CAT: DIVERSIFYING THE CONTRACEPTIVE METHOD MIX

MTN REGIONAL MEETING – 06 OCTOBER 2015

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

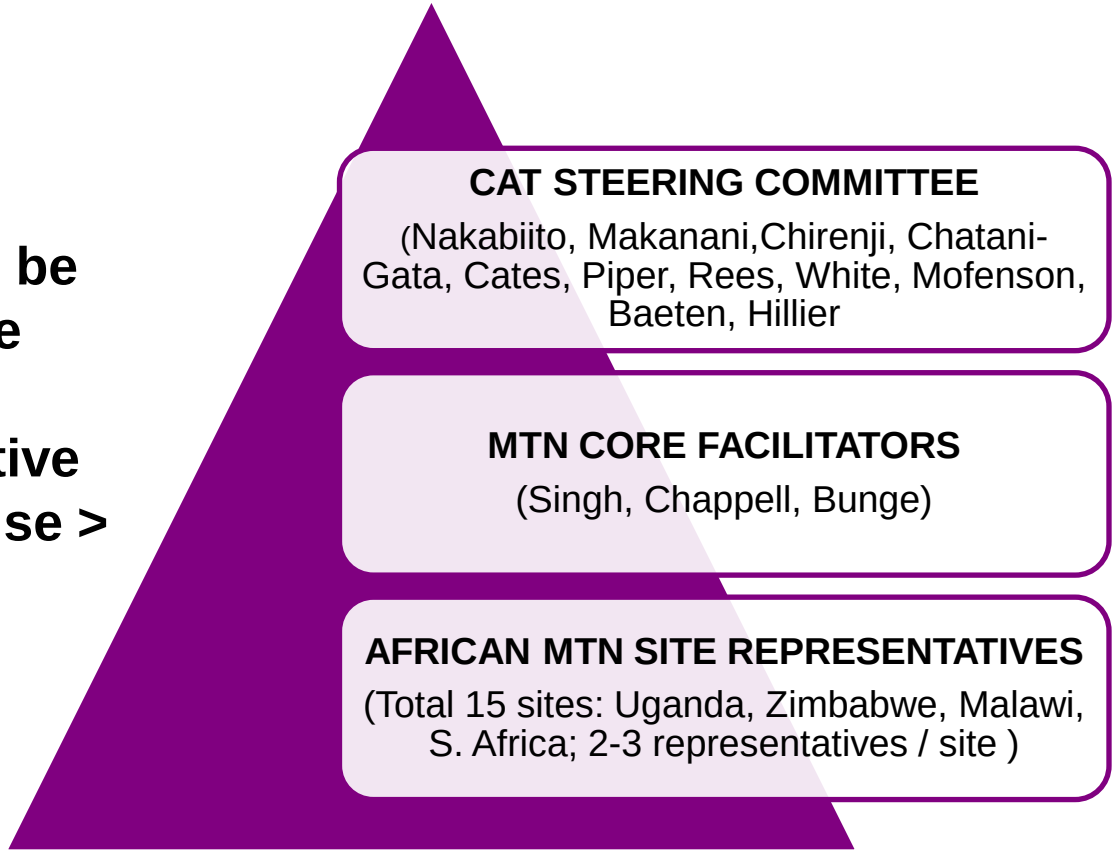
MTN
microbicide trials network

Overview

- Introduction to CAT
- Challenges
- Implementation
- Results
- Additional outcomes
- Lessons learnt

