

CAT: CHANGING THE CONTRACEPTIVE LANDSCAPE

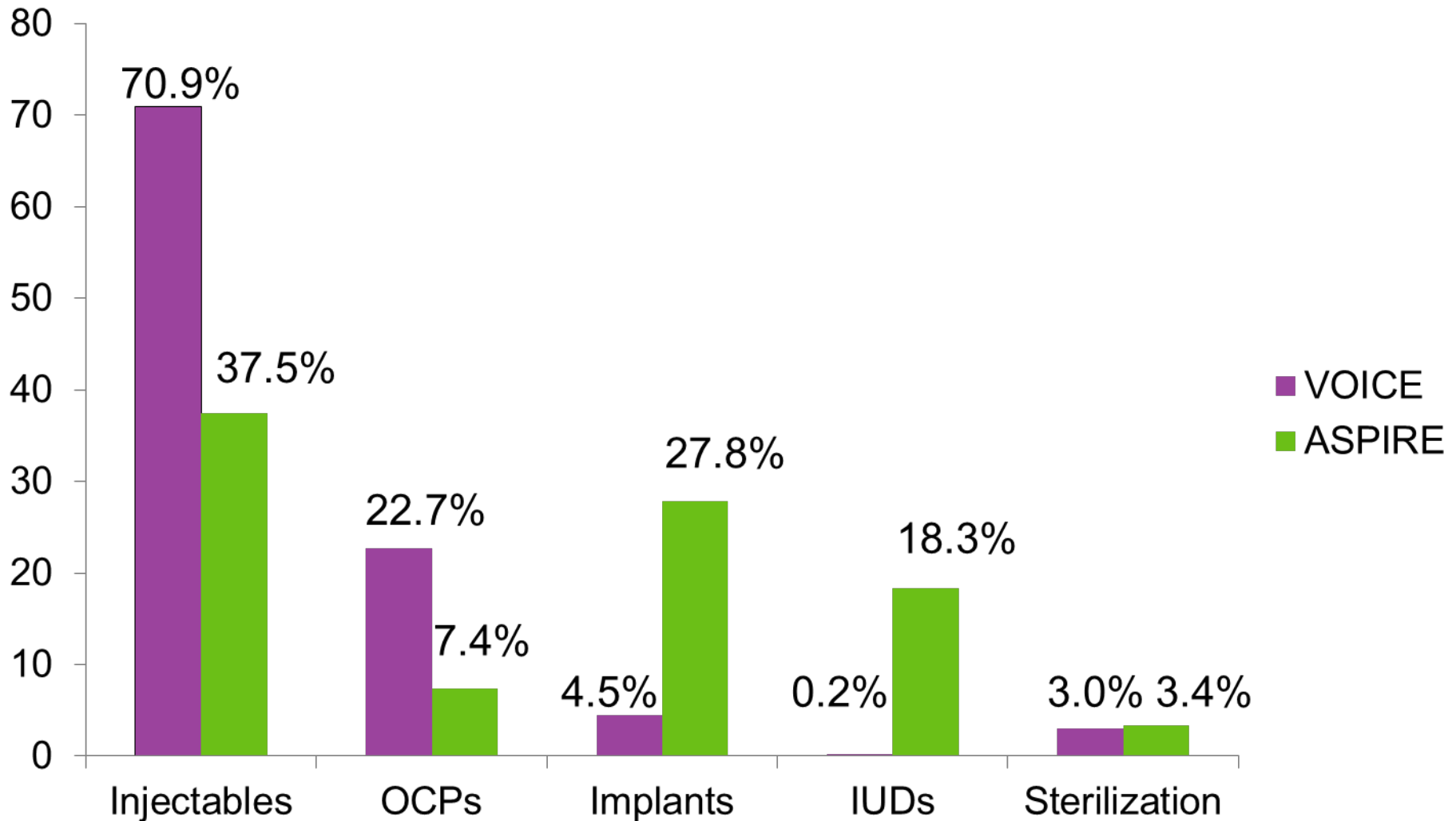
MTN ANNUAL MEETING - MARCH 2015

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**On behalf of the Contraceptive Action Team and ASPIRE
Clinical Research Sites**



VOICE versus ASPIRE





Overview

- ❑ Introduction to CAT
- ❑ Contraceptive landscape at baseline
- ❑ Challenges
- ❑ Implementation Plans
- ❑ Results
- ❑ Future direction of CAT

Introduction to CAT

□ WHO IS CAT (CONTRACEPTIVE ACTION TEAM)?

