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Maternal and Child Survival Program

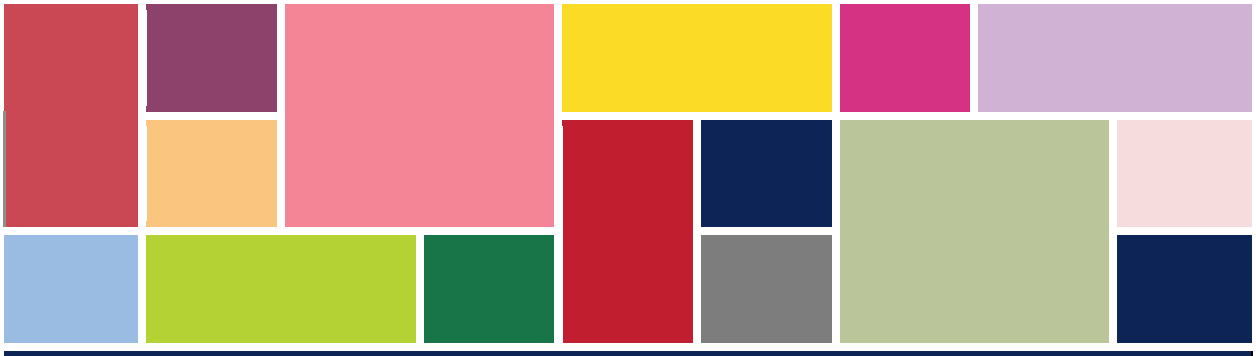
E2A EVIDENCE TO ACTION for Strengthened Reproductive Health

Long-Acting and Permanent Methods Community of Practice: *Transition to a Method Choice Community of Practice*

Expanding Contraceptive Method Choice Technical Consultation

Meeting Report

Human Rights Campaign Offices
1640 Rhode Island Avenue NW
Washington, DC
September 25, 2019



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The Maternal and Child Survival Program (MCSP) is a global, $560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. MCSP is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

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December 2019

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Abbreviations

CoP	community of practice
DHS	Demographic and Health Survey
E2A	Evidence to Action
FP	family planning
FP2020	Family Planning 2020
IUD	intrauterine contraceptive device
IUS	intrauterine system
LAM	lactational amenorrhea
LARC	long-acting reversible contraceptive
LAPM CoP	Long-Acting and Permanent Methods Community of Practice
MCSP	Maternal and Child Survival Program
MII	Method Information Index
MoH	Ministry of Health
PM	permanent method
PMA	Performance Monitoring for Action
PSI	Population Services International
RHSC	Reproductive Health Supplies Coalition
TWG	technical working group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WASH	water, sanitation, and hygiene
WHO	World Health Organization

Overview

Approximately 214 million women of reproductive age in developing regions have unmet need for contraception—that is, they want to avoid pregnancy but are not using a modern contraceptive method.[1] Expanding contraceptive options and access to voluntary family planning (FP) is critical to addressing this need.

Over the past 10 years, the Long-Acting and Permanent Methods Community of Practice (LARC & PM CoP) has served as a platform to share collective learning, technical advances, and updates, and to explore data trends in long-acting and permanent methods of contraception. The LARC & PM CoP has engaged in problem-solving for overcoming challenges, highlighting potential solutions and key recommendations on service delivery expansions across organizations and geographic boundaries. On September 25, 2019, the LARC & PM CoP became the **Method Choice CoP** and held a technical consultation meeting to acknowledge the transition.

The event, hosted by the United States Agency for International Development's (USAID's) flagship Maternal and Child Survival Program (MCSP) and Evidence to Action (E2A), provided an opportunity for partners, stakeholders, donors, ministries of health (MoHs), and country representatives to reorient the CoP's mandate and priorities through exploration of new data and trends in method mix and choice. It was also an opportunity to hear from global experts and learn from country experiences.

Meeting Goal

The meeting's goal was to support the LARC & PM CoP's transition to the Method Choice CoP through exploration of new contraceptive data and trends and hearing country experiences about what it takes to operationalize an environment where all individuals can freely choose a contraceptive method that best meets their reproductive desires and lifestyle.

Photo credit: Mubeen Siddiqui/MCSP July 2017

Meeting Objectives

The meeting objectives were for participants to:

- Develop an understanding of what the data tell us about contraceptive method choice, where they are inadequate, and what opportunities exist to better understand method choice
- Discuss the process of and lessons learned from introducing a new method and how it affects contraceptive choice at the country level
- Recognize, extract, and reflect on major arguments in the pursuit of balancing efforts between investment in new contraceptive method development with making better use of the contraceptive methods already available
- Identify and recommend key priority technical areas of focus for the new Method Choice CoP

Please see **Annex A** for the full meeting agenda.

[1] https://www.guttmacher. org/fact-sheet/adding-it-up-contraception-mnh-2017

Participants

The 122 meeting participants (77 in-person and 45 online) represented the following projects and/or organizations (see **Annex B** for a complete list of participants):

- Abt Associates
- Amfar
- Avenir Health
- The Bill & Melinda Gates Foundation
- CARE
- Clinton Health Access Initiative
- Chemonics International
- DKT International
- E2A
- Elizabeth Glaser Pediatric AIDS Foundation
- FHI 360
- Family Planning 2020 (FP2020)
- GIA
- Global Health Supply Chain Program-Procurement and Supply Management
- IntraHealth International
- Ipas
- Jhpiego
- John Snow, Inc.
- Johns Hopkins University
- The London School of Hygiene & Tropical Medicine
- Marie Stopes
- Management Sciences for Health
- MCSP
- MMC/Einstein
- Packard Foundation
- Palladium
- PATH
- Pathfinder
- Performance Monitoring for Action (PMA)
- Project Concern International
- Population Connection
- Population Council
- Population Reference Bureau
- Population Services International
- RemovAid
- Reproductive Health Supplies Coalition (RHSC)
- Save the Children
- Spark Street Digital
- The Manoff Group
- USAID
- United Nations Fund for Population Activities (UNFPA)
- WCG Cares
- World Vision

Welcome and Opening

Ellen Starbird, Director, Office of Population and Reproductive Health, USAID,[2] opened the meeting by welcoming everyone and expressing appreciation for the focus on contraceptive method choice, an indispensable part of volunteerism and informed choice. Starbird stressed that true method choice is a combination of many efforts, including strengthening of the policy environment, support for contraceptive research and introduction, provider training, social and behavior change, development of new contraceptives and technologies, and measurement. USAID and members of the LARC & PM CoP have had a long-standing commitment to method choice, and together have helped support the expansion of the range of contraceptive methods, counseling, and services for women, men, couples, and youth in multiple settings and geographies.

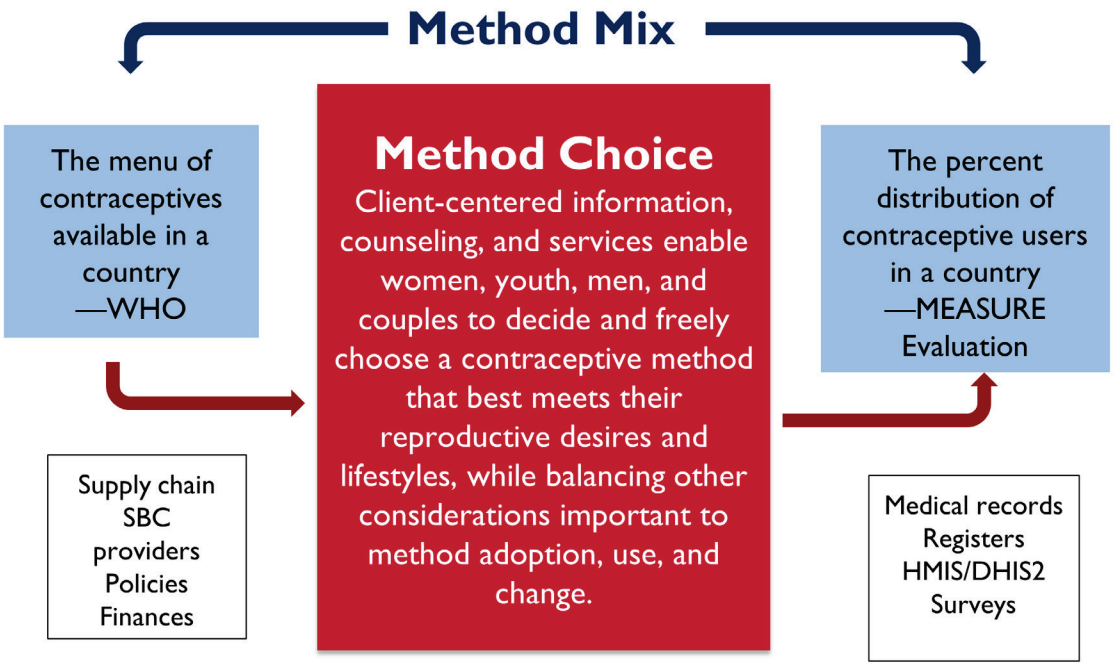
Starbird emphasized that USAID remains committed to being a leader in advancing contraceptive method choice, including methods at both ends of the spectrum, from fertility awareness methods to LARCs and PMs, and everything in between. The CoP's transition from focusing on LARCs and PMs does not leave them behind; rather, it reframes the methods in a broader context that helps us make real method choice available for more people in more places in the coming years.

Trish MacDonald, Senior Technical Advisor, USAID, shared an overview of the LARC & PM CoP. The CoP was established in 2009 and over the past 10 years has hosted a wide range of technical consultations and webinars on key topics, including data, counseling, youth, private sector, social franchising, integrated services, innovative service delivery approaches, method-specific (IUDs, implants, tubal ligation, vasectomy), introduction and scale-up. Over the years, the CoP also formed different subgroups to take on specific scopes of work such as research, toolkits, and curricula development/updates, indicators, postpartum IUDs and hormonal intrauterine systems (IUSs), implant removals, and vasectomy. Three projects (Respond 2009–2013, SIFPO/PSI 2013–2017, and MCSP 2017–2019) have served as secretariat for the LARC & PM CoP. Starting in October 2019, E2A will formally take over as the secretariat as the group transitions to the new Method Choice CoP.

The terms "method mix" and "method choice" are often used interchangeably. A small group at USAID working on these definitions found that method mix has two main definitions: the World Health Organization's definition, which focuses on inputs (i.e., what contraceptives are available in a given country) and MEASURE Evaluation's definition, which focuses on outputs (i.e., what contraceptives women are using). In contrast, method choice is defined as a client-centered concept that includes information, counseling, and services that enable women, youth, men, and couples to decide and freely choose a contraceptive method that best meets their reproductive desires and lifestyles, while balancing other considerations important to method adoption, use, and change (see Figure 1). Both system inputs (supply, demand, and enabling environment) and outputs (particularly data and information systems that provide us with information on how programs function) influence the availability of method choice.

[2] Additional information on all speakers can be found in **Annex C: Speaker Biographies**

Figure 1. Method mix and method choice



MacDonald concluded by sharing how within the broader landscape of the diverse FP technical working groups (TWGs) and CoPs, a CoP focused on method choice can accomplish several important things:

- Advance shared learning about FP methods (e.g., introduction to scale, service delivery approaches, use dynamics)
- Strengthen collaboration, commitment, and support for client-centered programming for enhanced method choice
- Provide thought leadership on emerging issues (e.g., humanitarian assistance settings) and in innovative ways (e.g., repositioning PMs with other nonhormonal options)

To watch the livestream video of this session or access presentations, please visit https://www.mcsprogram.org/september-25th-technical-consultation-expanding-contraceptive-method-choice/.

Presentations and Plenary Discussions

Data Panel: What Can Data on Contraceptive Method Availability and Mix Tell Us about Method Choice?

Moderator: Jane Bertrand, Professor, Department of Global Health and Management Policy, Tulane University

Bertrand introduced and moderated the first panel of speakers, which focused on learning from existing data and highlighting opportunities to understand and improve method choice using data. Speakers in this panel explored different data sources, including population survey data, supply chain data, service statistics, and client exit interview data, to probe the current landscape and trends for method mix and choice in low- and middle-income countries (LMICs). The panel concluded with a presentation on how a new Performance Monitoring for Action (PMA) panel design survey will soon provide longitudinal data sets.

What Can Data on Method Availability and Method Mix Tell Us about Method Choice?

Presenter: Jane Bertrand, Professor, Department of Global Health and Management Policy, Tulane University

Bertrand presented data on method choice, looking at both modern and traditional methods, noting that some methods, including lactational amenorrhea (LAM) and fertility awareness-based methods, are particularly difficult to capture in surveys and thus not fully represented in method choice analyses. Although the FP community often uses the term "balanced mix," there is no ideal method mix, which Bertrand highlighted by presenting long-term trend data[3] across many countries, showing:

- No single method dominates the mix globally and the leading method in each of the four main geographical regions differs, reflecting the methods that are available and meeting the needs of that population.
- The share of use of traditional methods has declined over time, but remains substantial (17% of total use).
- The share of vasectomy has declined from low to lower.
- In sub-Saharan Africa, hormonal methods lead the share of use, and there has been a shift from pill to injectables to implants.
- Twenty-nine percent of countries have method skewing (defined as >50% of FP use due to one method), down slightly from 35% in 2006.

A key takeaway is that both supply and demand influence contraceptive method mix, and some of the drivers are more challenging to understand or address than others. Bertrand closed with some questions for the audience to reflect on:

- Is method skew a problem, especially if prevalence is high?
- What is the role of donors and implementing agencies in influencing method mix?
- We can improve choice, but if we do everything and mix remains skewed, then where are we?

