FP: What's New, What's Hot, and What Does It Mean for E&E

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Content of This Presentation

I. Context / trends for FP in E&E Region

II. What's new in FP programming

III. What's new in FP methods (CTU) …

- E&E region modernizing: ↑ SE status
- High literacy
- “Rich” in health care providers
- FP use usually ↑ in this situation–and has in E&E
  - **modern FP use still relatively low**
  - **abortion rates still highest in the world** (though falling, with rises in modern FP use)

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- High “knowledge” of FP, but low knowledge of implants, injectables, and vasectomy
- World’s highest level of traditional method use (withdrawal)
- Widespread & exaggerated fears about some methods, especially hormonal FP
- Skewed method mix / high provider bias
- Poor fit of method use with reproductive intent
- High reliance on abortion for fertility control

Contraceptive Prevalence Rates (CPR): Worldwide (MWRA)

Region	All Methods	Modern Methods
World	63%	57%
Less Developed (Excluding China)	53%	**45%**
Northern Europe	82%	77%
Western Europe	75%	70%
North America	74%	69%
Eastern & Southern Europe	NA	**range: 8-47% (Albania / Russia)**

Source: PRB, *Family Planning Worldwide, 2008*

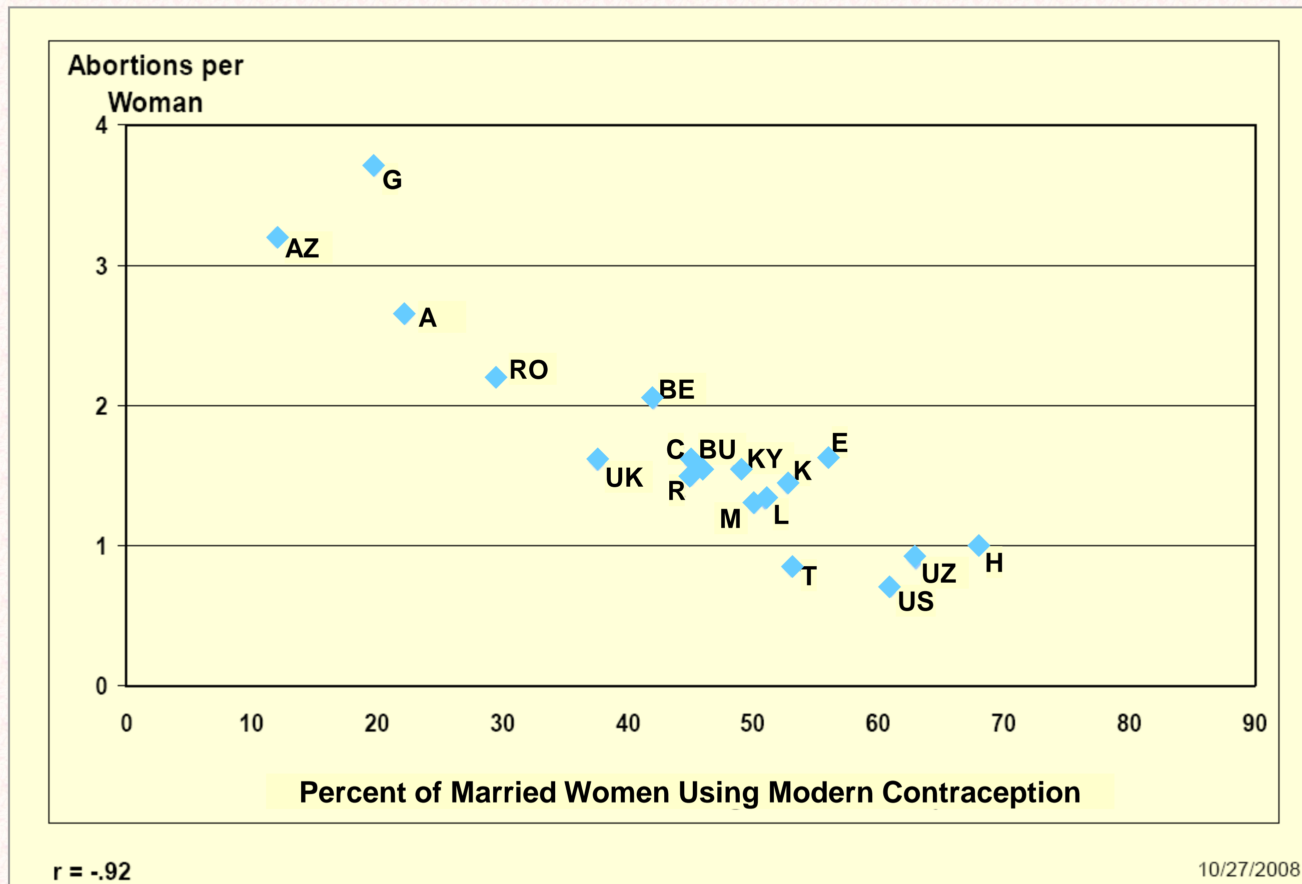
Contraceptive Prevalence Rates (MWRA): Selected E&E and other countries

Country	All methods	Modern Methods
Albania	75%	8%
Azerbaijan	51%	14%
Armenia	53%	20%
Georgia	47%	27%
Turkey	71%	43%
Russia	65%	47% / 53%
Ukraine	67%	48%
United States	73%	68%
France	79%	76%
United Kingdom	84%	81%

Source: PRB, *Family Planning Worldwide, 2008*

Contraception and Abortion:
Inversely correlated in E&E

The total abortion rate and the prevalence of modern contraceptive methods in 18 countries



Source: Westoff 2005.

