The provision of contraceptive methods during COVID-19: Considerations for DSD

CQUIN DSD and COVID-19 webinar series
5 May 2020

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  - If you would like to join the CQUIN-COVID WhatsApp group, please also add your telephone number 😊
- Please ask questions to the panelists in the “Q&A”
CQUIN DSD and the COVID-19 response webinar series

• Tuesdays in April & May at 12N Abidjan/2PM Joburg/3PM Nairobi
• [https://cquin.icap.columbia.edu/cquin-covid-webinars/](https://cquin.icap.columbia.edu/cquin-covid-webinars/)
• Can access previous slides and recordings
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2. Use the “chat” and select “All panellists and attendees” to discuss with the group and/or for any logistics challenges
3. Please note you are muted – so “raise your hand” if you would like to be unmuted
Today’s agenda

• **Contraception during COVID-19**- Dr Kavita Nanda, *Director of Medical Research*, FHI 360 USA

• **DSD and family planning**- Drs Chelsea Morroni & Helen Bygrave, *Consultants*, IAS Botswana & UK

• **Access to contraception among women living with HIV in Uganda during COVID-19**, Stella Kentutsi, *Executive Director*, NAFOPHANU, Uganda

• **Guidance in Kenya on continuity of Reproductive, Maternal health and Family planning services during COVID19**
  *Dr. Stephen Kaliti, Head*, Reproductive and Maternal Health, MOH Kenya

• **Panel discussion**- Dr Nanda, Dr Morroni, Dr Bygrave, Ms Kentutsi, Dr Kaliti, and Rumbidzai Chidora, *Technical Support Intern*, Zvandiri, Zimbabwe

• **Q&A, discussion and wrap up**
Contraception in the era of COVID-19

Kavita Nanda, MD, MHS
FHI 360
Why should FP be a priority in DSD?

• **50% of pregnancies are unintended**, with consequences ranging from unsafe abortion to serious pregnancy complications that contribute to maternal and infant mortality

• **Contraception is lifesaving** and an essential component of reproductive health care, lowering maternal mortality and improving newborn and child health

• As communities prepare to meet an unprecedented threat due to COVID-19, providers should strive to ensure **continuity of reproductive health** care to women and girls in the face of facility service interruption
Potential impacts of COVID-19 on FP

• Lockdown-related disruption over 6 months could leave 47 million women in low- and middle-income countries unable to use modern contraceptives

• Leading to a projected 7 million additional unintended pregnancies

Source: UNFPA
How can health systems maintain high quality reproductive health services to women and girls?
Use of telehealth (1)

Use telehealth (SMS, WhatsApp, video calls, or telephone calls) to:

- Counsel new clients requesting contraception and screen for medical eligibility
- Issue new prescriptions and refills for user-controlled methods (combined or progestin-only oral contraceptives, patches, or rings) if no contraindications are evident
- Send prescriptions directly to the pharmacy/clinic to limit contacts
- Prescribe/dispense multi-month refills
Use of telehealth (2)

Use telehealth (SMS, WhatsApp, video calls, or telephone calls) to:

- Manage and treat contraceptive side effects, including for LARC users, if possible
- Counsel on fertility awareness methods and correct and consistent condom use in case of commodity supply disruptions
Inform clients who desire LARC method insertion of available service locations

Use telehealth (SMS, WhatsApp, video calls, or telephone calls) to:

Counsel current LARC users on effectiveness of extended use*, postponing routine removals

- Copper IUDs – 12 years
- Levonorgestrel IUDs (Avibella, Mirena) – 6 years
- Etonogestrel implants (Implanon/Nexplanon) – 5 years
- Levonorgestrel implants (Jadelle, Levoplant) – if kept beyond 5 or 3 years, respectively, use additional method

*if not on enzyme inducing ARVs
Train for and offer self-injection of Sayana Press (DMPA-SC), where available

Promote self care for FP

Source: Burke 2018
Provide LARC methods safely

- Continue to offer insertion of LARC methods, such as intrauterine devices and contraceptive implants, to new users where possible with adequate safety preparations
  - make arrangements to avoid having too many clients in the waiting area (e.g., schedule clients individually, have clients wait outside, and/or ensuring adequate social distancing)

- Limit direct contact with current LARC users to situations where removal cannot be delayed or when management of side effects requires a physical/pelvic exam or other tests
Additional considerations

Consider placing clients who desire permanent contraception on waitlists and offering them short acting bridge contraception.

