A Decade of Learning in Contraceptive Implant Introduction and Scale-up:

A synthesis

KEY TAKEAWAYS

COORDINATED ACTION at all levels helped to fast-track implant introduction and scale-up; including national government stewardship and global coordination for investment, volume guarantees, clinical guidance, and sharing lessons learned

Ensuring **AVAILABILITY** of implants through multiple service delivery channels and task sharing were key strategies to increase access and uptake

Addressing price barriers through volume guarantees was critical for **EQUITABLE ACCESS,** but scale-up through the private sector will require new, innovative solutions and financing

Demand generation activities designed with providers and users helped ensure **ACCEPTABILITY** of implants

Comprehensive quality assurance systems and training programs helped ensure **QUALITY** of implant services – **BOTH INSERTIONS AND REMOVALS** – by a range of providers

Jhpiego and Impact for Health, as a component of the Expanding Family Planning Choices (EFPC) project, undertook rapid literature reviews and key informant interviews with experts in the contraceptive implant and family planning field to better understand programmatic learnings, tips, best practices and challenges for implant introduction and scale-up. The results of this review led to the development of a series of products for continued learning and sharing, including this synthesis.

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ACRONYMS

ASI	Accelerating Scale-up of Implants
AAAQ	Availability, Accessibility, Acceptability and Quality
BMGF	Bill & Melinda Gates Foundation
CHAI	The Clinton Health Access Initiative
CHEWS	Community Health Extension Workers
CHWS	Community Health Workers
CIFF	The Children's Investment Fund Foundation
FP	Family Planning
HEWS	Health Extension Workers
IAP	Implant Access Program
LAPM	Long-Acting and Permanent Methods
LARCS	Long-Acting Reversible Contraception
MSI	Marie Stopes International
OTJ	On-the-job
UNFPA	United Nations Population Fund

EXECUTIVE SUMMARY

The 2012 London Summit on Family Planning convened leaders around the world to commit to one goal: ***meeting women's unmet need for contraception.*** Accelerating ***the introduction and scale-up of contraceptive implants*** was identified as one key component to achieve the ambitious Family Planning 2020 (FP 2020) goal of increasing 'voluntary use of modern contraception by 120 million additional women and girls in the world's lowest-income countries by 2020'[i]. In response, the Implant Access Program (IAP) was introduced to address key barriers to implant introduction and scale-up. This coordinated effort across donors and implementers – including the Bill & Melinda Gates Foundation (BMGF), the Clinton Health Access Initiative (CHAI), the Children's Investment Fund Foundation (CIFF), United Nations Population Fund (UNFPA) and the governments of the United Kingdom, Sweden, United States and Norway – led to substantial improvements to expanding access to implants and method choice among women around the world. From 2012 to 2021 global procurement of implants for FP 2020 countries increased from 3.9 million[ii] to 10.6 million[iii], and is projected to increase in the coming years. (Figure 1).

Figure 1: Implant Procurement, 2012-2022

This learning synthesis aims to articulate the best practices and lessons learned in the 'story' of implant introduction and scale-up over the past decade. Specifically, this learning synthesis highlights 10 key lessons learned as they relate to the Availability, Accessibility, Acceptability, and Quality (AAAQ) framework[iv] of essential standards for sexual and reproductive health and rights services:

ENABLING ENVIRONMENT

LESSON 1: ***Coordinate action*** at all levels (global and national) to fast-track implant introduction and scale-up; including government stewardship for national action and global coordination for investment, volume guarantees, clinical guidance, and sharing lessons learned.

LESSON 2: Deliberately integrate ***rights-based approaches*** into implant introduction and scale-up to ensure informed choice at every touchpoint and eliminate over promotion of one method.

AVAILABILITY

LESSON 3: *Task share* to increase access to implant insertion and removals while ensuring sufficient linkages to the broader health system.

LESSON 4: 'Meet women where they are' through *multiple public service delivery channels*, including outreach and community opportunities, to increase access to implant insertion and removals, leveraging the potential of the private sector as appropriate.

LESSON 5: *Integrate implant data* with desired disaggregation into national/existing M&E systems to manage supply and measure progress.

ACCESSIBILITY

LESSON 6: Volume guarantees dramatically reduce the price of commodities and increase accessibility in the public sector; but scaling up implants beyond the public sector requires *innovative financing mechanisms* including coverage in national health insurance schemes.

ACCEPTABILITY

LESSON 7: Design *demand generation activities* with a clear understanding of the user and provider and implement through multiple channels to reach multiple audiences, and address multiple methods to maximize success.

QUALITY

LESSON 8: Establish *quality assurance systems* that measure quality at key touch points, including both insertion and removals, to support positive client-led referral feedback loops.

LESSON 9: Institutionalize *comprehensive implant training programs*, including management and side effects, removals, reporting, and supply chain management through a standard national curriculum for health workers.

LESSON 10: Plan for *implant removals* from the beginning and measure it. 'What gets measured gets done.'

These lessons learned and best practices can assist FP stakeholders to appreciate what has worked and why for the introduction and scale-up of implants. Importantly, these lessons can also inform implant introduction and scale-up efforts in different parts of the world, where implants have yet to be introduced or where it can be strengthened. In applying the AAAQ framework, we can also see how lessons learned for contraceptive implant introduction and scale-up can be applied to the introduction of other new FP methods.

