Injectable contraception in India: What does the future hold?

The second India e-FP topic was injectable contraception, and the discussion was open from May 22 to June 15, 2012. Participants addressed the following questions:

1. What are the major challenges to introducing injectables into the family planning programme?

2. How can the family planning community effectively address those challenges? What more can the National Rural Health Mission (NRHM) do? Is more research needed?

3. What have we learned about the private sector’s experience in providing injectables in India? How can we use those lessons?

The resource people for this session were Dr. Ritu Joshi, chairperson of the family welfare committee of the Federation of Obstetric and Gynaecological Societies of India and Dr. Kalpana Apte, assistant secretary general, Programme Implementation, for the Family Planning Association of India (FPAI). Both are medical doctors and have extensive advocacy, implementation, and monitoring experience in the field of family planning.

Injectable contraception has been a highly debated issue in India for the last several decades. There was active participation on the topic from members. The main points from the discussion, as well as the resources shared, are listed below.

**Background on DMPA in India**

- Extensive research has shown that depot medroxyprogesterone acetate (DMPA) is safe and effective. DMPA is used by women in 130 countries, including neighbouring countries in South Asia.

- In many countries throughout Asia, Africa and South America, community-based workers are providing injectable DMPA after being trained to counsel about side effects, to use eligibility checklists to screen clients, to safely provide the injection, and to follow standardized procedures on collecting and disposing of used needles and syringes.

  - Checklist for Screening Clients Who Want to Initiate DMPA — FHI 360
  - Provision of Injectable Contraception Services through Community-Based Distribution: Implementation Handbook — FHI 360

- Injectable contraception has been legally available in India since 1994. The product is widely available in India through private and social marketing channels and is being used by women across the country.

- Sales of DMPA in India have grown 25-30 percent per year. One million vials were sold last year.
More than four DMPA products are available on the Indian market.

In 1996, the Government of India inaugurated the target-free approach to the Family Welfare Programme and introduced the Reproductive and Child Health Programme. Under this new approach, centrally determined targets are no longer the driving force behind the programme. Hence, the fear of imposing injectable contraceptives on clients is no longer a concern.

In September 2003, the managing committees of the Federation of Obstetric and Gynaecological Societies of India issued a consensus statement on the use of injectables and wrote to the Government of India, calling for the method’s inclusion in the National Family Planning Programme.

A mystery client study conducted by Market-based Partnerships for Health (MBPH) in October–November 2011 revealed that 71 percent of providers were following quality of care protocols, had a positive attitude about DMPA, and were screening clients appropriately. Ninety percent discussed DMPA along with other methods. At end-line, all providers discussed amenorrhea as a side effect and most (92 percent in 2011 compared to 73 percent in 2009) remembered to tell clients that being amenorrheic while using DMPA did not necessarily mean they were pregnant.

The consumer end-line study conducted in December 2011 also showed progress made on increasing clients’ awareness of DMPA, improving their perceptions about it, and increasing their use of DMPA. The percentage of women using DMPA rose from 0.2% in 2009 to 0.7% in 2011; those intending to use DMPA rose from 1.5 percent at baseline to 2.7 percent at end-line.

**Challenges**

At a meeting held in 1995, the Drugs Technical Advisory Board (DTAB) made recommendations that included a statement saying, "Depo-Provera is not recommended for inclusion in the Family Planning Programme," in part because the board did not believe that the government’s health infrastructure had the capacity to properly manage side effects of DMPA, particularly menorrhagia. Untreated menorrhagia affects the reproductive health of women in lower socioeconomic groups who are already at risk of anaemia.

Some women’s groups, health groups, and human rights organizations oppose the introduction of injectable contraceptives in the national programme over fears about the method’s side effects and the potential for abuse.

Another common concern was about the decrease in bone mineral density associated with DMPA use by adolescents and perimenopausal women. The Indian Council on Medical Research (ICMR) has cleared all these doubts, and Drugs Controller General of India has to submit another report.

The opposition to including DMPA in India’s family planning programme is based on decades-old data and disproven hypotheses.

There is no hormonal method in the public sector for women who cannot use an estrogen-based method (for example, women on anti-tubercular treatment or women who are lactating).

The debate about the capacity of public-sector facilities to provide injectables without compromising quality seriously underestimates the ability of a system that is capable of providing millions of sterilizations annually.
Recommendations

- The introduction of any new method of contraception improves the contraceptive prevalence rate. Jain (1989) has estimated that the widespread addition of one contraceptive method to options currently available in a country increases the contraceptive prevalence rate by 12 percent. Adding injectables to the options offered by the public sector would help meet unmet need in the general population and specifically for women with unique circumstances that prevent them from using other methods. Introducing progesterone/progestin-only injectable contraceptives in the National Family Welfare Programme would be helpful in expanding women’s options and meeting the unmet need for contraception.