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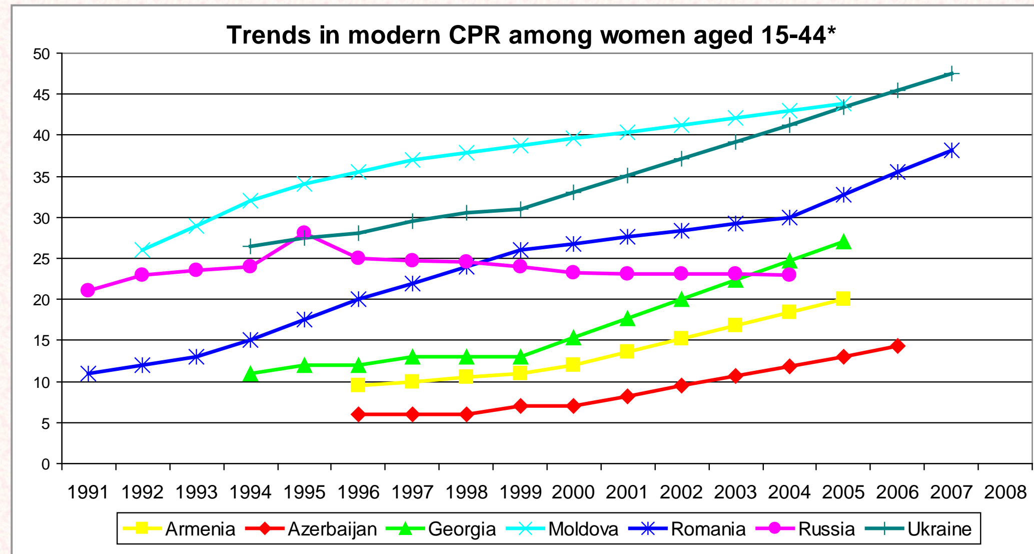
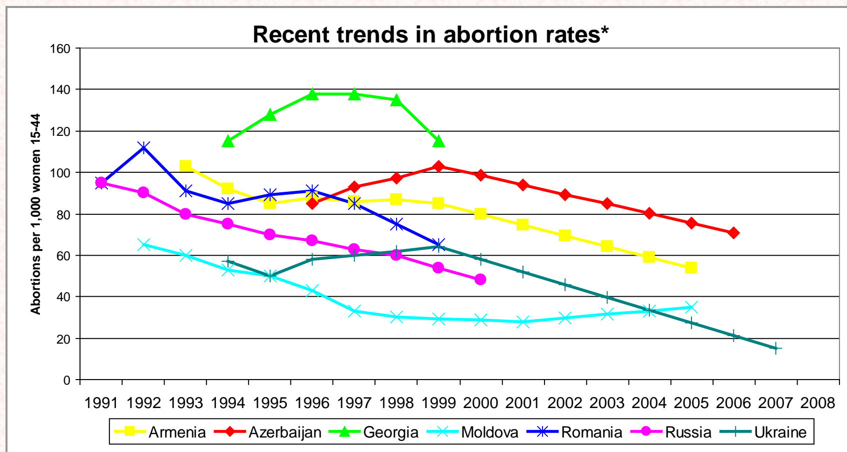
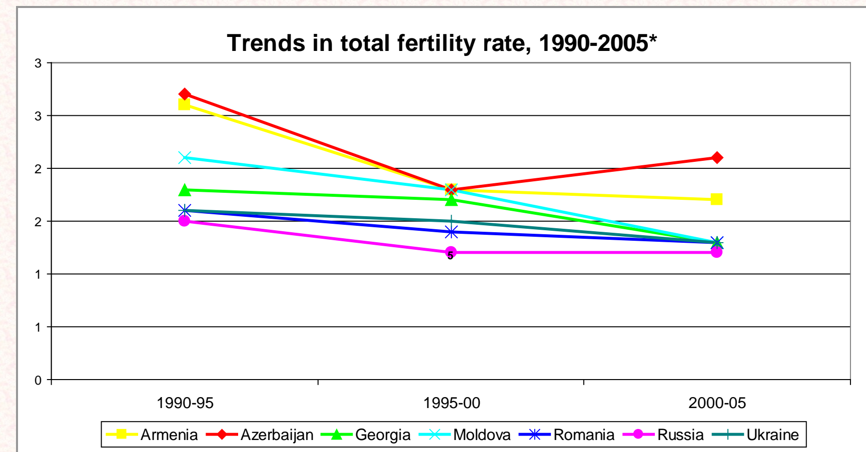
Trends in Contraception, Abortion, and Fertility in E&E







Source: Westoff 2005, plus MEASURE/DHS, Armenia Survey (2005), Azerbaijan Survey (2006), Moldova Survey (2005), Ukraine Survey (2007)..

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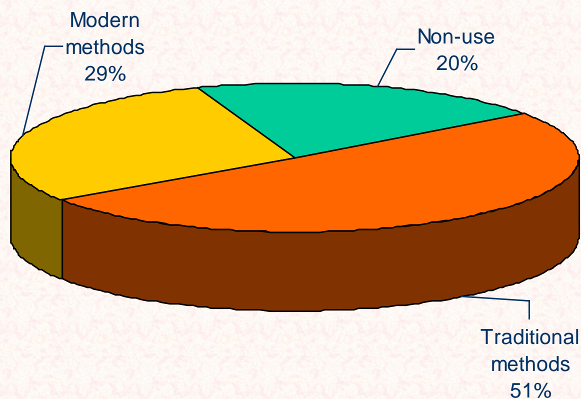
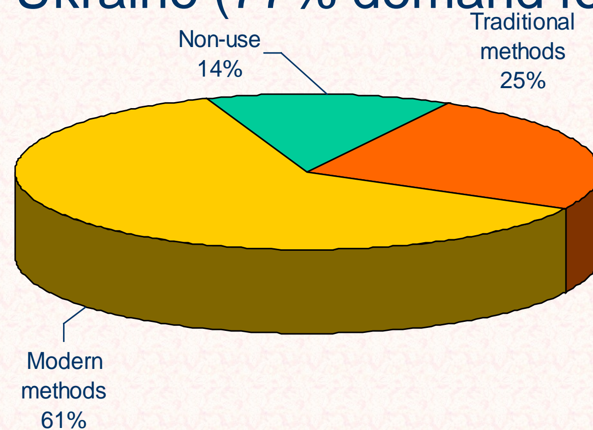
Reproductive Intent and FP Use:
Selected E&E countries

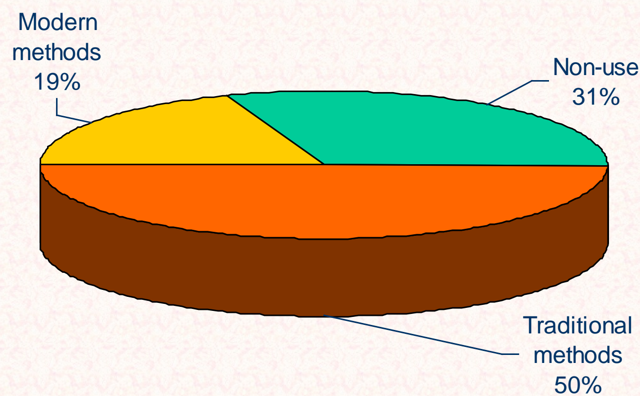
Armenia (67% demand for FP)



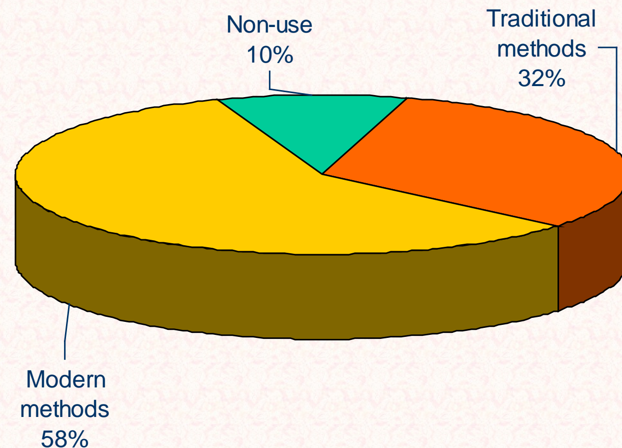
Ukraine (77% demand for FP)



Azerbaijan (74% demand for FP)



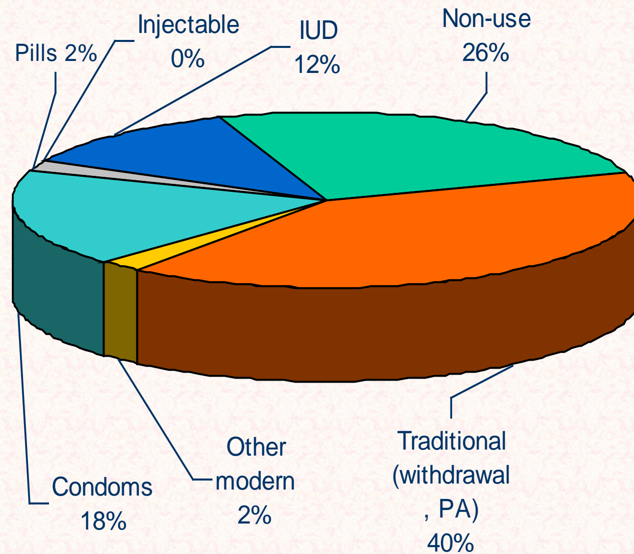
Moldova (75% demand for FP)