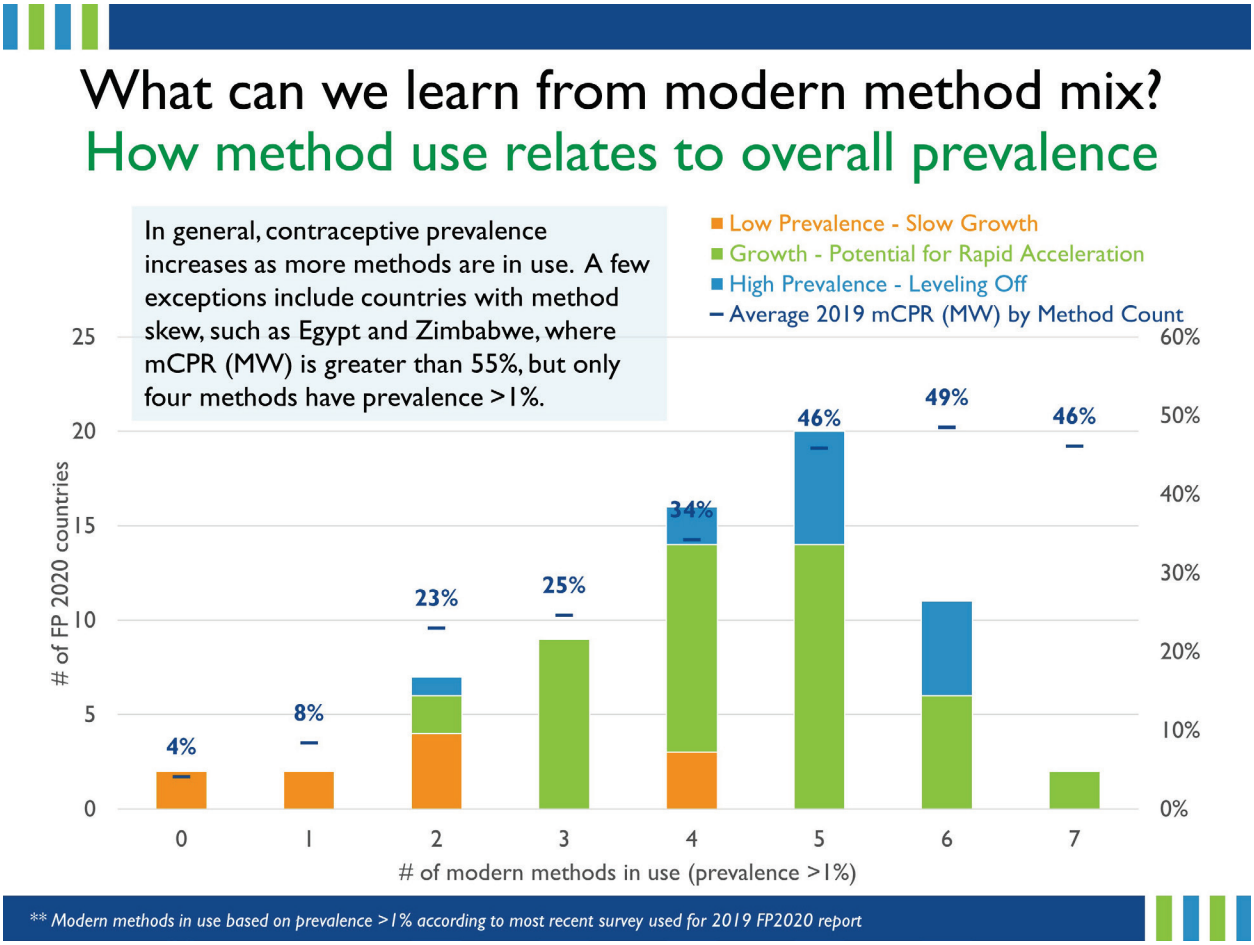
[3] From a forthcoming paper with J Ross, T Sullivan, K Hardee, J Shelton on *Recent Trends in Contraceptive Method Mix* (under review at International Perspectives on Sexual and Reproductive Health)

What Data Can (and Cannot) Tell Us about Method Choice

Presenter: Emily Sonneveldt, Director, Track20, Avenir Health

Sonneveldt presented data from FP2020 focus countries, starting with data showing that increasing contraceptive method mix seems to be correlated with increasing the contraceptive prevalence rate, with some exceptions. Most high prevalence countries have higher method mix (at least five methods are >1% of the mix). There is also a clear trend of increasing prevalence as mix increases (see Figure 2).

Figure 2. Method use and prevalence



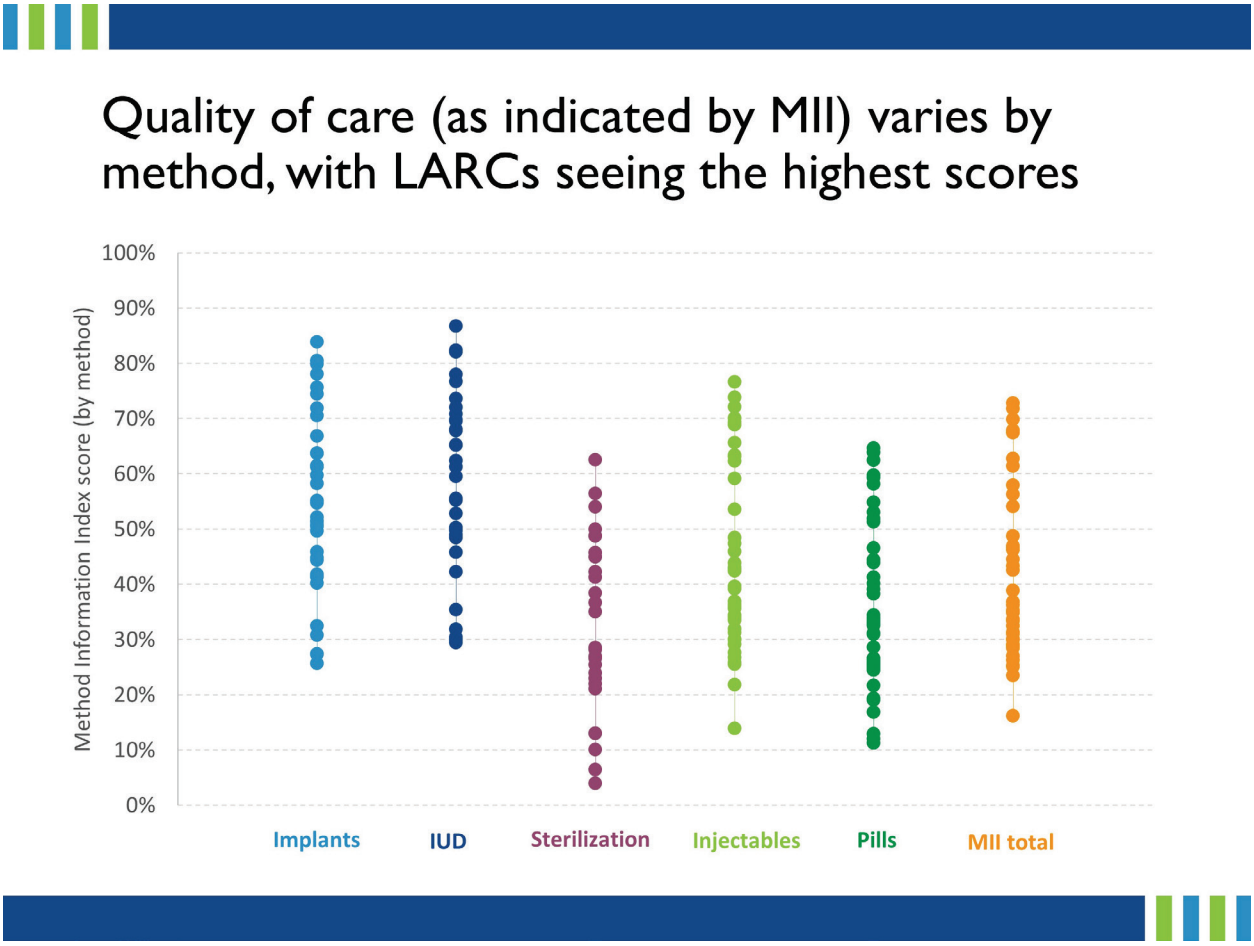
Sonneveldt explored some of the nuances in the data. For example, method used varies by marital status. Condoms are often the most commonly used method among sexually active unmarried populations, but not among married couples. Method mix can also vary substantially by subregion within a country, likely due to how programs roll out. In terms of changes over time, implants are growing fastest, followed by injectables, pills, and male condoms. Other methods remain relatively static. There is also a lot of variation by country in terms of how fast methods are growing.

Even if the data are imperfect, Sonneveldt noted that using service statistics to track method mix is still important because we can often learn when a method is taking off before the next Demographic Health Survey (DHS). Sonneveldt also presented on method choice, using the Method Information Index[4] (MII) and disaggregating it by chosen method to offer additional insight into method choice. Figure 3 shows how

[4] MII is an index measuring the extent to which women were given specific information when they received FP services. The index consists of three questions: Were you informed about other methods? Were you informed about side effects? Were you told what to do if you experienced side effects? The reported value is the percent of women who responded "yes" to all three questions.

women selecting LARCs are more likely to report higher MII, whereas those selecting sterilization or pills have lower MII scores.

Figure 3. FP2020 Method Information Index (MII) scores



Additional survey data indicates that women largely make decisions about contraception jointly with their partners, regardless of the method chosen. Lastly, Sonneveldt presented data from the National Composite Index for FP, highlighting that accessibility of methods varies by region. This data showed sterilization is least accessible, followed by long-acting methods, which impacts the extent to which women have full choice when selecting a method.

What Can We Learn to Inform Discussion of Method Choice?

Presenter: Michelle Weinberger, Technical Lead, Avenir Health

Weinberger presented data from the Reproductive Health Supplies Coalition's (RHCS's) Commodity Gap Analysis,[5] made up of data from 135 LMICs and both public and private sectors. The report has evolved and this year looked more at private sector and a wider list of countries. Results highlighted five key themes:

- Reduced or stagnant donor funding in the decade ahead
- Distinct method mix across the public and private sectors
- The significant, yet variable, role of subsidy within the private sector

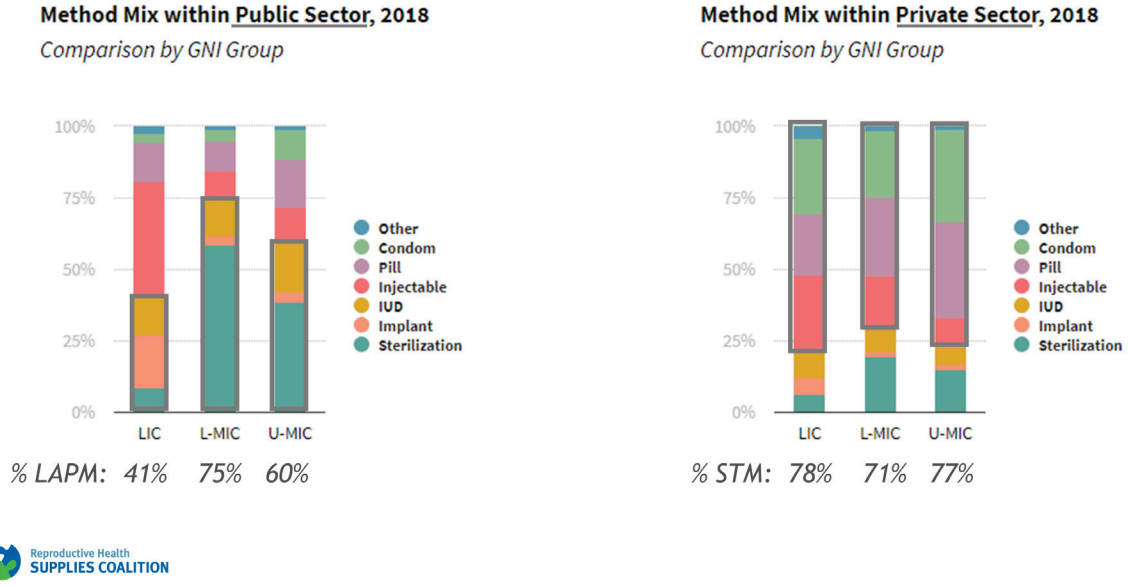
[5] https://www.rhsupplies.org/activities-resources/commodity-gap-analysis/

- The differences between the distribution of users and consumption costs
- The possibility of significant, yet uneven, growth

Weinberger highlighted that whereas LARCs and PMs dominate in the public sector, short-term methods continue to dominate in the private sector. Although the data does not tell us why, we note that many issues could contribute, such as differences in provider levels and skills, and affordability or accessibility to the various outlets.

Analyses presented were separated by low-, lower-middle-, and upper-middle-income countries since the key actors often differ between these groups of countries. The data presented showed how LARCs and PMs are less than 50% of the mix in the public sector in low-income countries, but more dominant in middle-income countries. Within the private sector, there is less difference by country income category, however, short-term method use is higher in low-income countries. (See Figure 4.)

Figure 4. Contraceptive method mix variation by income level

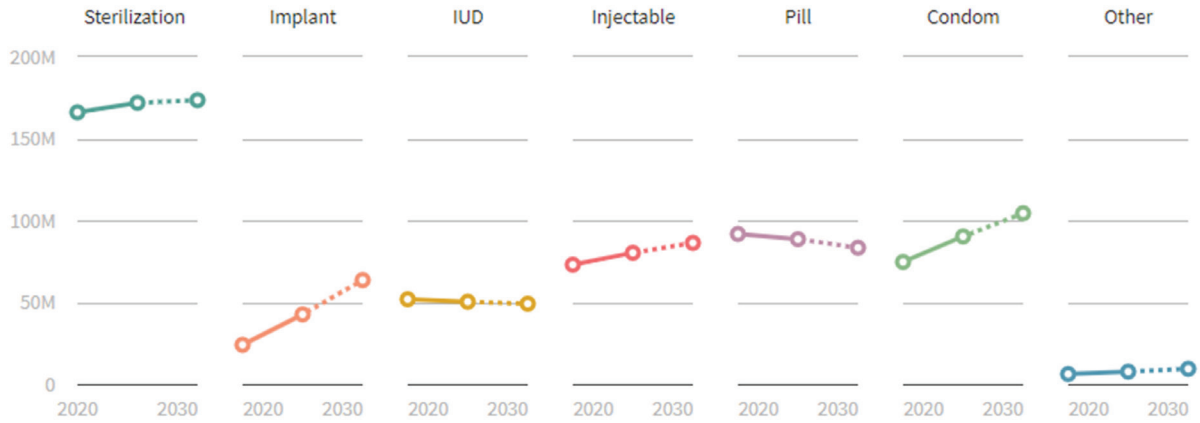


Notes. LIC: low-income countries; L-MIC: lower-middle-income countries; U-MIC: upper-middle-income countries; LAPM: long-acting and permanent methods; STM: short-term methods.

Weinberger noted that private sector does not always mean no public financing. The report looked at subsidies provided by donors or governments and found a wide range of variation by method, with IUDs and implants having the most subsidies. The role of subsidy is greatest in low-income countries. The amount spent on FP methods is mostly driven by short-term methods, which require frequent resupply. For example, pills are more often sought in the private sector where costs are higher, whereas many LARC and PM users rely on the public sector and typically do not have ongoing costs associated with their chosen method.

Future growth in users will not be evenly spread across methods over the coming decade. If current trends continue, there will be a rapid increase in implants and injectables and some decline in pills. Despite these anticipated changes, contraceptive method mix is still likely to be evenly split between short-term methods and LARCs/PMs (see Figure 5). Weinberger concluded by noting that the steep growth in implants is mostly funded by donors and partners, asking: What would it take to sustain this growth? And, if we create a shift in preferences, how do we make sure we can continue to meet user needs as funding shifts?

Figure 5. Anticipated changes in users by method in 135 low- and middle-income countries, 2020–2030



Reproductive Health SUPPLIES COALITION

Method Choice: What Do We Know about What Users Really Want?

