ADDRESSING THE GLOBAL CHALLENGE OF LARC REMOVALS

RESOURCES FOR PROGRAM MANAGERS

Hosted by the LARC & PM Community of Practice secretariat, Population Services International, through the USAID SIFPO2 Project
Agenda

Welcome, Overview & Introductions
Part I – Global Context/Making the Case
Part II – Removal Standards: Data, Resources, Research Questions
Part III – Existing and Upcoming Resources, Task Force Next Steps
Part IV – Questions and Discussion
Speakers

**Moderator**

Elaine Menotti, MPH  
*Health Development Officer*  
U.S. Agency for International Development

**Panelists**

Maryjane Lacoste, MA  
*Sr. Program Officer, Family Planning*  
Bill & Melinda Gates Foundation

Megan Christofield, MPH  
*Technical Advisor, Family Planning*  
Jhpiego

**Clinical Expert**

Mark Hathaway, MD, MPH  
*Sr. Technical Advisor, Family Planning*  
Maternal and Child Survival Program
MAKING THE CASE:
THE GLOBAL CONTEXT FOR LARC REMOVALS

Maryjane Lacoste
The Status of Global Family Planning Efforts

Since the 2012 London Summit, when FP2020 was launched, there are 30.2 million additional users of modern contraception.
What Does This Mean?

AS A RESULT OF MODERN CONTRACEPTIVE USE FROM JULY 2015-JULY 2016

82,080,000
unintended pregnancies were prevented

25,790,000
unsafe abortions were averted

124,000
maternal deaths were averted

Graphic courtesy of FP2020 Annual Progress Report
Country Example: Kenya

Kenya mCPR and Method Mix among Married Women, 2003–2015 (Source: DHS and PMA2020)
Country Example: Uganda

Uganda mCPR and Method Mix among Married Women, 2001–2016 (Source: DHS and PMA2020)
Country Example: Burkina Faso

Burkina Faso mCPR and Method Mix among Married Women, 2003–2016 (Source: DHS and PMA2020)
LARCs 101

Contraceptive Implants

- Long-acting (3-5 years, depending on type)
- Highly effective (99%) protection
- Requires little attention from client once in place
- Most common side effect: irregular bleeding
- Reversible: return to fecundity is immediate after removal
- Both insertion and removal require a trained provider

IUDs

- Long-acting (5-12 years, depending on type)
- Highly effective (99%) protection
- Requires little attention from client once in place
- Most common side effect: changes in bleeding patterns
- Reversible: return to fecundity is immediate after removal
- Both insertion and removal require a trained provider

*Modified from Family Planning-A Handbook for Providers
http://apps.who.int/iris/bitstream/10665/44028/1/9780978856373_eng.pdf
Implants Procured by Year in FP2020 Focus Countries, 2005-2015, and Projected Removals, 2010-2019

Implant Removals Task Force Core Members
Implant Removals Task Force: To Date

Sub-Groups:

- Data and Monitoring
- Training and Capacity Building
- Research
- Difficult Removals
REMOVAL STANDARDS: DATA, RESOURCES, AND RESEARCH QUESTIONS

Megan Christofield
Implant Removal Client-Centered Standards

- Supplies in Place
- Competent & Confident Provider
- System in Place for Managing Difficult Removals
- Removal Data Collected & Monitored
- Affordable (or Free) Service
- Service Available When She Wants, Within Reasonable Distance
- Reassurance Counseling and Resupply are Offered
- Woman Knows When & Where to Go for Removal
Provider is competent and confident

Where do we stand?

- Facilities in **Kenya, Uganda, and Ethiopia** report having staff trained in implant removal, and pre- and in-service trainings are reported to include both insertion and removal elements.¹,²

- High self-reported confidence in implant and IUD removal among implant providers in **Kenya and Uganda**.²

- During training events, 31% of implant and IUD providers in **Kenya**, and 50% of implant providers in **Uganda** did not have removal clients with whom to practice or test skills.²

- 93% of implant providers in **Kenya** and 60% in **Uganda** reported ever having challenges removing an implant.²

Efforts & Resources

- Many existing LARC training packages that include removal, accessible at: [www.k4health.org/toolkits/](http://www.k4health.org/toolkits/)

- Piloting of implant removal refresher training underway in multiple countries

- New job aid developed, soon to be released from the USAID-funded MCSP project.

Learning Gaps

- What implementation approaches improve competency among implant providers who offer implant removals infrequently?

- How do different service delivery channels offer opportunities for provider capacity building in implant removal (e.g. high volume static or mobile channels vs. low volume static or mobile channels)
Supplies are in place

Where do we stand?