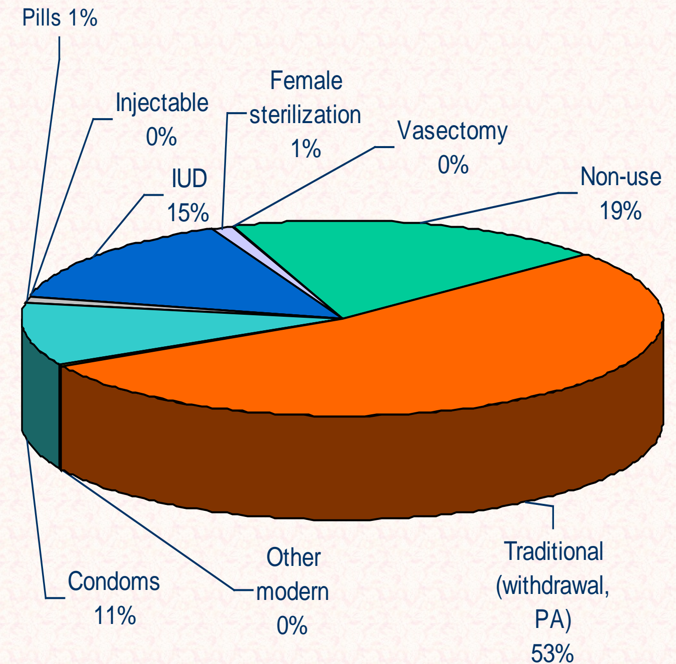
Source: MEASURE/DHS, Armenia Survey (2005), Azerbaijan Survey (2006), Moldova Survey (2005), Ukraine Survey (2007).

Fit of FP Method Use with Reproductive Intent: Armenia

Demand to space:
15% of MWRA



Demand to limit:
52% of MWRA



Source: MEASURE/DHS, Armenia DHS Survey, 2005.

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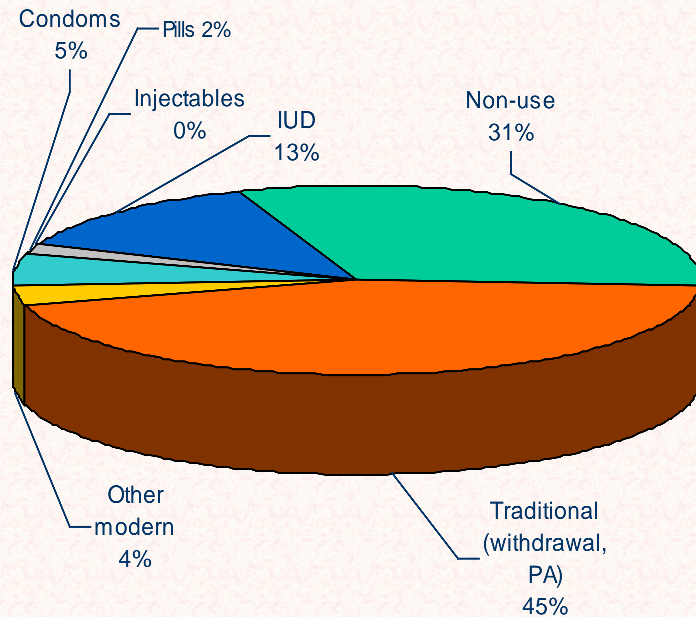
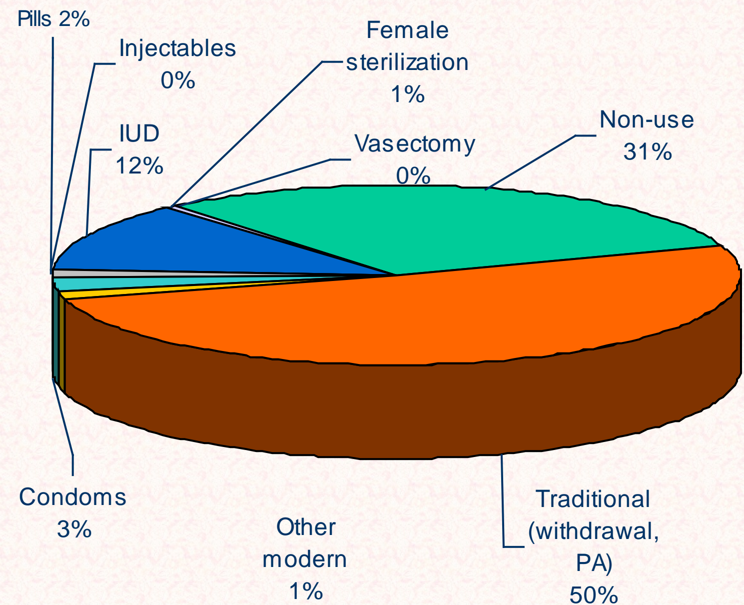
Fit of FP Method Use with Reproductive Intent: Azerbaijan

Demand to space: 11% of MWRA



Demand to limit: 63% of MWRA



Source: MEASURE/DHS, Azerbaijan DHS Survey, 2006.

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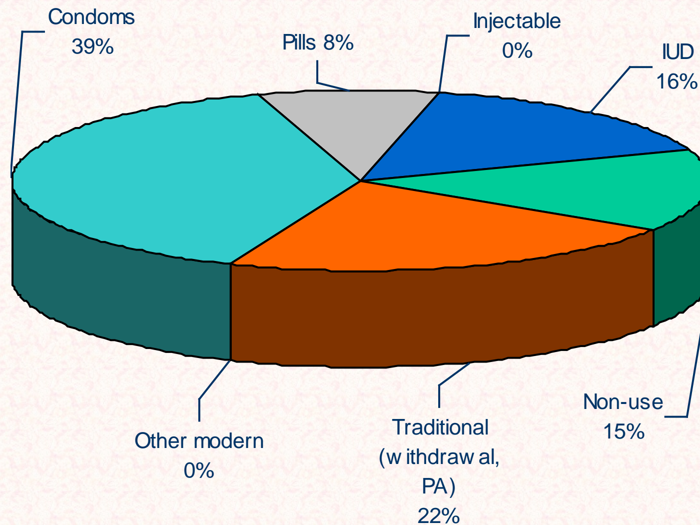
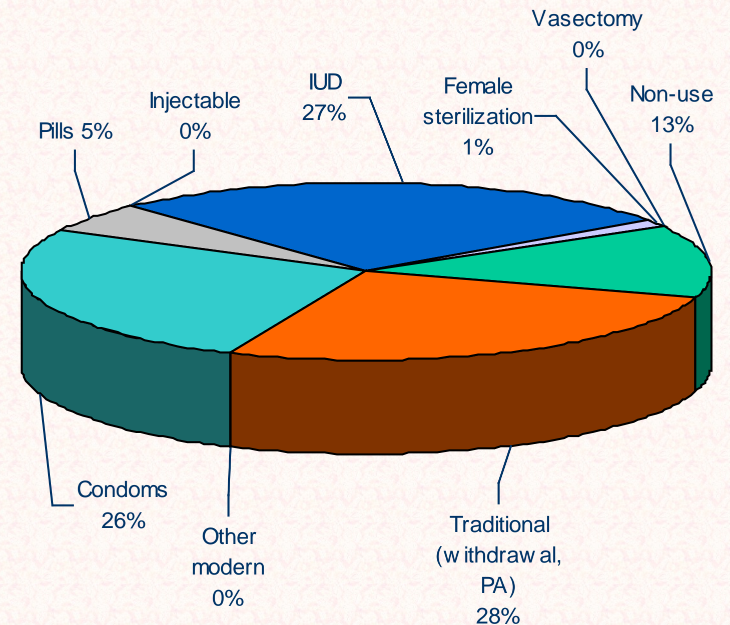
Fit of FP Method Use with Reproductive Intent: Ukraine

Demand to space: 28% of MWRA



Demand to limit: 49% of MWRA



Source: MEASURE/DHS, Ukraine DHS Survey, 2007.