Provide advance prescriptions for emergency contraception to increase awareness and reduce barriers to immediate access.
Considerations for postpartum women (1)

- Provide counseling on contraception before hospital discharge
- Provide LARC immediately postpartum for clients who desire LARC
- Perform permanent contraception procedures for clients who desire it at the time of cesarean delivery and/or after vaginal delivery, if available
Considerations for postpartum women (2)

- Counsel on correct use of the lactational amenorrhea method (LAM) for breastfeeding women
- Administer DMPA, if desired for non-breastfeeding women
- Prescribe or dispense user-controlled methods, including Sayana Press, in sufficient quantities
- Provide method specific instructions to delay until the client is medically eligible per WHO criteria for breastfeeding and non-breastfeeding women
• As the world grapples with the COVID-19 pandemic, we must continue to ensure that all women, men, and adolescents can access safe and affordable contraceptives.

• Adjustments are inevitable; however, efforts should be made to maintain quality of and access to FP services.
Acknowledgements

• Thank you to my coauthors, Elena Lebetkin, Irina Yacobson, Markus Steiner, and Laneta Dorflinger
  • Manuscript: https://www.ghspjournal.org/content/early/2020/04/20/GHSP-D-20-00119.full

• Thank you to other members of the ACOG LARC working group, whose recommendations formed the basis of many of these points

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DSD and family planning: opportunities during the COVID-19 pandemic

Leveraging differentiated ART delivery models to strengthen family planning care, 5 May 2020

Dr. Chelsea Morroni
Consultant, International AIDS Society, Botswana

Dr. Helen Bygrave
Consultant, International AIDS Society, UK
Where are we now?

Some progress…

- **53 million more women and girls** using a modern method of contraception since 2012\(^1\)
- Contraceptive prevalence rate in **Eastern and Southern Africa** has increased by 7% since 2012\(^1\)

But still…

- 225 million women have an unmet need for family planning annually\(^2\)
- **Unmet need is 45% in sub Saharan Africa**\(^2\)
- 44% of pregnancies in SSA unintended\(^3\)

↓

Unintended pregnancy high among women living with HIV\(^4\)
Recent Data

Malawi:
75% of pregnant women on ART reported pregnancy was unintended and 79% were using contraception (91% condoms) at conception.

Botswana:
49% of pregnancies unintended among women living with HIV; no LARC use.

South Africa:
28% of women attending ART clinics had an unmet need for contraception and 62% of pregnancies were unintended.

Zimbabwe:
39% of women in HIV care not using contraception; 80% in 15-19 year olds 35% of pregnancies unintended.

Among women with HIV in Sub-Saharan Africa 66-92% reported a need, but only 20-43% used contraception.

Substantial unmet contraceptive need
Low levels of LARC use
Condoms predominate over more effective methods
Low levels of dual use.

