Juliana Kanyengambeta, MoH, Malawi

DSD for HIV and beyond – where we are and where we're going

Enabling increased self-management: Lessons from DSD for contraception in Malawi

Where Malawi started with family planning (FP)

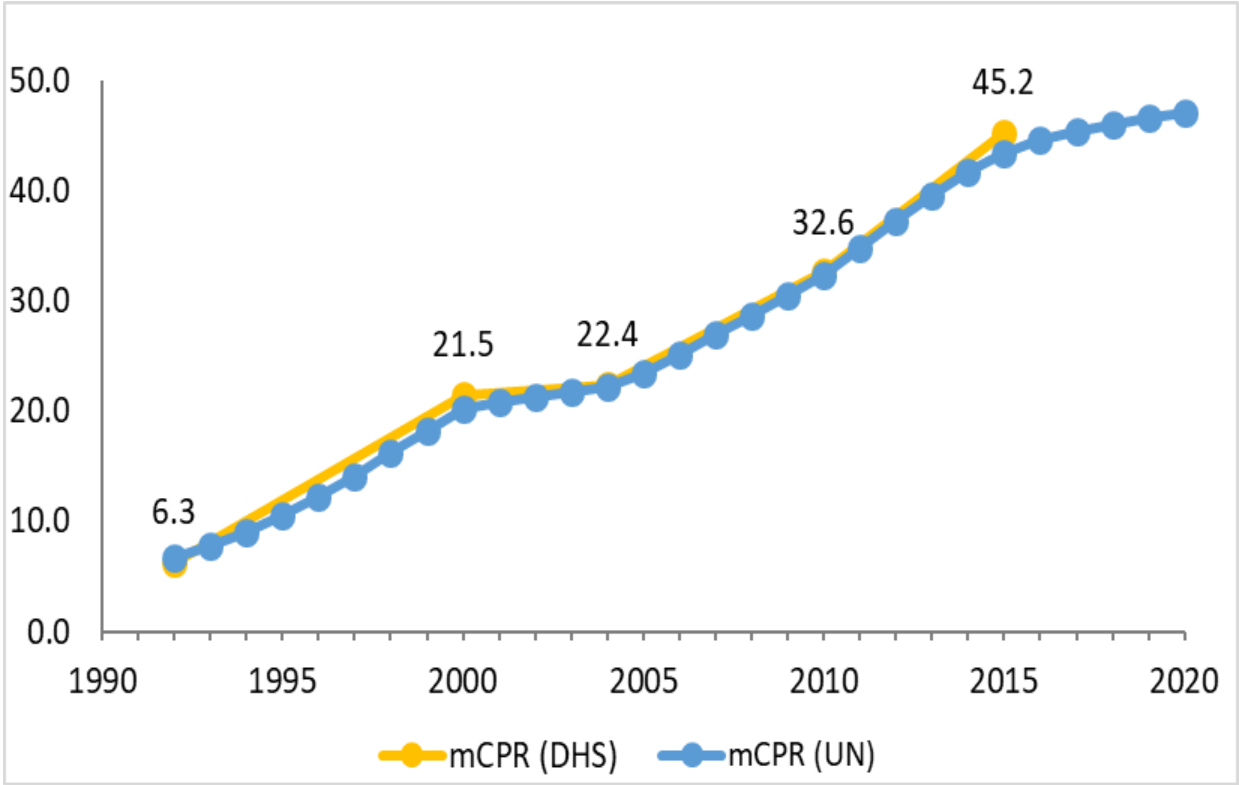
- Family planning (FP) including modern contraception methods, started in the1960s, banned in the 1970s and re-introduced in 1982.
- The 1982 program was restrictive with unfavorable policies
  - emphasized on child spacing
  - FP services provided at facility level only
  - Unmarried women were not allowed to use contraception methods
  - Husband consent was required for married women
- The program inhibited **equity,** promoted **discrimination** and stifled women **empowerment.**

Progress in meeting FP needs

- Modern contraception methods use increased significantly over the last 3 decades.