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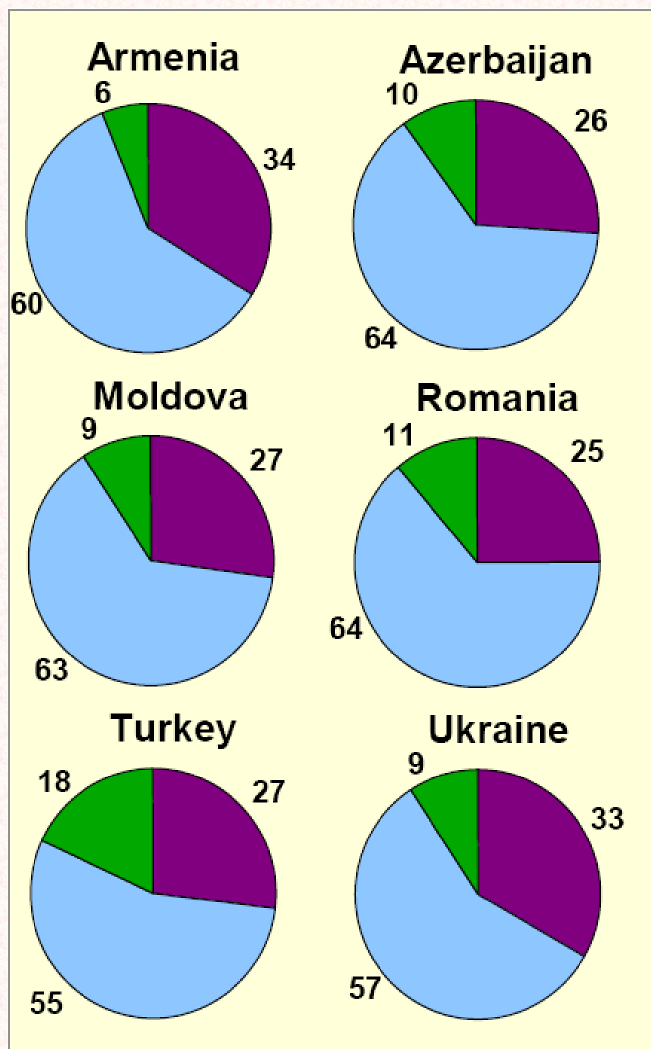
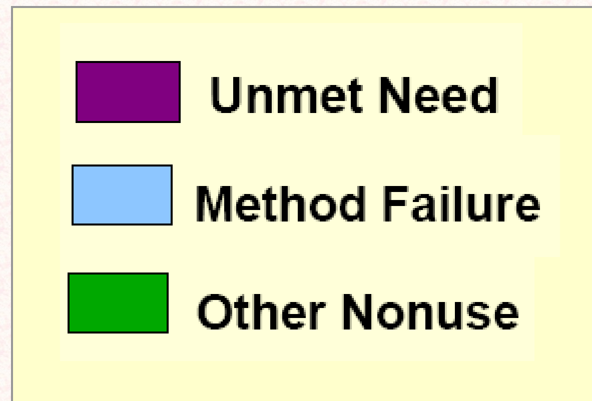
Main Factor Leading to Abortion in E&E: Method failure





Source: Westoff 2005.

- Despite these facts & clear need for ↑ access to more methods, FP is a "hard sell" at Missions & MOH, because:
  - Quite low fertility in E&E (1.3: well below replacement)
  - High concern about this low fertility: "too low"
  - Worry that ↑ modern FP will further ↓ TFR
  - Widespread "hormonophobia"
  - Safe abortion widely available—& remunerative
  - Competing (and legitimate) development priorities

- Heeding principles, dynamics & lessons of fostering & sustaining behavior change, especially in medical settings
- Ensuring access, in all its dimensions
- Holistic programming
- Greater focus on method effectiveness
- Meeting reproductive intent

Fostering Change in Medical Settings:
Some considerations

- **Perceived benefit**: most important variable re rate & extent of adoption of new provider (or client) behavior:
  "What's in it for me?"
- "Perceived" = eye of the beholder, the "changee"
- The greater the perceived **relative advantage**, the more rapid the rate of adoption/change
- Other important variables:
  - **Simplicity** of new behavior
  - **Compatibility** with medical system's norms, standards, practices

- U.S. examples:
  - 500,000 unnecessary C-sections, every year!
  - Unnecessary hysterectomies: 80,000 annually
  - Correct treatment of heart attacks: 11-year lag
  - Non-scalpel vasectomy (NSV):
    - 1972: invented in China
    - 1980s: proven better/main approach in programs
    - 2003: WHO still called it a “new method”
    - 2004: 51% (only) of vasectomies in U.S. via NSV

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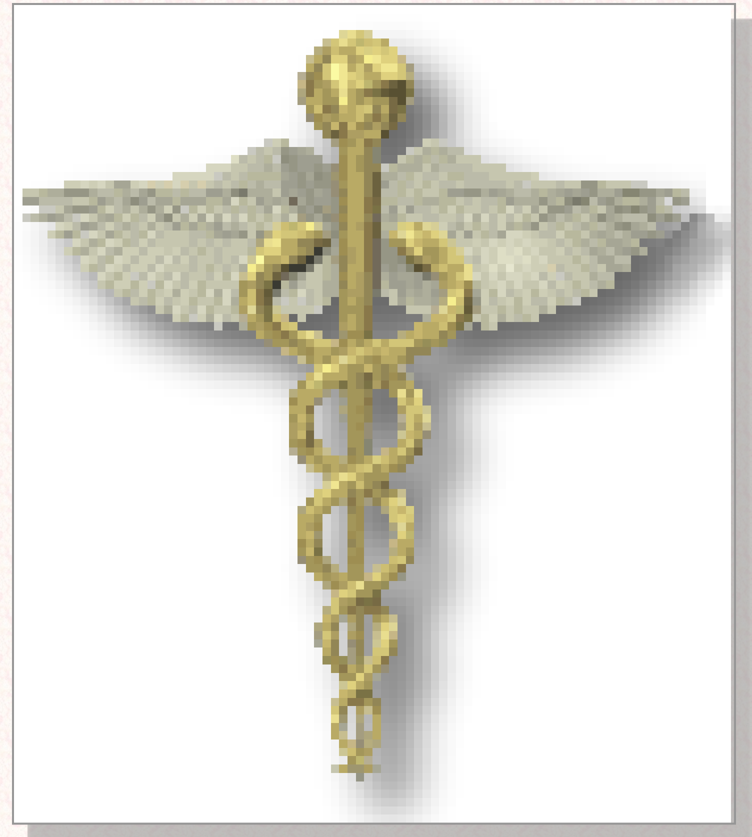
- Conservative
- Hierarchical
- Ignorance
  —of latest scientific findings
  —of benefits and risks of FP methods
- Fear of iatrogenic disease: *Primum non nocere:*
  Great fear of “harm of doing” vs. “harm of not-doing”
  “Gatekeepers” / FP perceived as a potential danger
- Lack of perceived need for change
  “What’s worked for me is working”
- Lack of provider motivation to change