www.iasociety.org
| Country   | DSD Models                                      | Unmet need | IUD | Implant | Oral pills | Injectable? | S/C injectable?
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</thead>
<tbody>
<tr>
<td>Eswatini</td>
<td>FT; Clubs; Individual community; CAGs</td>
<td>24%</td>
<td>0.2%</td>
<td>4.6%</td>
<td>12%</td>
<td>30%</td>
<td></td>
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<tr>
<td>Ghana</td>
<td>FT; Clubs; Individual community</td>
<td>37%</td>
<td>1.9%</td>
<td>28%</td>
<td>18%</td>
<td>28%</td>
<td>Y</td>
</tr>
<tr>
<td>Kenya</td>
<td>FT; Individual community; CAGs</td>
<td>23%</td>
<td>6%</td>
<td>18%</td>
<td>14%</td>
<td>48%</td>
<td>Y</td>
</tr>
<tr>
<td>Malawi</td>
<td>6 MMR; Individual community; CAGs</td>
<td>26%</td>
<td>1.8%</td>
<td>20%</td>
<td>4%</td>
<td>50%</td>
<td>Y</td>
</tr>
<tr>
<td>Uganda</td>
<td>FT; CLADs; CDDP</td>
<td>38%</td>
<td>4%</td>
<td>17%</td>
<td>6%</td>
<td>51%</td>
<td>Y</td>
</tr>
<tr>
<td>Zambia</td>
<td>FT; Clubs; CAGS</td>
<td>27%</td>
<td>1.5%</td>
<td>17%</td>
<td>16%</td>
<td>54%</td>
<td>Y</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>FT; Clubs; CARGS; Individual Community; Family groups</td>
<td>14%</td>
<td>0.8%</td>
<td>17%</td>
<td>57%</td>
<td>15%</td>
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DSD family planning principles

1. **Engage people living with HIV / recipients of care**

2. **Utilize DSD referral and follow-up as an opportunity for continuity of quality FP care**
   - Routinely before entry into a DSD model and every subsequent clinical interaction
   - Range of methods

3. **Promote long-acting reversible contraceptives (LARCs, IUD and implant) in DSD models**

4. **Align FP and ART re-supplies in DSD models**
   - Match ART and contraceptive pill refill duration
   - Match re-injection schedule to ART refill schedule

5. **Integrate FP and ART care in DSD models in facilities and communities**
   - Aim to provide FP and ART on the same day, in the same location, and by the same HCW
Using the building blocks for FP care in DSD

- WHEN
- WHERE
- WHO
- WHAT
Family planning care in CAGs, Ndihwa Kenya: The building blocks

<table>
<thead>
<tr>
<th></th>
<th>IUDs</th>
<th>Implants</th>
<th>Oral pills</th>
<th>Injectables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHEN</strong></td>
<td>Not available</td>
<td>Prior to entry into CAG DSD model or at any time contraception</td>
<td>Every 3 months, aligned</td>
<td>Every 3 months, aligned</td>
</tr>
<tr>
<td><strong>WHERE</strong></td>
<td>Not available</td>
<td>Same facility as DSD initiation and ART</td>
<td>Collect pill with ART at facility; group member in need nominated to collect ART</td>
<td>Given at facility; group member in need nominated to collect ART for others</td>
</tr>
<tr>
<td><strong>WHO</strong></td>
<td>Not available</td>
<td>Implant trained doctor, midwife or nurse</td>
<td>FP trained midwife, nurse or clinical officer provides script</td>
<td>FP trained midwife or nurse</td>
</tr>
<tr>
<td><strong>WHAT</strong></td>
<td>Not available</td>
<td>Jadelle &amp; Implanon NXT; counselling, insertion / removal, side effects</td>
<td>COCs &amp; POPs; counselling, dispensing, side effects</td>
<td>DMPA IM; counselling, giving of injection, side effects</td>
</tr>
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Questions for discussion

• For each of the models being implemented in your programmes, are women accessing family planning within the model?
• What are the opportunities for and challenges to strengthening provision of LARC during the COVID-19 outbreak?
• If contraceptive pill refill duration is less than that of ART what can be done in your setting to align refills?
• Are there opportunities for community distribution for FP and ART?
• Is the DMPA sub-cutaneous/self-injectable available and can it be scaled up?
• Dr Anna Grimsrud
• Aamirah Mussa
• Recipients of care who visit our clinics

10. Webb et al. Abstract IAS. 2019
Access to contraception among women living with HIV in Uganda during COVID-19

Stella Kentutsi
ED, NAFOPHANU
5 May 2020
Contraception access for women living with HIV in Uganda