⇒ Created by MTN in June 2012:

- Comprised of 2-3 representatives per African MTN site (Total 15 sites: Uganda, Zimbabwe, Malawi, S. Africa.)
- MTN Core facilitators
(*Singh, Chappell, Bunge*)
- Overseen by Contraceptive Action Steering Committee
(*Nakabiito, Makanani, Chirenji, Chatani-Gata, Cates, Piper, Rees, White, Mofenson, Baeten, Hillier*)

Introduction to CAT

□ WHY WAS CAT CREATED?

- To expand the range of effective contraceptive methods => WHY?
- Contraception use is often an enrollment eligibility criterion in MTN HIV prevention studies.
- Free contraceptive service provided as part of study.
- VOICE: Majority used OCP or injectable contraception.
- Growing concern: Injectable hormonal methods may be associated with increased risk of HIV acquisition

Introduction to CAT

- Importance of offering contraceptive choice was recognized, hence inception of CAT
- First meeting June 2012
- Specific CAT objectives were set:
 - Four methods of contraception would be offered at each site.
 - No single contraceptive method would comprise > 50% of the mix.



Contraceptive Landscape: Baseline

Oral Contraceptive Pill (OCP)

- Available at all sites

Injectables

- All sites offered at least one; 7 sites offered two

Sterilization

- No sites offered sterilization at site but able to refer

Intra-uterine Device (IUD)

- No sites offered on-site insertion but able to refer

Sub Dermal Implant

- 2 non-SA sites offered on-site insertion; others referred
- Not yet available in SA in 2012

Major Challenges



BARRIERS



PROVIDER BIAS

- (i) Myths/ misconceptions
- (ii) Lack of knowledge, skills, confidence

PARTICIPANT BIAS

- (i) Unfamiliar
- (ii) Myths/ misconceptions
- (iii) Partner/ community bias

ACQUISITION OF IUD/IMPLANTS

STAFF TRAINING

DETOUR



eThekwini

**Sounds
interesting
but.....**

**\$\$\$
?????**

**For our
participants?**

I wonder.....



Implementation:

(i) Action Plan: Provider bias

- ❑ Implementation of education programmes by CAT representatives
- ❑ All team members educated to appropriate level
- ❑ Multiple methods adopted incl. written tools, case discussions, formal presentations, quizzes
- ❑ Updates after each meeting
- ❑ Ongoing and active process



Implementation:

(ii) Action Plan : Participant bias

- ❑ Sites embarked on intensive education campaigns
- ❑ Education directed at both participant and community



Implementation:

(ii) Action plan: Participant bias

Community Education	Participant Education
One-on-one during street recruitment	Daily waiting room education sessions
“Education tables” in public areas	One-on-one with clinician
Formal addresses by staff at community events	More relaxed group discussions at “social” ASPIRE events
Discussions at male involvement workshops	Participants used as peer educators; staff used as “role models”
Discussions at couples’ workshops	Educational material e.g. pamphlets, posters
	Guest speakers e.g. DoH nurses at formal group events



Implementation:

(iii) Acquisition of IUDs/Implants

- ❑ No allocated budget for IUD/Implant acquisition
- ❑ Non-SA sites: Procurement of both through respective state health departments
- ❑ SA sites:
 - Majority purchase IUDs privately
 - Implants are largely accessed through DOH FP clinics
 - Implants are prohibitively expensive
 - Utilize a facilitated referral system
 - MTN: Provision of small supply of implants for on-site insertion – utilized for clinician training.