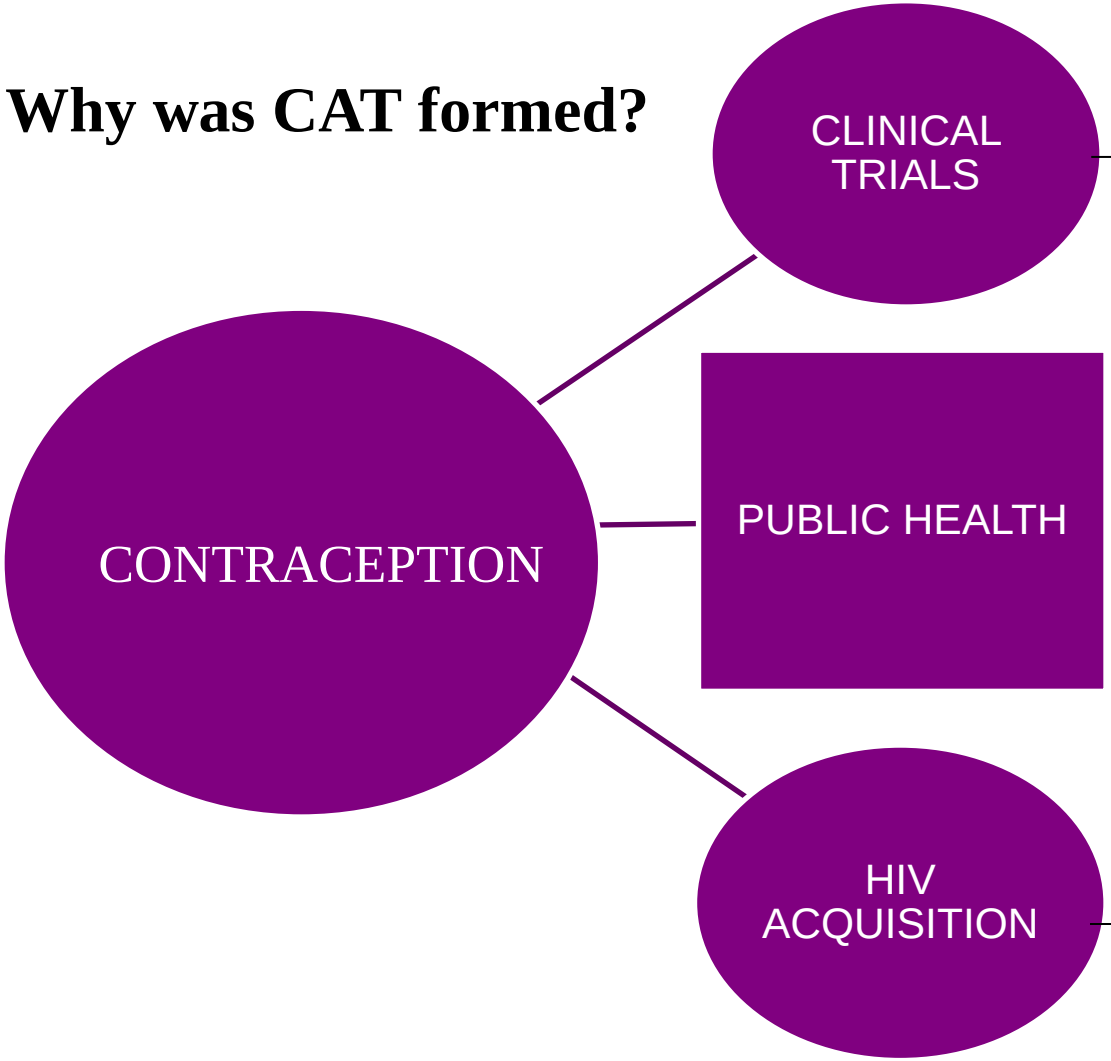
Introduction to CAT

- **Formed in June 2012**
- **CAT objectives**
  - **Four methods of contraception would be offered at each site**
  - **No single contraceptive method would comprise > 50% of the mix.**



Introduction to CAT

Why was CAT formed?