BACKGROUND

The 2012 London Summit on Family Planning convened leaders around the world to commit to one goal: ***meeting women's unmet need for contraception.*** This goal, which aimed "to empower the voluntary use of modern contraception by 120 million additional women and girls in the world's lowest-income countries by 2020"[v] was operationalized through the creation of Family Planning 2020 (FP2020), a global partnership and platform made of country governments, civil society organizations, the private sector, and other stakeholders[vi]. To date, this partnership has been extended (FP2030) to build on the lessons and progress made over the last decade and to reaffirm this global commitment to rights-based FP[vii]. ***Expanding access to long-acting reversible contraceptives (LARCs), including implants, was understood as a critical opportunity*** to meet this goal. In response, the Implant Access Program (IAP) was formed in 2013 by public and private organizations, including the Bill & Melinda Gates Foundation, the Clinton Health Access Initiative (CHAI), the Children's Investment Fund Foundation, United Nations Population Fund (UNFPA) and the governments of the United Kingdom, Sweden, United States and Norway. The IAP supported expanded access to implants and method choice among women around the world[viii], led to price reduction of implants by 50% to those procuring implants for FP2020 countries and addressed supply chain, service delivery and knowledge and awareness barriers[ix].

The IAP, alongside many other initiatives around the world have ***demonstrated how concerted and coordinated efforts by donors, implementing partners, researchers and country governments can increase contraceptive prevalence around the world.*** It is estimated that the IAP led to more than $500 million in cost saving[x]. Furthermore, global procurement of implants for FP 2020 countries increased from 3.9 million[xi] to 10.6 million[xii] from 2012-2021, and is projected to increase in the coming years. As a result, implants largely accounted for increases in modern contraceptive use in 11 countries in Sub-Saharan Africa between 2003-2017[xiii].

These results beg the question: what are the programmatic learnings, tips, best practices and challenges for implant introduction and scale-up? Jhpiego and Impact for Health, as part of the Expanding Family Planning Choices (EFPC) project, undertook rapid literature reviews and key informant interviews with experts in the contraceptive implant and FP field to answer this question. The results of this review led to this learning synthesis, and a series of other products for continued learning and sharing available here.

METHODOLOGY

This *learning synthesis* was developed based on a rapid literature review[1] and key informant interviews. A total of 37 peer reviewed and grey literature documents were extracted, alongside internal Jhpiego project documentation, of which 10 peer-reviewed articles, one grey literature document and eight Jhpiego project documentation were reviewed and prioritized for this analysis. The desk review was complemented by seven key informant interviews with donors, implementing partners and healthcare providers. Findings were collated and analyzed to understand overarching best practices and lessons learned for implant introduction and scale-up.

KEY FINDINGS: LESSONS LEARNED AND BEST PRACTICES FOR IMPLANT INTRODUCTION AND SCALE-UP

To systematically capture the key lessons and best practices for implant introduction and ground these learnings within a robust FP framework, the *Availability, Accessibility, Acceptability and Quality (AAAQ) framework* was selected. The AAAQ framework articulates the four essential and interrelated standards for *sexual and reproductive health and rights services.* To enhance the AAAQ framework and acknowledge the importance of the wider context, the *Enabling Environment* was added at the core of the AAAQ framework to articulate cross-cutting standards from the user (i.e. rights based approaches) and systems (i.e. coordination) perspectives. Figure 2 shows how the *10 key lessons learned* emerged from the AAAQ framework.

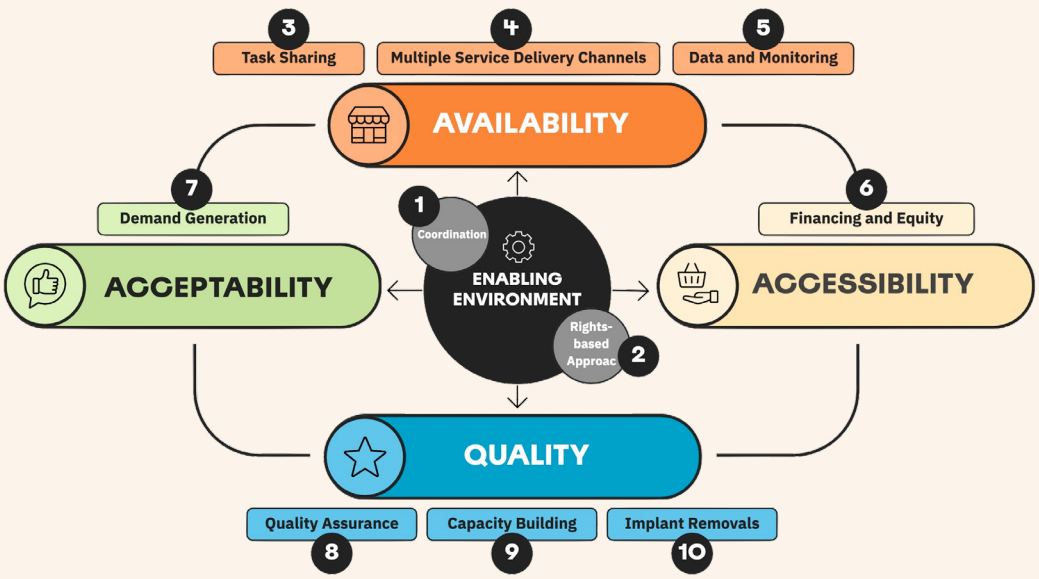
Key findings are detailed below against the overarching component of the above framework.