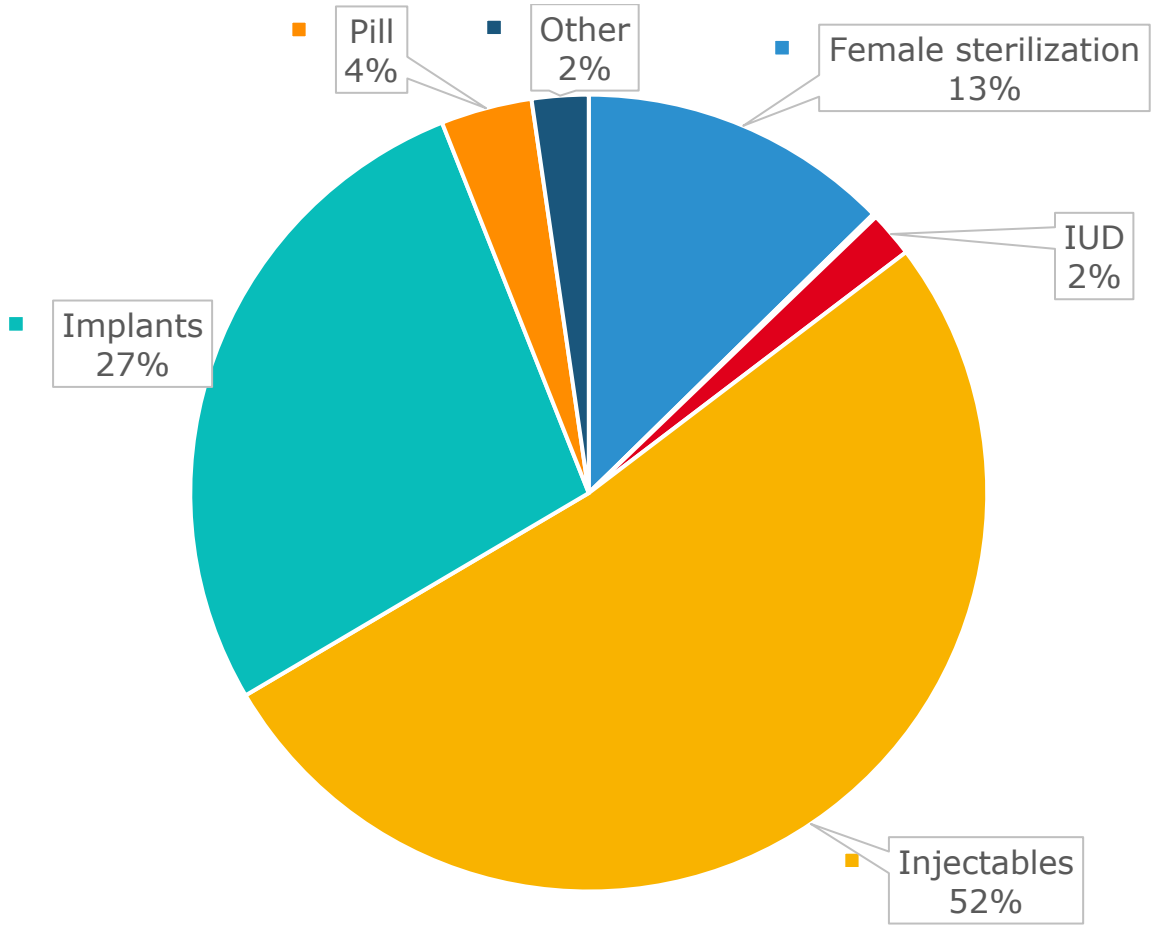
- The proportion of women whose demand for contraception is satisfied with modern methods also increased rapidly from 14.9% in 1992 to 74.6% in 2016.

Progress in modern contraception method use (1992-2020)



Contraception method mix

- The most commonly used modern contraception methods are:
  - Injectables (**52%**)
  - Implants (**27%**)
- Only **4%** of women prefer and are able to access oral contraception.



Shifts: Methods and access approaches

Contraception methods

- Hormonal IUD
- Sub-cut self-injectable (DMPA-SC)
- Oral contraceptive pills
- Implants (Implanon, Levoplant, Jadelle)
- Condoms
- Vasectomy

Increasing access to methods

- Health Suveillance Assistants (HSAs) trained in provision of all contraception methods for demand creation and administration of short-term methods
- Sub-cut DMPA: self-injection and assisted self-injection
- Community-based distribution agents (CBDAs) residing in their communities trained and distributing pills and sub-cut injectables
- Community mobilizers create demand for all contraceptives including hormonal IUDs, implants with outreach services for tubal ligation and male sterilization options