Medical Barriers

"… well-intentioned but inappropriate **policies or practices**, based at least partly from a medical rationale, that result in scientifically unjustifiable impediment to, or denial of, contraception."

doctors are "the gatekeepers"



Shelton, Angle, Jacobstein, *The Lancet*, # 340, 1992

Common Medical Barriers in E&E

- *Provider bias* against (or for) a method
- *Limitations on which provider cadre can provide* a method (e.g., only Ob-Gyns can provide hormonals)
- *Inappropriate eligibility restrictions*
  - Age ("not for the young"); Parity; "Not PP or PA"
- *Process hurdles*
  - Mandatory and unnecessary routine F/U
  - Marriage/spousal consent requirements
- *Unsubstantiated "contraindications"*

  (e.g., "must be menstruating")

FP Access

"**Access**": Degree to which FP services can be obtained at an effort & cost acceptable to a potential client & within her means

- Cognitive (informational access)
- Socio-cultural / psychosocial
- Geographic (adequate # and location of service sites)
- Economic / Financial (cost / affordability)
- Health care system factors
  - Structural and/or administrative access to services
  - Provider-level factors

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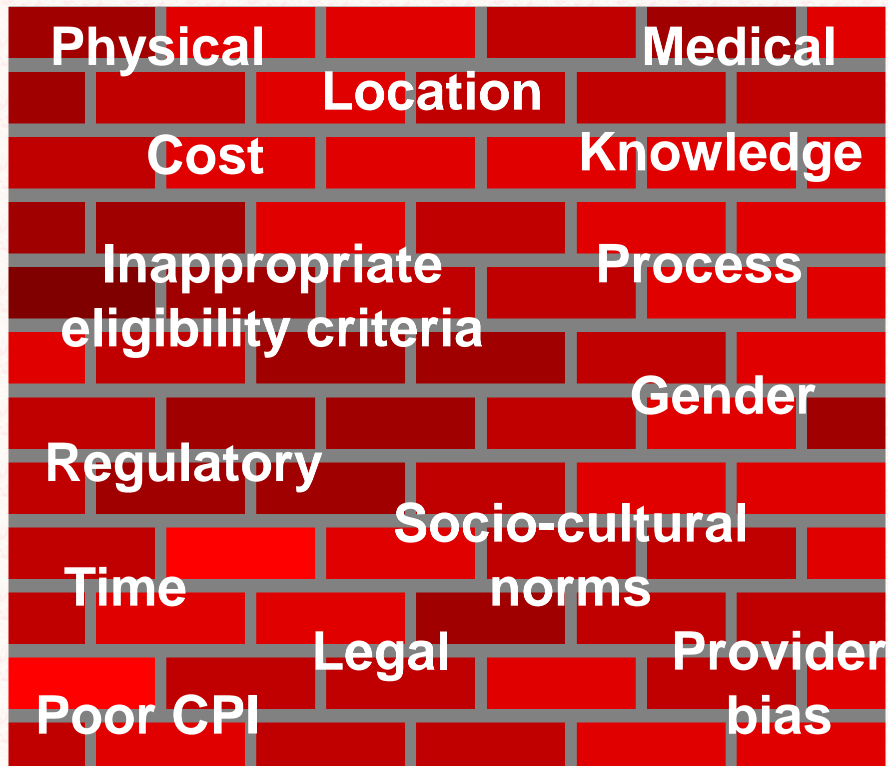
Barriers to Access in E&E:
The Brick Wall

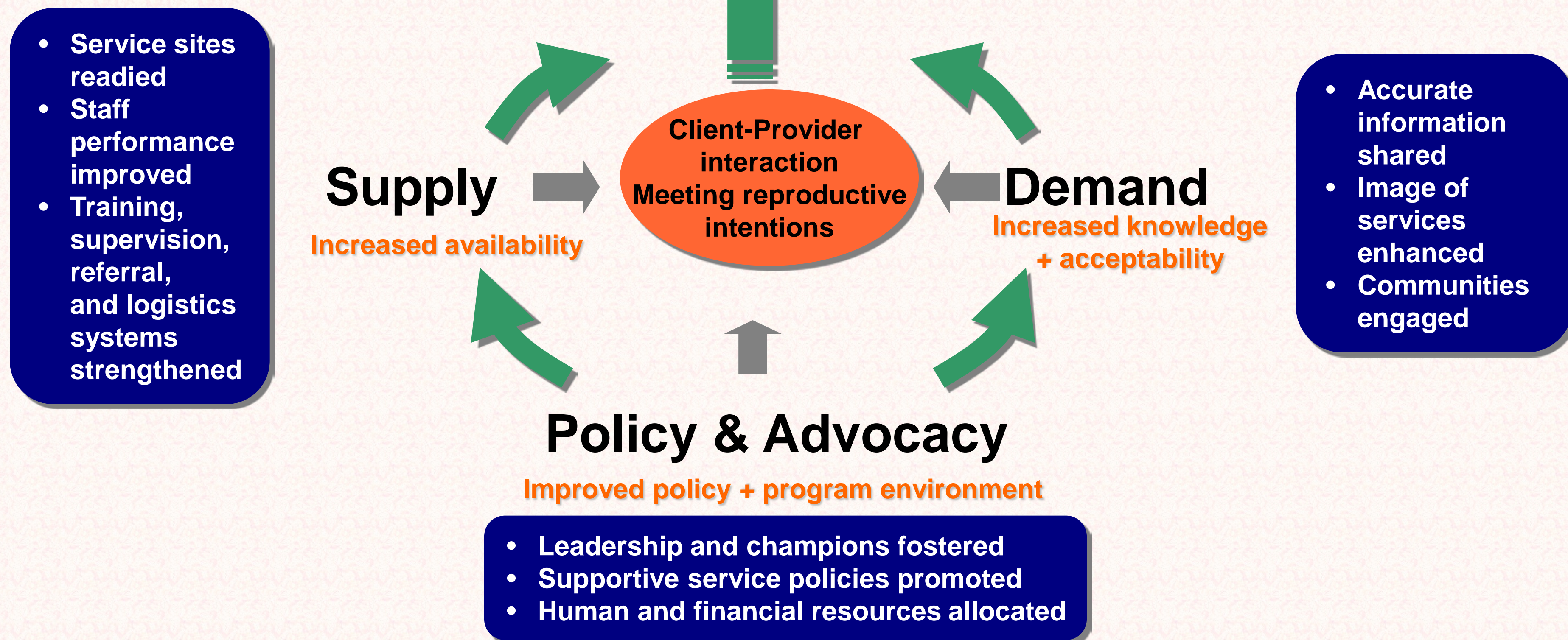
Barriers to effective family planning services