ENABLING ENVIRONMENT

LESSON 1: *Coordinate action* at all levels (global and national) to fast-track implant introduction and scale-up; including government stewardship for national action and global coordination for investment, volume guarantees, clinical guidance, and sharing lessons learned.

Coordinate global action: Over the past decade, several coordinated global efforts between researchers, donors, manufacturers, distributors and implementers assisted in fast-tracking the introduction and scale-up of implants, resulting in over a three-fold increase of global procurement of contraceptive implants. Key milestones include the following:

Figure 2: AAAQ framework for implant introduction and scale-up



[1]**Search Criteria:** Scope: 2012-2022 (10-year period); Region/Countries: All. Search terms: Long-acting reversible contraceptives (LARC), Contraceptive implant, Private sector, Challenge and/or opportunity, Best practice and/or lessons learned, Service delivery, Provider or provision, Coverage/reach, Feasibility, Health impact, Sustainability, Cost, Market, Product, method introduction, Jadelle and/or Levoplant and/or Implanon and/or Nexplanon and/or Implanon NXT. Sources: PubMed and Google Scholar were used to review and extract peer-reviewed articles. Organizational websites were used to review and extract grey literature

- The *2012 FP Summit and launch of FP2020* secured US$2.3 billion towards meeting the unmet need for contraception including implants and coordinated FP2020 countries around a common goal[xiv].
- The *Implants Access Program's volume guarantees* with manufacturers (2013-2014) resulted in price reduction of implants by 50% through 2018, to those procuring implants for FP2020 countries[xv].
- The updated *WHO Guidance on Task Shifting and Medical Eligibility Criteria* (2013 and 2015), suggested that auxiliary nurses and midwives could insert and remove implants when appropriately monitored. In 2015, the fifth edition of the Medical Eligibility Criteria reduced restrictions around the use of implants for adolescents and breastfeeding women less than 6 weeks postpartum[xvi].
- The *IAP Operations Group* (formed in 2015) facilitated and coordinated donor investment for operational and service delivery aspects of contraceptive implant scale-up, setting a precedent for coordination around new product introduction and scale-up[xvii].
- The *Implants Removals Task Force* (formed in 2015), brought together researchers, donors and implementors to address barriers to removal services through coordination of efforts and guidelines[xviii].
- The *pre-qualification of Levoplant* in collaboration with DKT WomanCare Global (2017) and with the support of FHI360[xix], was introduced as a third pre-qualified product, expanding the range of contraceptive implant options[xx].
- The *recommitment by manufactures* to maintain reduced pricing of implants until 2023 supports continued affordable access (2018)[xxi].

A visual depiction of this Journey to Scaling Implants is available here.

> ***"At a global level, it was important to build a network of all relevant stakeholders to support the introduction of the product (support for training, demand, data). Having that cohesive and comprehensive group of stakeholders is very important. It should be replicated in country as well; sharing lessons learned and creating that community and network. If there is a country just thinking about introduction, make sure that removals is part of the conversation at the beginning and making a plan for that"***
> ***- Implementing Partner***

Coordinate national action: IAP countries noted that a key element to successful national scale-up and avoidance of duplicating FP efforts was coordination efforts led by government stakeholders. These efforts brought together the MOH, donors, implementing partners, social marketing organizations, and the private sector around national scale-up plans - specifically sharing of information, problem solving, and alignment of goals and commitments. Coordination between implementing partners in IAP implementing countries and the MOH led to better management of supply and demand, such as through the creation of FP dashboards in Nigeria and Kenya[xxii].

LESSON 2: Deliberately integrate *rights-based approaches* into implant introduction and scale-up to ensure informed choice at every touchpoint and eliminate over promotion of one method.

Avoid over promoting one method over another. As implants were introduced, concerns emerged in some contexts about whether implants were over promoted in comparison to other methods in an effort to generate demand and interest in this new method. For example, in South Africa, during the early stages of the implant program, concerns arose that contraceptive users were not being given an adequate choice of methods, with the implant being strongly promoted as the first-line method, and with insufficient counseling about possible side-effects or alternative contraceptive

options[xxiii]. Despite implants and other LARCs having several advantages, such as being long-acting, higher efficacy and cost-effective, other factors also influence choice at different stages in a women's life. These factors can include managing side effects, fertility desires, frequency of sexual intercourse with partner, and personal or cultural concerns around side effects[xxiv]. By recognizing it is not a one-sized fits-all approach, complete information about new methods, including their advantages and side effects, should be part of comprehensive counseling.

Incorporate informed choice in training of providers on implant counseling. Training that incorporates insertion, removals, management of side effects and informed decision making and choice are all facets of ensuring providers are well equipped to provide services that are rights-based and facilitate informed choice. Availability of trained health workers (i.e. trained to provide the service and counsel for informed choice)[xxvi] as well as access to available safe and effective insertion and removal services[xxvii] can act as key contributing factors to decision making around continuation and discontinuation.