Family planning policy today

METHODS		IUD	Implant	Oral pill	Sub-cut self-injectable	IM injectable
WHEN Service frequency	Clinical review	*6-7 years*	*3-5yrs*	*3-monthly*	*Annual*	*3-monthly*
	Script length			*6-monthly*	*Annual*	*3-monthly*
	MMD			*3-monthly* * 6-12 monthly if travelling*	*4 units*	*1 unit*
WHERE Service location	In facility/ In Community/ Both	*Facility FP services*	*Facility FP services and Outreach clinics*	*Facility FP services and outreach clinics Community & Home*	*FP services & outreach clinics Community & Home*	*Facility services & outreach clinics*
WHO Service provider	Cadre	*FP nurse/clinicians, doctors, CMAs*, CHNM**	*FP & MNCH nurse/clinicians*	*Nurses/HSAs/CBDAs*	*Nurses/HSAs*	*Nurses/clinicians/ HSA*
	Self-administered			*Yes*	*Yes*	*No*
WHAT Service package	Added/integrated			*Integrated with other services*	*Client calendar Pregnancy self-test Call line*	*Integrated with other services*

*CMA = Community midwife assistant and CHNM = Community health nurse midwife

Community-level contraception access: Implementation

DSD approaches/flexibilities

- Expanding lay provider cadre: HSAs and CBDAs who live in communities
- Tailored approach to fit specific needs and beliefs of the community
- Integration with existing health services
- Male involvement
- Expanded methods available at community level:
    - Oral pills
    - Male and female condoms
    - Injectables both DMPA-IM and DMPA-SC by Health surveillance Assistants

Lessons learnt

- Increased uptake and acceptance of contraception methods
- Using culturally appropriate messaging and channels helps dispel myths and increase awareness
- Integration is key to reaching a wider population
- Men play a significant role to family size.
- Task shifting is pivotal to decongestion of health facilities
- Intensive supportive supervision of providers is crucial to ensure adherence to protocols.

Scaling up long-acting reversible methods: Implementation

Approaches/DSD flexibilities

- **Reducing health facility short-acting method refill burden** – longer refills, distributed outside of health facilities
- **Scaling up training** through CPD certification and accreditation, standardised training materials and engagement with professional bodies
- **Service entry point healthcare workers able to insert and remove** (FP, STI,CACX,GYN clinic/post-natal/ART)
- **Improved supply chain** through accurate quantification and forecasting, bimonthly commodity tracking and regular redistribution of commodities

Lessons learnt

- Hormonal IUDs require increased demand creation and education to address sterilization/infertility concerns + considered an attractive option due to purported medical benefits
- Partnership with stakeholders (NGOs, private sector and CBOs) to reach broader audience
- Community mobilizers for ongoing support and follow up
- Motivational interviewing FP counselling approach
- Interpersonal demand generation approach yielding better results
- Mobilizers to observe limits of information given to clients - facts only
- More case scenarios/role plays for mobilizer training
- Orientation of all service providers on new interventions improves service and commodity data management system
- Implant removal reluctance/delays by health workers discourages potential clients

Sub-cut self-injectable: Implementation

Approaches

- **DMPA-SC task force** to oversee the roll out
- **Development of monitoring evaluation and learning (MEL) plan**
- **Costing** the MEL plan
- **Demand creation**: District council & community sensitization
- **Training approach**: Provider training in facilities **and in communities**; job aides and visit schedule calendars
- Conduct **competency checks** after training providers
- **District DMPA-SC review meetings** at cluster level
- **National FP review meetings**
- **Public private partnership**: MOUs with private facilities which include clinics, pharmacies and drug stores – only pay consultation fee

