Melanie Lopez: Thank you so much, Jeff. Would it be possible to provide resources or references for return to fertility please?

Response from Jeff: Sure - there was a good review of this issue by Chelsea Polis at Guttmacher Institute (see link below)

https://www.sciencedirect.com/science/article/pii/S1521693414001035

John Townsend: Are injectables at higher risk of stockout with procurement issues associated with unreliable international development assistance?

Response from Jen: *Not according to the latest FP 2020 progress report: http://progress.familyplanning2020.org/en/measurement-section/contraceptive-stock-outs-and-availability-indicators-10-11. "The data show that stock-outs vary considerably both by level and by type of method...The levels of of stock-outs range widely, from lows of 0% for condoms in some countries, to the other extreme of 94% of facilities in one country experiencing implant stock-outs. In general, stock-outs are lower for the most commonly used methods in countries (highlighted in Figure 14). In East Africa, for example, where injections are the most common method, stock-out levels are a relatively low 9.8%, with only one country—Sudan—experiencing high double-digit stock-outs in 2017."*

Sanchika Gupta: can you please elaborate on HIV risk and Injectables usage?

Presenter response: Based on WHO 2017 MEC Guidance, DMPA is a category 2 for women at high risk for HIV because of increasing concern around potential risk of HIV acquisition among women at high risk of HIV using DMPA-IM/SC and NET-EN, but uncertainty still remains about the risk - the evidence is inconclusive. MEC indicates that the benefit of using the methods outweigh proven or theoretical risk. Women at high risk of HIV should not be denied use of progestin-only injectables (POIs) if that's the method they choose. Women at high risk of HIV (or all women choosing POIs if HIV risk cannot be assessed) should be counseled on the potential HIV acquisition and advised on HIV prevention strategies including condom use, initiation of HIV+ partner on treatment and PrEP if available in the country. For more information, please refer to WHO 2017 updated Guidance on HC-HIV and USAID 2017 updated HC-HIV brief
http://www.who.int/reproductivehealth/publications/family_planning/HC-and-HIV-2017/en/

https://www.usaid.gov/sites/default/files/documents/1864/Hormonal-contraceptives-brief-508.pdf

Response from Jen: *The primary outcomes for the self-injection feasibility studies described in the webinar were % of women who demonstrate injection competence at 3 months and % of women who reinject on time, within 1 week (+/-) of their reinjection date--rather than contraceptive effectiveness (which is well established for this method). More info on the primary outcomes is available here: https://www.path.org/publications/files/RH_Self_injection_Feasibility_Acceptability_fs.pdf.*

No pregnancies occurred among self-injectors during the course of the Senegal and Uganda feasibility studies.

KP: Do we have data on effectiveness from the senegal and uganda studies?

Response from Fred: Yes, we do. In Uganda together with PATH, we conducted a study to assess the effectiveness of Sayana® Press as compared to DMPA IM in terms of women's continuation rates, when administered by community health workers already providing both types of contraceptives. A prospective study followed 609 DMPA IM and 615 DMPA SC users over 9 months. Continuation rates were higher for DMPA SC, but not significant. Continuation rates higher than national average due to CBFP. Reasons for discontinuation: Lateness for injection, side effects, lack of sexual relations.

James White: In terms of self-injection there has been some discussion about the issue of sharps disposal. Are there further details on how the Senegal and Uganda studies/programmes addressed this?

Response from Jen: *In the feasibility/acceptability studies described in the webinar in Senegal and Uganda, women were advised to place the spent devices in a puncture proof container with a lid (such as a wide-mouth water bottle or petroleum jelly jar) until they could dispose of them. For disposal, they were advised to either return the spent devices to the clinic or to discard the devices in a pit latrine, retaining the container. Many women, especially in Uganda, discarded the devices in the latrine. After the study in Uganda, when PATH, the MOH, and other partners were working to design an initial self-injection program to be integrated in routine service delivery, the MOH clarified that ongoing latrine disposal would not be a feasible option. In the current program, women are now given (rather than advised to use) a low-cost puncture proof container (in Uganda, petroleum jelly jar) along with their other self-injection supplies. The impact of that container on overall program costs appears to be pretty negligible. Women are then advised to store used units in the containers until they are able to return the units to a health worker or clinic for safe disposal, at the woman's convenience (e.g., for a resupply visit, a visit to a clinic for another health issue or family member). An evaluation is just beginning in Uganda that will gather information on how that system works:*
https://www.path.org/publications/files/RH_Uganda_SI_best_practices_br.pdf.

Adrienne Allison:

- **Why do we continue to collect data on married women and unmarried women - rather than ALL women only?**
- (Presenter answer: There is data on all women in the DHS and the UN Pop Division databases and reports.)
- **Hi Jeff! So we can discard the "married women" category? And use only "all women" in our programs now? Is that one step too far?**
- (Presenter answer: I don't think so - we should show both)

Tembi Mugore: Fred - are the VHTs trained to initiate or re-inject?

Response from Fred: In Uganda, the VHTs are trained to initiate the first injection and to re-inject as per current policy following their 7-10-day training that includes a practicum and attachment for supervision at a facility until the supervising midwife or nurse clears them to do community distribution.

Elizabeth Creel: Question for Fred: Could you talk more about the quality improvement component of the work in Uganda?