Presenter: Rebecca Callahan, Associate Director, Contraceptive Technology Innovation, FHI 360

Callahan presented data from several research studies looking at what women and men really want from their contraceptives. Historically, contraceptive development has been driven by technical feasibility. The idea of collecting data on acceptability of existing or potential methods is a newer idea. Highlights included:

- **A study in Burkina Faso and Uganda** looked at user preferences for six long-acting methods not currently on the market, by including a short module in the PMA survey, supplemented with qualitative interviews.
    - Survey data showed that effectiveness, duration, limited side effects, and cost were mentioned most frequently as being important to potential users.
        - In Burkina Faso, some women thought it important to be able to use their method secretly, and in Uganda, some women did not want changes in menstruation.
    - The qualitative data from focus groups with women showed findings similar to the survey.
        - In Burkina Faso, fewer side effects and partner approval were most important, and in Uganda regular menstruation and provider approval ranked most important.
    - In terms of desired duration, women most wanted a method that lasts at least 1 year.
    - When asked about the six specific methods not currently on the market, and which one women most wanted if it was available, a 6-month injectable was the most popular.
        - Among current and recent users, nearly 75% would choose one of the new methods.
        - Among nonusers, 90% would choose one of these new methods over continuing not to use.
- **A mixed methods study conducted in India and Nigeria** sought to understand interest in a contraceptive microneedle patch.[6]

[6] A small adhesive patch with polymer microneedles that is applied to the skin. The microneedles dissolve and release the contraceptive. The sharps-free backing is removed and discarded.

- In both countries, there was a strong preference for a product that would not affect menstruation. Desire for a method that lasts 6 months (over 1 or 3 months) was the second most important attribute.

- **Qualitative research in Rwanda and Kenya** with FP users focused on interest in a longer-acting (6-month) injectable.
  - The research found similar characteristics as being important to women, including high effectiveness, ability to use while breastfeeding, and, ideally, a better side effect profile than existing injectables.

- **Ideation work in India and Kenya** leveraged human-centered design methodologies to facilitate insight-driven ideation for generating new product ideas in women's contraceptive technology.
  - An ongoing project is using design thinking methodologies to develop innovative, "disruptive" product ideas, including holding ideation workshops to look at out-of-the-box ideas.
  - The ideation phase is complete. It focused on immersive, rapid field research to develop materials, including user profiles, to provide context for ideation workshops in the two settings.

Callahan concluded by highlighting the common theme that emerged across studies: Women want NEW effective methods with fewer side effects (including effects on menstruation). She asked the audience: How are we addressing these preferences, calling for game-changing innovation, and focusing on expanding choice?

What Can PMA Panel Data Tell Us about Method Use Dynamics?

Presenter: Scott Radloff, Director, PMA 2020, Johns Hopkins University/Gates Institute

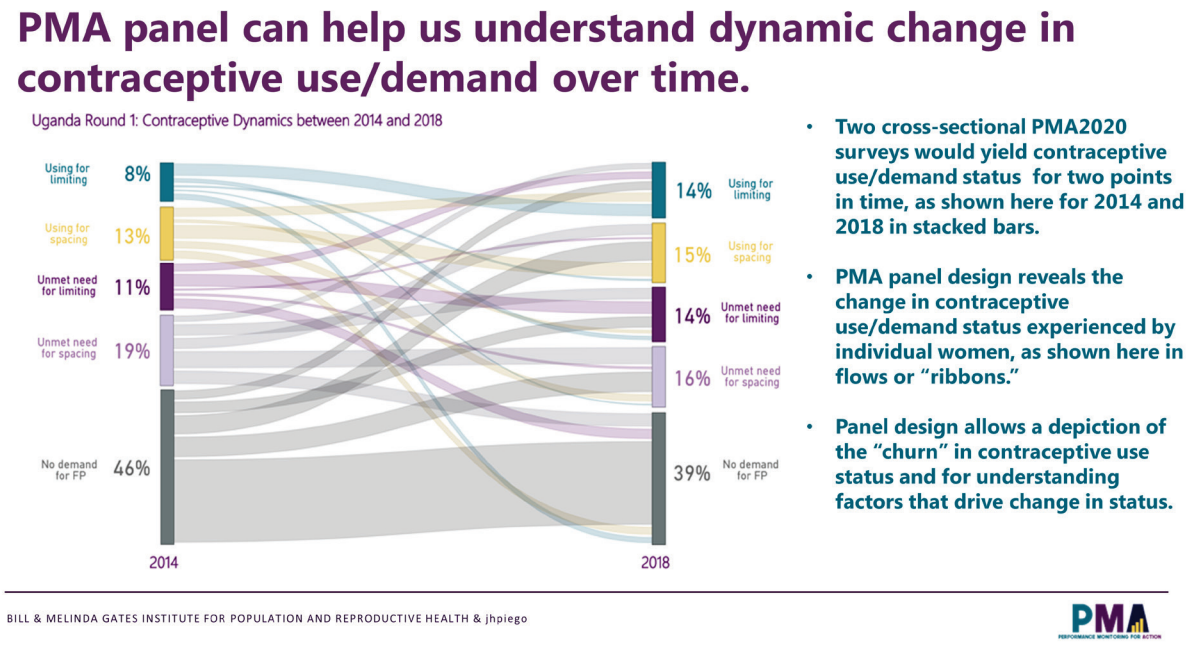
Radloff presented an overview of PMA's design and data collection moving forward, highlighting the following key new elements:

- **Design:** Multipanel design with annual cross-sectional data
  - Household/female panel
  - Facility panel
  - Client exit interview panel (with follow-up by phone)
- **Content:** New panel baseline questions
  - Community norms
  - Quality of care
  - Women and girls empowerment
  - Adolescent-specific questions
- **Geographies:**
  - Four new countries: Benin, Guinea, Togo, Pakistan
  - Eight continuing countries: Burkina Faso, Cote d'Ivoire, Democratic Republic of the Congo (DRC), Niger, Nigeria, Kenya, Uganda, India/Rajasthan
  - Ethiopia has a separate, but linked PMA program with a maternal and newborn health emphasis.

Notably, PMA added a panel design and is planning three rounds of annual data collection. It is an open panel design, implemented with households, women, and service delivery facilities. The open design allows women and men to age in and out of the panel, and also allows for migration. It will be a self-refreshing sample in this regard. This will continue to be supplemented with annual cross-sectional estimates, as well as a facility panel and client exit interviews with phone follow-up 4 months later. Panel data will improve understanding of the dynamic change in use/demand over time, the understanding of choice, and the ability to make a choice. The panel baseline will also include data on community norms, quality of care, female empowerment, and adolescent-specific questions so that moving forward we will be able to look at how these facets predict other behaviors.

Radloff also shared some results from past data collection. PMA conducted 4-year follow-up interviews with the same women in Uganda interviewed in round 1. They found some decrease in women with no demand and unmet need for spacing, and many changes in women's desires. Interestingly, women with no unmet need at baseline were more likely to adopt over time than women with unmet need at baseline (see Figure 6).

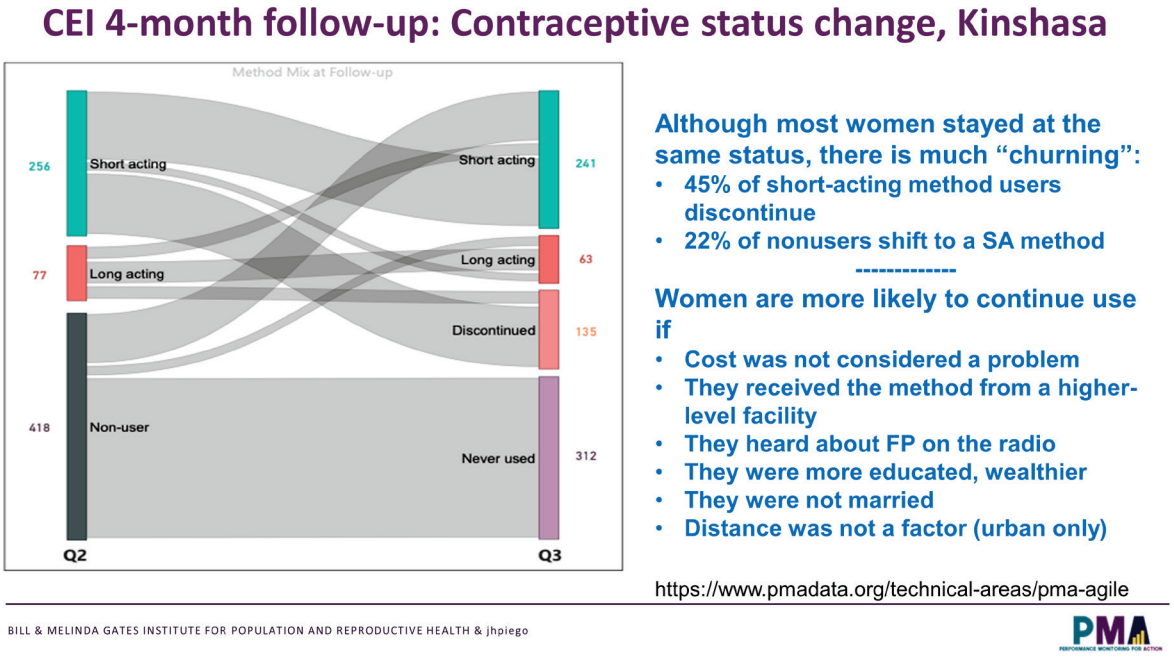
Figure 6. Uganda contraceptive dynamics between 2014 and 2018



Additional findings also suggest unmet need may not be useful in predicting use, but intention to use is predictive of uptake. Thus, it may be better to look at intentions than at the global definition of unmet need. Future analysis will look at why women switch methods or go from use to nonuse or vice versa.

Initial results from client exit interviews and 4-month follow-up phone calls in Kinshasa (urban area) found a high level of churn over 4 months, with 45% of short-acting method users discontinuing and 22% of nonusers shifting to a short-acting method. Factors contributing to continued use include: received service from a high-level facility, heard about FP on the radio, more educated and wealthier, and not married. Cost was not considered a problem. In addition, distance was not found to be a factor, but Kinshasa is an urban area. (See additional details in Figure 7.)

Figure 7. Kinshasa contraceptive status change



To watch the livestream video of this panel or access the presentations, please visit https://www.mcsprogram.org/september-25th-technical-consultation-expanding-contraceptive-method-choice/.

Key Points from the Question and Answer Session

- **Is there evidence of women using emergency contraception as a routine method?**
  - Currently the evidence is minimal, but it is starting to emerge. Some countries are now collecting emergency contraception data in routine monitoring systems. However, it is hard to measure whether use is routine or intended to be routine.
- **Can we break down menstruation preferences?**
  - Irregular bleeding is the least preferable, and amenorrhea is sometimes seen as a benefit. (When women were asked if they would use a method that causes amenorrhea, a surprisingly high number said yes.)
- **Do we have data on how many different contraceptive methods women use over their reproductive life?**
  - No. We can look at different ages, but we do not have 30 years of data to pull from; in addition, recall decays significantly by that point.
- **Are there plans to collect more information on traditional methods?**
  - This year's FP2020 report will include a special analysis.
  - A paper on traditional methods is forthcoming.

Country Experience Panel: What Does It Take to Introduce a New Method and How Does It Affect Contraceptive Choice at Country Level?

Moderator: Martyn Smith, Managing Director, Family Planning 2020

Smith introduced and moderated the second panel of speakers, highlighting that 38 of the 47 FP2020 commitment-making countries have made specific commitments around expanding method choice in their context. Drawing on lessons from country experience in a diverse range of settings, this panel sought to unpack the processes and dynamics involved in introducing a new method. The panel discussed the implications of introducing a range of new methods in multiple countries and explored what components (regulatory, leadership, finance, service delivery, client factors, etc.) need to be in place to deliver an expanded contraceptive method mix.

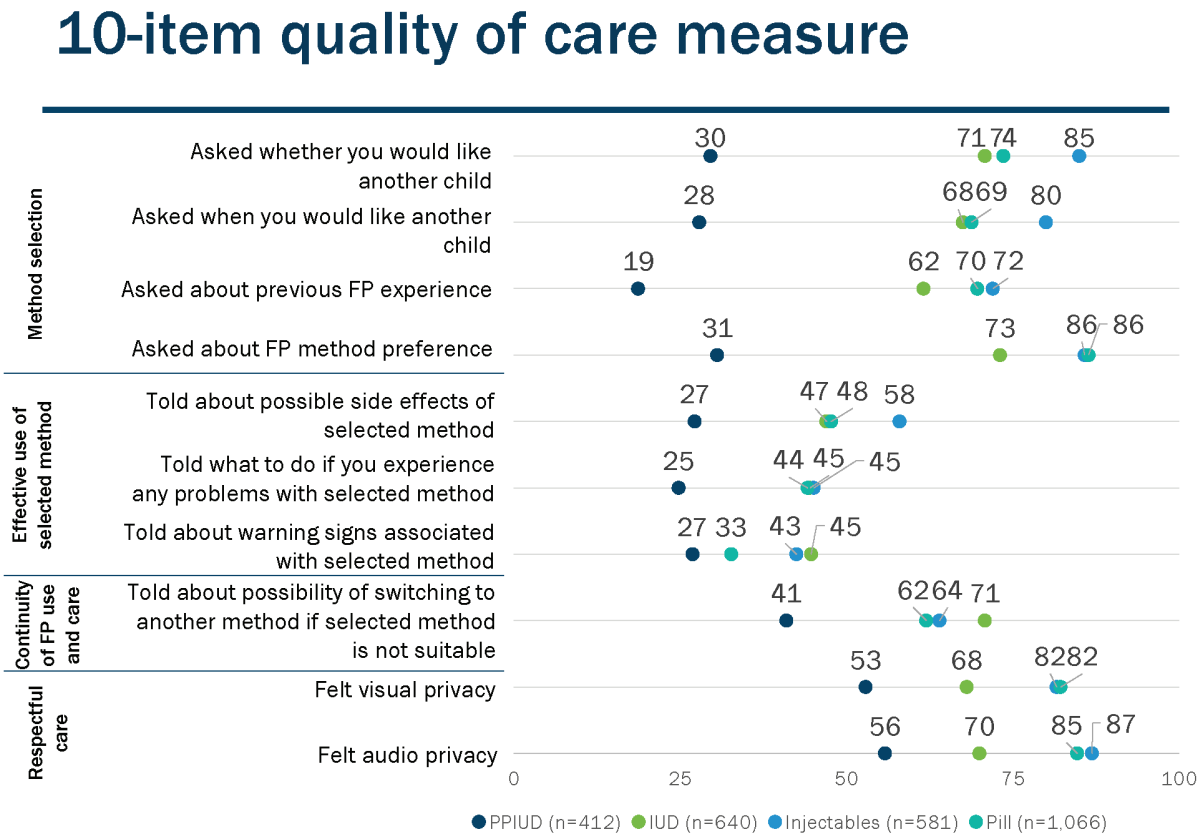
Method Choice among Reversible Contraceptive Users in India

Presenter: Aparna Jain, FP/Deputy Technical Director, Evidence Project, Population Council

Jain set the stage by highlighting that even with a balanced method mix, women may not be receiving the contraceptive method of their choice. Measures being used to operationalize method choice include MII and MIIplus. The latter asks, "Were you told about the possibility of switching to another method if the method you selected was not suitable?" Findings show that this is a better predictor than MII alone in terms of contraceptive continuation 3 months later. The Population Council conducted a longitudinal study in India with reversible contraceptive users, asking about the quality of care they received at the time of method adoption. Less than 50% reported receiving complete information on the MIIplus.