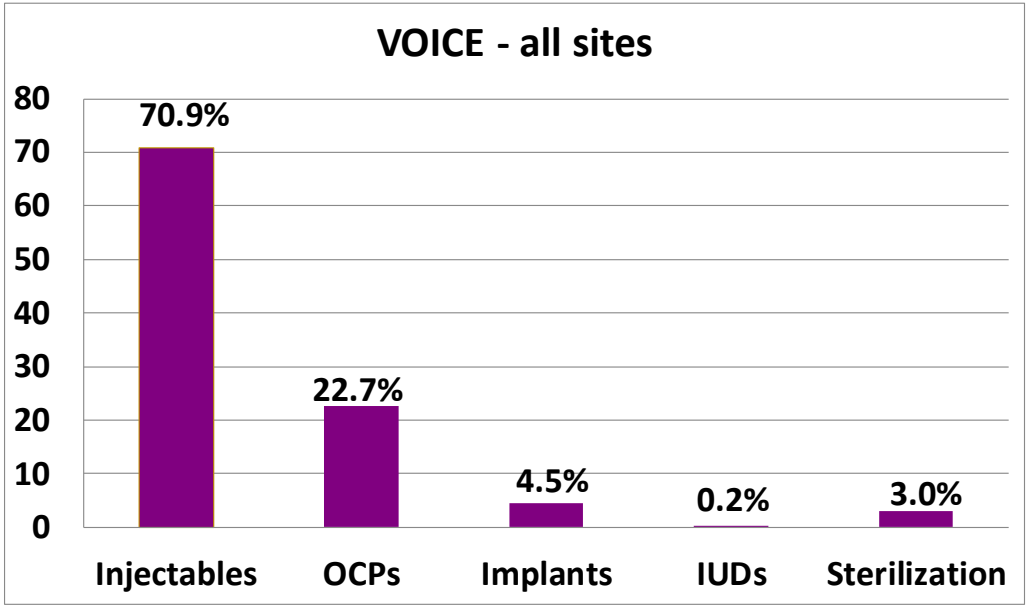


- **Prevention of Pregnancy:**
  - **As safety of study product in pregnancy is unknown.**
  - **To avoid reducing the power of the study by reducing time off study product.**

- **Evidence that hormonal contraception increases risk of HIV acquisition**
- **WHO statement 2012:**
  - **Advise women using progestogen injectables on condom use.**
  - **Expansion of method mix & further research needed.**