AVAILABILITY

LESSON 3: ***Task share*** to increase access to implant insertion and removals while ensuring sufficient linkages to the broader health system.

Expand provider capacity for implant services through task sharing to increase access to implants. According to the WHO, task sharing, sometimes referred to as task-shifting, is a viable method to expand and strengthen the health workforce to increase access to health services. It is defined as "(…) the systematic delegation of tasks, where appropriate, to less specialized workers in order to maximize the efficient use of resources. Task-sharing involves training mid- and low-level cadres of health workers—such as clinical officers, auxiliary nurses, and CHWs—to deliver some services offered by higher-level cadres in order to optimize the reach of a limited health workforce"[xxviii]. In the context of implants, this is best reflected in Zambia, where retired midwives were employed as dedicated providers for LARCs in high-volume public sector facilities, leading to more than 22,000 implants delivered in 18 facilities over 14 months[xxix]. Further in Ethiopia, the Integrated Family Health Program, trained more than 10,000 health extension workers (HEWs), who are mid-level providers, for implant service delivery[xxx].

Couple task-sharing with supportive supervision, ongoing training, and demand generation to sustain quality implant service provision. Task sharing can be a practical solution to expand access to implants, when coupled with ongoing demand generation, refresher trainings and supportive supervision to maintain and practice skills[xxxi]. For example, a pilot study assessing the feasibility of task sharing in two Northern states in Nigeria trained 166 community health extension workers (CHEWs). This study implemented a six-month post-training supervision and monitoring plan, with monthly community mobilization efforts to help maintain skills and ensure a sufficient number of insertions took place. At the end of the six months, certified CHEWs were linked with state and local government area teams for continuous supportive supervision[xxxii]. Despite CHEWs rating their skills and confidence to insert implants as high, lack of demand was noted as a barrier to providing services, encouraging regular sensitization and mobilization activities to promote awareness and acceptance for increased demand and scale-up[xxxiii].

Include mechanisms to support follow-up and removal services in task sharing efforts. Task sharing must include barrier-free avenues for removals. In Ethiopia, HEWs are only able to insert implants and must refer to higher-level facilities for removals. Although a referral system can ensure an avenue is in place for removals, particularly complicated removals, barriers to removal services may still remain. For example, distance and transportation to referred higher-level facilities for women in rural areas may act as barriers to getting timely removals. Implementing training for removals at the same

health system level as insertions can avoid these barriers and ensure women receive timely removals and avoid extended use of implants[xxxiv].

> *"In [country redacted] retired midwives are really willing and as long as they have the strength to counsel and offer the service, they offer a really good job"*
> *- Implementing Partner*

NIGERIA'S TASK SHIFTING POLICY AND WHAT IT MEANS

In 2014, Nigeria adopted a task shifting policy allowing CHEWs to insert and remove implants. Initially, changing the task shifting policy was a challenge, as nurses and midwives felt this was a task for them. However, by having an acceptable training manual for the entire health care system, initial reticence was overcome. A cost-benefit analysis and human resources for health review were also undertaken which found that majority of health care workers were actually CHEWs, This information, coupled with data, resulted in acceptance of CHEWs to provide implant services[1].

Braun & Grever. 2020. Scaling Up Access to Implants: A Summative Evaluation of the Implants Access Program, Global Health Science Practice, 8(2). https://www.ncbi.nlm.nih.gov/pmc/articles PMC7326518/pdf/GH-GHSP200015.pdf

LESSON 4: 'Meet women where they are' through *multiple public service delivery channels*, including outreach and community opportunities, to increase access to implant insertion and removals, leveraging the potential of the private sector as appropriate.

Expand service delivery channels to help reach "Any woman, any place, any time"[xxxv]. This approach, described by Hathaway et al., notes that women should be able to access LARCs in a range of settings. In South Africa, this strategy has been used to help strengthen implant provision. For example, implant services have been successfully incorporated into HIV and TB clinics. In addition, implant services have been added to existing mobile outreach services, such as for sex-worker programs [xxxvi] to improve access to implants. Furthermore, in Sub-Saharan Africa, MSI Reproductive Choices (MSI) employed two models of mobile outreach. The first model was through teams that delivered services in existing health centres in rural areas. The second model was through smaller teams with lower-tiered cadres that offered implants in client homes or non-health facility locations. Both these models of mobile outreach accounted for 70% of all implants delivered by MSI in Sub-Saharan Africa[xxxvii].

> *"Channel innovation has showed that lower-level cadres of providers can do this. In Nigeria, PPMVs (patent and propriety medicine vendors) are inserting implants which has been an interesting innovation"*
> *- Implementing Partner*

> *"Most of these methods, 90% are provided within the MOH channels but we overlook some channels, like private sector. But in [country redacted] this is now shifting towards that because right now we have started training pharmacists to provide injectables, I think sooner or later we need to think about a new channel of service provision"- Implementing Partner*

Identify opportunities to expand access through private sector service delivery channels. Efforts to provide and improve women's access to implants have largely focused on free public sector provision. Yet there are several untapped opportunities for

the public and private health sectors to work efficiently together to expand access to implants and achieve national health goals. Particularly in countries where there is a heavier reliance on the private sector for health services, engagement with the private health sector can improve access and coverage of implants[xxxviii]. For example, public-private partnerships have been noted to reduce the cost of implants, ultimately improving access, availability and use of implants[xxxix]. Between 2013 and 2017, private provider networks affiliated with Population Services International, improved uptake of implants by providing over 2.6 million implants across its Sub-Saharan African programs[xl]. To learn more about the opportunities to expand coverage of implants through the private sector, read our comprehensive analysis deck on Private Sector Engagement Barriers, Opportunities and Recommendations, and our infographic on 5 Steps to a Healthy Private Sector Market.