Method choice falls within the context of quality of care, and across quality of care measures, postpartum IUD users reported receiving less quality of care than users of other methods. Pill and injectable users tended to report higher levels of quality, particularly for respectful care measures (see Figure 8).

Figure 8. Method choice within a broader quality of care scale



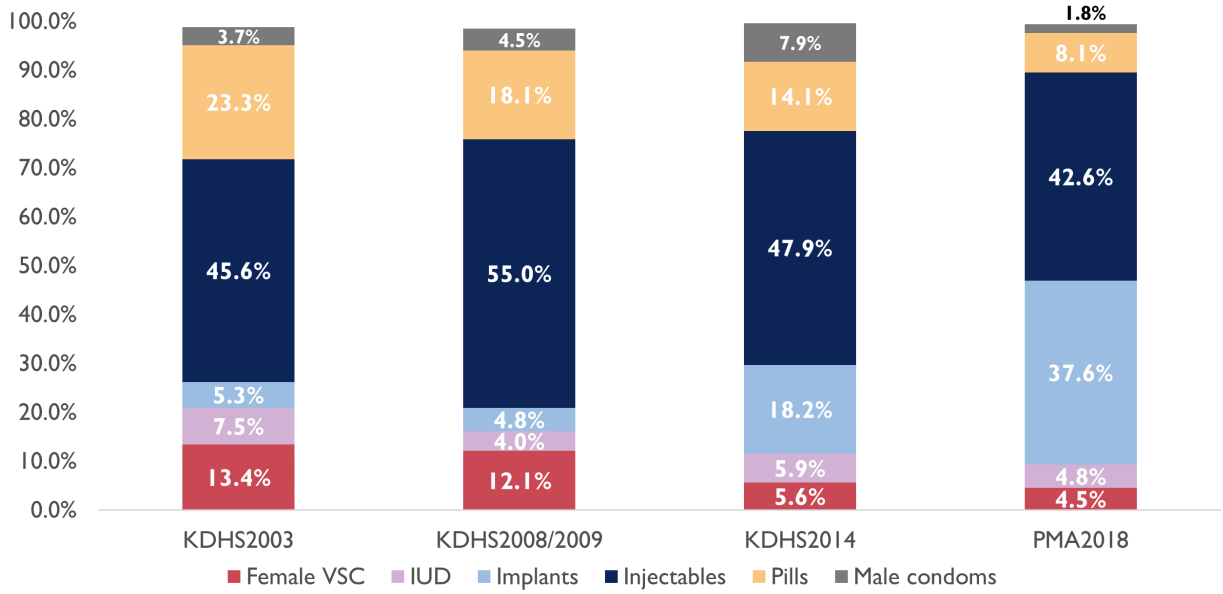
Jain concluded by reminding us that we must continue to help women find methods appropriate for their needs, rather than finding women appropriate for the method.

Expanding FP Method Choice in Kenya

Presenter: Gathari Ndirangu, Technical Director, Jhpiego Kenya

Ndirangu began his presentation by highlighting that even though Kenya has seen a recent shift toward greater LARC use and is on the high side of the S-curve, much variation exists between counties. Some of the current trends highlighted included an increase in contraceptive prevalence rate over time, injectables forming the main method in the method mix (representing about half of married users), the recent shift toward LARC use, especially implants (with corresponding increase in removals, as expected), the HIV epidemic affecting contraceptive uptake, and a decrease in female sterilization. (See Figure 9.)

Figure 9. Modern contraceptive method mix among married users in Kenya



Notes. VSC: voluntary surgical contraception; KDHS: Kenya Demographic Health Survey.

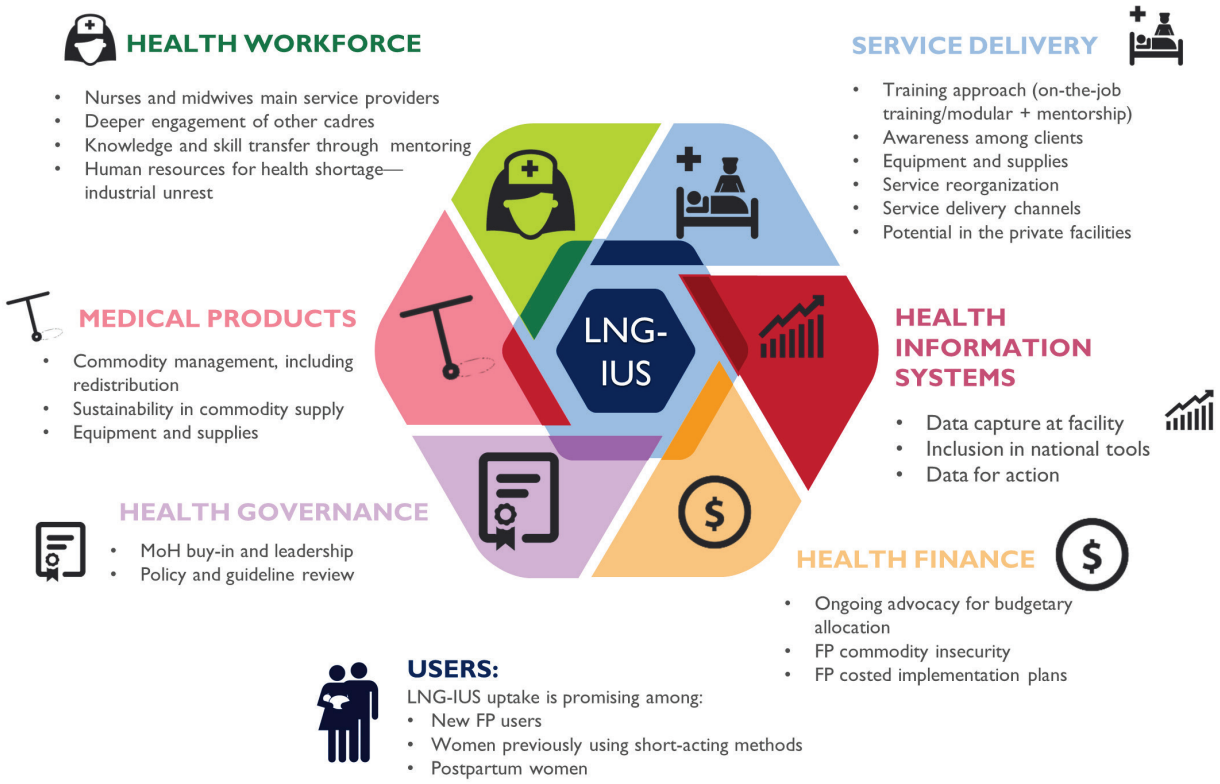
After setting the stage, Ndirangu discussed the expansion of the hormonal IUD in the public sector in Kenya. First introduced more than 30 years ago, the levonorgestrel intrauterine system (LNG-IUS) is one of the most effective forms of contraception and has helped revitalize interest in LARCs in Europe and the United States. However, the high cost of existing LNG-IUS products has meant limited availability of the method in many LMICs, including Kenya.

In 2016, with funding from USAID, and in partnership with the Kenyan MoH, MCSP built capacity for LARCs in public health facilities in Kisumu and Migori counties. Subsequently, MCSP supported adding LNG-IUS within that platform, using commodities donated by the International Contraceptive Access Foundation.[7] MCSP used an integrated service delivery approach, developed in close collaboration with the MoH, to integrate LNG-IUS directly into the contraceptive method mix at select high-volume facilities.

In both counties, MCSP's LARC capacity-building approach involved a modular, facility-based approach for training and mentorship, integrating LNG-IUS. Implementation took place via previously trained MoH LARC clinical mentors. Once the LARC mentors were fully trained and certified competent in LNG-IUS in addition to the other LARCs, they, in turn, provided stepdown training using an on-the-job approach. Additional details on the health system building blocks addressed during implementation are illustrated in Figure 10.

[7] http://www.ica-foundation.org/

Figure 10. Key elements to LNG-IUS expansion in Kenya's Kisumu and Migori counties



As of October 2019:

- 70 public health facilities (48 in Migori and 22 in Kisumu) are providing LNG-IUS as part of the method mix
- 48 MoH providers are certified as LNG-IUS mentors
- 190 service providers have been trained in LNG-IUS
- 1,500 clients adopted an LNG-IUS

A positive political and policy environment in Kenya that favors FP and access to LARCs was key to the success of introducing a new LARC method into the method mix as it allowed for critical MoH ownership and leadership of LNG-IUS work, which created an enabling environment at both national and county levels. In terms of next steps, the Kisumu County Government is looking to move forward with procuring direct donations from the International Contraceptive Access Foundation. The national MoH is planning a site visit in October 2019 to inform planning for scale-up. Three additional counties interested in adding LNG-IUS to their method mix will join that visit.

Expanding Method Choice Through Task Sharing: The Experience of Ethiopia

Presenter: Mengistu Asnake, Senior Country Director, Pathfinder International Ethiopia

Asnake shared the Ethiopia experience, relating how in 2005 the government saw a need to shift primary health care to the community level. The government introduced the Health Extension Program and through that, introduced FP at the community level countrywide. However, it was not until 2009 that the government integrated implants into the Health Extension Program (in addition to pills, condoms, and injectables). USAID's Integrated Family Health Program was chosen to be part of this initiative and learning sites were

identified (in preparation for going to scale) in 32 districts (*woredas)*. This was implemented via four partners, each responsible for eight districts, and with independent monitoring and evaluation from FHI 360.

Although contraceptive use grew continually from 2000 to 2019, this trend increased following a pilot in 2009 and scale-up in 2010 (see Figure 11). Use of short-acting methods declined while LARC use increased, especially among youth. There was a reduction in the equity gap, and disparities between urban and rural users decreased (see Figure 12).

Figure 11. Changes in the contraceptive prevalence rate (CPR) in Ethiopia, 2000–2019

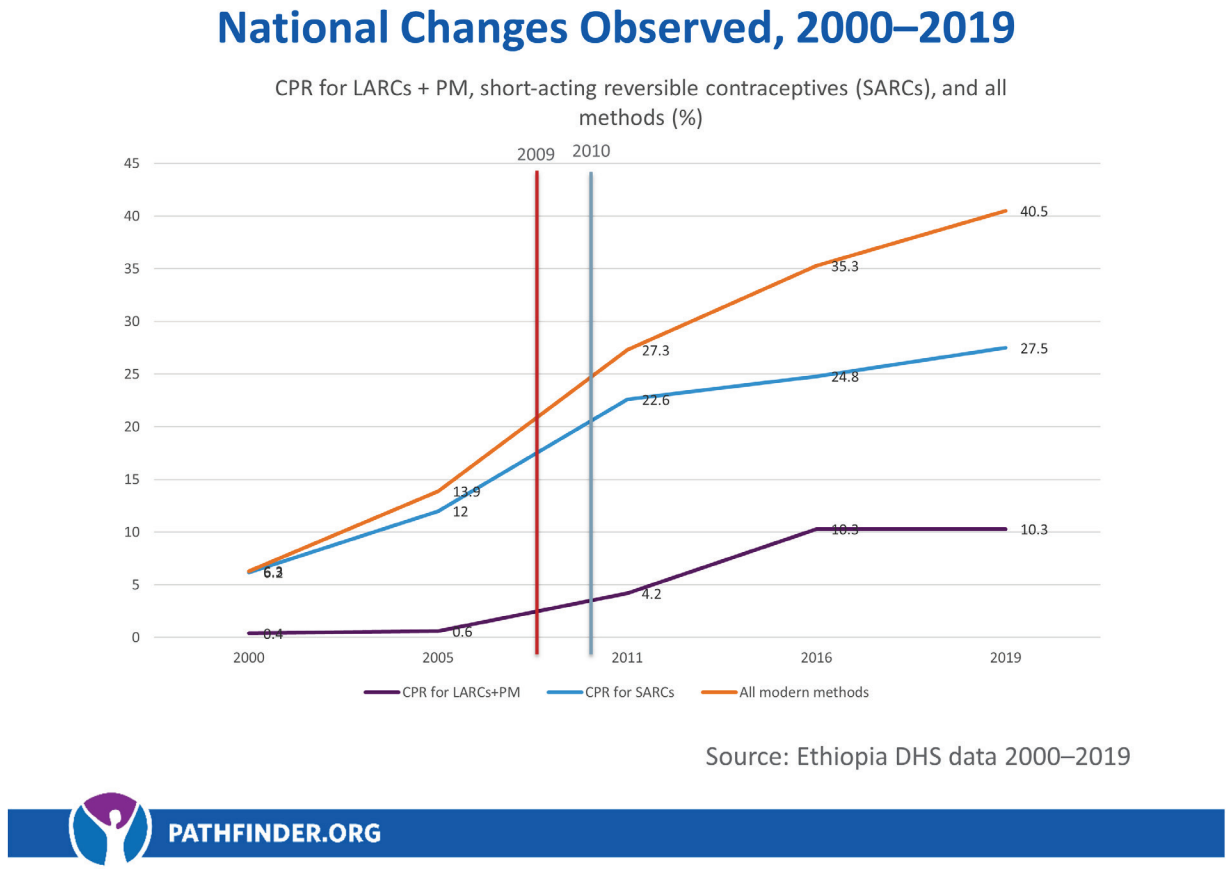
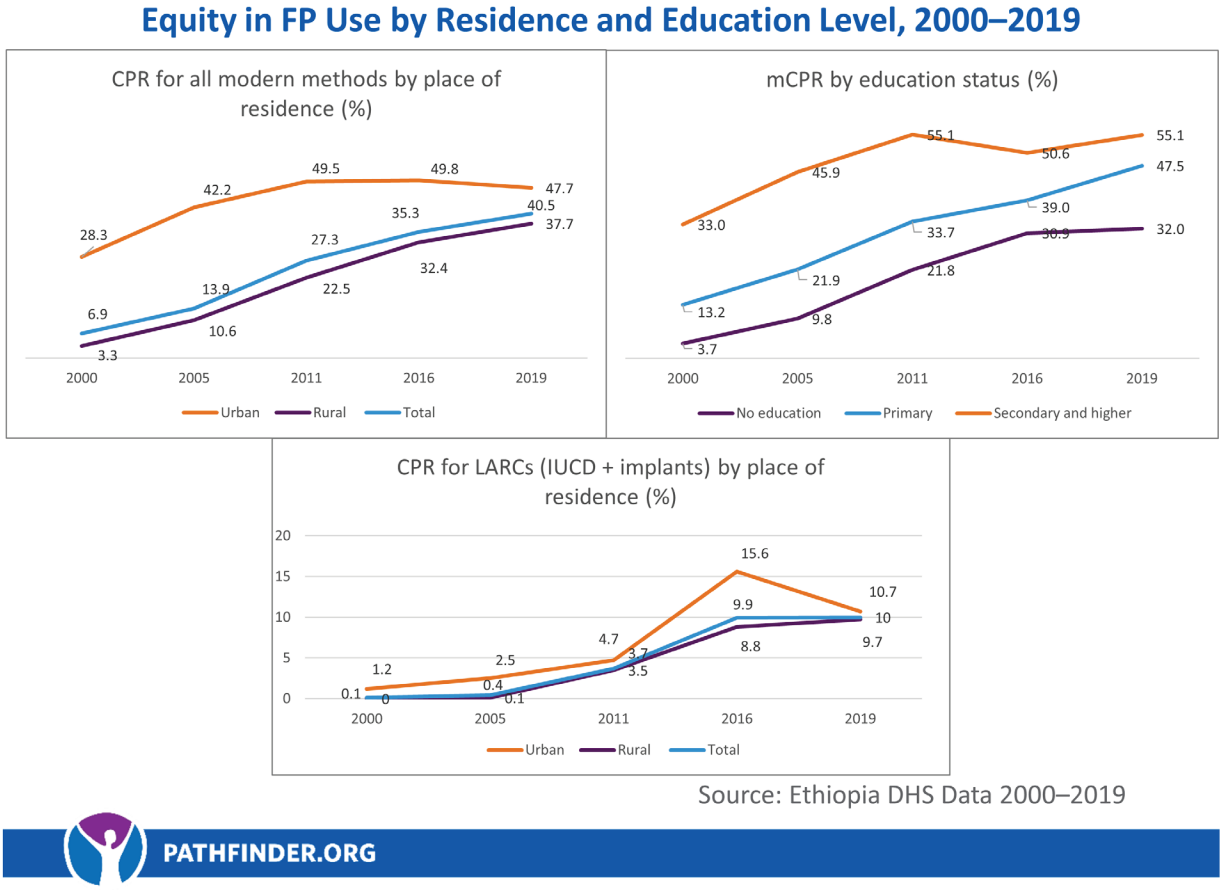