- Family planning centres at District Hospital, Community Health Centre and Primary Health Centres should designate a dedicated health worker/medical social worker who can provide counselling and follow-up support to women who accept the method. Similar efforts in the private sector have helped increase acceptance and continuation.

- Advocacy is needed at all levels in society, including the following groups:
  - Medical fraternities
  - Private voluntary organizations — FPAI, Janani Bihar, Parivar Seva Sanstha, others
  - International agencies — DKT, EngenderHealth, UNICEF, USAID, others
  - Ministry of Health and Family Welfare (MOHFW) and other government agencies
  - Women’s groups that are favourably inclined and that understand the needs of women and couples

- Also, advocacy efforts must address the right people at the highest levels. “Right” is defined as people who have decision-making powers in the country’s political circles. The Prime Minister, for example, should appoint a high-level family planning coalition (similar to the nutrition coalition) to examine issues related to expanding contraceptive choices. We need to draw attention to the fact that denying women the right to contraceptive choice is a serious issue and then generate momentum to change.

- We must follow up with MOHFW and ICMR on publishing the results of the DMPA study on injectables.

- Once a network of health care providers is established, it requires minimal support to provide quality services. For example, the Dimpa program invested in initial start-up training for network doctors. After that, the only “training support” doctors received were job aids, new client tracking tools, and on-going mentoring programs. The results of the provider end-line study conducted in the last quarter of 2011 show that doctors can provide a high quality of care for women who use injectables, and that the service is cost-effective if on-going support can be reduced significantly over time while maintaining high standards in service delivery.

- The task of counselling patients should be shifted from doctors to paramedics. The network management experience revealed that doctors have little time to counsel clients. So, program managers trained paramedic staff of network clinics to provide family planning counselling to address the missed opportunity at the clinics.

- Information and communication technology interventions can help improve continuation rates. For example, a helpline can be a good way to improve client continuation rates for DMPA because it is efficient and offers clients anonymity. MBPH conducted a pilot intervention from July 2011 to March 2012 in which clients who provided their phone number were reminded by the Dimpa helpline when it was time to get their next injection.
Also, clients who had any concerns about the method were counselled by the helpline’s trained tele-counselors. Users who got even one call after the first injection had a higher continuation rate compared to the control group who did not receive any calls from the helpline. In the control group, only 40 percent of women continued the injections, compared to a continuation rate of 88 percent (which went up steadily to 93 percent) for women who were contacted up to three times before the second injection was due.

- The MBPH Dimpa program developed several new methods and tools, such as the new client tracking cards and an outbound call mechanism through the Dimpa helpline to increase client continuation rates. The program also implemented an integrated outreach activation plan that combined family planning counselling at low-income homes (Mahila Goshthies) with subsequent visits at health camps that saw a higher rate of conversion to FP methods in general and DMPA in particular.

- Strengthening the public health system will further increase uptake and continuation of injectables. The NRHM mostly strengthens infrastructure and human resource management with the aim of providing quality services. The presence of accredited social health activists at the village level and two auxiliary nurse midwives at subcentre are examples of improved manpower and increased potential to provide long-term follow-up to women who accept the method.

- To maintain quality of services in the public health sector, India Public Health Standards have been developed under NRHM. On-going training on infection prevention, counselling, and other topics has proven useful. Existing state- and district-level quality assurance committees that address quality of care in family planning services can be further strengthened to ensure quality of services related to injectables.

Key Resources:

- Issue Brief on Injectable Contraception in India — India e-FP
- Technical Guide on Injectables — FPA India
- Note that addresses concerns raised by DTAB on introduction of injectable contraceptives in the public health system in 1995 — Dinesh Aggarwal, UNFPA
- Expanding Access and Demand for DMPA in Uttar Pradesh, Jharkhand, and Uttarakhand — USAID
- Executive Summary of Dimpa Initiative: A Program to Promote Demand and Use of Injectable Contraceptives — USAID
- FHI Brief 1: The Status of Family Planning in India: An Introduction — FHI 360
- FHI Brief 2: Why and How Injectables Can Improve Modern Contraceptive Use in India — FHI 360
- FHI Brief 3: Types, Availability, and Use of Injectables — FHI 360
- FHI Brief 4: Method Characteristics, Contraindications, Indications, and Health Benefits — FHI 360
- FHI Brief 5: Addressing the Health Issues Surrounding Injectables — FHI 360
- FHI Brief 6: Research on Injectable Contraceptives Conducted in India — FHI 360
- FHI Brief 7: Users’ Perspectives on Injectable Contraceptives — FHI 360
Injectable Contraceptives: Perspectives and Experiences of Women and Health Care Providers in India — Population Council

K4Health Injectables Toolkit

Family Planning: A Global Handbook for Providers — USAID

Technical Statement on Hormonal Contraception and HIV — WHO

HIV and Hormonal Contraception: FAQ — UNAIDS and WHO