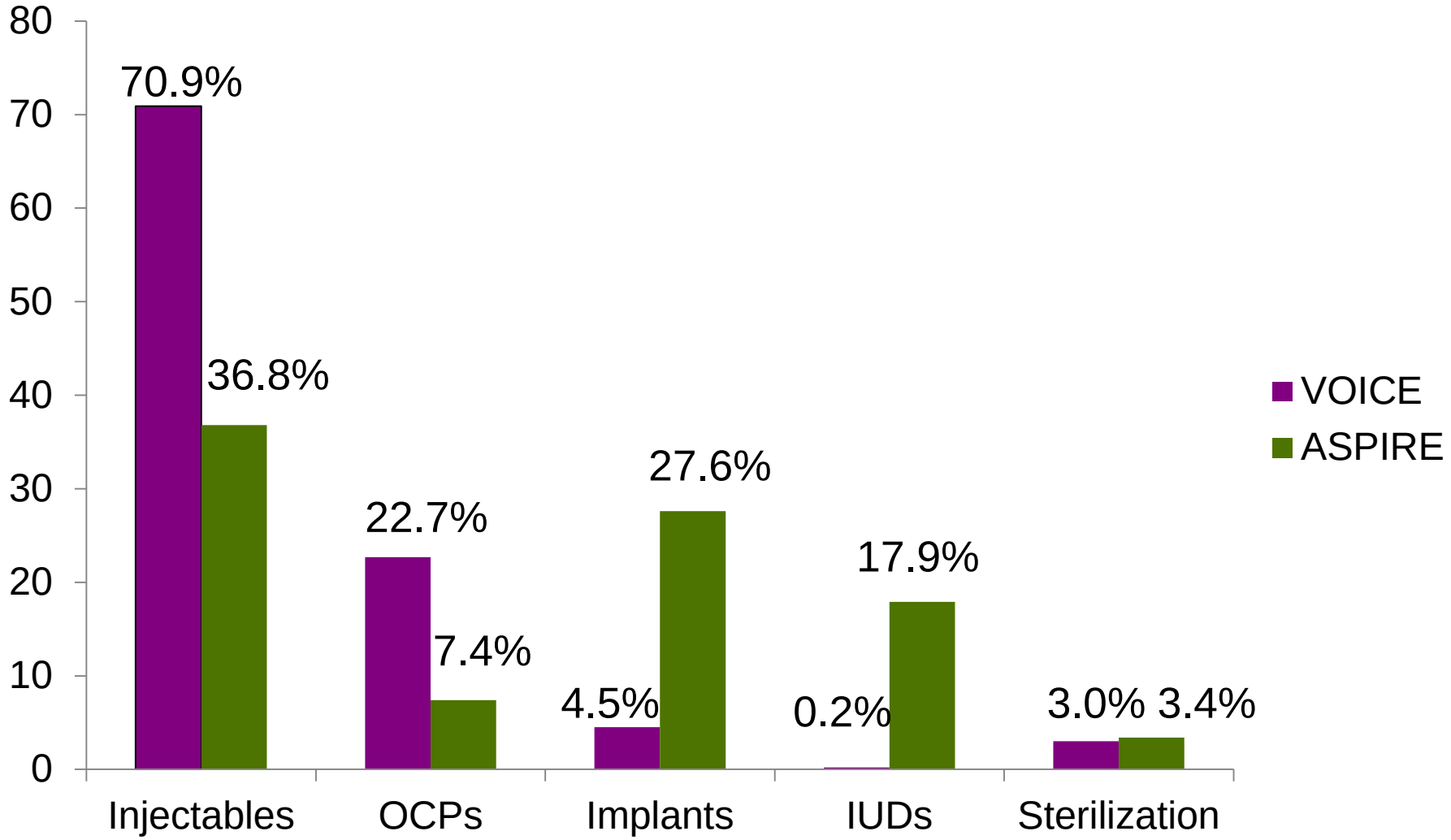
Introduction to CAT

Why was CAT formed?



Contraception method	No. of sites offering method
Oral Contraception (OCP)	**All**
Injectables	**All (7 sites had 2 types)**
Sterilization	**0**
Intra-uterine Device (IUD)	**0**
Sub-Dermal Implant	**2**

VOICE versus ASPIRE



Major Challenges

STAFF TRAINING

- Certification of staff for IUD/Implant insertion

ACCESS TO IUD/IMPLANTS

- No separate budget
- ? Via state or purchase

PARTICIPANT BIAS

- Unfamiliar
- Myths
- Partner/ community bias

PROVIDER BIAS

- Myths/ misconceptions
- Lack of knowledge, skills, confidence

Implementation:
Provider/Participant bias

- **Early implementation of education programmes by CAT representatives aimed at:**
  - **Staff**
  - **Participants**
  - **Community**

- **Staff programmes: All team members educated to appropriate level**

- **Education programmes involved a combination of various methods and strategies.**

Implementation:

Provider/Participant bias

Staff Education	Community Education	Participant Education
Provision of written tools	One-on-one during street recruitment	Daily waiting room education
Structured presentations	“Education tables” in public areas	One-on-one with clinician
Case discussions	Formal addresses at community events	Relaxed discussions at “social” ASPIRE events
“Competency quizzes”	Discussions at male involvement workshops	Participants as peer educators; staff as “role models”
	Discussions at couples’ workshops	Educational material e.g. pamphlets, posters
	Discussions at CAB meetings	Guest educators e.g. DoH nurses