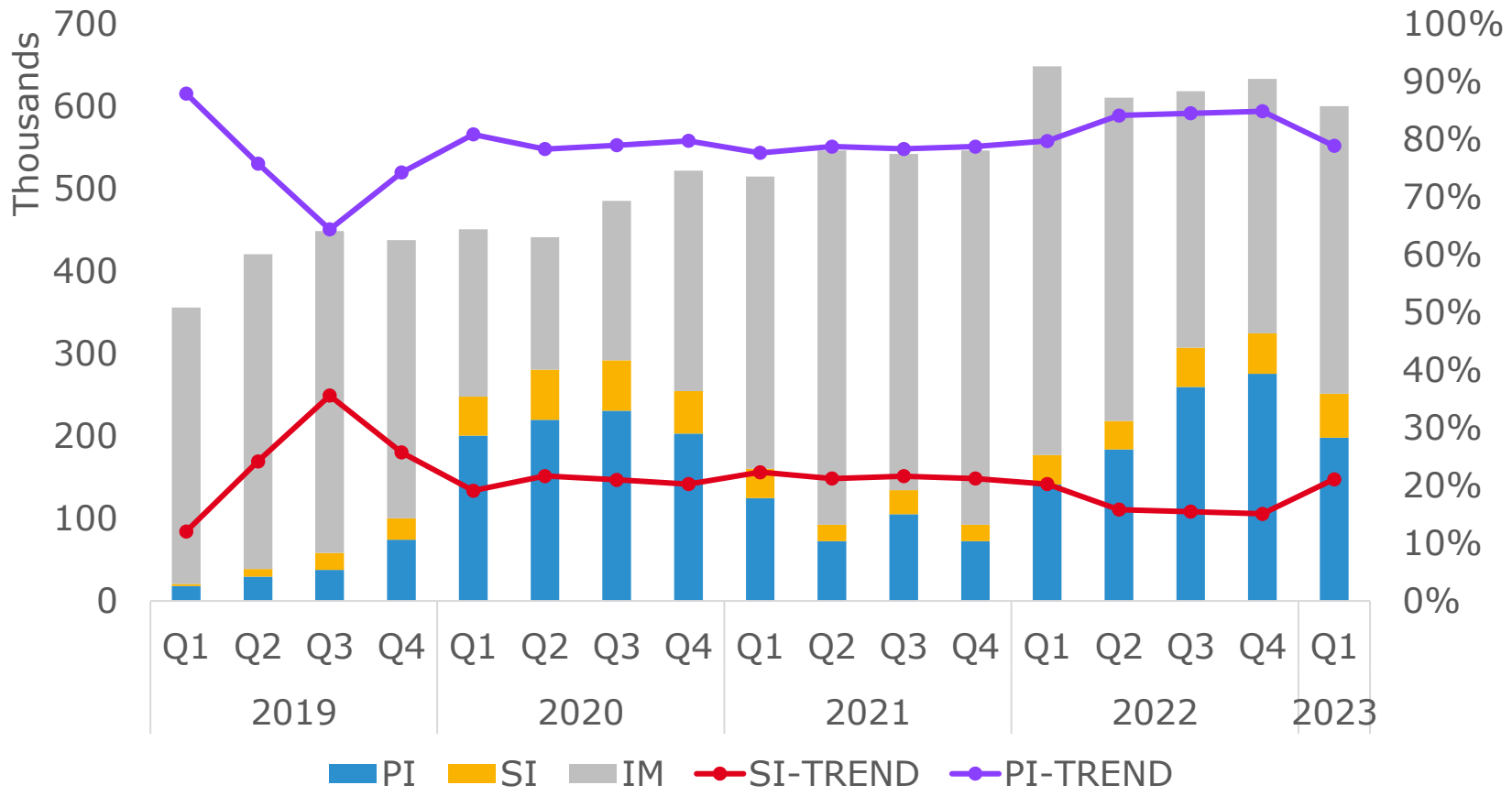
Lessons learnt

Initial low uptake of sub-cut self-injectable required increased demand creation:

- "Moment of truth" motivational interviewing counselling approach for DMPA-SC?
- Good coordination between government and implementing partners key to successful rollout
- Women feel empowered – citing conveniences (able to self-inject from home, continue with daily chores)
- No wastage as women able to self-inject without practice doses
- Potential for male involvement: Some women ask to bring their husband for training to support injecting them.