LESSON 5: ***Integrate implant data*** with desired disaggregation into national/existing M&E systems to manage supply and measure progress.

Integrate implant data into existing monitoring and evaluation systems to help prepare for and manage the supply chain and measure progress.
MSI integrated their supply chain data into national supply chain systems across Sub-Saharan Africa[xli] to ensure a reliable supply of implants were available for MSI programs and to prevent stockouts at the national level. Further, in Kenya and Nigeria, as part of the IAP, FP dashboards were created to improve supply chain visibility and coordination. These dashboards integrated service delivery data, consumption and training to improve availability of supplies to facilities with trained providers. The dashboards were later expanded to cover all FP methods in an integrated manner to improve supply planning[xlii].

SCALING UP ACCESS TO LARCS THROUGH COMMUNITY OUTREACH IN NIGERIA & ZAMBIA

As part of Jhpiego's Accelerating Scale-up of Implants (ASI) project, mobile outreach was undertaken to reach rural communities without health facilities or non-functioning health facilities. This included outreach to sexually active adolescents in school and out of school young adults. Mobile outreach allowed for providers in these areas to continue maintaining their skills. A total of 18 community family planning outreaches were facilitated, resulting in over 700 women reached, and 530 new LARC acceptors. In Zambia, portable examination couches and tents during outreach allowed providers to offer LARCs, given privacy was a noted barrier.

Jhpiego. 2016. Accelerating Scale-up of Implants to Expand Access to Long-Acting and Permanent Methods of Family Planning Services: Lessons from Kenya, Nigeria, Zambia, and South Africa End-of-Project Report.

LINKING LARC INDICATORS TO EXISTING M&E SYSTEMS TO IMPROVE PROGRAMMING IN KENYA

In Kenya, as part of Jhpiego's Accelerating Scale up of Implants (ASI) project, LARC indicators were integrated into existing M&E systems to improve programming, supply chain monitoring and follow-up support. To support these efforts, facility staff were trained in reproductive health commodity management to manage stocks and minimize stockouts. Further, Jhpiego partnered with the Kenya Urban Reproductive Health Initiative (Tupange project) and leveraged the project's SMS commodity tracking system, to help monitor FP commodity data. Tupange's SMS commodity tracking system is linked to Kenya's Medical Supplies Agency's e-mobile system, which included demand and supply side data.

Jhpiego. 2016. Accelerating Scale-up of Implants to Expand Access to Long-Acting and Permanent Methods of Family Planning Services: Lessons from Kenya, Nigeria, Zambia, and South Africa End-of-Project Report.

Disaggregate data on implant provision, including removals, to improve programming. Disaggregating implant data by age and specific groups of women, such as post-abortion women, and other social stratifiers can help identify gaps in provision, training, quality of care and factors affecting uptake and continuation[xliii]. This improved visibility on implant provision can support planning of removals expected, as well as provide information on uptake and reasons for discontinuation or method switching. For example, MSI established a Client Information Centre, a database of women who have had an implant inserted, to help with scheduling removals, and overall monitoring and evaluation efforts[xliv]. Capturing this type of information can inform national FP programming, by identifying gaps in service provision, demand generation activities, training, and quality of care[xlv].

ACCESSIBILITY

LESSON 6: Volume guarantees dramatically reduce the price of commodities and increase accessibility in the public sector; but scaling up implants beyond the public sector requires *innovative financing mechanisms* including coverage in national health insurance schemes.

Ensure equity in uptake, to the extent possible. In seven Sub-Saharan African countries, implant use has been equitable across several sociodemographic categories, such as women in all five wealth quintiles, older women, younger women, women in rural areas and unmarried women[xlvi]. This was due to multiple factors, including reduced commodity cost, increased commodity supply, enhanced government commitment to expanded method choice, and the delivery of services through multiple channels[xlvii].

Establish volume guarantees to decrease the price of the commodity. The IAP established two price volume guarantees with manufacturers to make upfront investments, build long-term demand confidence, and thereby reduce prices. This allowed for implants to be available at a 50% reduced price to those procuring implants through 2018, making implants more available to women in some of the world's poorer countries. An integral part of the initial price agreement was the understanding that implementation support, such as provider training, would be covered by other entities.

> ***"When the prices were reduced and the agreement was put in place, it was a win-win for both sides. It was the right intervention to really unlock the demand and potential to engage manufacturers those who weren't deeply engaged"- Donor***

Plan for the cost of removal services as a key component to overall implant service provision. Failing to do so can lead to barriers, such as additional costs, in accessing these services in a timely manner. A landscape analysis on the implant removal context in Burkina Faso, Democratic Republic of the Congo (DRC), Nigeria and Tanzania, found that implant removal services included associated fees in public facilities in Burkina Faso, the DRC and Nigeria, and in faith-based and private facilities in Tanzania. In all countries, facility staff or clients reported that the fees were not affordable[xlviii].