Implementation:
Acquisition of IUDs/Implants

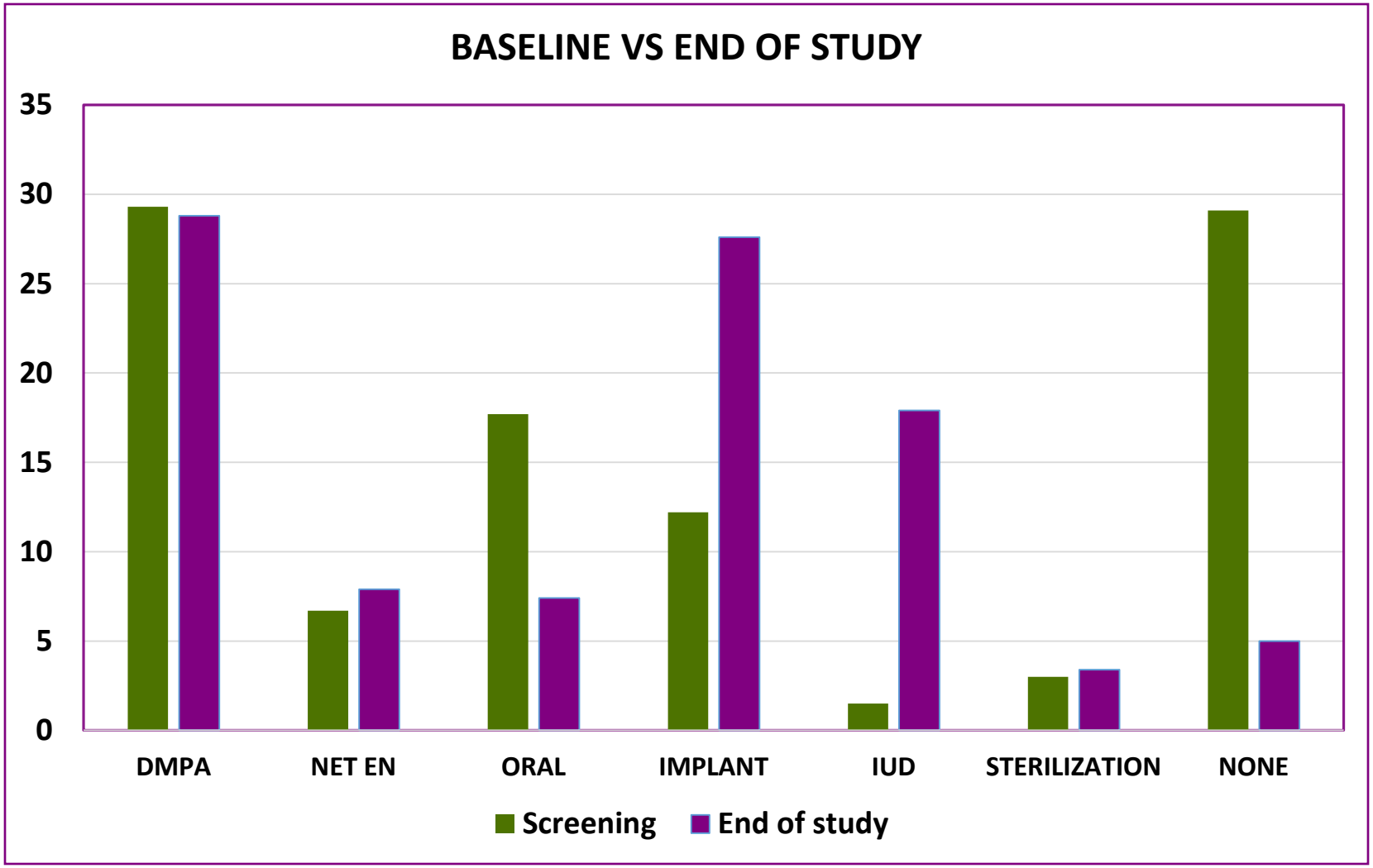
- **No allocated budget for IUD/Implant acquisition**
- **Non-SA sites: Procurement of both through respective state health departments**
- **SA sites:**
  - **Majority purchase IUDs privately**
  - **Implants are largely accessed through DOH FP clinics**
    - **Implants are prohibitively expensive**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