Figure 12. Changes in equity in family planning use in Ethiopia, 2000–2019



Source: Ethiopia DHS Data 2000–2019

Given the promising results, task sharing implant service delivery with health extension workers appears to have both addressed unmet need and reduced inequities in FP use. To conclude, Asnake shared key lessons learned from this experience:

- Government leadership is important.
- The learning phase is critical to adjust course (for instance, initial training for health workers was 5 days, but did not provide enough time for clinical practice, so was changed to 6 days).
- The involvement of various stakeholders, including professional associations, from the initial project design is critical.
- Projects should include a built-in monitoring and evaluation system.
- Strong supply chain systems and management should be supported.

Global Structures Needed to Help Support Method Choice

Presenter: MaryJane Lacoste, Senior Program Officer, Family Planning Service Delivery and Quality, Bill & Melinda Gates Foundation

Lacoste focused her remarks on the global structures that need to be in place to support contraceptive method choice more broadly so that countries can reach their visions and goals. She stressed the importance of supporting all methods and clarified that despite the existence of the Implant Access Program and the Access Collaborative (for DMPA-SC), the Bill & Melinda Gates Foundation is not focused on pushing a particular method; rather, it is looking at the broad basket of contraceptive options. The hypothesis is that introducing new products into a method mix will lead to greater uptake across all methods (as seen in the

Ross and Stover paper from 2013,[8] as well as in program data from the Implant Access Program). Lacoste stressed that a broader quality approach is needed when adding a new product, encouraging us to see it as an opportunity to improve counseling, strengthen the supply chain, and update health management information system and data use for decision-making across all methods.

The FP2020 era has seen a lot of movement in product introduction. Under the Implant Access Program, uptake of implants increased via the volume guarantee. A donor collaborative group (comprised of USAID, UNFPA, the Department for International Development, Children's Investment Fund Foundation, Swedish International Development Cooperation Agency, and Norway) also met on a regular basis to discuss progress and share updates. Through these discussions and observations at the donor level, it became clear that on-the-ground realities needed more attention. Key questions that emerged included: Was the training too long, or too short? Should implant-specific training be expanded to LARC training? How are we addressing the transition to the Implanon NXT® implant? Is implant removal being adequately addressed? To look at these issues, the group created a subgroup, with donors and implementing partners, focused on supporting country efforts (and replicated a similar structure for the Access Collaborative for DMPA-SC). The dedicated focus and coordination at the global level was particularly valuable, as well as helpful for developing resources that can be used at the country level.

These past years have seen significant change with new contraceptive products, such as the introduction of a new device for the 1-rod implant and DMPA-SC. Recognizing that these new devices rely on the same providers, Lacoste asks how do we get smarter, more cost-effective, and efficient with method introduction—and not have new product introduction fatigue. This is especially key as we look forward to the post-2020 world. The Bill & Melinda Gates Foundation is interested in contraceptive technology and what can be done to improve it, particularly regarding side effects. It will continue to invest in that space, along with other donors, so we will have a pipeline of new products coming out that will present their own unique challenges. Lacoste closed by highlighting the importance of working on a more formal market management function for our sector that would look across methods, as well as at manufacturers and supply, and could also support new product introduction.

Key Points from the Question and Answer Session

- **What are some programmatic recommendations in the context of India?**
    - In regard to quality of care and the introduction of new methods, any time a new method is introduced, there is an opportunity to reintroduce quality of care, regardless of the method. New method introduction is also an opportunity to support new roles among providers at different levels of care (e.g., encouraging accredited social health activists to ask about side effects and, based on what they learn, make referrals or encourage method switching).
- **What is the current landscape regarding continuity of financing for new methods over the longer term in Kenya?**
    - There are difficulties securing financing for the health sector in general in Kenya. During recent advocacy discussions with the government around LNG-IUS, the following question kept coming up: How do you adopt a new method that is relatively expensive when resources for existing methods are already limited? It is important to continue to talk about how to ensure commodity security and sustainability, while also emphasizing the value of expanding the contraceptive method mix. However, huge deficits in financing for commodities persist in Kenya, with donors stepping in to fill some gaps, but donors are also putting more pressure on local governments in terms of financing. This push for accountability should continue, including by the citizens of the country.

[8] Ross J, Stover J. 2013. Use of modern contraception increases when more methods become available: analysis of evidence from 1982–2009. *Glob Health Sci Pract.* 1(2):203–212. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4168565/

- **Beyond increasing access to LARCs in Ethiopia, what are the drivers to further improve method choice?**
    - The main driver has been government commitment and partner coordination, with both sharing responsibility for implementation. The existence of the community platform allowed the services to expand throughout the nation, and through this community platform they have been able to reach key segments of the population, including rural communities and youth. Access remains a key issue and we need to continue to look at reducing opportunity costs of transport, loss of time, etc.
- **What has the Bill & Melinda Gates Foundation learned from its programs that can be applied to thinking around investment in new contraceptive methods and on the potential new market management function?**
    - Some of the key lessons and opportunities were around closer coordination among donors, including how to collaboratively shape investment thinking moving forward. Another key lesson was the relationship with manufacturers (e.g., Bayer, Merck, Pfizer), who all reported that they valued the relationship, especially having insight into what was happening on the ground with their products. These relationships provide opportunities for them to work closely together on key issues.
- **In Kenya, how do we know if the increase in use of implants is based on what women want or on the price guarantee, which is making them more available?**
    - *Jhpiego Kenya*: The main platform for gathering information has been conversations with women (the contraceptive users) in the community. These conversations allow programs to hear clients' voices. We have begun seeing younger women starting to use contraception and, overall, that women are more vocal than they used to be in expressing dissatisfaction with services. The empowerment of women should continue to take center stage to ensure that the user is at the center in terms of selecting the best contraceptive method for her, in a context of volunteerism and informed choice.
    - *Bill & Melinda Gates Foundation*: The Foundation supported service delivery when the volume guarantees were signed. Engender Health conducted client exit interviews in the three countries where they were supporting implant work. Women reported getting the method they wanted and also that they were counseled on other methods. But continuing to ensure that client exit interviews, or other quality assurance efforts, are included in routine programming is critical to ensure that we do not forget to protect against coercion.
- **Is switching not already covered in the MII as it exists, without having to add the question about switching to other methods in the MIIplus?**
    - When the Population Council looked at the data from India, it found that women who were specifically told about the opportunity to switch were more likely to still be using contraception 3 months later than women who were not offered the opportunity to switch. This was not inherent in the question, which is why it was included—to ensure that women are in fact getting the comprehensive information they need.
- **How are decisions made to introduce a new method? What drives introduction?**
    - *Pathfinder Ethiopia*: The National FP TWG, comprised of government, nongovernmental organizations, and professional associations, assesses what is lacking in the method mix and makes decisions to change it if needed (e.g., rural women were reporting that LARCs are only for well-to-do women because you can only get them in the fancy clinics, supporting the case for introduction of LARCs at community level).
    - *Jhpiego Kenya*: The process is similar through the national TWGs, where key actors have open conversations, synthesize evidence, collaborate, and so on. But users should remain an important member of this conversation as well, since ultimately they have to make the informed, voluntary choice and live with/manage any side effects.

- *Bill & Melinda Gates Foundation*: Implants were not a new product, but were underutilized due to price. The decision to put in extra effort was in response to voices from the field and client demand for the product. Women wanted the method, but governments were choosing other products when doing supply planning because it was cost-prohibitive.

- **How do we reconcile the huge increase in implant use with our understanding of what women want regarding preference for methods with no impact on the menstrual cycle?**

  - *Jhpiego Kenya*: Client education is key, and it is important to explain what not having menses means. It is also critical to emphasize to women that they can change or remove their method for any reason. High quality of care and counseling is key because it builds trust between clients and providers, meaning clients feel more comfortable coming back to discuss concerns. The tools used in Kenya also probe a bit around removals to better understand why women are removing specific methods.

  - *Population Council*: From research in Bangladesh, we found that irregular menstruation affects not just the use of the contraceptive method but also a women's daily lives—for example, in some countries there are activities you can and cannot do while menstruating. It is important to look at these issues.

To watch the livestream video of this panel or access the presentations, please visit https://www.mcsprogram.org/september-25th-technical-consultation-expanding-contraceptive-method-choice/.

Debate: Do We Need New Contraceptive Methods to Ensure More Choice?

Moderator: John Townsend, Director, Country Strategy, Population Council

Townsend summarized the morning's discussions around the complex issues of client rights, and method choice. He then introduced the speakers and moderated the debate session, in which two panelists debated the pros and cons of investing in new contraceptive method development or making better use of the methods already available.

This session was designed to provoke thought and stimulate conversation. The debaters do not necessarily hold these positions, but rather agreed to argue a specific side in order to create a lively debate-format session for the audience.

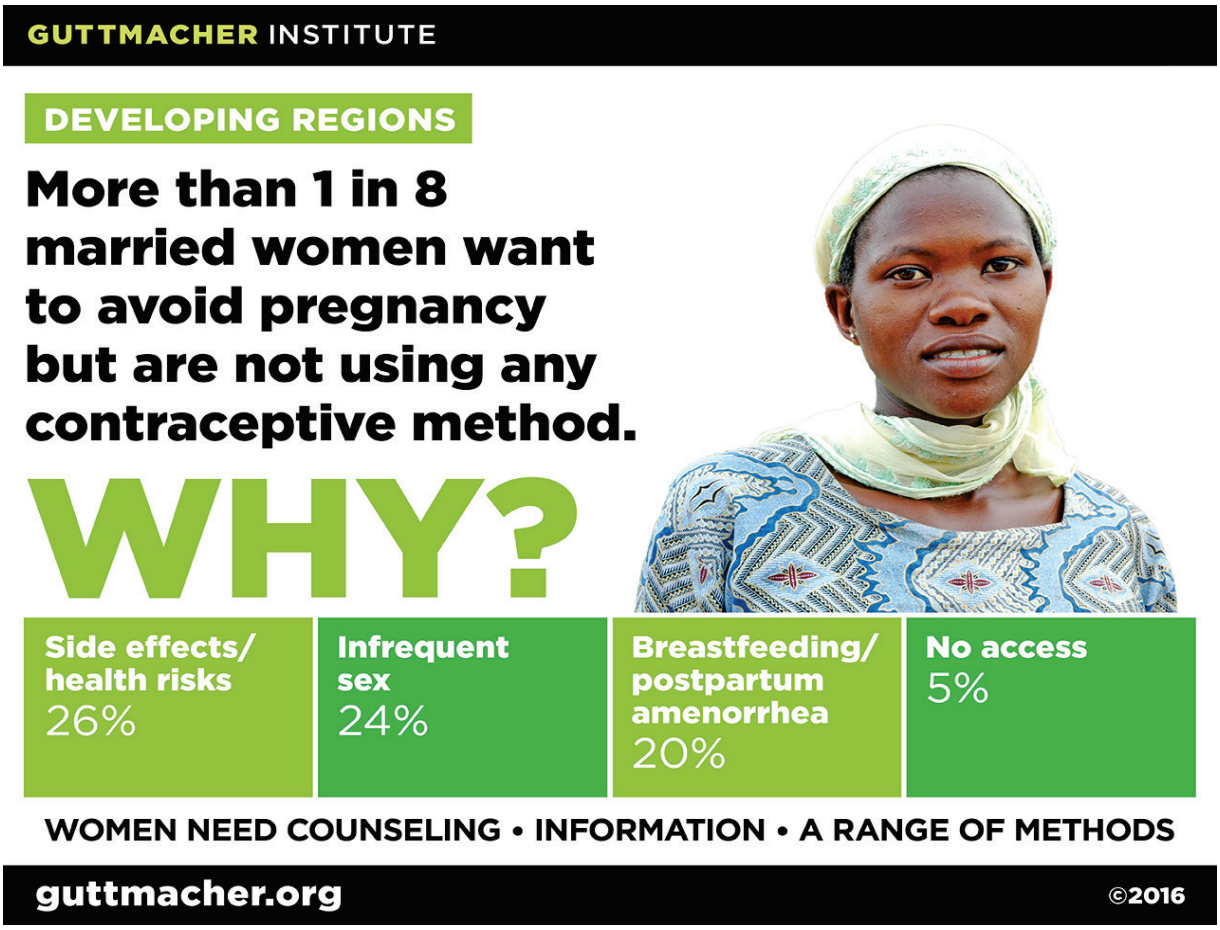
Position 1: We Should Continue Investing in New Methods to Expand Choice

Presenter: Laneta Dorflinger, Director, Contraceptive Technology Innovation, FHI 360

Dorflinger provided a strong argument for why new contraceptive options are essential to ensure more choice and provide a higher quality experience for millions of users. She positioned her argument for why women and couples need better and new choices that meet their needs stating that "our focus should be on researching what best works for women and couples to improve uptake."

To reach the collective goal of enabling women to have families of their desired sizes, we must provide new options to ensure choice and quality. Dorflinger asked the audience if they had changed their cellphones in the past few years, and how many times women in the audience had changed their contraceptive method over their lifetime. She stressed that 214 million women still have an unmet need for FP and do not use modern contraception. Dorflinger insisted we need new methods to reach this unmet need, touching on key data around nonuse (see Figure 13).