Identify innovative ways to engage the private sector for implant service delivery. Implants provided for free or at a reduced cost in the public sector provided no value add for private sector engagement. This ultimately disincentivized private sector providers to offer implant services, and requires new and sustainable solutions such as reducing donor subsidies and including implants and other contraceptives in national insurance schemes for sustained domestic financing. Including FP in health insurance schemes can improve universal coverage and affordable access, when services are reasonably reimbursed[xlix]. To learn more about this, check out our comprehensive analysis of the barriers, opportunities and recommendations for private sector engagement for implant service delivery here.

> *"[Country redacted] has a national insurance scheme to move into UHC. This is done by working with local health insurance company to take a look at their guidelines and put in the quality element into their FP services, meaning clinical practice guidelines that are linked to FP services, including implants"- Implementing Partner*

REDUCING COSTS AND INCENTIVIZING THE PRIVATE SECTOR

In efforts to improve availability of an affordable supply for the private sector across Sub-Saharan Africa, MSI's Blue Star's social franchising network supported franchisees to receive implants for free or at reduced cost. MSI's financing mechanisms included: using a surplus from developed countries to support programming in developing countries and likewise revenue generated from services delivered to wealthier clients was used to subsidize services for lower-income clients. Further, donor subsidies also helped reduce implant and operations costs and bulk pricing. In addition, vouchers were used to subsidize implant insertion, follow-up and removal visit fees in areas with high unmet FP need.

Duvall et al. 2014. Scaling up delivery of contraceptive implants in sub-Saharan Africa: operational experiences of Marie Stopes International, Global Health Science Practice, 2(1). https://pubmed.ncbi.nlm.nih.gov/25276564/

ACCEPTABILITY

LESSON 7: Design *demand generation activities* with a clear understanding of the user and provider and implement through multiple channels to reach multiple audiences, and address multiple methods to maximize success.

Conduct intentional dialogues with program planners, health providers and end-users to identify and address barriers to uptake, including myths and misconceptions and factors for discontinuation[i]. In Zambia, modern FP methods were prohibited in a hospital affiliated with the Catholic church. In response, Jhpiego negotiated with the hospital's authorities to train providers in LARC sensitization, although the providers were not allowed to insert or remove implants in the facility. As demand increased, implant insertions were offered at a nearby outreach post, outside the hospital. Over three months, 116 women received LARC services and were encouraged to return to the hospital for follow-up and management of any side-effects[li].

Create multi-platform, multi-audience, and multi-method demand generation activities, where possible. Demand generation was not an explicit IAP objective as there was judged to be latent demand for the method based on earlier experience. However, IAP country partners found that demand varied with high uptake in some areas as soon as providers were trained and low utilization in other areas. These IAP country partners included activities that engaged various stakeholders, such as religious leaders and institutions government, political leaders, health facility workers, women in the community, and were inclusive of male community members. This engagement was successful in raising community awareness and sensitization among country partners[lii]. In Uganda, MSI's demand generation activities – that used multiple platforms to reach multiple audiences for the promotion of multiple contraceptive methods -- led to a seven-fold increase of implant users between 2006 and 2011. MSI Uganda utilized mobile outreach to

offer services through community health workers (CHWs), who led door-to-door mobilization and group information sessions, and announcements through radio. Services offered through MSI clinics included activities such as radio show appearances by MSI clinical staff and setting up kiosks at markets and popular events[liii].

Ensure sufficient demand so providers have a steady client load and opportunities to practice and maintain skills on insertions and management of removals. To increase demand for FP methods, the Integrated Family Health Program in Ethiopia as part of the Implanon scale-up program facilitated community awareness through a mobile van. Demand generation activities took place prior to the training of health extension workers to ensure once providers were trained, there would be a sufficient demand for services[liv]. This ultimately helped ensure that providers not only could maintain a steady client load but could maintain skills for quality service provision with sufficient hands-on experience.

CREATING DEMAND FOR FAMILY PLANNING WITH ZAMBIA'S TRADITIONAL LEADERS AND VILLAGE CHIEFS

To promote the uptake of LARC services, Jhpiego's Accelerating Scale-up of Implants (ASI) project implemented demand generation activities in Zambia through: 1) engaging with community health volunteers at facilities working in other health areas on FP and LARC messaging; and 2) engaging traditional leaders and village chiefs in five chiefdoms on FP. This led to the further engagement of village headmen who were educated on FP by health facility staff and encouraged to seek FP services.

Jhpiego. 2016. Accelerating Scale-up of Implants to Expand Access to Long-Acting and Permanent Methods of Family Planning Services: Lessons from Kenya, Nigeria, Zambia, and South Africa End-of-Project Report.

QUALITY

LESSON 8: Establish ***quality assurance systems*** that measure quality at key touch points, including both insertion and removals, to support positive client-led referral feedback loops.

