Contraceptive Implants:

The Future Is Here, It's Just Not Widely Distributed Yet

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Managing Partner: EngenderHealth; Associated Partners: FHI 360; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council

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Much attention to implants lately, for good reasons

- Most effective of all methods
- Ultra-low amount of hormone
- Very convenient
  - Discreet
  - One act can secure up to 3-5 years of contraception
  - Readily reversible
- Almost all women are eligible to use implants
  - All ages, including young, unmarried
  - Good for all reproductive intentions -- delay, space, limit
- Quickly and easily provided and removed
- Now much lower cost (price-volume guarantees)

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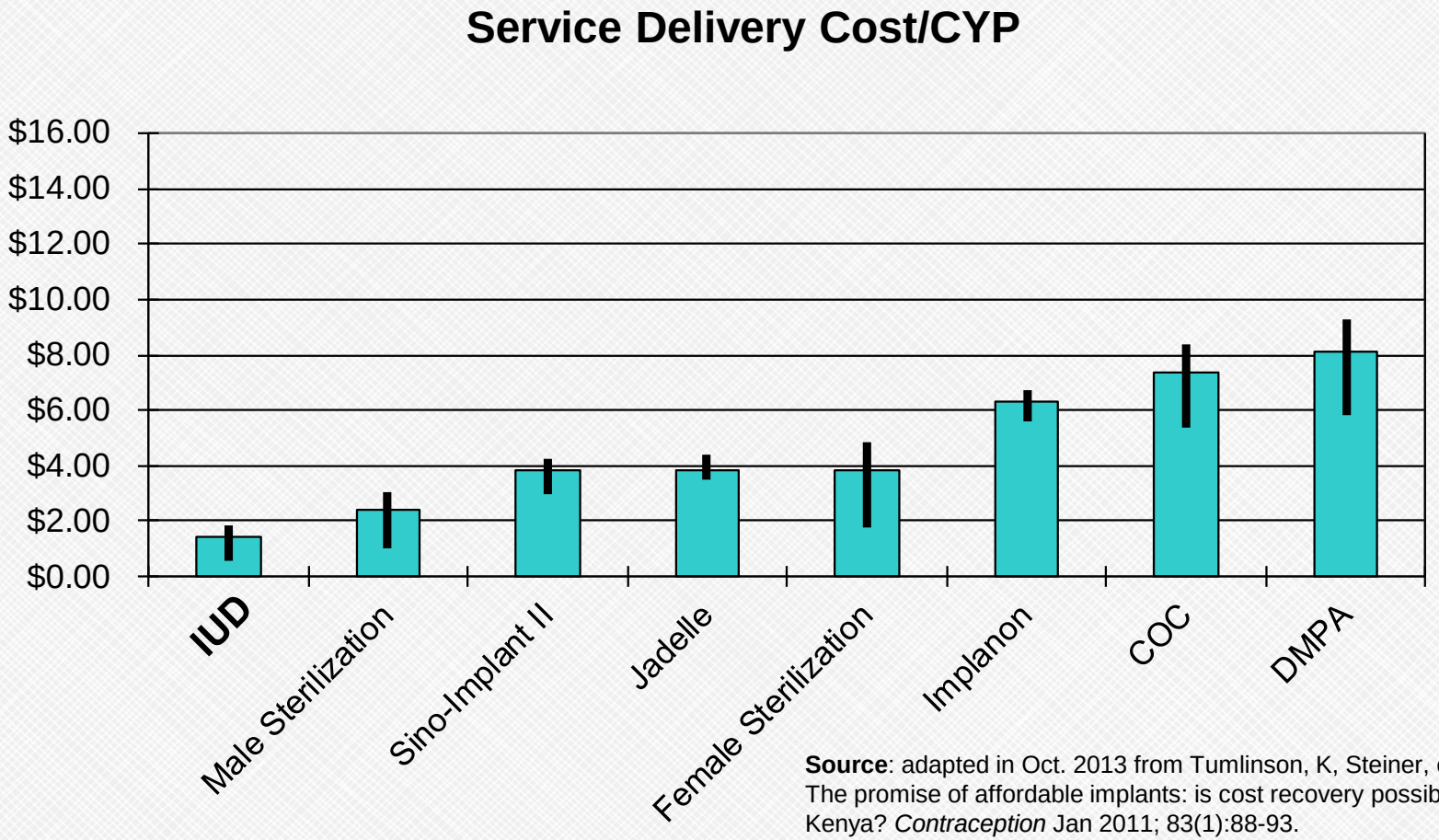
Very high absolute and relative effectiveness

