

An Illustrative Communication Strategy for Contraceptive Implants

Step 1: Analyze the Situation

Health and Commodity Context

**The majority of the information in this section is a global-level analysis for purposes of illustration. The country-specific situation analysis should be focused on the local context.*

Health Context

Women of reproductive age in developing countries have an increased risk of unintended pregnancy. Each year there are an estimated 75-79 million unintended pregnancies worldwide, 46 million of which end in induced abortion, and about 20 million of which are considered unsafe abortions in non-medical settings (Singh et. al., 2009). There is an estimated 215 million women with an unmet need for contraception (Guttmacher Institute, 2008). Although globally contraceptive use has steadily increased in the past three decades, use in some of the poorest areas of the world, such as sub-Saharan Africa, remains low. It is estimated that less than one-fifth of couples in sub-Saharan Africa are using contraception (UN, 2011). There is global consensus that contraception has direct and indirect influences on a number of health outcomes including maternal, neonatal and infant health and community health (Kerber, 2007; Ronsman & Graham, 2007).

Globally, it is also recognized that expanding method choice leads to higher levels of contraceptive use. When women and couples can access a wide range of family planning methods, they are more likely to find a method they like and can use over a period of time, to switch methods when life circumstances change, and to meet their contraceptive intentions. Even among those who currently use contraception, many who would like to have no more children have no access to long-acting and permanent methods. Also, for women who live far from health services or who are not able to visit health clinics easily, long acting reversible contraception (LARC), including implants and intrauterine devices (IUDs), may be a preferred and more convenient option. Youth, in particular, must overcome significant barriers to

access contraception that meets their needs and vulnerability to unprotected sex.

Although increased use of contraceptive implants could substantially reduce the numbers of unintended pregnancies, abortions, and maternal deaths, worldwide use of implants is low. Among married women between the ages of 15 and 49 around the globe, 53 percent use a modern method of contraception but less than one percent use implants.

Commodity Context

Hormonal implants consist of small, thin, flexible plastic rods, each about the size of a matchstick, which release a progestin hormone into the body. They are safe, highly effective, and quickly reversible long-acting progestin-only contraceptives that require little attention after insertion. Clients are satisfied with them because they are convenient to use, long-lasting, and highly effective. Implants, which are inserted under the skin of a woman's upper arm, prevent pregnancy for an extended period after a single administration. No regular action by the user and no routine clinical follow-up are required.

Implants are available from three main manufacturers - Bayer Pharma AG (Germany), Merck/MSD Inc (USA), and Shanghai Dahua Pharmaceuticals Co., Ltd (China) - with a cost ranging from \$8.00 to \$18.00 per unit. Two are currently prequalified by the World Health Organization (WHO). The most common types include:

- **Jadelle** (WHO prequalified): two rods each containing 75 mg of levonorgestrel, effective for five years, with recent price-reduction agreement with donor volume guarantees;
- **Sino-implant (II)**(not yet pre-qualified by WHO and is currently marketed under various trade names including Zarin, Femplant and Trust): two rods each containing 75 mg of levonorgestrel, effective for at least four years;
- **Implanon** (WHO prequalified) and **Nexplanon**: both with one rod containing 68 mg of etonogestrel, effective for three years. Nexplanon is radio-opaque, allowing x-ray detection if the rod is difficult to locate due to deep insertion, and also has an improved trocar. Recent price-reduction agreement reached with donor volume guarantees

Norplant (six rods each containing 36 mg of levonorgestrel, effective for five to seven years) was discontinued in 2008.

Implants are included in the WHO Essential Medicines list (2011) and specified as the two-rod levonorgestrel-releasing implant, each rod containing 75 mg of levonorgestrel (150 mg total). One rod implants are still not included in the WHO list. In addition, service delivery policies and protocols, are in place in many countries, which support implant provision, including both two-rod and one-rod presentations. Given the different implant products that are available in diverse markets, technical requirements for competent training in counseling, insertion and removal of each product as well as related procurement processes is required to ensure that these commodities are provided appropriately. In some settings, policies allow task-shifting, which permit lower cadres of health care providers (i.e. providers other than doctors such as nurses or midwives) to insert and/or remove implants.

Jadelle is prequalified by the World Health Organization and distributed commercially by Bayer Pharma. Implanon is prequalified by the World Health Organization and is distributed commercially by Merck/MSD. Sino-implant (II) is not prequalified yet by the World Health Organization. It is marketed under a variety of names by different distributors in countries where it is registered: as Zarin by Pharm Access Africa, Ltd., as TRUST by DKT Ethiopia, and as Femplant by Marie Stopes International.

Given the up-front cost of implants, their high level of effectiveness and their longer duration of use, both public and private sector financing strategies are used. In the public sector, subsidies are provided to clients who are unable to pay, either through lower prices to users or through alternative financing arrangements such as vouchers. In the private sector, users in the higher wealth segments usually pay full price for this product, or modest subsidies are provided through public-private partnerships such as franchises or social marketing schemes.

