Second DMPA-SC Evidence to Practice Meeting

Increasing Access, Empowering Women

Meeting Report: Dakar, Senegal

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ET DE L'ACTION SOCIALE

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Abbreviations

CHAI	Clinton Health Access Initiative
CIFF	Children's Investment Fund Foundation
DFID	UK Department for International Development
DMPA-SC	subcutaneous depot medroxyprogesterone acetate
ECHO	Evidence for Contraceptive options and HIV Outcomes
IM	intramuscular
IPPF	International Planned Parenthood Federation
JSI	John Snow, Inc.
PSI	Population Services International
STI	sexually transmitted infection
USAID	US Agency for International Development
WHO	World Health Organization

Executive summary

Introduction and scale-up of subcutaneous depot medroxyprogesterone acetate (DMPA-SC) has been rapidly evolving over the past several years, including the introduction of self-injection. Progress quickly accelerated after the Increasing Access to Next Generation Injectables meeting in Dakar, Senegal, in 2017. The following year, the Evidence to Practice meeting in Nairobi, Kenya, showcased the depth and breadth of evidence generated on the potential impact of DMPA-SC and self-injection, and evidence generation has continued since then. The Nairobi meeting was a major turning point in the way people around the world thought about the product and self-injection and its potential benefits for women.

In October 2019, a second Evidence to Practice meeting provided an opportunity to sustain progress and ensure that women have access to this contraceptive innovation as quickly as possible. Delegates from 20 countries across Africa and Asia attended sessions on the state of global scale-up, self-injection evidence and best practices, family planning and HIV integration, the role of the private sector, skills building (monitoring, learning, and evaluation; commodity forecasting; and advocacy), demand generation, innovative training approaches, and a conversation with five DMPA-SC donors. Some key themes that emerged from the meeting include:

- Great progress has been made in planning for introduction and scale-up of DMPA-SC and self-injection, but countries still have unique challenges to overcome related to operationalizing these plans.
- DMPA-SC should not be viewed as a stand-alone product but part of an improved method mix providing more options for women.
- Self-injection is the most innovative aspect of DMPA-SC and is key to maximizing its benefit for women.
- Government stewardship and donor engagement are needed to help ensure effective integration of sexual and reproductive health information and services so that women can get the services they need.
- Self-care, which has the potential to empower women and increase their autonomy, is regaining momentum thanks in part to self-injection of DMPA-SC.
- The private sector has a key role to play in scaling up DMPA-SC and making it available to more women, yet there are many challenges to overcome.
- Innovative provider training approaches that save time and money but maintain positive outcomes are needed for DMPA-SC to scale up quickly while preserving quality of care.
- More evidence and experience are needed around demand generation for DMPA-SC, but there are some emerging lessons from implementation experience.
- Introduction of a new product can be met with uncertainty in actual demand, and this must be closely monitored to ensure adequate supply of product.

- Donor organizations reiterated their commitment to expand access to DMPA-SC as an important contraceptive option, including pursuing development of a generic product and improved monitoring of use of DMPA-SC versus intramuscular and self-injection (for example, the US Agency for International Development will incorporate this differentiation into its Demographic and Health Surveys).

Post-meeting, it is important to ensure that action plans are implemented and momentum is sustained. Partners and donors will work with country programs to ensure that this happens.

Introduction

In 2017, global and in-country advocates and implementers gathered at the Increasing Access to Next Generation Injectables meeting in Dakar, Senegal, co-hosted by Advance Family Planning, IntraHealth International, and PATH. The purpose of the meeting was to review evidence and develop advocacy plans for policy change that would expand access to subcutaneous depot medroxyprogesterone acetate (DMPA-SC), an exciting new option in the family planning method mix.

In May 2018, delegates from 18 countries attended the first DMPA-SC Evidence to Practice meeting, co-hosted by PATH and the Kenya Ministry of Health, to share the substantial evidence base generated on DMPA-SC and self-injection acceptability, continuation, cost, and use in the private sector.