• In Uganda, an assessment of 20 facilities reporting having conducted implant removals in the past 3 months, no facility had all the required supplies and consumables. Most commonly out of stock were: drape, adhesive bandage, iodine, surgical blade, and mosquito forceps.¹

Facilities with Equipment and Supplies LARC Insertion and Removal, Kenya¹

<table>
<thead>
<tr>
<th></th>
<th>Private Facilities (n=21)</th>
<th>Public Facilities (n=36)</th>
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<tbody>
<tr>
<td>Implant Insertion and Removal</td>
<td>29%</td>
<td>50%</td>
</tr>
<tr>
<td>IUD Insertion and Removal</td>
<td>33%</td>
<td>47%</td>
</tr>
<tr>
<td>Implant and IUD Insertion and Removal</td>
<td>5%</td>
<td>25%</td>
</tr>
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Efforts & Resources

• Procurable implant consumable kit from UNFPA procurement system includes necessary consumables for insertion and removal.

Learning Gaps

• To what extent do supply or equipment shortages contribute to the unavailability of implant removal services? Are these shortages greater/more frequent than those for insertion supplies and equipment? Specifically, what supplies or equipment are most frequently unavailable at the service delivery point?

• What approaches successfully address supply or equipment shortages related to the implant removal services?

¹ Jhpiego project data
System in place for managing difficult removals

Where do we stand?

- In a 2016 assessment, 93% of facilities in Kenya and 75% in Uganda reported having referral mechanisms for difficult removal management.¹
- 93% of implant providers in Kenya and 60% in Uganda reported ever having challenges removing an implant.²
- There is a precedent: Difficulties with removal (both in access and quality) during Norplant scale-up had negative repercussions on the method’s reputation, use, and user satisfaction.²

Efforts & Resources

- **Forthcoming**: Video demonstrating identification and management of difficult, deeply placed implants
- **Forthcoming**: Expert trainings planned in specific countries to build capacity for surgical removal of very deep, non palpable implants
- **Forthcoming**: Mapping of expert removal providers underway across a large number of countries
- New job aid developed, soon to be released from the USAID-funded MCSP project.

Learning Gaps

- At what incidence do varying characteristics of difficult implant removal occur, for example broken rods, non-palpable implants, palpable but difficult to remove?
- How, and to what extent, do frontline health workers currently manage difficult removals?
- What capacity building and implementation approaches improve competency among implant providers to provide difficult removals?

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Client knows where and when to go for removal

Where do we stand?

- Implant clients reported being told about the duration of protection:
  - Ethiopia: 99% ¹
  - Kenya: 99% ¹
  - Tanzania: 95% ²
  - DRC: 82% ²
  - Uganda: 94% ²

- Implant clients correctly reported the duration of protection:
  - Ethiopia: 79% ¹
  - Kenya: 87% ¹

- Implant clients reported being told where to go have the implant removed:
  - Ethiopia: 84% ¹
  - Kenya: 89% ¹
  - Tanzania: 85% ²
  - DRC: 71% ²
  - Uganda: 85% ²

Efforts & Resources

- Do clients receive information about removal timing and location during time of insertion? Does this vary by insertion setting? Does receiving this information impact whether the woman knows where to go for removal and does she go to that place first?

- What factors contribute to or inhibit clients’ knowledge of implants’ duration of effectiveness? For example, does provider knowledge play a role?

- Does a client’s understanding of where and when to get her implant removed vary by place of insertion (e.g. static vs. mobile, interval vs. postpartum)?

- For women who knowingly keep their implant beyond its duration of effectiveness, what factors influence their knowingly keeping the implant for that length of time? What factors influence their seeking a removal?

- What are clients’ expectations around accessing implant removal services; for example, do they expect to visit a referral center for this service? Would they be willing to do so?

- How do clients understand duration of effectiveness, e.g. is the possibility of early removal clearly described at the time of insertion? Does length of effectiveness affect implant uptake if clients assume they must keep the method for the entire effectiveness period?

Learning Gaps

- ¹ PMA2020; ² EngenderHealth Project Data
Service available when she wants, within a reasonable distance

Where do we stand?

- 4% of current implant users in Kenya and 7.2% in Ethiopia have attempted to have their implant removed but were unsuccessful.¹
- Women access removals across service delivery channels within provider networks:²
  - Afghanistan: 1.7% removed during outreach (vs. 98.3% in centers)
  - Zimbabwe: 86.5% removed during outreach (vs. 13.5% in centers)
  - Ghana: 36.7% removed during outreach (vs. 63.3% in centers)

Efforts & Resources

- In Ethiopia, where by policy Health Extension Workers are allowed to insert but not remove implants, ‘back-up’ systems have been put in place to support clients’ need for removals.³

Learning Gaps

- To what extent are women seeking an implant removal turned away from the service delivery point? For what reasons? Do the extent and/or reasons vary by type of service delivery point (e.g. static vs. mobile)? Do providers offer solutions for seeking the service?
- How does availability of implant removal services vary by static vs. mobile service delivery channel?
- Can an expected removal rate be modeled and subsequently utilized to inform itinerant service delivery frequency and timing?
- Do clients face disproportionate distance barriers to accessing implant removals as compared to insertions?
- Is there a relationship between where women access insertion services and where they access removals? For example, do women move between static and mobile settings? Public and private?
- To what extent do women perceive distance as a barrier?