Response from Fred: Collaborative Quality Improvement can be successfully applied and scaled up in CBFP. For the case of Uganda CBFP and CBA2I was most successful in the districts where we implemented QI. The teams including VHTs, clients, midwives and district health teams start by developing common improvement aim and objectives with indicators that are included in your charter. Usually this is based on findings from a baseline assessment of health system and service delivery. Then they go through the following steps:

- A change package is drafted, which is a combination of explicit, evidence-based standards and best practices for the organization of service delivery. For example, one change implemented by the team is direct observation by midwives of VHTs offering FP counseling including counseling on LARC side effects) to clients during the VHTs' resupply visits.
- Then there is implementation of the "change package" and tracking of indicators.
- There is a coaching system for supporting the teams in implementing changes and measuring its effects. Select members of QI teams (VHT, midwives and in-charges) are trained to be coaches and also receive project support.
- Learning sessions are conducted approximately every six months bringing teams together so they can share their experiences, supported by data from monitoring, and learn about and plan how to replicate best practices. The first learning session the change package is "finalized" based on teams experiences. Also as we scaled-up QI within districts and to new districts learning sessions were essential. VHT, midwives and in-charges learn best from each other.

https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/uganda_qi_brief_final_508.pdf

https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/8_5x11_uganda_qi_brief_2_v1_508.pdf

Awa D. Dieng: Question for fred: Why are injectables more popular than LARCS in Uganda?

Response from Fred: The reasons are varied, but are mainly related to the following:

1. Opposition to use by spouses(men) which is averages at about 15% in various PMA 2020 rounds and is fourth main reason for non use: Many women chose the method because it can't be detected by their spouses unlike implants.
2. Ease of access is also a critical factor especially since in over 28 districts there is Community Based Distribution by VHTs/CHWs unlike the LARCS.
3. Method related issues, such as , management of side effects are also critical, since CHWs can be accessed easily fort hat purpose, yet with Implants for instance ,they mostly provided through one time outreaches. Many women have wanted to remove for instance implants and can't be helped because providers at facilities where it inserted can't do it.
4. Stock/availability of the method at service delivery points is also critical. At the most recent PMA Round, 17, it showed that DMPA IM was stock at almost 90%,DMPA SC at 20% compared to Implants at 12.6% and IUDs at 9.5%.

5. Cost is also a factor for peri-urban and urban dwellers who may need to procure, as the cost of IUDs and Implants(purchase and insertion) is much higher than that of DMPA Injectable's Provision.

I must say though that the picture might begin to change if it hasn't already with the National wide trainings of providers on Implanon NXT and ensuring it's availability through multi-CSO scale up effort led by PATH. APC/360 supported integrated DMPA SC and Implanon NXT trainings in 7 districts.

Raffaela Schiavon: Do you have general (world) data showing : 1) increased overall CPR and NOT only shifting among methods?

Response from Jen: Some helpful data from FP 2020 here: http://progress.familyplanning2020.org/en/measurement-section/fp2020-and-the-pace-of-progress-core-indicators-1-2-additional-users-and-mcpr

Evans Majune: DMPA SC availability is it standard across the health facilities or only in research settings

Response from Fred: In Uganda it's available even outside research settings and has been included on the Essential Medicines List of the Ministry of Health such that it can be distributed routinely by the National Medical Stores just like DMPA IM.

Response from Jen: *DMPA-SC/Sayana Press is widely available across several levels of the health system through routine delivery in an increasing number of countries, including Burkina Faso, Niger, Nigeria, Senegal, and Uganda. Pilot introductions are underway and wider rollout is being planned in several more, including DRC, Kenya, Madagascar, Myanmar, and Zambia, to name a few. The product has regulatory approval in several FP 2020 countries as well as the UK and Europe.*

To date, self-injection is available outside of a research setting on a more limited basis than DMPA-SC injections from health workers. Self-injection is being offered outside of a research setting in Uganda; Senegal is finalizing a plan to take self-injection to national scale; and Malawi is looking at policies and programs needed to offer self-injection routinely. Many other countries already delivering DMPA-SC in their systems are considering self-injection in their settings as well, as the evidence continues to build that the practice is highly feasible and acceptable and can increase contraceptive continuation.

Shannon Pryor: Question to Fred: 1: would you share how you were able to achieve refresher trainings every 3-6 months? This has been a challenge in other settings. 2) What was the method mix in the community versus health facilities in the program districts?

Response from Fred: The refresher trainings are part of training plan from the start, with logistical requirements planned out with the District. In our case, we support the districts to conduct the first refresher training and do not leave it to them to do it as part of CME or OJT so that we are sure it happens and is able to address the emerging issues that VHTs /CHWs or their facility supervisors might have from the first six months of providing the injectables at community level

Laila Akhlaghi: recommendations on recapping on SI?

Response from Jen: *We have been advised by WHO and other leaders that recapping is not recommended, as contradictory public health messaging on recapping among different injectable products could create confusion.*

Leigh Wynne: I wanted to mention that the Malawi study also demonstrated that community health workers can safely train women to self-inject DMPA-SC.

Response from Jen: *Yes, thanks Leigh, we are excited to see those results published! The study by FHI 360 and the College of Medicine in Malawi shows really encouraging results in terms of CHWs training women to self-inject DMPA-SC, especially given the high continuation rates in the study.*