Implementation

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

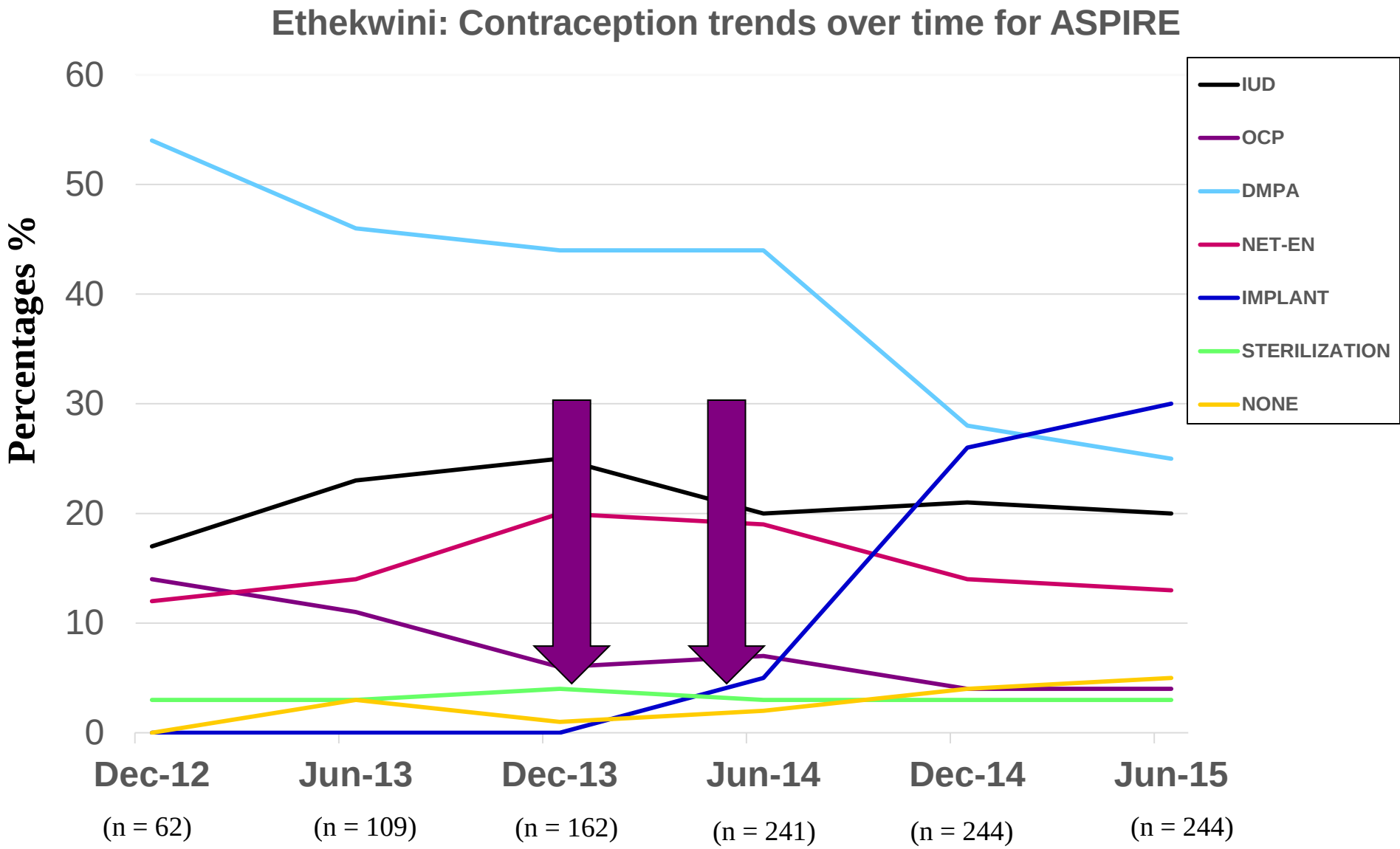
Results: All Sites



Results: Per Country

COUNTRY	BASELINE vs END OF STUDY CONTRACEPTION USE (%)						
	DMPA	NET-EN	ORAL	IMPLANT	IUD	STERILIZE	NONE
	33.5	12.4	4.7	0.5	1	3.1	44.1
S.AFRICA	29.3	14.6	8	22.2	12.8	3.5	5.5
	43.9	0	13	7.1	4	2.8	29.2
UGANDA	21.7	0	5.5	21.7	39.9	2.8	7.6
	10.8	0	52	28.5	1.5	0.4	5.6
ZIMBABWE*	26	0	8.5	36.3	25.7	0.6	3.5
	40	0	3.3	37.9	1.5	9.6	7.7
MALAWI*	39	0	2.6	39	4	10.7	2.9

Results: Ethekwini



Results:Pregnancy rates

- **Pregnancy rate in prevention trials (per 100 woman years):**
  - **Partners PrEP - 10**
  - **HPTN 035 – 11.3**
  - **CAPRISA 004 - 4**
  - **Fem-Prep - 9.6**
  - **VOICE - 9.7**
- **Pregnancy rate in ASPIRE - 3.9 (95% CI: 3.4,4.6)**

CAT: Additional Outcomes

- Capacity building opportunities for site staff
- Expansion of contraceptive service by other site teams
- Community Education and Sensitization
- Male involvement in Family Planning
- Networking → stronger support structure for future endeavours
- Research: Understand patterns of use and contraceptive needs in local communities. ? Better biological understanding.

CAT: Lessons learnt

- Key attributes for implementation success are perseverance, accountability and teamwork.
- Research organizations and NGOs can play a vital public health role.
- African women will use LARC methods if given the opportunity.
- There is potential for African males to become involved in FP decisions, if given the opportunity.
- Contraception counselling must be interactive, with focus on individual needs and active recognition of changing needs.

Conclusion

- CAT was created to provide contraceptive choice.
- Despite many challenges, the primary objectives were achieved, and the positive impact of CAT has spread beyond ASPIRE.
- Young women are the drivers of HIV infection in Africa, and in face of all that we think we know, contraception cannot be ignored in the fight against HIV.
- The work of CAT continues….

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