Measure quality from multiple perspectives and at multiple points in time to support ongoing improvements based on data and to support positive feedback loops whereby clients refer services to new clients[lv]. For example, across Sub-Saharan Africa, MSI monitored: clinical quality control of implant service provision (FP counseling, insertion, infection prevention, management of follow up care and referral system); the service delivery environment (customer service, facility cleanliness, and privacy); and program operations (commodities management, record keeping, and demand generation)[lvi]. Data from MSI showed that "friendliness and respect from the healthcare provider" was the highest rated component of the service delivery experience for clients. This in addition to MSI's "good reputation" and knowing someone who used the service, were the most influential factors for choosing MSI for FP services[lvii]. Quality of service delivery was monitored through a mix of methods, including clinical protocols, such as competency-based and updated training and refresher courses and referrals to facilities for complications or implant removals; regular supervision; and occasional quality checks, such as mystery client visits and audits. To learn more about quality assurance measures taken by MSI, check out country pages for Cambodia and Ghana. For information on implementing quality contraceptive implant removal services, check out this comprehensive hub of resources.

Integrate removal services, as well as insertions, within quality assurance systems. Emerging data indicates that the capacity for implant removals has not been able to keep pace with insertion[lvii]. Routine reporting of data on removals can provide a better understanding for the reasons for removals, like method switching, factors for

discontinuing and timing. Subsequently this can support with planning of insertions provided, anticipate volume of removals and access to these services, as well as quality of care[lix]. For example, in Botswana an implant database was developed following the introduction of implants in 2016 to track both insertions and the demand for removals from 2019[lx].

> ***"High quality here includes considerations for compliance to counseling, voluntariness and importantly choice, strict infection prevention practices and control; and ensuring both insertion and when necessary, removal are included"***
> ***- Implementing Partner***

Ensure service sites have the appropriate equipment and consumable supplies to offer implant services. A number of studies[lxi, lxii] underline the importance of consistent availability of all necessary equipment and consumables to ensure quality service provision. In 2015, several global partners, including UNFPA and CHAI, developed a standardized consumables kit for contraceptive implant services[lxiii]. The kit includes supplies for insertion and removal, offering an easily procurable option for places where supply planning has been an issue. This guidance should be used to ensure all consumables are consistently available. To learn more about the items required to LARC services, including implants, check out this comprehensive resource list.

LESSON 9: Institutionalize ***comprehensive implant training programs,*** including management and side effects, removals, reporting, and supply chain management through a standard national curriculum for health workers.

Institutionalize training on implants in national health worker education programs to create an enabling environment where health providers are well equipped on knowledge and skills for implant provision and other FP methods. In all countries with dedicated implant support, implants training was integrated into a standard curriculum for health worker education programs[lxiv] to ensure that providers were able to sustain capacity and skills to provide implant services.

Support comprehensive training that incorporates on-the-job (OTJ) training, supportive supervision, and ongoing mentoring and coaching to sustain provider competence and confidence. As part of the IAP, partners tested various training models and found that combining OTJ training with follow-up of supportive supervision, mentoring and coaching, served to be more cost effective compared to traditional in-service training models. OTJ training also led to fewer disruptions compared to off-site training, and additional opportunities to practice and maintain skills[lxiv]. Further expanding new and refresher training courses to cover insertion, removals, informed decision making and choice, pre-insertion counseling including side effects, and long-term support and management of side effects, can strengthen provider confidence and competence in insertion and removals. Moreover, to ensure competence of insertions and removals is up to date, training efforts should be updated against WHO medical eligibility guidelines for the implant, such as suitability of implants for women of all ages, such as adolescents[lxvi]. Clear guidance on different implant brands should also be considered in trainings, particularly in contexts where different implant brands are available[lxvii].

Ensure training includes all aspects of implant service delivery, including management of side effects and removals. Management of side effects and removal support services are all critical elements to overall comprehensive and quality implant service delivery. Training methods that are too short or do not include management of side effects and removals are insufficient to support effective implant service provision. In South Africa, a general lack of capacity and resistance to perform removals led to incorrect and repeated unsuccessful attempts at removals, which led to negative media and public perceptions of implants[lxviii]. In other countries, such as Ethiopia, some providers are only permitted to support insertions and not removals, such as Ethiopia's Health Extension Workers (HEWs) who instead were trained to counsel

women on where to get removals. Where possible, it is recommended to train all health workers to insert and remove implants to avoid barriers such as transportation or distance to high level facilities to get removals when referred[lxix].

BUILDING CONFIDENT PROVIDERS FOR IMPLANT INSERTION IN KENYA

When Implanon was updated to Implanon NXT, the ASI project supported retraining providers on the new inserter device using an on-the-job training approach. In Kenya, this approach was developed jointly by Jhpiego and the Kenyan government. The OTJ approach was used in four counties, with 639 providers from 116 health facilities where implants were being provided. Results from one OTJ course found that 98% of providers felt confident to provide implants, and after two months of training, data from 581 of the trained providers, found that 98% of them had provided one or more insertions to clients post-training. The OTJ approach for Implanon NXT was considered a feasible approach for experienced implant providers.

The project supported the review of the additional materials (revised learning guides, slides, and notes on new methods) to be included in an addendum within the current national long-acting and permanent methods (LAPM) curriculum. The project also developed a job aid for the insertion of Implanon NXT and a removal job aid in consultation with the MOH, MSD/Merck and Bayer. The addendum and job aids have been included as part of the national LAPM training package.

Jhpiego. 2016. Accelerating Scale-up of Implants to Expand Access to Long-Acting and Permanent Methods of Family Planning Services: Lessons from Kenya, Nigeria, Zambia, and South Africa End-of-Project Report.