Implementation

(iv) Staff Training: IUD/Implant

- ❑ **1st step : Identify trainer**

- ❑ **Non-SA sites: Agreements in place with state sector**

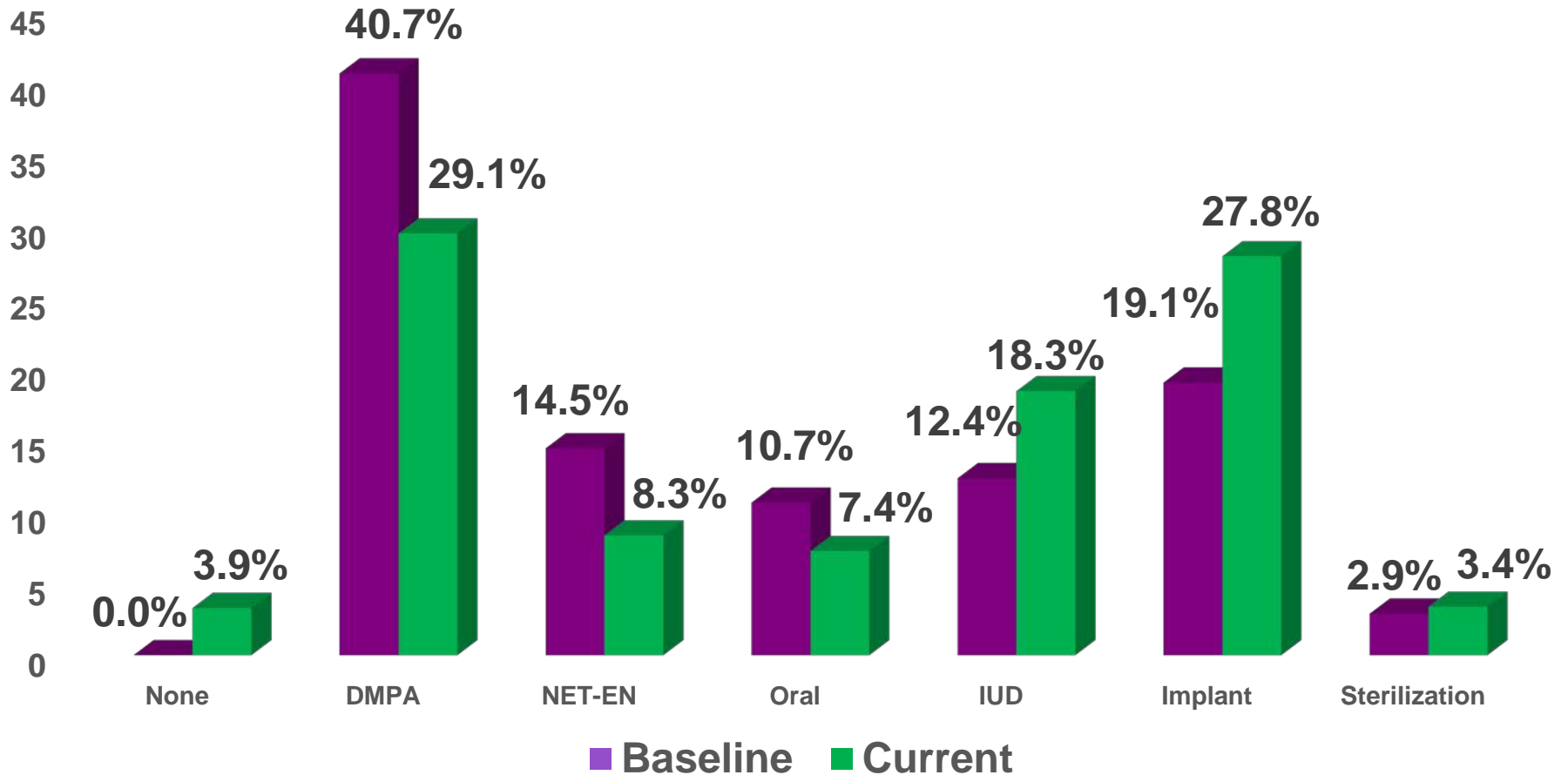
- ❑ **SA sites:**
 - **No formal agreements in place for NGOs by DoH**