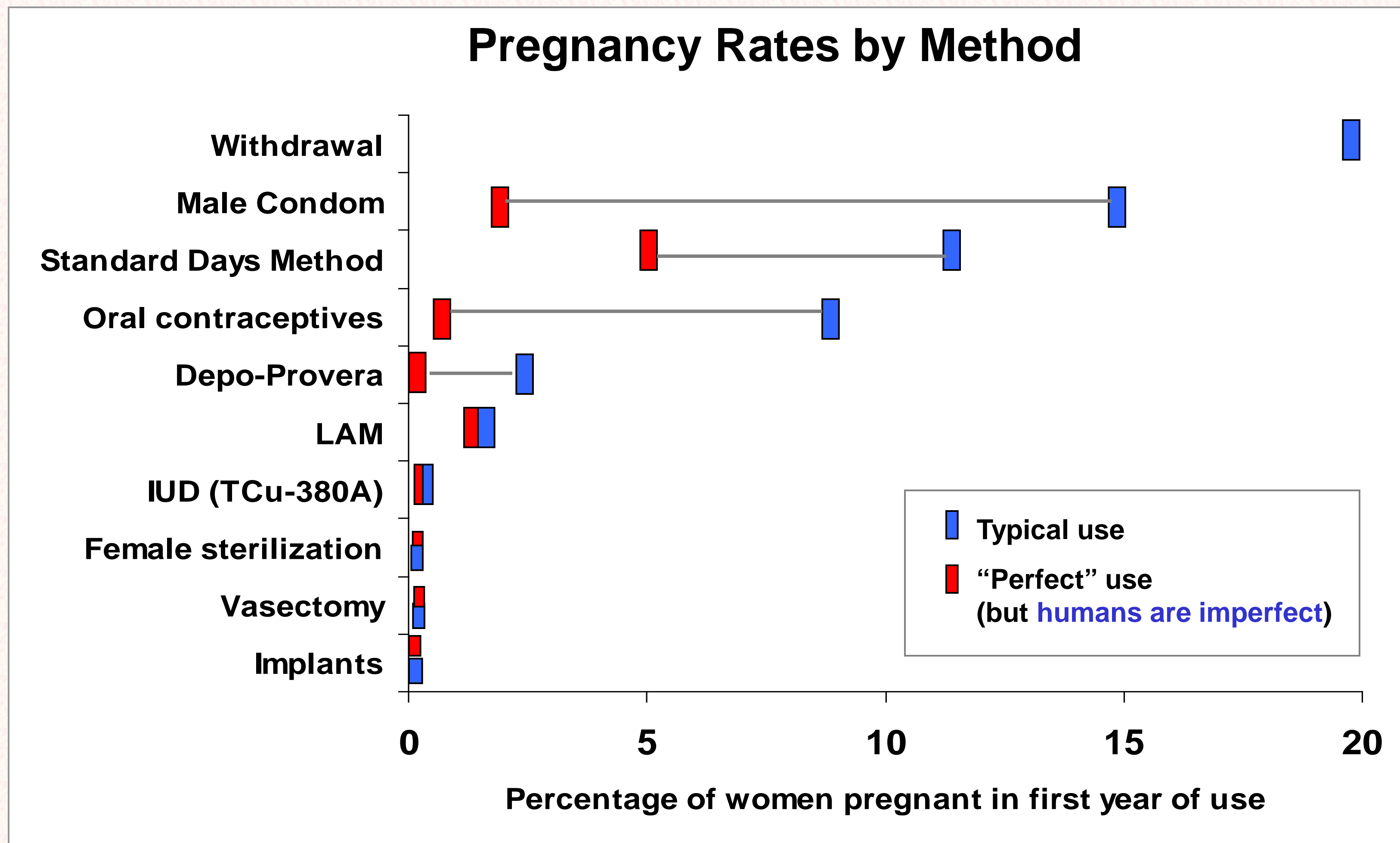
Outcomes when barriers are overcome:

- → ↑↑ Access to services
- → ↑↑ Quality of services
- → ↑↑ Contraceptive choice and use
- → ↓↓ Abortion

Holistic Programming:
"A chain is only as strong as its weakest link"



FP Method Effectiveness:
“Not all family planning is the same”



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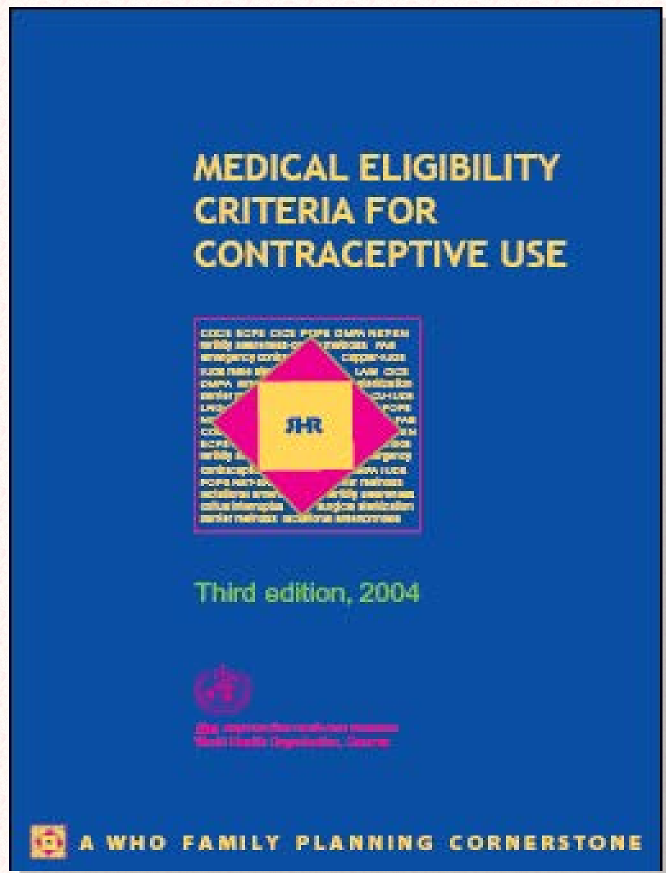
- WHO's "Four Cornerstones"
- Emergency contraception
- Injectable contraception
- Contraceptive implants
- Levonorgestrel-releasing IUD (Mirena®)

Medical Eligibility Criteria for Contraceptive Use

(MEC, 2004; updated its guidance 2008)



- 19 methods, 120 medical conditions
- ~ 1700 recommendations on who can use various contraceptive methods
- Gives guidance to programs & providers for clients with medical problems or other special conditions
- Informs national guidelines, policies & standards with best available evidence
- Helps ↓ medical policy & practice barriers
- Helps ↑ quality & use of FP services

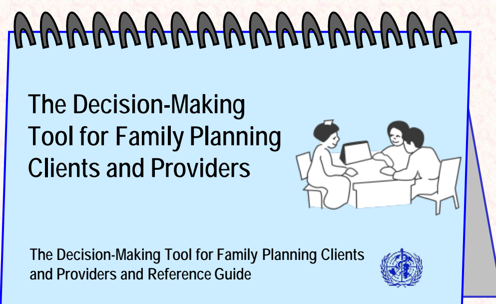
Четыре краеугольных камня - руководства ВОЗ по ПС

Медицинская приемлемость

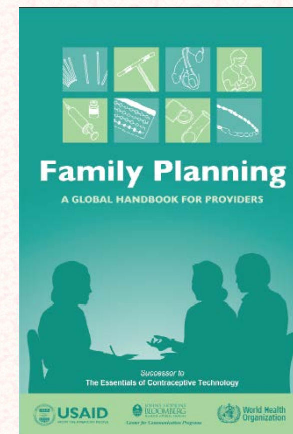
Свод практических рекомендаций

Руководство для политиков и менеджеров программ

Руководство для мед-работников и клиентов



Инструмент принятия решения по планированию семьи для клиентов



Планирование семьи: универсальное руководство для поставщиков услуг по ПС

What Questions Are Answered by the Medical Eligibility Criteria (MEC)?