Figure 13. Reasons for nonuse



To strengthen her argument, Dorflinger shared study findings from FHI 360's work that sought to assess potential user preferences for six long-acting contraceptive technologies in various stages of development to inform and guide ongoing product development and introduction activities in Burkina Faso and Uganda. The study revealed that women preferred a longer-acting injectable and single rod implants, but also that they still thought the idea of a nonsurgical PM was interesting.

Dorflinger referenced work in Kenya and India that used a human-centered design approach to facilitate ideation for far-future methods, including contraceptive jewelry, on-demand (e.g., drinks, lotions), bio-autonomy, and so on. If we are serious about ensuring choice by filling gaps in the contraceptive method mix, we must include women who have infrequent sex since no highly effective on-demand method currently exists for them. Dorflinger stressed that women want innovative contraceptive delivery systems that offer user control for self-care, multipurpose technologies (sexually transmitted infection prevention, health benefits, etc.), effective nonhormonal reversible approaches, reversible male contraception, and nonsurgical PMs. Dorflinger also acknowledged the hurdles for new methods, including physiology, product development life cycle, and funding, which, while high, are not insurmountable.

Dorflinger concluded by noting there are many reasons we want to ensure more choice, most notably high discontinuation rates, which signal dissatisfaction with the methods currently available. She stressed that there is high willingness to try new methods as well as a mismatch of existing products to women's needs. To ensure better contraceptive options that match women's desires and ensure greater choice, innovation and investment in new methods is required. Let's work together to ensure that our grandchildren are not using the same birth control in 60 years while using their iPhone 30s!

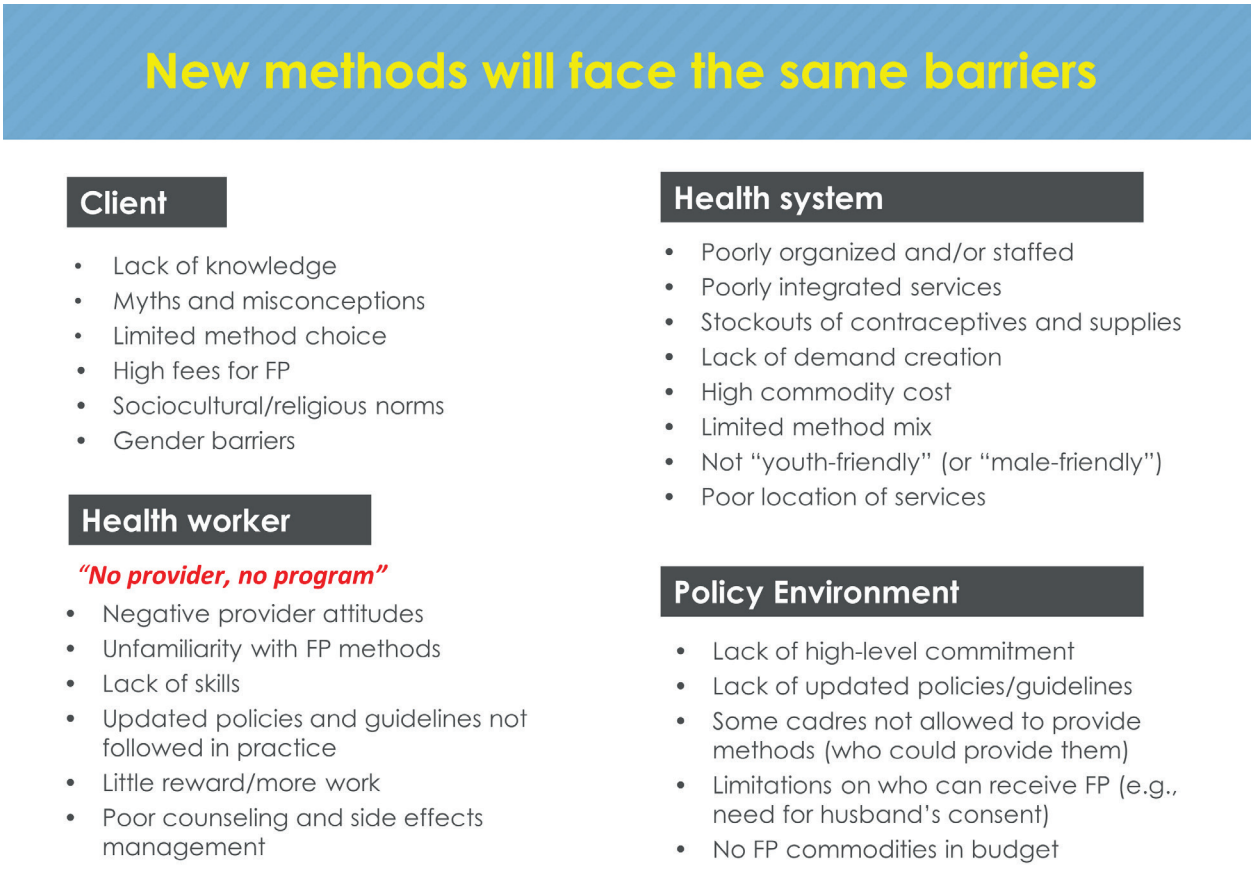
Position 2: We Have Enough Method Options, We Need to Invest in More Implementation Strategies

Presenter: Roy Jacobstein, Global Technical Lead, IntraHealth International

Jacobstein provided a strong counterargument, stating that we have all the methods we need and that our focus should be on removing the gaps and barriers that hinder uptake and use. Five common arguments for which he provided rebuttals were:

- **Argument 1: We need more new methods to get more choice.**
  - Jacobstein countered this argument by stating that needing more choice is not the same as needing more methods. Availability and access to more methods depend on the health system, and some FP programs already provide a wide range of method choice, showing it can be done now, within the existing method mix.
- **Argument 2: Unmet need is high so we need new methods.**
  - Jacobstein acknowledged that unmet need is high (214 million women) and highlighted that the lifetime risk of maternal death differentials is shocking (e.g., in Canada it is 1 in 8,800 versus the DRC where it is 1 in 24). But there are also 20 serious morbidities for every mortality, and the situation is even worse for poor women. We cannot afford to wait to invest in new methods that may still be 30 to 40 years away; rather, we need to better use our scarce resources and provide greater access to existing methods now. Jacobstein also stressed that barriers to new contraceptive methods will be much the same as those for existing methods (see Figure 14).

Figure 14. Barriers for new contraceptive methods



- **Argument 3: Current methods have side effects that lead to discontinuation.**
    - The "Holy Grail" of methods is one that is safe, highly effective, convenient (easy to access and few required client actions), has no side effects, and is woman-controlled and low-cost—a set of characteristics that no existing methods can claim and is unlikely to apply to new methods. All methods have side effects and the new methods often cost more.
- **Argument 4: Existing male methods are inadequate.**
    - Jacobstein highlighted that 40 years of work on male hormonal contraceptive methods has been without success. Yet, an excellent male method—vasectomy—has been available in the method mix during this time, but with little investment. Indeed, vasectomy has a 22% prevalence in Canada and is relied on by 15–20% of women in Korea, the United Kingdom, the United States, and New Zealand. But there is negligible availability in almost all low-income countries, despite the demand to limit births (which is larger than the demand to space births in all regions but West and Central Africa). Jacobstein invited the audience to imagine where we would be with male method use if vasectomy investment had been substantial and begun 40 years ago.
- **Argument 5: Innovation is needed and contraceptive research and design is needed.**
    - Jacobstein countered that FP has always been innovative, arguing that innovative approaches have been scaled and sustained so much that we often take them for granted. This has been mainly from program innovation (as well as tweaks to existing methods like DMPA-SC and Nexplanon). Although excellent new methods were developed at one point in time, this was long ago (e.g. Cu-T, implant, LNG-IUS) and no new methods of import are on the horizon.

Jacobstein concluded by reminding us that developing and scaling new methods takes time and smart programming, walking participants through the product development cycle for implants (from when Population Council started with them in 1966, to the trials in 1974, approval in 1990, niche method status in 2011, and wide us by 2013–2018).

After a short 5-minute rebuttal from Jacobstein and Dorflinger, the audience voted on who won the debate. The results yielded a tie.

Key Points from the Question and Answer Session

- **Regarding a male hormonal contraceptive, Facebook is saying it is not marketable because men will not accept side effects. What are the actual facts?**
    - Side effects were an issue. But no method will be side effect-free, so the question is how much will men tolerate and how much of the risk will shift to women?
    - Regarding the gel method trial with the National Institutes of Health, we do not yet know the side effects of too much testosterone.
- **If we have more methods, how do we avoid confusing providers and clients, and how do we ensure the money does not all go to big pharma?**
    - The key is to focus on a person's/couple's reproductive intentions to determine a suitable method.
    - Although we will always need big/medium pharma and people who understand supply chain, we need to look at who leads innovation before pharma can invest in the product. We need to invest in early product development to de-risk products and show proof of concept to engage investors or stage public sector investment to bring in pharma.

- It is important to create a better market for FP commodities. This market is coming, but we need to ensure an income for people all along the supply chain—not just big pharma, but also small women-led pharma—and possibly move manufacturing from north to south.

- **Recognizing that research and development in reproductive health is significantly underfunded, what should we target for advocacy funding?**

  - Investing in both near- and far-future opportunities is key, as is exploring other opportunities. The Reproductive Health Investors Alliance members are trying to bring in seed funding from rich investors when they do not have funds for their own foundations.

  - It would be advantageous to target small southern pharma and opportunities to bring in companies that want to make a joint investment.

  - Public–private partnerships are key, as is targeting governments in developing countries.

Discussion: Shaping the Method Choice Community of Practice Together

Moderator: Elaine Menotti, Senior Technical Advisor, USAID

Menotti introduced and moderated the final session, which focused on transitioning to a Method Choice CoP. Menotti opened the session by talking briefly about the CoP's core functions and how it is advancing the FP community through both informal and formal ways, including supporting technical resource development (e.g., training materials, job aids, toolkits, models, and procurement lists), consensus statements to advance policy and practice, global policy review/input, data and analysis, and research studies, as well as serving as a forum for thought leadership and problem-solving, vetting, sharing information and experiences, and disseminating technical resources and program models.

USAID hopes the Method Choice CoP will be part of this advancement, and that it will be:

- Community-driven (by both members and stakeholders)
- Practitioner-oriented (pulling from the variety of expertise of members)
- Responsive to and reflective of the needs of the field and the global FP community
- Impactful and influential beyond its members

Menotti concluded by reminding us that even as we change focus to a broader rubric, we will not lose the ability to focus on specific methods, or groups of methods, nor the ability to form time-limited working groups. Menotti encouraged meeting participants to engage directly in shaping the mandate and objectives of the Method Choice CoP.

Transitioning to the Method Choice Community of Practice

Presenter: Rita Badiani, Project Director, E2A

Badiani opened her session by acknowledging the role MCSP played as chair of the Method Choice CoP over the past 2 years and expressed how honored E2A is to have been asked to lead the Method Choice CoP. Badiani stressed that, as a FP community, we all have a shared commitment to advance global learning and build on the insights of country programs. E2A is confident that, together as a global community, we can advance contraceptive choice and create a dynamic environment with new technologies, new trends, new policies, new stakeholders, new policies, and the ability and drive to address new needs. The Method Choice CoP will aim to provide a dynamic and inclusive platform for engagement and exchange. Badiani concluded by stating that continued engagement by CoP members is vital to the continued success of these platforms.

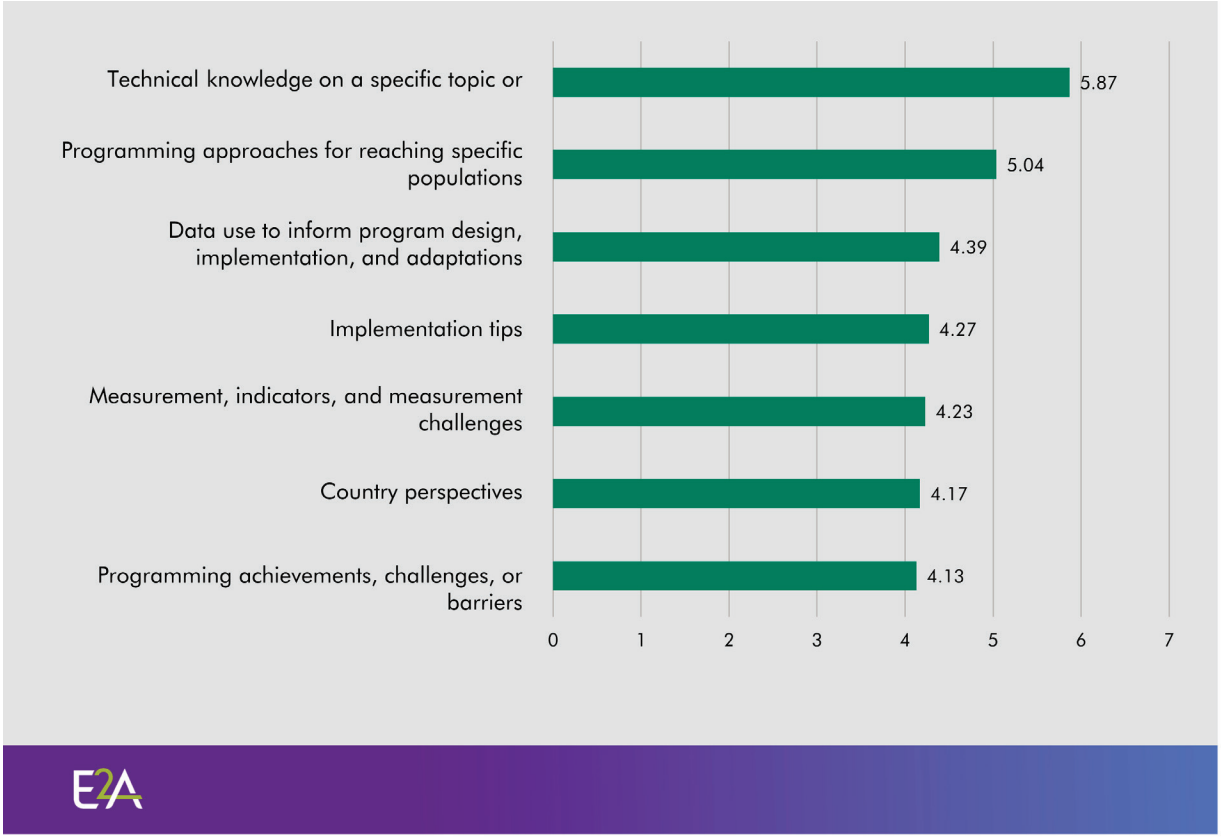
Looking Back and Charting the Way Forward: Learnings from the Pre-Meeting Survey

Presenter: Fariyal Fikree, Senior Research Advisor, E2A

Fikree presented key findings from the pre-meeting survey, which was a 12-item questionnaire developed by MCSP, E2A, and USAID. The survey included both closed and open questions, and was circulated to all members of the LARC & PM CoP, as well as members in a wide range of other FP CoPs, TWGs, and task forces.