Following upon this progress, a second DMPA-SC Evidence to Practice meeting was convened in Dakar, Senegal, in October 2019. This report seeks to outline the discussions and key takeaways from this meeting, which over a three-day period hosted 207 participants, with 160 delegates from 20 countries (Benin, Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Guinea, Kenya, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Niger, Nigeria, Pakistan, Senegal, Togo, Uganda, and Zambia) as well as 47 global and regional attendees from donor organizations, bilateral and multilateral organizations, and international nongovernmental organizations.

The meeting was a pivotal turning point in the acceptance and development of scale-up plans for a new contraceptive product whose value proposition includes:

- Expanding access given the ease of use and the option for self-injection.
- More new users, as evidenced by data showing that when DMPA-SC and/or self-injection are newly introduced into the method mix, about one-third of doses are administered to first-time family planning users.
- Higher continuation, with studies from Uganda, Malawi, Senegal, and the United States showing that continuous use of DMPA at 12 months is significantly higher in all four countries among self-injectors than among women who receive DMPA injections from health workers.
- Increased self-care, with self-injection adding to the options for non-facility-based contraceptive methods, putting more power in women's hands.

What is DMPA-SC?

DMPA-SC is a lower dose, easy-to-use injectable contraceptive. Sayana® Press, the subcutaneous DMPA product available to Family Planning 2020 countries, is manufactured by Pfizer Inc. and combines the drug and needle in the prefilled BD Uniject™ injection system, which was originally developed by PATH.

DMPA-SC is making it easier for women to access injectable contraception. The user-friendly design means that any trained person can administer it, including community health workers, pharmacists, and even women themselves through self-injection.

The goal of the meeting was to catalyze scale-up of DMPA-SC to improve women's awareness of and access to an expanded range of high-quality family planning products and services. To reach this goal, the objectives of the meeting were to:

- *Identify* country-specific barriers and solutions to the scale-up of DMPA-SC within the contraceptive method mix, including self-injection.
- *Enhance* awareness of tools, resources, and evidence to aid the development of comprehensive family planning programs, including their effective integration with HIV prevention programs.
- *Develop or update* country-specific commitments and action plans to scale up rights-based, high-quality, total market family planning programs, including DMPA-SC and self-injection.
- *Strengthen* two regional Learning and Action Networks that promote continued cross-country sharing of experiences, dissemination of evidence, and collaboration on scale-up of DMPA-SC.

The expected outcome of the meeting was for country delegations to develop DMPA-SC action plans, which are intended to complement any existing country action plans to catalyze scale-up of DMPA-SC and self-injection as part of an expanded contraceptive method mix.

A global gathering

Since the initial Evidence to Practice meeting, a range of country implementation experiences have emerged from which to learn. With new countries making the decision to introduce DMPA-SC or to approve self-injection, the October 2019 meeting in Dakar was well timed to catalyze continued country scale-up and to provide an in-person forum for cross-country learning and experience sharing.

Site visits

Prior to the start of the meeting, approximately 104 participants, including facilitators, attended optional site visits to local health facilities. Participants learned about DMPA-SC provision in Senegal and the early stages of introducing self-injection programming at a variety of locations, including public health centers, private clinics, private adolescent-focused outreach programs, and a social marketing organization. One group also visited the national supply pharmacy to learn about the supply chain and distribution system in Senegal. Facilitators noted that most participants already had a good understanding of the feasibility of self-injection and were more interested in exchanging experiences and ideas with other countries on implementing self-injection. Participants were also very interested in sharing and learning about programmatic issues such as waste disposal, how self-injection information is captured in registers, and engaging men in conversations about family planning.

Where are we now?

Building on the 2018 meeting in Nairobi, the 2019 meeting shifted focus from evidence to support DMPA-SC and self-injection scale-up to emphasize country implementation experiences, challenges, and

opportunities, as most countries are focusing on scaling up programs. The meeting included sessions on the state of global scale-up, self-injection evidence and best practices, family planning and HIV integration, the role of the private sector, skills building (monitoring, learning and evaluation; commodity forecasting; and advocacy), demand generation, innovative training approaches, and a conversation with five DMPA-SC donors. Summaries of each session follow, but some key themes that emerged from the meeting include:

