 444.0 woman-years of follow-up. There have been no documented pregnancies in implant users during the 2 years of postexpiration follow-up. Calculated failure rates in the fourth and fifth years for the implant are calculated as 0 (1-sided 97.5% confidence interval, 0—1.48) per 100 years and 0 (1-sided 97.5% confidence interval, woman-years at 5 years. Among 496 levonorgestrel users, 696.9 woman-years of follow-up have been pregnancies have been reported. The failure rate in the the levonorgestrel intrauterine device is calculated as dence interval, 0.04—1.42) per 100 woman-years; failur seventh year is 0.43 (95% confidence interval, 0.08— woman-years. Among implant users with serum etonoges median etonogestrel level was 207.7 pg/mL (range 63.8-8 the time of method expiration, 166.1 pg/mL (range 67.9 25 mL) at the end of the fourth year, and 153.0 pg/mL (range 7 by body mass index at each time point and a statistical d noted at the end of 4 years of use with overweight wome highest serum etonogestrel (195.9; range 25.0-450.5 p compared to normal (178.9; range 87.0-463.7 pg/mL) and ob range 66.0-470.5 pg/mL) women ($P = .04$).

CONCLUSION: This study indicates that the contraceptive 52-mg hormonal intrauterine device continue to be highly effe least 2 additional years of use. Serum etonogestrel evaluatio strates median levels remain above the ovulation threshold of 90 women in all body mass index classes.

Key words: effectiveness, Food and Drug Administration—app duration, implant, intrauterine device, prolonged use

Introduction

Thank you

jhpiego