 - **MTN: Didactic training, models/other training aids**

 - **Identifying clinical training opportunities took perseverance**

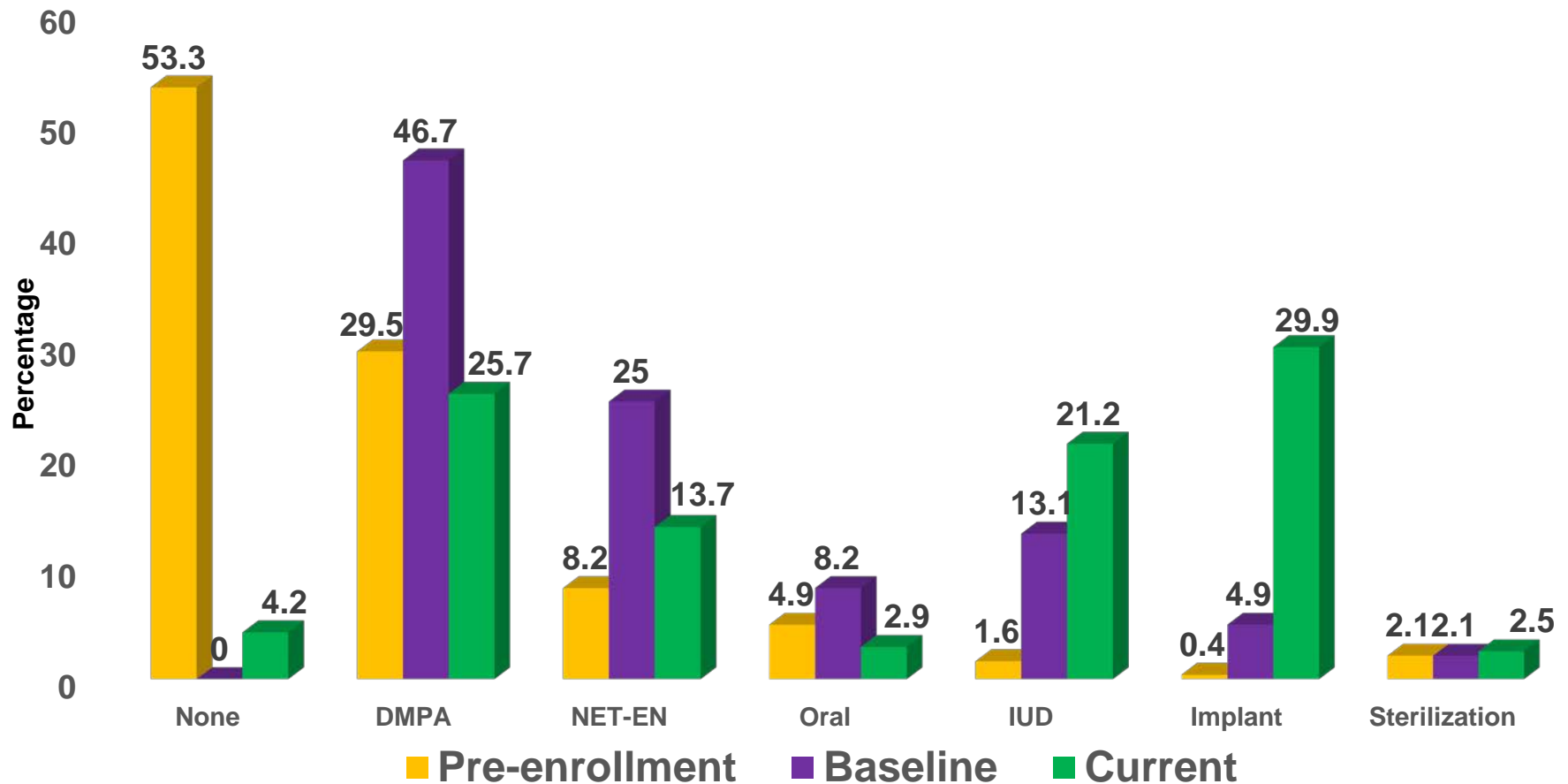
Results: All Sites

MTN All Sites Contraception Use



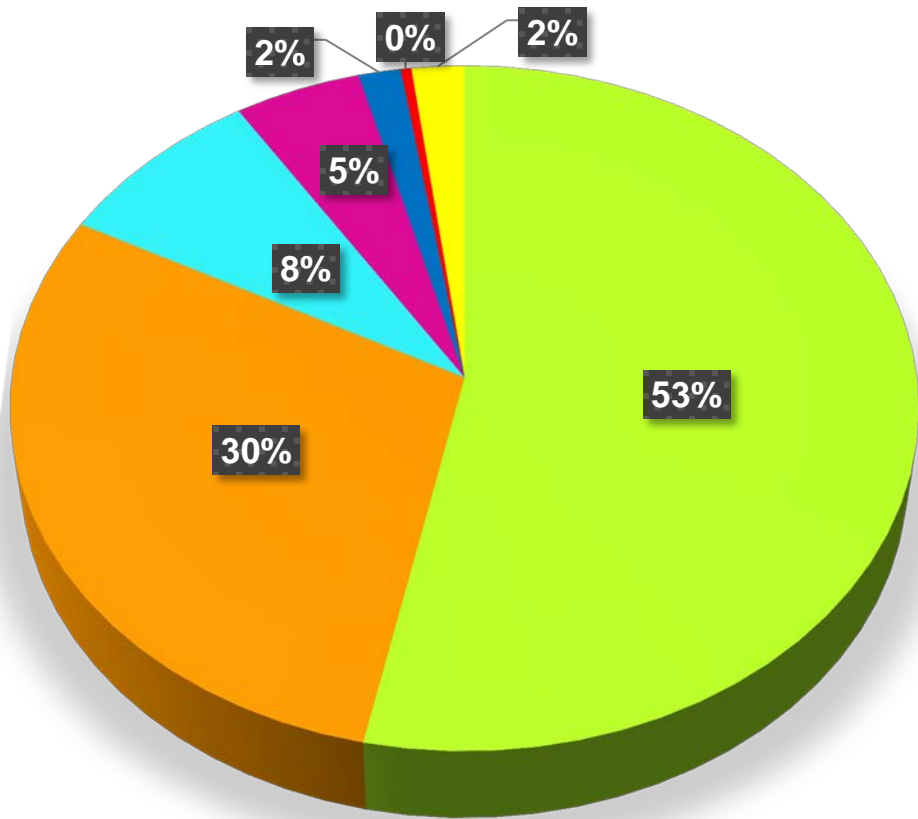
Results: eThekwini

eThekwini Contraception Use

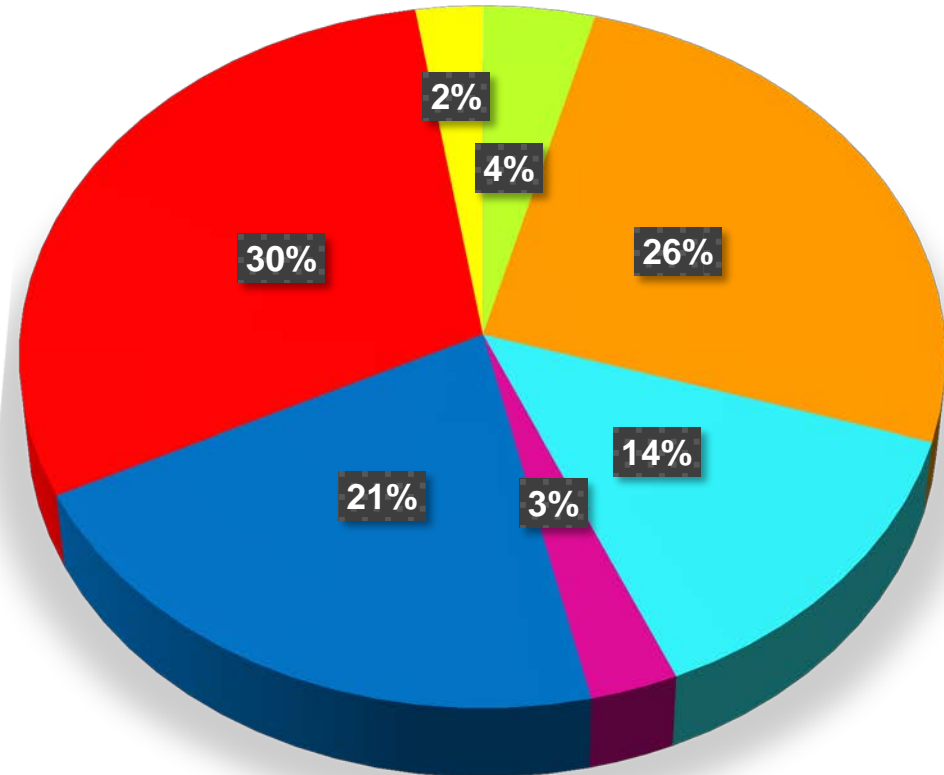


Results: Ethekwini

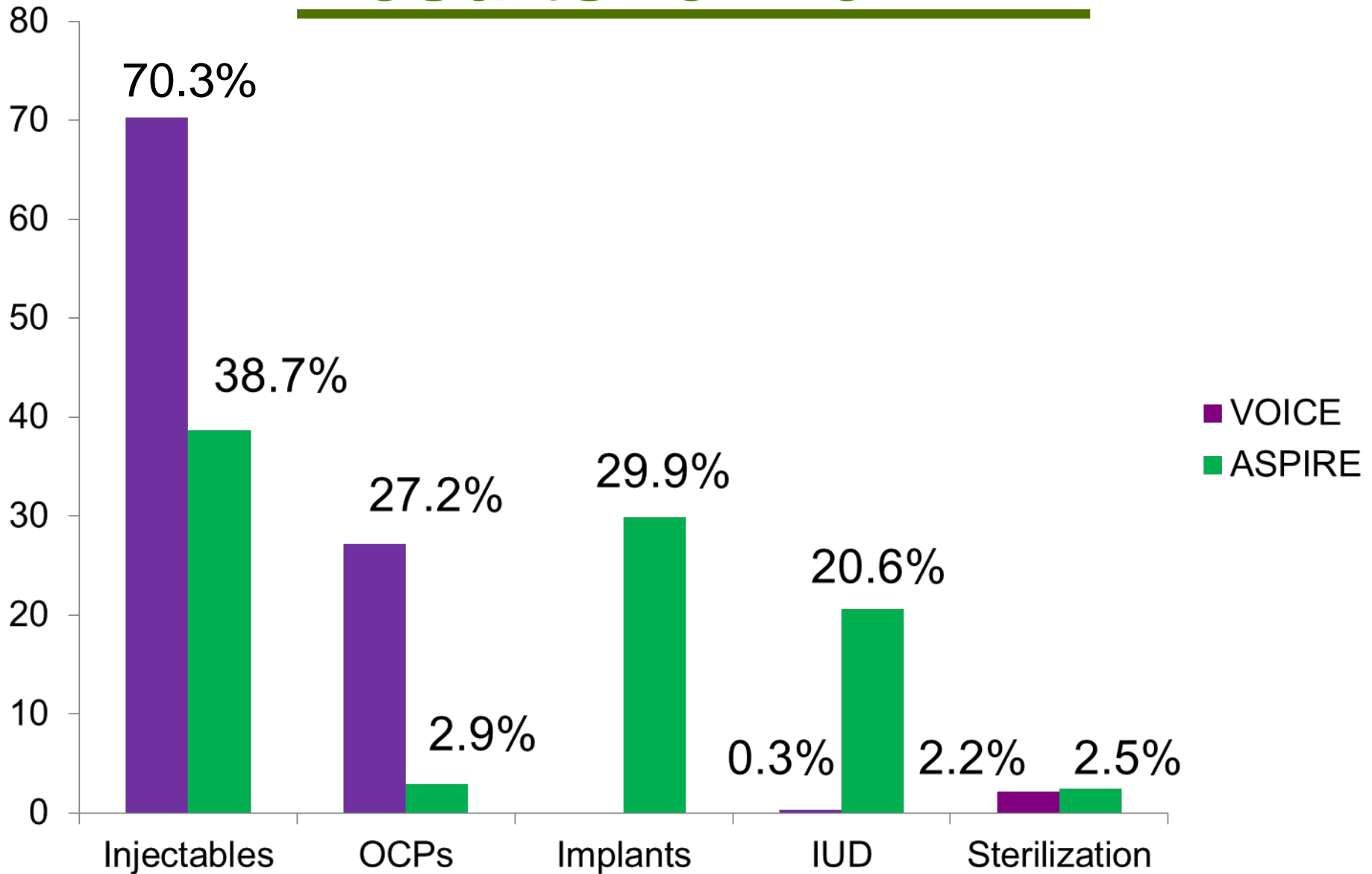
Screening



Current



Results: eThekwinini





CAT: Future Direction

- Completion of training: current staff and new staff**
- Continue education programmes**
- Maintain current links and expand existing network**
- Develop formal links with DOH**
- Contraception research**

Conclusion

- ❑ **CAT: created to provide contraceptive choice.**
- ❑ **Major implementation challenges: provider/participant bias, acquisition of IUDs/Implants, staff training.**
- ❑ **Specific objectives met: All sites able to offer minimum of 4 methods; no method accounts for > 50% of mix.**
- ❑ **African women use LARC methods if given a choice.**



eThekwini



***LINDIWE**
“I want to wait for
my soul-mate””

*Name changed to protect confidentiality

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THANK YOU

