How self-injection contributes to contraceptive autonomy and the power of making self-injection count

Opening Plenary

Caitlin Corneliess, MPH
Project Director, Access Collaborative
“What does it mean that we live in a society where the systems we create [and decisions we make] are based on data, but we don’t collect what we need?”

-Mimi Ọnụọha, The Library of Missing Datasets
Expanding method choice and contraceptive autonomy

Photo credits: Family Planning NSW (row 2, left); all other photos PATH
The Access Collaborative

Purpose
The AC aims to ensure **sustainable availability of DMPA-SC self-injection as part of an expanded range of contraceptive methods.**

Vision
The AC’s work will increase women’s and girls’ contraceptive choices and empowerment.

Functions
The AC is a **coordination and technical assistance** effort that:

- Supports ministries of health in close collaboration with country partners to introduce and scale-up self-injection.

- Informs data-driven decisions on self-injection, family planning, and self-care by global and country level stakeholders.
1 Welcome
2 The importance of self-injection for contraceptive autonomy
3 The broader context of self-care for SRHR
4 The landscape of self-injection data today
5 Experiences of self-injection from the lens of a client, an advocate, and a provider
The importance of self-injection for contraceptive autonomy

Dr. Fannie Kachale
Director, Reproductive Health Services
Malawi Ministry of Health
The broader context of self-care for SRHR

Briana Lucido

World Health Organization
Department of Sexual and Reproductive Health and Research
Welcome

The importance of self-injection for contraceptive autonomy

The broader context of self-care for SRHR

The landscape of self-injection data today

Experiences of self-injection from the lens of a client, an advocate, and a provider
Participant poll

1- Are you involved in the **collection** of contraceptive self-injection data in your work?  Yes/No

Êtes-vous impliqué dans la **collecte** de données sur l’auto-injection contraceptive dans votre travail?  Oui/Non

2- Have you **reviewed or used** data on contraceptive self-injection in your work?  Yes/No

Avez-vous **revu ou utilisé** des données sur l’auto-injection contraceptive dans votre travail?  Oui/Non
Global commitment to self-injection as part of an expanded method mix has increased
Data systems and availability vary across the 16 countries introducing self-injection

<table>
<thead>
<tr>
<th>Country</th>
<th>Self-injection data availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>Data not collected</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Unknown data availability</td>
</tr>
<tr>
<td>Cote d'Ivoire</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>DRC</td>
<td>Data available in narrow geographic scope</td>
</tr>
<tr>
<td>Ghana</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Guinea</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Malawi</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Mali</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Senegal</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Togo</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Uganda</td>
<td>Data available in HMIS</td>
</tr>
<tr>
<td>Zambia</td>
<td>Data available in HMIS</td>
</tr>
</tbody>
</table>

- Red: Data available in HMIS
- Pink: Data available in narrow geographic scope
- Gray: Data not collected
- Light gray: Unknown data availability
What is the value of disaggregating self-injection from provider-administered DMPA-SC?

The FP2020 Arc of Progress Report found that injectables are the most commonly used modern method of family planning in most countries.
Global survey data will be increasingly more available for DMPA-SC self-injection

**DHS** is integrating a DMPA-SC question and mode of administration to capture self-injectors in their next round (DHS 8). They will be implementing these new questions in field work beginning in 2021.

**FP2020** collates data on expanding method choice through several measures: contraceptive use, changes in the method mix, and method prevalence. 9 countries total listed DMPA-SC on their registers. 2 countries disaggregate self-injection vs provider injection.

**PMA** is collecting data on DMPA-SC in 7 countries and will include self-injection in all 7 countries by 2021.

Countries have **increased capacity** to provide women access to DMPA-SC through multiple channels

Since 2018, training has dramatically increased.

- **145,752** providers trained in provider administered DMPA-SC
- **79,964** providers trained in self-injection initiation

Of 16 countries, 4 have 50% or more public sector SDPs active in self-injection initiation:
- Burkina Faso
- Malawi
- Senegal
- Togo
Self-injection visit data available to the Access Collaborative

Data vary in representativeness and time period for each country. Half of the countries reporting have higher percentages of DMPA-SC visits for self-injection, in the range of 10-45%.

Estimated proportion of DMPA-SC visits for self-injection by country, using cumulative raw and modeled data

The six countries below have data for 6 or more months and a sample representative of their SI programs.

<table>
<thead>
<tr>
<th>Country</th>
<th>Raw Data</th>
<th>Modeled data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guinea</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Madagascar</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Malawi</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Senegal</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Togo</td>
<td>13%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Three countries have data limited in scope or time: Burkina Faso and Uganda data represent a limited number of service delivery points. Nigeria has national data available but only for two months.

<table>
<thead>
<tr>
<th>Country</th>
<th>Raw Data</th>
<th>Modeled data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>10%</td>
<td>23%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Uganda</td>
<td>13%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Three countries’ data are limited in both time and scope.

<table>
<thead>
<tr>
<th>Country</th>
<th>Raw Data</th>
<th>Modeled data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin*</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>DRC*</td>
<td>2%</td>
<td>12%</td>
</tr>
<tr>
<td>Zambia*</td>
<td>2%</td>
<td>6%</td>
</tr>
</tbody>
</table>

*New country for this quarter
Self-injection uptake varies across countries

In some countries, one-third of DMPA-SC visits choose to self-inject. As countries integrate SI into national information systems, more data will be available. Currently, six countries’ data represented is limited in geographic scope and timing.

Burkina Faso and Uganda data represent a limited number of service delivery points. Nigeria has national data available but currently only for two months. Benin, DRC, and Zambia have a limited scope and two or less time points of data available.
SI client age patterns are not drastically different than other modern methods of family planning.

Early SI adopters in Madagascar tend to be a slightly older demographic than other modern method users though younger than DMPA-SC provider-administered clients.

While in Senegal, family planning clients are older. Senegal SI clients fall more into the 20-24 year age range compared to other injectables and other modern methods.
Provider administered DMPA-SC and DMPA-IM trends vary in high SI uptake subnational units.

In four out of nine subnational units with the highest SI uptake rates, more than 50% of injectable visits were for DMPA-IM. In the other five subnational units, DMPA-SC visits accounted for more than 50% of injectable mix.

There remains a gap in data to describe client choices vs. client access to Family Planning products.
Self-injection data integration into national systems can answer questions

*These data can shed insights on programming implications such as bias against or for DMPA-SC as a self-care method, need for more demand generation, supply constraints, among others.*

Some subnational units have a high percentage of DMPA-SC compared to IM but very low SI uptake rates.

While other subnational units with high percent of injectable visits for DMPA-IM have high rates of SI uptake.
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Experiences of self-injection from a client’s perspective

Matilda
Volunteer health worker
Kibalinga Health Centre, Mubende, Uganda
Experiences of self-injection from a provider’s perspective

Dr. Swomen George MD
Programme Officer
Planned Parenthood Federation of Nigeria
Experiences of self-injection from an advocate’s perspective

Fatimata Dème
Présidente
Réseau des Femmes Sénégalaises pour la Promotion de la Planification Familiale
Next Session

Session 2. The “why” and the “how” of routine data collection: Real world examples of using data from routine HMISs in policy and programming

We will now take a short break, and Session II will begin at 9:30 ET/3:30PM GMT

Access the next session by clicking back into the Schedule and click on Session 2.

All our sessions will be recorded this week and will be posted to the Resource Library at the conclusion of the workshop.

Please take the short session survey located on the Session page.