In the presence of a given **condition** or **client characteristic**, e.g., STIs or HIV/AIDS can a particular FP method be used?

… and with what degree of caution or restriction, as reflected in four **classification categories** or gradations, based on the evidence of benefits and risks?

WHO Medical Eligibility Criteria Classification Categories

Classification Category	With Clinical Judgment	With Limited Clinical Judgment
1	No restriction: Use method in any circumstances	Yes Use the method
2	Generally use: benefits generally outweigh risks	Yes Use the method
3	Generally do not use: risks outweigh benefits	No Do not use the method
4	Unacceptable health risk: method not to be used	No Do not use the method

- Safer than pregnancy and delivery (all)
- ↓ risk of ectopic pregnancies by > 90% (all)
- ↓ menstrual cramps, pain and blood loss (all)
- ↓ risk of ovarian cancer (COCs)
- ↓ risk of endometrial cancer (COCs, IUDs)
- ↓ symptomatic PID (COCs, implants, injectables)
- ↓ symptoms of endometriosis (all)
- Alternative to hysterectomy for menorrhagia (LNG-IUS)

Emergency Contraception (EC)

- Method of *preventing* pregnancy *after* unprotected sex
- Mechanism of action: inhibits/delays ovulation
- Hormones of regular OCs are used
  - in a special higher dosage
  - within 5 days of unprotected intercourse
- Safe and suitable for all women
- Does not interrupt established pregnancy (is not RU-486):

  "EC is contraception, not abortion"
- IUDs can also be inserted for EC
  - up to 7 days afterward; reduces risk by 99%

- Progestin-only pills
  - preferred regimen, 1.5 mg levonorgestrel
  - → **89% reduction in risk** (1 in 100 become pregnant)
  - Less nausea and vomiting (6%) than with COCs (23%)
  - Marketed in the U.S. as **“Plan B”** (dedicated product)
- Combined Oral Contraceptives (COCs)
  - 2 doses of pills, containing ethinyl estradiol (100 mcg) & levonorgestrel (0.5 mg), taken 12 hrs apart
  - → **75% reduction in risk** (2/100 become pregnant, vs. 8/100)

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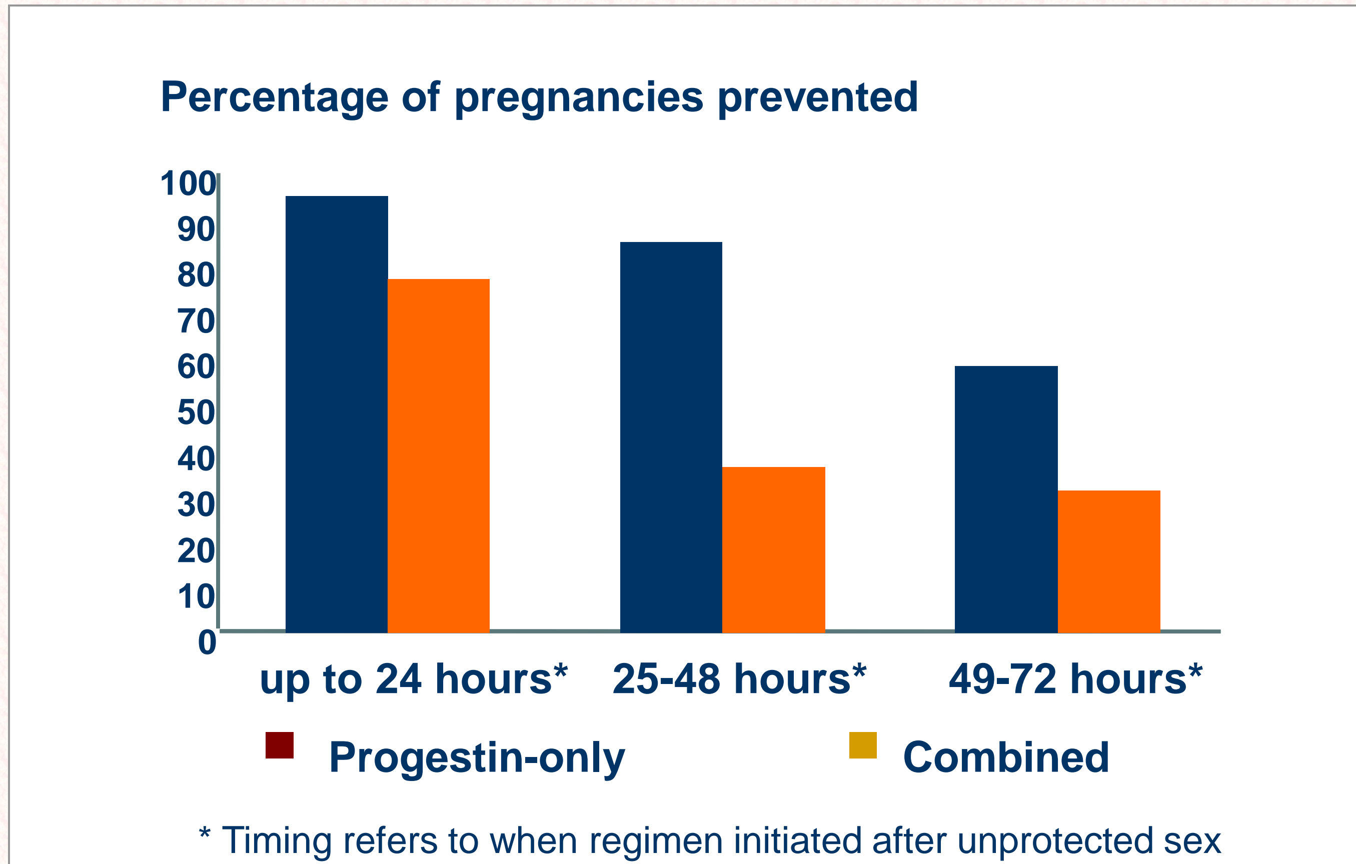
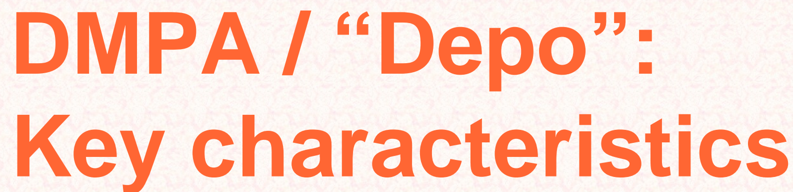
ECPs: Most Effective When Taken Early

"The Sooner, the Better"



Source: WHO Task Force, *Lancet*, 1998; 352: 428-33.