Contraceptive Method	# of unintended pregnancies among 1,000 women in first year of typical use	Relative effectiveness compared to other methods in typical use
Implant	**0.5** (1 pregnancy per 2,000 women)	Implants greater relative effectiveness:
Vasectomy	**1.5**	3 times more effective than vasectomy
Female sterilization	**5**	10 times more effective than female sterilization
IUD (Copper-T 380A)	**8**	16 times more effective than IUD
Injectable	**60**	120 times more effective than the injectable
Pill	**90**	180 times more effective than pills
Male condom	**180**	
Withdrawal	**220**	
No method	**850**	

Source: Trussell J. Contraceptive failure in the United States. *Contraception* 2011; 83:397–404.

Cost-effectiveness of implants is now comparable to other clinical methods, and exceeds that of OCs and injectables



Source: adapted in Oct. 2013 from Tumlinson, K, Steiner, et. al.. The promise of affordable implants: is cost recovery possible in Kenya? *Contraception* Jan 2011; 83(1):88-93.

* Costs include the commodity, materials and supplies, labor time inputs and annual staff salaries. The height of each bar shows the average value of costs per CYP across 13 USAID priority countries.

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But there are many other access barriers to implants as a method choice besides cost

Barriers to effective family planning services

Outcomes when barriers are overcome:

- ↑↑ Access to services
- ↑↑ Quality of services
- ↑↑ Contraceptive choice and use
- ↓↓ Unintended pregnancy

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Key client-level considerations

- Menstrual bleeding disturbances with implants are **universal**
  - The specific bleeding pattern is **unpredictable**
  - **Sociocultural meaning** of bleeding and amenorrhea is very important
- Has important implications for:
  - **Client's choice** of methods
  - **Counseling**
  - **Side effects management** ("anticipatory guidance")
  - Client **follow-up** (mHealth opportunity)
- Bleeding side effects: main reason women discontinue
  - Sometimes as early as 1 month after insertion
  - Continuation rates: 80-90% in clinical trials / in programs?
  - Right to have an implant removed at any time is **absolute**
  - Removal services must be **regular, reliable, accessible**

Photo by M. Steiner/FHI 360

Photo by M.Tuschman/EngenderHealth

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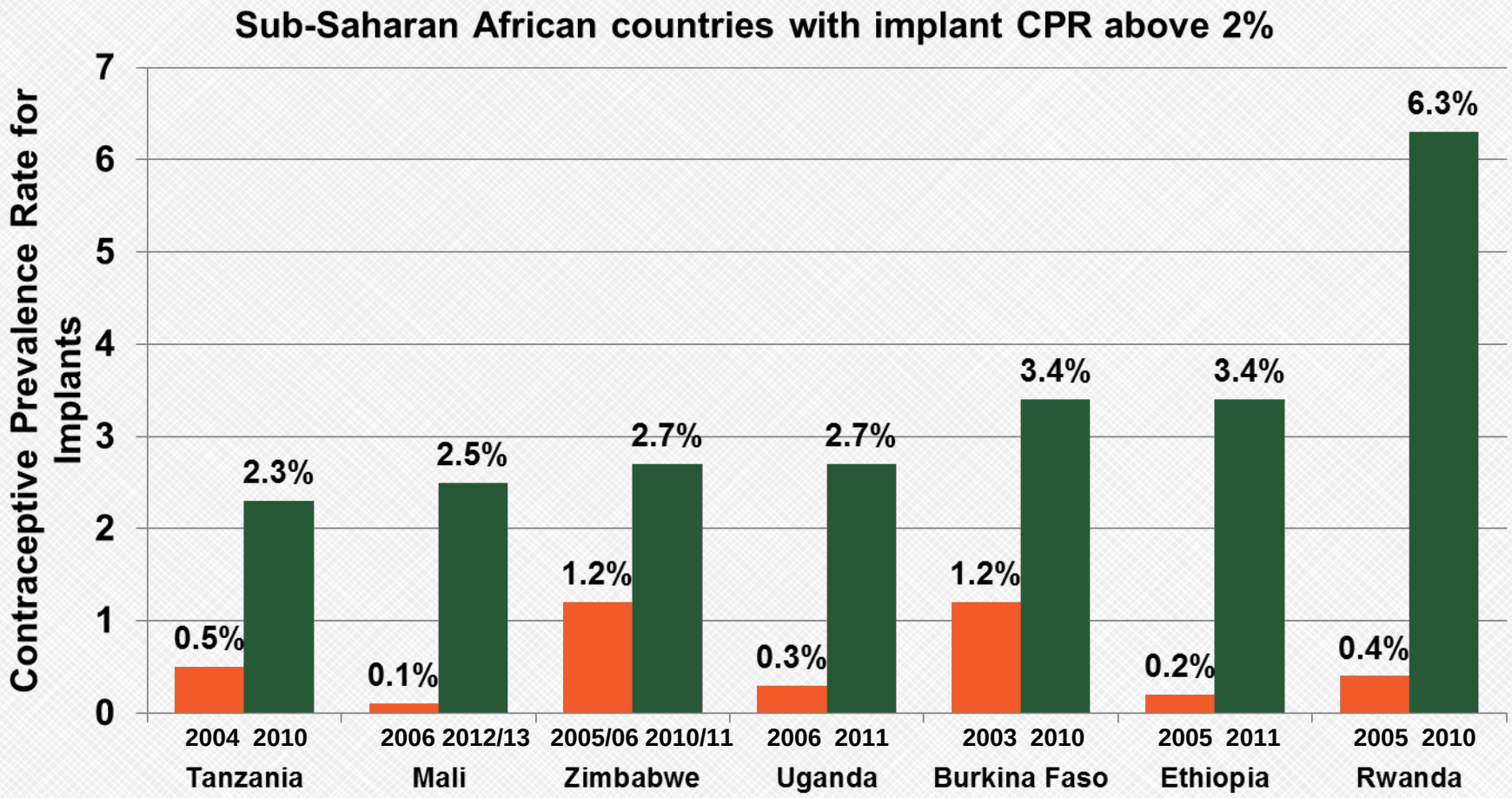
Implants could help meet the high unmet need for FP among young and unmarried women