¹ PMA2020; ² Marie Stopes International Project Data; ³ Pathfinder International via: http://www.pathfinder.org/its-not-just-about-access/
Reassurance, counseling and resupply are offered at the return/removal visit

### Where do we stand?

- Among women who had their implant removed in various settings, many took-up another method on that visit: ³
  - Afghanistan: 39.3%  
  - Zimbabwe: 35.8%  
  - Ghana: 27.1%

- Among women in **Kenya** and **Ethiopia** who attempted but failed to have their implant removed, “Provider counseled against” was cited as a reason. ²

### Efforts & Resources

- Authors of various global and national LARC training packages are revisiting and strengthening side effect management chapters and tools.

### Learning Gaps

- **To what extent are women seeking an implant removal earlier than the product’s duration of effectiveness turned away by providers?** What drivers contribute to this behavior?

- **Among implant users, what is the incidence, timing and factors driving switching to another method, discontinuation, and reinsertion?**

- **What factors facilitate or limit ability of clinical staff to provide good counseling on removal, reinsertion, and switching at the time of removal?**

- **Do providers perform any patient follow-up post insertion?** If so, does this impact removal, reinsertion or switching rates?

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¹ Marie Stopes International Project Data; ² PMA2020
Removal data is collected and monitored

Where do we stand?

• **Survey Data**: Implant removal questions have been incorporated into PMA2020 surveys in Kenya, Ethiopia, and Burkina Faso.

• **Routine Data**: Among 13 surveyed countries, at least 5 report collecting implant removal numbers in registers and in their HMIS.

Efforts & Resources

• Reviewed current survey and clinic data collection tools and results and create a compilation of various indicators, tools, and questions/survey data.

• **Forthcoming**: Proposing standard implant removal indicators and developing a monitoring tool to assist governments in collecting, reporting, analyzing, and using implant removal data as part of their family planning DHIS/HMIS systems.

• **Forthcoming**: Developing tools and guidance to support the meaningful analysis and use of existing data on implant removals to make programmatic decisions

Learning Gaps

• How can implant removal survey data be better utilized to forecast the resource needs for the service?

• How can routinely collected implant removal service delivery data (e.g. from HMIS’s, etc) be utilized to forecast the resource needs for the service?
Service is affordable or free

Where do we stand?

- Implant clients reported cost as a reason they were unable to have their implant removed:
  - Ethiopia: 3\% (n=1)\(^1\)
  - Uganda: 9\% (n=1)\(^2\)
  - Kenya: 17\% (n=4)\(^1\)

Efforts & Resources

Average Cost in USD of LARC Services in Kenya\(^3\)

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<tr>
<th></th>
<th>Implants</th>
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<th>IUDs</th>
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<tbody>
<tr>
<td></td>
<td>Insertion</td>
<td>Removal</td>
<td>Insertion</td>
<td>Removal</td>
</tr>
<tr>
<td>Public Facility</td>
<td>0.23 [0-2.36]</td>
<td>0.31 [0-3.31]</td>
<td>0.17 [0-2.36]</td>
<td>0.22 [0-3.31]</td>
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Learning Gaps

- What is the ‘acceptable’ out-of-pocket cost that a user will pay for implant removal, and does that ‘acceptable’ cost compare to the cost paid for insertion? Does this vary by geography and income level?
- Do out-of-pocket costs for implant removal deter clients from having their implant removed? Does this vary by reason for removal? Does this vary by the cost paid for insertion?
- For women who desire subsequent implant insertion after removal, does price paid for removal factor into whether she gets a follow-on implant?

\(^1\) PMA data; \(^2\) EngenderHealth project data; \(^3\) Jhpiego project data
EXISTING AND UPCOMING RESOURCES

Maryjane Lacoste
Resources

Links to Existing Removal-Specific Resources

- Implant Removals Commentary: http://www.ghspjournal.org/content/4/3/366
- PMA2020 Site (for removals data): www.pma2020.org
- Pathfinder post on LARC removal work: http://www.pathfinder.org/its-not-just-about-access/

Upcoming Resources from the Task Force

- A training video that demonstrates how to conduct difficult, deep implant removals
- Tools to support data collection and data use as it pertains to LARC removals
- A research agenda and compilation of research tools to collect information on implant removal
- A list of expert difficult removal providers across various countries
- What else would YOU like to see?
Q&A

Moderated by: Elaine Menotti
THANK YOU

Gratitude is especially extended to the members of the Implant Removals Task Force for the insights and data provided in this presentation.

To join the LARC and PM Community of Practice, sign-up here: https://knowledge-gateway.org/la_pm_cop