Implants are safe for use by most women, including lactating mothers, women living with HIV, women who smoke cigarettes, women over the age of 35, women who have just had an abortion, women with diabetes, women at risk for cardiovascular disease (including those with

high blood pressure), and adolescents. Women on antiretroviral therapy should discuss the use of implants with their doctor as the possibility of an interaction exists which might lead to somewhat reduced implant effectiveness. Implants can be initiated immediately after childbirth if a woman is not breastfeeding, and six weeks postpartum if a woman is partially or fully breastfeeding.

Stock-outs of contraceptive commodities and other needed equipment, instruments, and supplies for family planning provision are commonly reported in service programs. The unavailability of either the method or other needed instruments and supplies means that implants services are also unavailable. Thus, attention to logistics is critical, and must include instruments, expendable medical supplies as well as the contraceptive implant itself. One challenge for supply-chain management is that implants are often combined in information systems and on procurement lists.

(Source: Quoted from *Key Findings: Contraceptive Commodities for Women's Health*, 2012).

Audience and Communication Analysis

A recent global synthesis of existing demand creation evidence for implants found 15 peer-reviewed articles, grey literature and reports from 2003-2013 that specifically examined demand generation for contraceptive implants. The evidence was documented primarily from countries in sub-Saharan Africa (Health Communication Capacity Collaborative, 2013).

The literature identified three key determinants of implant demand and utilization:

Knowledge, especially of benefits: The long duration of implants effectiveness emerged as the most common perceived advantage of implants. Additional benefits identified included the ability to use when breastfeeding, comfort, and ease of insertion and removal (The RESPOND Project, 2010; 2012; Hubacher et al., 2011). Implants were also found to overcome a significant barrier among women in Ethiopia seeking family planning services but hesitant to expose their bodies because it does not require pelvic examination (Pathfinder-Ethiopia, 2008).

Fear of side effects: Fear of side effects was a common barrier across different country contexts. In Ethiopia, married women in urban areas cited concern about side effects as a reason for not long-acting methods, including implants and IUDs (Alemayehu, Belachew & Tilahun, 2012). In Nigeria, sexually active adolescent students did not use long-acting methods (including implants, IUDs and injectables) because they believed it could interrupt pregnancy or cause infertility and because of fear of side effects and religious and cultural barriers (Eke & Alabi-Isama, 2011). Fear of side effects was also found in Bangladesh, especially concerning changes in menstrual patterns (The RESPOND Project, 2012). In Tanzania, research shows concerns about painful insertion and fear it could cause cancer and weight loss or weight gain were also prevalent (The RESPOND Project, 2010).

Provider knowledge and bias: Although there was little evidence of social and behavioral drivers among providers, a study in Bangladesh found private providers had a low level of knowledge of method-specific side effects and poor perception of IUDs and implants as having too many or too adverse side effects (SHOPS/Abt Associates, 2012). Knowledge was also lacking on policy-related issues, such as who is allowed to provide long-acting methods. A high percentage of those surveyed claimed they felt competent to insert an implant, and many were doing so, but had never received training. The study also found that although women cited their husbands were generally supportive of long-acting reversible methods, the majority of providers believed that husbands were opposed and that women should not use them without their husbands' support. For women attending public clinics in Zambia, barriers to using long-acting methods appeared to be more focused on provider barriers, such as lack of skilled providers, provider bias and commodity supply issues, as well as individual lack of knowledge (Neukom et al., 2011).

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Example of Table to Organize Key Information

	Current Behaviors	Primary Barriers to Desired Behavior	Primary Benefits of Desired Behavior
End-user/community members (e.g. women, men, caregivers)	<p>Each year there are an estimated 75-79 million unintended pregnancies worldwide, 46 million of which end in induced abortion, and about 20 million of which are considered unsafe abortions in non-medical settings</p> <p>Among married women between the ages of 15 and 49 around the globe, 53 percent use a modern method of contraception but less than one percent use implants</p>	<p>Very limited contraceptive options in developing countries for women and couples</p> <p>Limited awareness and promotion</p> <p>Fear of side effects including:</p> <p>Interrupt pregnancy,</p> <p>Cause infertility,</p> <p>Change menstrual patterns,</p> <p>Cause cancer or weight loss/gain</p>	<p>Long duration of effectiveness</p> <p>Can use when breastfeeding, comfort, ease of insertion and removal</p> <p>Does not require pelvic examination</p>
Providers (incl. public and private, clinic- and	Low levels of promotion and insertion/use of contraceptive	Low levels of knowledge of	Method easily incorporated into

community-based)	implants	method-specific side effects Poor perception of IUDs Low numbers of providers trained on inserting contraceptive implants	current FP counseling Insertion of contraceptive implants is quick and easy Long-lasting – do not have to give on a monthly basis
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