> ***"You need the mentorship and oversight, so providers have the confidence and comfortability to do it and do it independently. Training for implants must embed support post-training. The big challenge was training people for removals"- Implementing Partner***

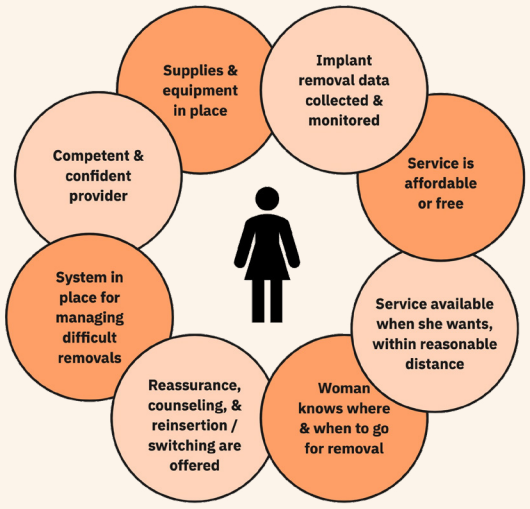
LESSON 10: Plan for *implant removals* from the beginning and measure it. 'What gets measured gets done.'

Integrate implant removals in all aspects of program design, strategies, and implementation. Access to implant removal services is a key component to implant service delivery, to ensure that all women can continue or discontinue the use of a particular method. Barriers to safe and accessible removal services affects not only quality of care, but demand among new users[lxx]. This calls for a comprehensive approach to quality removal services, where multiple conditions are considered best practices to ensure access to quality implant removal services (Figure 3):

1. Collecting and monitoring implant removal data (See Lesson 8)
2. Services are affordable and free (See Lesson 6)
3. Services are available when she wants and within a reasonable distance (See Lesson 4)
4. Clients know where and when they can get an implant removed (See Lesson 2)
5. Services include reassurance, counseling and re-insertion/switching services (See Lesson 2)
6. A system is in place to manage difficult removals (See Lesson 3)
7. Providers are competent and confident (see Lesson 9)
8. Supplies and equipment are available and present for procedures to take place (See Lesson 6)

To learn more about the items required to LARC services, including implants, check out this comprehensive resource list.

Figure 3: Client-centered conditions for ensuring access to quality implant removal



> ***"I think planning for removals from the beginning as much as possible [should be done]. You know in hindsight it's something I wish we had addressed sooner. I mean, it wasn't too late into the buying guarantee, but still I think it would have been good to do that a little bit more up front [...] One key lesson learned was that when countries would be introducing implants, that removals need to be part of that conversation from the very beginning. The good thing is now there are resources available around removals that the task force has developed that can help countries"***
> ***- Implementing Partner***

INNOVATIVE APPROACHES TO TRAIN PROVIDERS IN IMPLANT REMOVALS IN UGANDA AND KENYA

In Kenya and Uganda, Jhpiego built the capacity of 271 LARC providers on removal services. This included modifying national LARC curricular to improve instructions and support materials for removal services and side effects management.

Specifically in Uganda, a low-dose, high-frequency (LDHF) training approach was utilized to reduce learners' time away from site, preventing service disruption. Jhpiego used this approach to update clinical skills on implant removals and side effect management. Training was conducted for 19 district trainers, who trained 104 providers from 63 facilities. Subsequently, Jhpiego collaborated with MSI Uganda to use 73 of their outreach sessions for hands-on skills building. The LDHF methodology allowed for mentorship with outreach, which was considered a more effective approach in ensuring skills are retained among providers than traditional training.

In Kenya, Centers of Excellence (COEs) were established for quality implant removal services, including difficult removal management. COEs provide continuous mentorship on quality removals to other facilities in the catchment area. Catchment facilities were selected based on low volume removals, indicating a gap in removal services being provided. COEs were selected based on availability of adequate staff and equipment for training. COEs also served as referral centers for difficult removals.

Jhpiego. 2018. Identifying Best Practices to Ensure Access to Quality Implant Removal Services.

CONCLUSION

The expansion of implants over the years has led to improved method choice among women around the world. Global commitments and advocacy over the past decade have resulted in several initiatives on implant introduction and scale-up. These initiatives have led to programmatic learnings, tips, best practices and challenges that are worthy to review, document and disseminate to FP stakeholders worldwide in continuing and improving on these efforts. To organize these best practices and lessons learned, we utilized the AAAQ framework and uncovered a total of 10 important themes (Figure 2). These themes speak to a greater narrative, one that is transferrable to implant introduction and scale-up to different parts of the world, where implants have yet to be introduced or strengthened, but also to other FP methods more broadly.

Collectively, these learnings have reaffirmed the importance of ensuring that FP service delivery uphold four essential and interrelated standards: that services are available, accessible, acceptable and of quality and are contextualized within a broader enabling environment. As we continue in our commitment towards equitable access to reproductive health services, it is critical that FP stakeholders reflect on these best practices and lessons learned, to ensure that barriers to equitable access to FP services are addressed, that all women, are well-informed around implants and other contraceptives methods, and that all women have the right and ability to make a choice for their health, well-being and future.

INTERESTED TO LEARN MORE ABOUT IMPLANTS?

Check out our interactive website of resources at the link below.

LEARN MORE

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