In terms of survey responses, most members were from North America and Africa, and members expressed interest in both in-person and online CoP events. The following takeaways were reported as most useful from previous CoP events (see Figure 15):

Figure 15. Most useful takeaways from previous CoP events

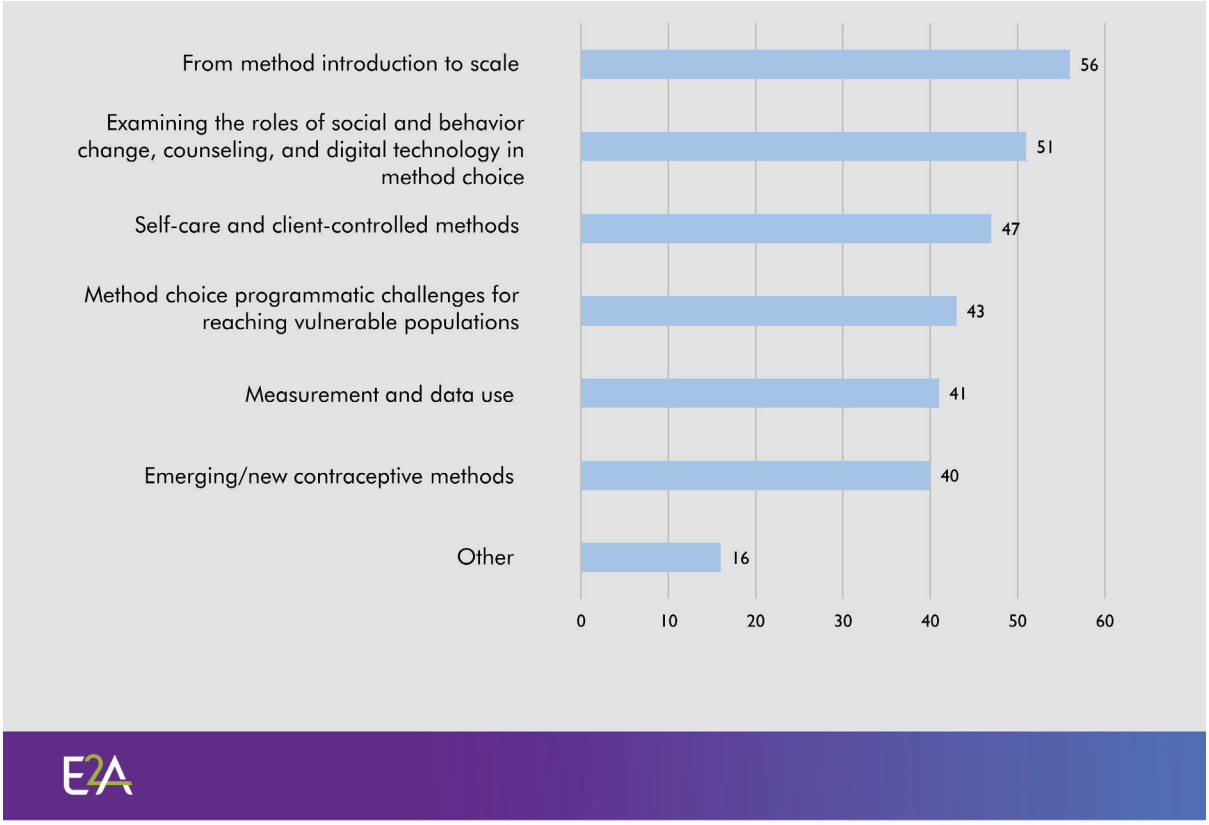


The survey also asked respondents (in an open-ended question) to note the various ways they applied the knowledge gained in their work. Responses broadly fell into four categories: knowledge updates/sharing, trainings, programming, and advocacy. Challenges listed reflected participation and technical content, including the following key quotes:

- "Not having a similar CoP at regional or country level."
- "The new CoP should not simply be a rebranding of the LARC & PM CoP. It should tackle broader issues of method choice across the full range of contraceptive options, including short-acting methods."
- "CoP seems siloed from cross-cutting TWGs (e.g., gender)."
- "As it is such a large topic, it was often difficult to come together around smaller topics—so it was nice when smaller task teams or working groups, like the vasectomy group, spun off."

Figure 16 shows the priority areas of focus moving forward.

Figure 16. Priority areas for the Method Choice CoP



Additional key issues that arose included policy effects on method choice, the role of task sharing, information channels, and health workforce. In terms of next steps, E2A will:

- Create and maintain an updated aggregate mailing list of the CoPs, TWGs, and task forces currently operating
- Convene planning sessions with existing FP CoPs, TWGs, and task forces
- Conduct one webinar annually with existing groups, focusing on field contributions
- Host one technical consultation in Washington, DC each year (in close collaboration with other groups)
- Partner with other organizations/meetings to host joint technical consultations at a regional level

Fikree concluded the session by asking for additional input from participants. Suggestions included considering partnerships with partners from other donors, as well as improving dissemination of the information to a broader audience that was not at the meeting (i.e., county colleagues). The final suggestion was ensure that the Method Choice CoP is a safe space to share challenges across methods and diverse groups, since there are commonalities that we can learn from within them.

For full presentations please visit https://www.mcsprogram.org/september-25th-technical-consultation-expanding-contraceptive-method-choice/.

Reflections on Community of Practice and Closing

Moderators: Trish MacDonald, Senior Technical Advisor, USAID, and Anne Pfitzer, Family Planning Technical Lead, Maternal and Child Survival Program

MacDonald closed the technical consultation by asking for audience feedback. The responses were overwhelmingly positive, with participants expressing particular thanks for the focus on clients, both men and women, in discussions. Others expressed excitement over the shift to looking at all methods and method choices, whereas others encouraged us to renew our commitment to vasectomy, the ultimate task shifting of FP to men. Questions arose around what new technology looks like and how we measure quality counseling, themes that could be further explored under the Method Choice CoP. As we capitalize on opportunities to promote method choice and expand the method mix, it is important to remember that the burden of contraception on women makes the conversation around method choice and male engagement an important one.

To close out the event, Pfitzer shared reflections on key insights she gained in the course of the day, including the churning data presented by PMA that shows how method use changes over time. How much churning is to be expected during the reproductive life course? Is churning always an indication of discontinuation because of dissatisfaction with a method or curiosity to try a different one? Also, can churning relate to passing FP responsibility between the couple over time? To know what is normal, we need to improve our data to answer these questions, but discussions throughout the day definitely generated food for thought. In conclusion, MacDonald emphasized that it takes a lot of villages and communities across different areas to come together to improve FP programming. The CoP meetings are a good platform to come together to work on these key issues and build specific task forces to solve particular problems. Let's work together to build the community from within!

Annex A: Meeting Agenda

Long-Acting Reversible Contraceptives and Permanent Methods Community of Practice

Technical Consultation

Expanding Contraceptive Method Choice

Date: September 25, 2019

Time: *In-person*: 8:30 a.m.–4:00 p.m. (EDT)
Remote viewing: 9:00 a.m.–12:45 p.m. & 1:30 p.m.–2:30p.m. (EDT)

Venue: Human Rights Campaign
1640 Rhode Island Ave NW
Washington, DC 20036

Goal

To support the Long-Acting and Reversible Contraceptive and Permanent Methods Community of Practice's (LARC & PM CoP) transition to a Method Choice CoP through exploration of new contraceptive data and trends and by hearing from country experiences about what it takes to operationalize an environment where all individuals can freely choose a contraceptive method that best meets their reproductive desires and lifestyle.

Objectives

Participants will:

- Develop an understanding of what the data tell us about contraceptive method choice, where it is inadequate for doing so, and what opportunities exist for understanding method choice better
- Discuss process of and lessons from introducing a new method and how it affects contraceptive choice at the country level
- Recognize, extract, and reflect on major arguments in the pursuit of balancing efforts between investment in new contraceptive method development with making better use of the contraceptive methods already available
- Identify and recommend key priority technical areas of focus for the new Method Choice CoP

Agenda

Time	Session & Presenters	
Breakfast and Registration (*for in-person attendees*)		
8:30–9:00	Breakfast & Registration	
LIVESTREAM EVENT BEGINS		
Welcome and Opening		
9:00–9:05	Welcome	Ellen Starbird, USAID
9:05–9:20	Looking Back, Looking Ahead	Trish MacDonald, USAID
Data Panel: What Can Data on Contraceptive Method Availability and Mix Tell Us about Method Choice?		
9:20–10:35	**Moderator:** • Jane Bertrand, Tulane University **Panelists:** • Emily Sonneveldt, Avenir Health • Michelle Weinberger, Avenir Health • Rebecca Callahan, FHI 360 • Scott Radloff, PMA	
10:35–11:00	Question & Answer	
BREAK		
11:00–11:20	Break	
Country Experience Panel: What Does It Take to Introduce a New Method and How Does It Affect Contraceptive Choice at Country Level?		
11:20–12:25	**Moderator:** • Martyn Smith, FP2020 **Panelists:** • Aparna Jain, Population Council • Gathari Ndirangu, MCSP Kenya • Mengistu Asnake, Pathfinder International Ethiopia • Maryjane Lacoste, Bill & Melinda Gates Foundation	
12:25–12:45	Question & Answer	
LIVESTREAM EVENT ENDS		
LUNCH		
12:45–1:30 Lunch		

Time	Session & Presenters	
Debate: Do We Need New Contraceptive Methods to Ensure More Choice? *(Remote participation available)*		
1:30–2:10	**Moderator:** • John Townsend, Population Council **Debaters:** • Laneta Dorflinger, FHI 360 • Roy Jacobstein, IntraHealth	
2:10–2:30	Audience Perspective/Voting	
BREAK		
2:30–2:50	Break	
Discussion: Shaping the Method Choice CoP Together		
2:50–3:45	Transitioning to a Method Choice CoP	Elaine Menotti, USAID Rita Badiani, E2A Fariyal Fikree, E2A
3:45–3:50	Next Steps	
Closing		
3:50–4:00	Closing Words	Anne Pfitzer, MCSP Trish MacDonald, USAID

Annex B: List of Meeting Participants

In-Person Participants

	Last Name	First Name	Organization
1.	Abdur-Rahman	Afeefa	USAID
2.	Akhlaghi	Laila	JSI
3.	Angel	Alexandra	PSI
4.	Arnold	Bethany	MCSP/Jhpiego
5.	Aronovich	Dana	JSI
6.	Asnake	Mengistu	Pathfinder
7.	Badiani	Rita	E2A
8.	Baker	Maggwa	USAID
9.	Ballard Sara	Anne	JHU
10.	Bellows	Ben	Nivi
11.	Bertrand	Jane	Tulane
12.	Bodenheimer Gatto	Alison	FP2020
13.	Brunie	Aurelie	FHI 360
14.	Cabiness	Jvani	JHU
15.	Callahan	Rebecca	FHI 360
16.	Charurat	Elaine	Jhpiego
17.	Christenson	Kaitlin	PATH
18.	Christofield	Megan	Jhpiego
19.	Cole	Kimberly	USAID
20.	Cucuzza	Laurette	USAID
21.	Datta	Isha	UN Foundation
22.	Dorflinger	Laneta	FHI 360
23.	Drake	Jennifer	PATH
24.	Dumas	Erin	PSI
25.	Elliott	Leah	MCSP/Jhpiego
26.	Engwenyi	Keshia	MCSP/Jhpiego
27.	Farrell	Marguerite	USAID
28.	Fikree	Fariyal	E2A
29.	Gibson	Anita	Jhpiego
30.	Gichuhi	Gathari Ndirangu	MCSP/Jhpiego
31.	Goetsch	Brittany	JHU
32.	Greeley	Meghan	Jhpiego
33.	Greenbaum	Charlotte	Population Reference Bureau
34.	Gural	Demet	Independent
35.	Hardee	Karen	Hardee Associates
36.	Hathaway	Mark	MCSP/Jhpiego

	Last Name	First Name	Organization
37.	Hill	Kathleen	MCSP/Jhpiego
38.	Iboa	Zulema	Amfar
39.	Jacobstein	Roy	IntraHealth
40.	Jain	Aparna	Pop Council
41.	Jallow	Fatou	Independent
42.	Kuenzle	Katherine	AMFAR
43.	Lacoste	Maryjane	Gates Foundation
44.	Lu	Ricky	Jhpiego
45.	MacDonald	Patricia	USAID
46.	Mackenzie	Devon	MCSP/Jhpiego
47.	Martin	Erika	USAID
48.	May	Ados	PHI
49.	Menotti	Elaine	USAID
50.	Mielke	Erin	USAID
51.	Mills	Erica	E2A
52.	Mugore	Stembile	IntraHealth
53.	Nasiruzzaman	Mohammed	USAID
54.	Newhouse	Krista	FP2020
55.	Newman-Williams	Marjorie	Marie Stopes
56.	Obure	Joseph	Save The Children
57.	Ojaswi	Adhikari	USAID
58.	Okegbe	Tishina	FHI 360
59.	Orankoy	Ilayda	E2A
60.	Otai	Jane	Jhpiego
61.	Pfitzer	Anne	MCSP/Jhpiego
62.	Rademacher	Kate	FHI 360
63.	Radloff	Scott	PMA
64.	Ramirez	Eric	E2A
65.	Salem	Ruwaida	JHU
66.	Sitrin	Deborah	MCSP/Jhpiego
67.	Smith	Martyn	FP2020
68.	Sonneveldt	Emily	Avenir
69.	Starbird	Ellen	USAID
70.	Sussman	Linda	USAID
71.	Townsend	John	Pop Council
72.	VanEnk	Lauren	WorldVision
73.	Vatsia	Usha	Independent
74.	Weinberger	Michelle	Avenir
75.	Wille	Jacqueline	MCSP/Jhpiego

	Last Name	First Name	Organization
76.	Williams	Elspeth	Pop Council
77.	Wornell	Cory	USAID

Remote Participants

	Last name	First name	Organization
1.	Ba	Marie	IntraHealth
2.	Bhatnagar	Neeta	Jhpiego
3.	Brady	Martha	PATH
4.	Chidanyika	Agnes	UNFPA
5.	Cohen	Megan	Johns Hopkins University
6.	Cruikshank	Lila	GIA
7.	Danna	Kendal	PSI
8.	Duvivier	Roger	MMC/Einstein
9.	Edeh	Onyinye	Family Planning 2020
10.	Gupta	Sanchika	Consultant
11.	Harris	Danielle	WCG Cares
12.	Hathaway	Charles	Independent
13.	Hoang	Julie	MSH
14.	Hubacher	David	FHI 360
15.	Jackson	Ashley	Population Services International
16.	Jones	Lea	Ipas
17.	Kenyi	Edward	Jhpiego
18.	McCarthy	Ona	LSHTM
19.	McGinn	Erin	Palladium
20.	Mickler	Alex	USAID
21.	Molla	Yordanos	Pathfinder International
22.	Morgan	Gwen	MSH
23.	Murphy	Stacie	Population Connection
24.	Mutua	Jacqueline	Save the Children
25.	Nanda	Kavita	FHI 360
26.	Nicholson	Martha	MSI
27.	O'Hara	Holly	MCSP/Jhpiego
28.	Patykewich	Leslie	JSI
29.	Pile	John M	Independent Consultant
30.	Pleah	Tsigue	Jhpiego
31.	Rademacher	Kate	FHI 360
32.	Rawlins	Barbara	Jhpiego
33.	Robertson	Valerie	RemovAid

	Last name	First name	Organization
34.	Sebikali	Boniface	Intrahealth
35.	Solovyev	Tim	Spark Street Digital
36.	Steiner	Markus	FHI 360
37.	Stratton	Sara	Palladium
38.	Sullivan	Tara	JHU Center for Communication Programs
39.	Van Boven	Tom	Consultant
40.	Wallner	Katie	Elizabeth Glaser Pediatric AIDS Foundation
41.	White	Alanna	USAID
42.	Wickstrom	Jane	Bill & Melinda Gates Foundation
43.	Williamson	Jessica	Avenir Health
44.	Wood Santos	Trisha	Bill & Melinda Gates Foundation
45.	Yacobson	Irina	FHI 360

Annex C: Speaker Biographies

Rita Badiani, MA, of Pathfinder International, is the Director of Evidence to Action (E2A) Project, USAID's flagship family planning project with a focus in 16 USAID priority countries. Badiani is an internationally recognized expert in reproductive health, family planning, policy dialogue, and advocacy for policy reform. She has 30 years of program management and development experience in reproductive health, family planning, adolescent and youth reproductive health, and integration. For more than 2 decades, she has led, managed, and implemented reproductive health projects in multiple countries across Africa and Latin America.