- 39% of women (including women living with HIV) in Uganda use Family Planning (FP), mostly short term methods like pills
- COVID-19 lockdown has severely disrupted access to FP → no transport means, few frontline healthcare workers at facilities
- A few women can access nearby health facilities, others at home waiting for lifting of lockdown
- Likely to have a post COVID-19 baby boom
- Noted challenges of abstinence and negotiating condom use when spouses are mostly in the house
Rapid assessment on the needs of people living with HIV in the context of COVID-19 with UNAIDS & NAFOPHANU

- Conducted in late March-early April 2020 on survey monkey
- Reached 78 PLHIV (55% male, 67% urban, average age 27 years)
- 60% of participants **had two or more people** on ART in the household including the respondent
- 23% (18/78) of respondents had children in the household who were taking ARVs
- 73% of the respondents knew three months as the usual/standard supply for ARVs (3MMD)
  - 68% of all respondents had ARV supplies for only a month or less
  - 32% had ARV supplies for 2 or more months, no significant difference by gender or age
Access to condoms and contraception

33% of those who want contraception have access

57% of those who want condoms have access
PLHIV access to condoms and contraception

- Out of 78 respondents, 61 wanted to use condoms. Of these 31 were females that wanted to use condoms, however 16 respondents could access and 15 did not have access. On other hand, out of 30 males that wanted to use condoms 19 had access and 11 did not have access.

- Out of 78 respondents, 51 wanted to use contraception. Of these 31 were females that wanted to use contraception, however only 8 respondents could access and 23 did not have access. On other hand, out of 20 males that wanted to use contraception, 9 had access and 11 did not have access.
Proposed changes

• Integrate FP services in delivery of HIV/TB/OIs services
• Work with expert clients and other peer buddies to call PLHIV who require FP services so that home deliveries for drugs also include FP
• District/national taskforces should prioritize unmet need of FP during COVID19
• A specific study on access to FP services by WLHIV and impact on eMTCT
Uganda – Discharging COVID-19 patients
Guidance in Kenya on continuity of reproductive and family planning care and services during COVID-19

Dr Stephen Kaliti
Head of Reproductive and Maternal Health
Ministry of Health, Kenya
5 May 2020
Ensuring continuity of care and services

- Practical guide
- Preventive and clinical aspects
- Comprehensive
- Inbuilt country specific tools and extractable job aids
- Balance: Risk Benefit Analysis
- Popular version completed
Implementation

- Fright, Flight and Fight response of Health Systems
  - Recognizing system evolution through COVID-19 threat key to getting acts together to restart service
- COVID-19 outbreak challenged traditional architecture of service provision
- Health Care system designed on physical visits and face to face consultations
- Telemedicine
- Access within containment measures
Family planning and contraceptives

- Method specific
- Decongest facilities
- Telemedicine
- Shift to emphasis on low interaction, low skill method mix
- Dual protection
- Supply chain protection: Months of stock
Challenges

- Infodemic - Scaremongering to public
- Competing for attention - RMNH/FP need for sustained prioritization
- Resources to restructure service delivery – significant and need concerted unified approach
- Panic response – Motivational prescriptions not backed by delivery architecture
- Strained HR For Health – Material and operational constraints
Lessons learned

• Telemedicine/Digital access to care is not an alternative – it is an integral part of Health Care Delivery
• Creative partnerships can easily overcome traditional barriers to service access
• Vulnerable groups must be at the initial table of discussions during periods of violent assault to health systems
• Central command and government leadership is key to minimizing damage and shortening the time to recovery
• Purposeful clear guidance offers a lifeline to organized recovery
• Important to separate needs from wants – guides in resource allocation
Discussion and Q&A
Thank you

- Details of the past and future webinars in this series can be found at https://cquin.icap.columbia.edu/cquin-covid-webinars/
- DSD & COVID-19 resources:
  - bit.ly/DSDCOVID
  - https://cquin.icap.columbia.edu/network-focus-areas/covid-19/
  - http://itpcglobal.org/resources/