- Great progress has been made in planning for introduction and scale-up of DMPA-SC and self-injection, but countries still have unique challenges to overcome related to operationalizing these plans. There are common themes among these challenges (provider training, private-sector engagement, supply chain, and so on) allowing cross-country experience sharing to benefit all.
- DMPA-SC is not a stand-alone product but part of an improved method mix providing more options for women. It needs to be introduced in the context of existing systems and within the overall method mix, including in approaches to provider training, client counseling, demand generation, supply chain management, monitoring, and other aspects of scale-up.
- Self-injection is the most innovative aspect of DMPA-SC and is key to maximizing its benefit for women. Generating evidence was vital to developing self-injection policy and programming. With that in mind, new evidence and lessons from country programming can be leveraged to influence operational areas of scale-up—for example, implementing innovative, cost- and time-saving provider training and integrating the evidence on client self-injection training approaches.
- Government stewardship and donor engagement are needed to help ensure effective integration of sexual and reproductive health information and services, including those focused on contraception, HIV, and sexually transmitted infections (STIs), so that women can get the services they need.
- Self-care, which has the potential to empower women and increase their autonomy, is regaining momentum thanks in part to self-injection of DMPA-SC. Self-care should not be viewed in isolation from the health system but rather as a part of the health system, including ways to ensure women remain connected and supported.
- The private sector has a key role to play in scaling up DMPA-SC and making it available to more women, yet there are many challenges to overcome. These include policy and regulatory barriers, affordable supply of commodities, linkages of the public sector through monitoring (including collecting data on private provision) and supervision, and more.
- Innovative provider training approaches that save time and money but maintain positive outcomes are needed for DMPA-SC to scale up quickly while preserving quality of care.
- More evidence and experience are needed around demand generation for DMPA-SC, but there are some emerging lessons from implementation experience. Generating demand for family planning use generally can help with DMPA-SC as one method in a broader method mix.

- Introduction of a new product causes uncertainty in actual demand, and this must be closely monitored to ensure adequate supply of product. DMPA-SC needs to be integrated into existing health and logistics management information systems, and these systems must enable effective visualization and use of data to inform scale-up. Additionally, existing supply chain systems and processes (e.g., information management, distribution) need to be able to manage the additional product. Routine quantification of family planning products, including DMPA-SC, must also be done.
- Donor organizations continue to support expanded access to DMPA-SC as an important contraceptive option, including in several critical areas such as development of a future generic product, demand generation, greater inclusion of the private sector, and improved ability to monitor use of DMPA-SC versus intramuscular (IM) and self-injection.

Day 1

Opening remarks

The meeting was officially opened by Mr. Alassane Mbengue, the Secretary General of the Senegal Ministry of Health and Social Action. He welcomed the delegations that came to Dakar and noted that the choice of Senegal to host the meeting was linked to the fact that Senegal was one of the first countries to use DMPA-SC, and he thanked everyone for their trust in the country. He alluded to the Family Planning 2020 goals being a national priority within the government of President Macky Sall given that reducing infant mortality and mastering demographic growth can help sustain Senegal's development. He concluded by saying he was looking forward to exchanging successes and challenges over the past years and suggesting solutions.

DMPA-SC Access Collaborative Project Director Kaitlin Christenson from PATH and Deputy Director Carmit Keddem from John Snow, Inc. (JSI) also provided opening remarks. Ms. Christenson welcomed the country delegations and the regional and global participants to the meeting and highlighted how it was appropriate to host the third DMPA-SC–focused meeting in Dakar, as Senegal has been home to a lot of early research around the topic. Ms. Christenson gave a brief background of the two previous meetings, including:

- 2017: Convening to advance advocacy efforts around DMPA-SC (titled "Increasing Access to Next Generation Injectables"), co-hosted by Advance Family Planning, IntraHealth, and PATH and held in Dakar, Senegal.
- 2018: Convening to increase voluntary and high-quality access to DMPA-SC within a wide range of contraceptive methods and inform related policy decisions with existing evidence and experience (titled "DMPA-SC Evidence to Practice"), co-hosted by PATH and the Kenya Ministry of Health and held in Nairobi, Kenya.

She then highlighted that the focus of this 2019 meeting was to further catalyze the great scale-up work that has occurred at the country level and to learn from participant experiences, successes, and challenges to help plan for future scale-up of DMPA-SC.