Jane T. Bertrand, PhD, MBA, is a professor of the Department of Health Policy and Management at the Tulane School of Public Health and Tropical Medicine. She also holds the Neal A. and Mary Vanselow endowed chair. Her professional interests involve program evaluation and behavior change communication in the areas of international family planning and HIV prevention, as well as contraceptive method mix. Dr. Bertrand has been on the Tulane faculty since 1979, except for the period from 2002–2009, when she directed the Center for Communication Programs at the Johns Hopkins Bloomberg School of Public Health. Her published research focuses largely on Latin America and sub-Saharan Africa. In recent years, she has worked primarily on the implementation and evaluation of family planning programs to increase contraceptive use in the Democratic Republic of the Congo.

Rebecca Callahan, PhD, MPH, is a public health scientist with more than 15 years of experience in the field of global reproductive health. Dr. Callahan serves as associate director for FHI 360's Contraceptive Technology Innovation Department, where she manages research grants for the development of new contraceptive technologies and leads studies focused on user preferences for new methods in development. She was previously a family planning technical advisor with USAID and served as a Peace Corps volunteer in Nepal. She obtained her PhD in public health from the Johns Hopkins Bloomberg School of Public Health.

Laneta Dorflinger, **PhD,** is a distinguished scientist and the director of the Contraceptive Technology Innovation Department at FHI 360. A passionate advocate for expanding reproductive choice for nearly 35 years, Dr. Dorflinger has spent her career advancing contraceptive technology research, development, and introduction with a focus on low- and middle-income countries. She currently leads a multimillion-dollar program to develop and introduce new mid- to long- acting contraceptive methods to meet the needs of women in low-resource settings. Since joining FHI 360 in 1991, Dr. Dorflinger has held several leadership positions, including Vice President of Clinical Research, Vice President of Research and Development, Director of Clinical Trials, and Director of Regulatory Affairs and Quality Assurance.

Fariyal F. Fikree, DrPH, MPH, MD, is PATH's senior research advisor on the Evidence to Action (E2A) Project. Dr. Fikree is an internationally recognized women's health expert with more than 25 years of experience in designing, implementing, and evaluating health programs addressing health care delivery systems; maternal, newborn, infant, and child health; and family planning. Since 2010, Dr. Fikree has led E2A's research on expanding method choice for adolescents and youth. She has coauthored more than 50 peer-reviewed articles and several technical publications.

Gathari Ndirangu Gichuhi, MD, MPH, is a family planning, reproductive, maternal, newborn, child, and adolescent health specialist with 19 years of experience in health systems strengthening, technical support, service delivery, research, and program management in sub-Saharan Africa. He has successfully led complex large-scale integrated health projects at Jhpiego and IntraHealth International. Gathari is a thought leader and seasoned health professional with superior expertise providing leadership and management to integrated programs that focus on improving outcomes in maternal, newborn, child, and adolescent/youth health; family planning; immunization; malaria; nutrition; HIV/AIDS; water, sanitation, and hygiene (WASH); infection prevention and control; gender issues, including sexual and gender-based violence; and noncommunicable diseases. He has provided technical support to senior ministry of health leaders in the East and Southern Africa region and contributed to the establishment and strengthening of multiple health

training and mentorship systems. Currently, Dr. Gathari is the technical director of the USAID-funded Afya Halisi Project in Kenya, a 5-year multipartner family planning/reproductive, maternal, newborn, child, and adolescent health/nutrition and WASH award that focuses on strengthening the health systems at the national and subnational levels toward improving the lives of women and children.

Roy Jacobstein, MD, MPH, is a pediatrician and public health physician who has worked on family planning and reproductive health in low-resource settings for more than 3 decades. He is currently IntraHealth International's global technical lead for family planning. Dr. Jacobstein serves as an expert technical advisor to the World Health Organization (WHO), where he has been a key contributor to developing and updating its guidance documents, *Medical Eligibility Criteria for Contraceptive Use* and *Family Planning: A Global Handbook for Providers*, and most recently was a reviewer of WHO's revised guidance subsequent to the ECHO Trial. Among his many peer-reviewed papers are those that address the recent and blossoming implant use in sub-Saharan Africa, vasectomy, female sterilization in Malawi, hormonal contraception, the fragility of sub-Saharan African health systems, and fostering change in medical settings (and why it is so difficult). Before joining IntraHealth, Dr. Jacobstein served for 12 years as medical director of EngenderHealth, and 13 years as chief of the Communication, Management, and Training Division in USAID's Office of Population. He is an adjunct professor of maternal and child health at the Gillings School of Global Public Health of the University of North Carolina, and has an MFA in creative writing.

Aparna Jain, **PhD, MPH,** has more than 15 years of experience in international public health and currently is the deputy technical director for the Evidence Project, a USAID-funded Population Council initiative to expand access to high-quality family planning services worldwide through implementation science. Dr. Jain's research focuses on contraceptive use dynamics including determinants of contraceptive switching and discontinuation, task-sharing provision of injectable contraceptives to drug shops owners and private pharmacies, and mitigating barriers to adolescents' access to family planning and reproductive health services. She is a member of FP2020's Performance Monitoring and Evidence Working Group, the Population Association of America, and sits on the editorial committee for *Studies in Family Planning*.

Mengistu Asnake Kibret, MD, MPH, is a public health physician with more than 30 years of experience in clinical service, program management, training, and operation research both in government and nongovernmental organizations. He is currently the senior country director for Pathfinder International in Ethiopia. In addition, he is chief of party for the Transform: Primary Health Care Project, a USAID flagship family planning/maternal, newborn, and child health program led by Pathfinder International in Ethiopia contributing to preventable childhood and maternal deaths. In various occasions, Dr. Kibret served as an expert in global discussions for family planning/HIV integration, community-based family planning, long-acting family planning, and adolescent issues. Before joining Pathfinder, Dr. Kibret worked at various levels of Ethiopia's Ministry of Health and nongovernmental organizations. In a voluntary capacity, he has served as the president of the Ethiopian Public Health Association (2006–2009) and president for the World Federation of Public Health Associations (2014–2016). He has an MD from Gondar College of Medical Sciences, Addis Ababa University, and an MPH from Addis Ababa University. He authored and coauthored more than 35 scientific and technical papers in peer-reviewed journals and technical publications. Dr. Kibret speaks Amharic and English.

Maryjane Lacoste, MA, joined the Bill & Melinda Gates Foundation in May 2014, working with the family planning team as the senior program officer for Family Planning Service Delivery and Quality. As such, she leads and manages implementation of both the Implant Access Program and DMPA-SC introduction/ scale-up portfolio, ensuring that the strategy focuses on expanding access to method choice and strengthens quality of care including counseling, interpersonal communications, clinical training, service delivery, and performance monitoring. Prior to joining the Foundation, Lacoste worked with Jhpiego for more than 20 years, spending the last 15 years in the field as country/regional director in Tanzania, Indonesia, and Malawi. She has worked with ministries of health, donors, and other stakeholders to develop and manage implementation of large reproductive health, maternal, newborn, and child health and HIV projects in many countries in sub-Saharan Africa, as well as in Indonesia. She holds a Master of Arts degree from the University of Maryland and a Bachelor of Arts degree from Loyola University.

Trish MacDonald, MPH, is a registered nurse and public health specialist in family planning and reproductive health. Over the last 3 decades, she has lived and worked in several countries in Africa and Asia, training clinical providers, strengthening quality of care and health systems, designing and conducting programmatic research, and managing maternal and reproductive health projects. As a senior technical advisor in the Office of Population and Reproductive Health in USAID's Bureau for Global Health, she provides leadership in areas of contraceptive method choice, long-acting reversible contraceptives/permanent methods, family planning integration with maternal and child health, service communication, and scaling up evidence-based high-impact practices. MacDonald received an MPH in health behavior and health education from the University of Michigan

Elaine Menotti, MPH, is a technical advisor at USAID's Office of Population and Reproductive Health, where she manages private sector-led family planning and reproductive health and other health service delivery programming, engages in strategic efforts to expand method choice and access globally, and serves as deputy division chief in the Service Delivery Improvement Division. Previously, she worked in USAID's Nutrition division on community-based maternal and child health programming. Before joining USAID, Elaine worked at Futures Group (now Palladium) to strengthen family planning and reproductive health policies and programs in multiple countries. She worked in Central America with local and international nongovernmental organizations, as well as domestically, to design, implement, and monitor community-based maternal and child health, family planning, and nutrition programs. She has an MPH in health behavior and health education and a Certificate in reproductive and women's health from the University of Michigan and a BA in anthropology from Duke University.

Anne Pfitzer, MHS, is the family planning technical team leader for the USAID-funded global Maternal and Child Survival Program. Prior to this, she was deputy director for Save the Children's Saving Newborn Lives program, funded by the Bill & Melinda Gates Foundation. She has also served as country director in Ethiopia for Jhpiego and performance improvement advisor for a family planning USAID bilateral program, called STARH, in Indonesia.

Martyn Smith, MA, MSc, is the managing director of FP2020. He is committed to ensuring that all women, no matter where they live, have access to lifesaving contraceptives, and is keenly focused on the ultimate goal of universal access to sexual and reproductive health services and rights as enshrined in the Sustainable Development Goals. Smith was born in the UK, currently holds both British and Indian citizenship, and is poised to become a US citizen in the next few weeks (if he can find the time to fit the oath ceremony into his travel schedule). Smith works closely with the 46 countries that have committed to FP2020 and thoroughly enjoys the work in partnership with colleagues from Afghanistan to Haiti to Zimbabwe, as well as working with the wealth of data that the team has generated some 7 years into the initiative. Before arriving at UNF/FP2020, Smith led and transformed Marie Stopes International organizations first in Sierra Leone and India, delivering sexual and reproductive health services in remote rural areas.

Emily Sonneveldt, PhD, joined Avenir Health in 2009. She currently leads activities that focus on monitoring health programs, increasing data use at the national and global levels, and developing and applying innovative tools and models that support data-based decision-making. She has extensive experience supporting governments to develop, implement, and monitor health policies, including facilitation of goal setting and priority identification workshops that have resulted in policy and priority changes. She has performed district- and national-level applications of computer models focusing on family planning, safe motherhood, postabortion care, and the impact of rapid population growth on development. She has worked on implementing health programs in Africa and the Balkans and served as a technical advisor for policy, advocacy, and research activities in Africa, the Caribbean, Southern Asia, and Eastern Europe. Her primary areas of expertise are family planning and maternal health.

Ellen Starbird, MA, is the director of USAID's Office of Population and Reproductive Health. She provides high-level leadership to the Agency's family planning/reproductive health agenda and portfolio, valued at approximately US$600 million annually, and directs the Office's US$100 million program. Starbird has more than 25 years of experience designing, managing, monitoring, and evaluating international family planning and

reproductive health programming. She is widely known as a strategic thinker who is committed to advancing access to family planning for women, men, couples, and adolescents around the world. Starbird joined USAID in 1989 and has spent her career in the Office of Population and Reproductive Health, starting in the Policy, Evaluation, and Communication Division, where she was chief from 1995 to 2006. She served as deputy director of the Office for the next 6 years, and has been director since 2013. She has an MA in development economics from the Fletcher School of Law and Diplomacy at Tufts University.

Scott Radloff, PhD, is trained in demography, sociology, and economics and is a senior scientist at the Bill & Melinda Gates Institute within the Department of Population, Family, and Reproductive Health at Johns Hopkins Bloomberg School of Public Health. He joined the Department in 2013. Dr. Radloff is the director of PMA2020, an innovative program that recruits women from their communities and trains them to use smartphone technologies to collect household- and facility-level data on a quick-turnaround, low-cost, and routine basis. The program is designed to collect family planning data, but has been expanded to encompass water/sanitation, maternal/newborn, primary health care, and nutrition data as well. The program is being implemented in 11 countries in Africa and Asia and has trained and deployed more than 1,700 female resident enumerators. Dr. Radloff also co-teaches a masters-level course in family planning policies and programs offered third term. Before joining the Department, Dr. Radloff was the director of USAID's Office of Population and Reproductive Health within the Bureau for Global Health.

John Townsend, PhD, is Director of Country Strategy at the Population Council. In this role, he provides leadership and support across the Population Council's country offices with the aim of maximizing the Council's positive impact and ensuring that the organization's knowledge is effectively influencing national policy and programs. He is responsible for the initiation, development, and monitoring of Council country strategies and provides technical and managerial guidance related to program priorities in reproductive health; poverty, gender, and youth; and HIV/AIDS; as well as support for the introduction of new health technologies in countries with Council presence. Dr. Townsend is chair of the Reproductive Health Supplies Coalition and serves as co-chair of the Board of Trustees of the International Contraceptive Access Foundation, a public–private cooperation with Bayer AG, which provides access to long-acting intrauterine methods in developing countries.

Michelle Weinberger, MSc, is a senior associate with Avenir Health. She works across a range of projects including Track20, SHOPS Plus, and HP+. Her work focuses on data analysis and modeling that informs strategic policy and programmatic decisions related to family planning and reproductive health. Weinberger serves as the technical lead for the Reproductive Health Supplies Coalition's annual Commodity Gap Analysis (2016), is the modeling lead for HP+, and serves on the High Impact Practices Technical Advisory Group. Before joining Avenir Health, Weinberger headed the impact analysis team at Marie Stopes International, where she oversaw the development of impact models and metrics. This included developing the Impact 2 model, which estimates the health impact of reproductive health service provision. Before that, she worked for Family Health International in Tanzania on reproductive health and HIV prevention programs. Weinberger has an MSc in population and development from the London School of Economics.