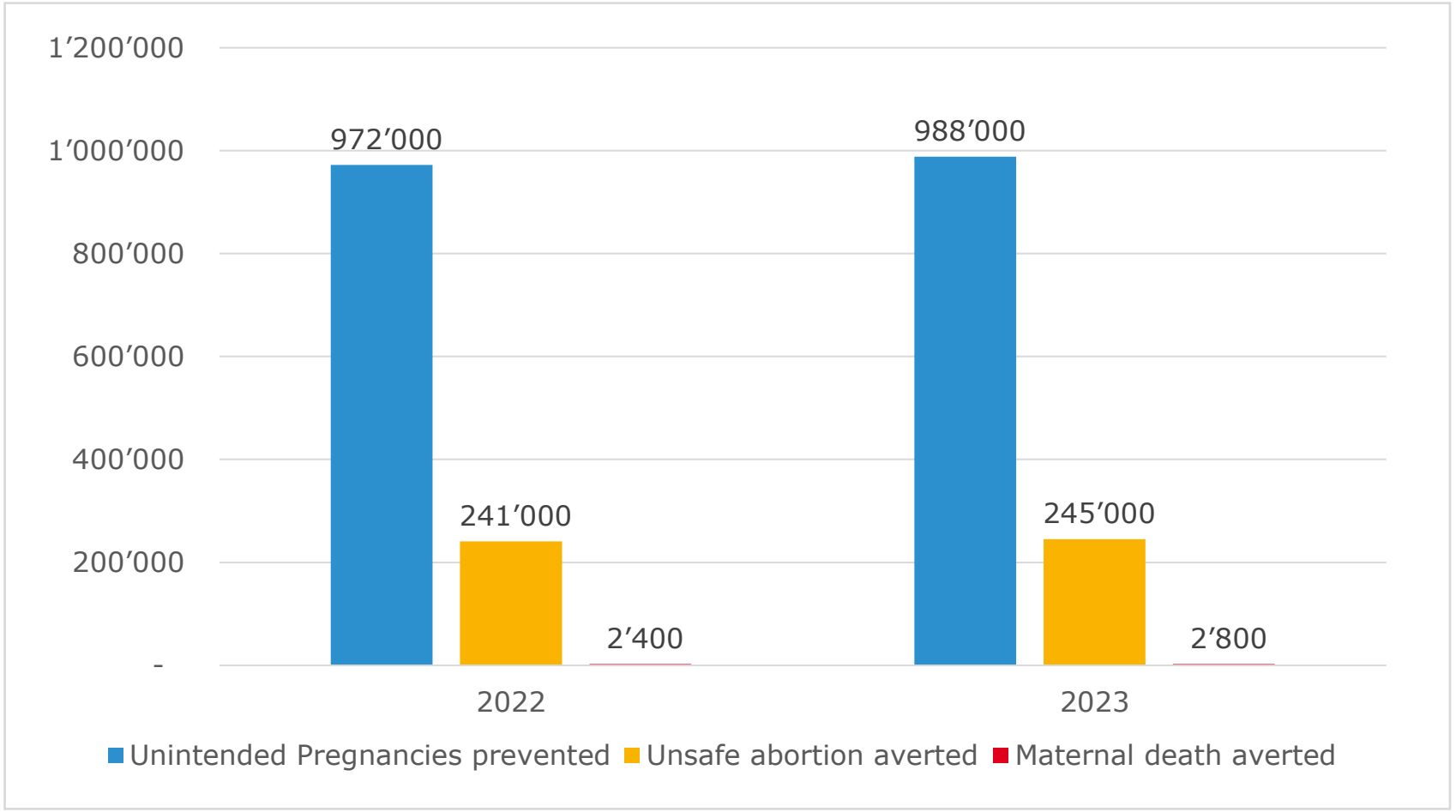
AIDS 2024

DMPA-SC uptake 2019-2023



Impact: Contraception coverage

- 2022 impact estimation based on 2,475,000 women using modern contraception methods
- 2023 impact estimated based on 2,526,000 women using modern contraception methods



Where to next for DSD for contraception?

- Increase flexibility with DSD building blocks:
  - Flexible service hours
  - Additional methods
  - Additional delivery models
- Enhance training of healthcare providers providing skills to assess clients needs and offer personalised recommendations.
- Involve community, faith leaders in the design and delivery of services.
- Improve FP service delivery M&E to identify areas for improvement.
- Use digital platforms to improve information sharing.

Where to next for integrated DSD?

- **Comprehensive care through a one stop service**
- Improve cost effectiveness by leveraging existing infrastructure and resources
- Increase access to FP services – train ART providers on FP and FP providers on PrEP
- Leverage DMPA-SC for ART clients using injectables
- Implement fast track 3MMD for oral contraceptives and expand to 6MMD for those receiving 6MMD ART or travelling
- Integrate PrEP into FP services with 3MMD oral and DMPA-SC for women using short-acting contraceptives
- Implement Joint Quality Data Analysis (QDAs) to improve data collection and monitoring