- 26% of the world's 7 billion people are aged 10-24
- FP demand in young and unmarried women is high, but access is constrained in low-resource countries and unmet need is high:
  - 50-80% demand for FP among married women age 15-24; 20-40% unmet need
  - ~ 90% of unmarried women 15-24 do not want to become pregnant, but their unmet need for FP is even higher: 50% in some sub-Saharan African countries
- Almost all young and nulliparous women are eligible to use LARCs
- LARCs are highly effective, convenient, and user-independent
- Low access, high unmet need for FP, and provider factors are also a problem in the U.S., for many of the same reasons:

> "The American College of Obstetricians and Gynecologists recommends that its [provider] members encourage adolescents age 15-19 to consider implants and IUDs as the best reversible methods for preventing unintended pregnancy, rapid repeat pregnancy, and abortion in young women."
>
> --ACOG Committee Opinion #539, *Obstet. Gynecol., 2012; 120(4):983-988*

Use of implants is already rising in country programs



All data are from the *Demographic and Health Surveys* (DHS), for women ages 15-49 currently married or in union.
Total modern CPR is 9.9% in Mali (2012-13) and 15% in Burkina Faso (2010).

Some young, unmarried, educated, and urban women are choosing implants at even higher rates

Country & Category	Implants Use (CPR)
Rwanda, secondary & higher educ.	8.9%
Rwanda, sexually-active unmarried women, age 20-24	7.9%
Rwanda, married women	6.3%
Ethiopia, sexually-active unmarried women, age 15-19	6.7%
Ethiopia, married women	3.4%
Burkina Faso, Ouagadougou	6.3%
Burkina Faso, married women (Total Modern CPR in Burkina Faso: 15%)	3.4%
Mali, Bamako	6.1%
Mali, married women (Total Modern CPR in Mali: 9.9%)	2.5%

Data source: Most recent respective DHS survey.

So, what are some important things to do to scale up access to implants in a milieu of choice and rights?

- Political will is critical; we must "walk the talk" of ensuring adequate resources:

> "… We call upon other African leaders to increase funding for family planning commodities and related services from national budgets."
>
> —*Pierre Damien Habumuremyi* Prime Minister, Government of Rwanda
> — *Meles Zenawi* Prime Minister, Government of Ethiopia
> www.thelancet.com July 10, 2012

- Programs must ensure good client choice, counseling, follow-up, side effects management, and regular, reliable access to removal services, from the start of any introduction or scale-up effort
- Task-sharing / task-shifting
- Eligibility for implants in breastfeeding women immediately postpartum
- Many successful service modalities – next three panel presentations

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