- Progestin-only injectables
  - Depot-medroxyprogesterone acetate (DMPA, “Depo")
    - 150 mg, IM, **every three months**
    - also lower dose formulation, 104 mg, subcutaneous
      - “Depo-provera” (Pfizer, Belgium)
      - Megestron® (Organon/Merck, Netherlands)
  - Norethisterone enanthate (NET-EN)
    - Given **every two months**
    - Noristerat® (Bayer-Schering, Germany)
- Combined injectable contraceptives (CICs)
  - progestin plus estrogen / given **monthly**
    - Cyclofem®, Mesigyna®, Lunelle®, and others



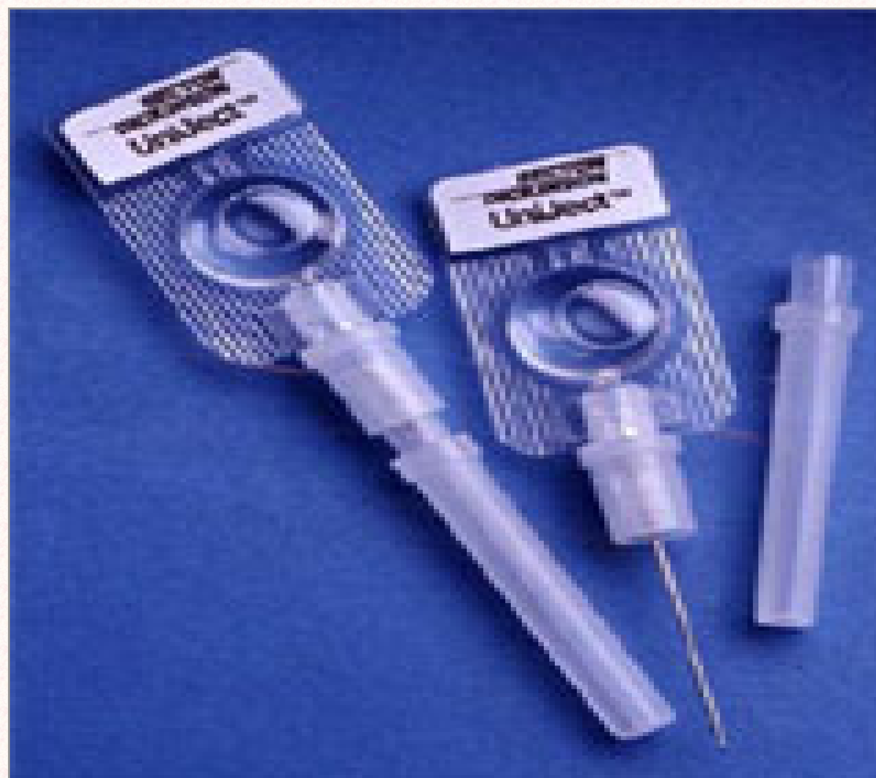
DMPA / "Depo": Key characteristics

- Safe and suitable for almost all women
  - MEC Category 1, age 18-45; (younger or older: Category 2)
  - Any parity (have or have not had children)
  - Post-abortion, or PP (if breastfeeding, 6 wks PP)
  - HIV-infected, or with AIDS
- Mechanism of action: prevents ovulation
- Use-effectiveness: 3 pregnancies per 100 women-yrs
- Cost: ~$0.90 - $1.00 / dose (including needle & syringe)
- Counseling important re bleeding (common, not harmful)
  - 10-30% amenorrhea after 1 dose; 40-50% after 4th injection

DMPA / "Depo": New developments

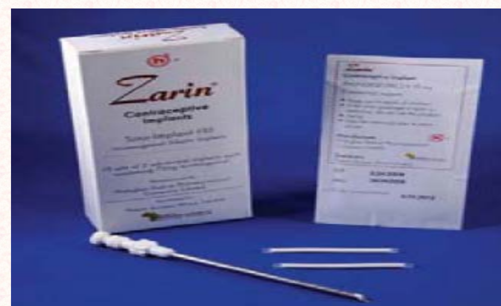
- Rising popularity in many countries, most regions
  - 16% SE Asia; 7% Africa; 5% Asia; 4% LAC; 3% UK; 2% North America
  - 28% Indonesia; 28% South Africa; 18% El Salvador; 14% Peru
  - 0% Armenia, Azerbaijan, Ukraine; 0.4% Albania; Uzbekistan: ~2.7%
- "Grace period" extended, WHO (SPR), 2008: OK to be given up to 4 weeks late, or early (was 2 weeks)
- ↓ Bone density (temporary, reversible, no Δ in MEC [WHO, 2005])
- No association with HIV acquisition or progression (FHI/NICHD study, 2005)
- Community-based provision (CBD) of injectables: Quality and continuation same as nurses and nurse-midwives in fixed sites (and nurses perform as well or better than doctors)

New Formulation of DMPA:
Subcutaneous, Lower Dose, in Uniject



New Progestin Implants:
Jadelle, Implanon, Sino-Implant

- *Jadelle®*
  - Two rods, 75 mg LNG in each
  - Easier to insert (2 minutes) and remove (~5 minutes) than *Norplant*
  - Labeled for 5 years of use
  - Cost to USAID: ~$22.00
- *Implanon®*
  - One rod, 68 mg etonorgestrel
  - Insertion 1 minute, removal 3 minutes
  - Different insertion technique
  - Labeled for 3 years of use
  - Cost comparable to Jadelle
- *Sino-Implant®*
  - Generic Jadelle / same characteristics
  - Labeled for 4 years of use
  - **Cost $7-10 [major consideration]**



- Small, progestin-releasing, subdermal rods
- Highly effective (pregnancy rate ~ 1 / 2000 in 1st yr)
- Effective for 3-5 years, depending on implant type
- WHO MEC Category 1 for nearly all women
- Continuation rates high (depends on **good counseling & side effects management** [bleeding pattern will change])
- Good insertion = good removal
- Gaining popularity as prices ↓ (convenience, effectiveness, safety, few & manageable side effects, long-lasting)

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- "IUS"— hormone-releasing "system"
- Highly effective: < 0.5% 5-yr cumulative pregnancy rate
- Labeled effective for up to 5 yrs
- WHO MEC Category 1 for nearly all women
- 20μg LNG daily, into uterine cavity (local effects)
- Only 1-2% discontinue because of hormonal side effects
- → ↓ ↓ bleeding, or amenorrhea (anemia; alt. to hysterectomy)
- High satisfaction & rising popularity in Europe and US
- but Copper-T an excellent IUD (& major cost differences)

Mirena® LNG-IUS

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Mirena®
(levonorgestrel-releasing intrauterine system)
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Pregnant or just had a Baby?

Growing Family?

Family the Right Size?

Already using Mirena®?

Like to keep life simple?
Imagine birth control you don't have to think about.[1]

Want hassle-free, 99.9% effective birth control for up to 5 years (or less, if you choose)[2]? **Mirena**® is an estrogen-free intrauterine contraceptive (IUC) for women who are looking for a contraceptive option to help simplify their lives. It's for women who have decided their families are just the right size, it's for expectant mothers to consider after they have had their baby, and it's for women who aren't satisfied with their current form of contraceptive. And, it can be removed at any time for a quick return to fertility[2]. Like to keep life simple? Then **Mirena** may be right for you. **Of course, there's some important safety information you should know. »**

Mirena is an intrauterine contraceptive (IUC) made of soft, flexible plastic.

See the Flexibility

Simple Tips for Romancing the Bedroom »

Mirena® Media Spotlight

TV Ad

Watch now »

IV. Conclusion: Rationales for FP Are Still Valid in E&E

- A country is not modern when modern FP use is low (and traditional use is high)
- Access to a range of FP methods that enable reproductive intent to be met is an equity/gender/human rights issue
- Almost all women can safely use hormonal contraception
- Modern FP reduces abortion rates (but not E&E fertility rates)
- Modern FP reduces maternal mortality & morbidity, & has many other non-contraceptive health benefits

- Understand how health system actors ‘see’ the change you want to introduce, and intervene accordingly
- Program holistically
- Convey evidence-based information (scientific model)
- Take a ‘provider perspective’
  - Address their needs, fears, myths, reward systems
- Keep messages simple and memorable
  - Repetition (not ‘one-off’ events) is the key to adult learning & BC
- Support, nurture, publicize ‘early adopters’ & ‘champions’

THANK YOU!

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