Ms. Keddem then recognized the collective success everyone had contributed to by expanding women's contraceptive choices and autonomy through increased access to DMPA-SC, including self-injection. She noted that since the previous meeting in Nairobi, which focused on the evidence generated, many countries have gone on to operationalize that evidence into their programs. She highlighted that the aim of this meeting was to further use that data to discuss challenges and successes in scaling up. She also underscored that the meeting would be discussing the operational aspects of self-injection and the use of data to monitor introduction efforts.

Plenary: Seizing the opportunity to ensure comprehensive sexual and reproductive health services and a broad contraceptive method mix for women

Moderated by Beth Fredrick of Advance Family Planning, the opening plenary framed DMPA-SC within the overall messages for the meeting, including the expanding role of injectables in the method mix, increasing the share of DMPA-SC and self-injection, the importance of integration of family planning and HIV services, self-injection as self-care, and the future of DMPA-SC. The panelists represented a broad cross-section of family planning stakeholders:

- Chilufya Kasanda, Treatment Advocacy and Literacy Campaign, Zambia
- Roy Jacobstein, IntraHealth International
- Dr. Mareme Ndiaye, Senegal Ministry of Health and Social Action
- Aminatou Sar, PATH, Senegal
- Maryjane Lacoste, Bill & Melinda Gates Foundation

The panel first discussed challenges to scale-up, including:

- Myths and misperceptions: At the community level, myths and misperceptions can deter access, particularly for young women. For example, a young woman born and raised in a sub-Saharan African country might experience a community belief that a young woman does not have the right to her sexual choices and find herself judged by health care providers when she seeks services. (Ms. Kasanda)
- Training: Despite rapid progress in ensuring availability of services, more providers need to be trained in DMPA-SC at the community level, including those in the private sector. (Dr. Ndiaye)

> "What are we doing as influencers, donors, funders, CSOs and the community itself? There's nothing without us, the community... Even if you try and put in so much money, if women are not placed at the center, then it's just going to be a dream, and not a reality."
>
> —Chilufya Kasanda

- Financing: We have the evidence that DMPA-SC is changing women's lives, but we need to finance the scale-up to ensure that all women have access to this product. Political will is also needed to make the decisions that will lessen reliance on external donors and increase domestic financing. (Ms. Sar)
- Advocacy: If making self-injection available as widely as possible is truly the aim, then more advocacy is needed to increase access through the private sector. A multi-supplier market would keep the market healthy and prices low, especially as the situation moves toward less donor financing. (Ms. Lacoste)
- Diversifying method choice: There has been a longstanding effort to increase access to family planning (including DMPA-SC) through task shifting, which the health ministers of the Economic Community of West African States (ECOWAS) endorsed in 2018 as a high-impact practice to be adopted in West Africa. A recent study of 12 sub-Saharan African countries showed that use of injectables rose in all 12 countries, with injectables the most widely used method in 10 of the countries. However, the injectables' share of the method mix has declined in 9 of the 12 countries and plateaued in two others because use of contraceptive implants has risen at a higher rate. Kenya has high use of modern contraception (55 to 60 percent modern contraceptive prevalence rate [mCPR]) and a diversified method mix. DMPA-SC's share of the method mix in Kenya is already 2 to 3 percent, and wider availability is predicted over the next few years. (Mr. Jacobstein)

Despite remaining obstacles to scale-up, there is an abundance of opportunities, including:

- Improving the health system: While introducing a new product in a country, there is an opportunity to look at other areas that might need strengthening, such as data management. (Ms. Lacoste)
- Self-care: The topic of self-injection has re-opened discussion around the importance of self-care and women having more control over their bodies and health. (Ms. Sar)
- Integration: There is an opportunity to develop strategies to meet the diverse needs of women and to make sure women are receiving the correct messages when it comes to both contraception and HIV prevention. (Ms. Kasanda)
- Policy: There is an opportunity and need to elect more women legislators. (Mr. Jacobstein)

> "One must keep working for methods to be accessible, for systems to be strengthened and women must at all times have access to information to help them make their choices."
>
> —Dr. Mareme Ndiaye

Group sessions

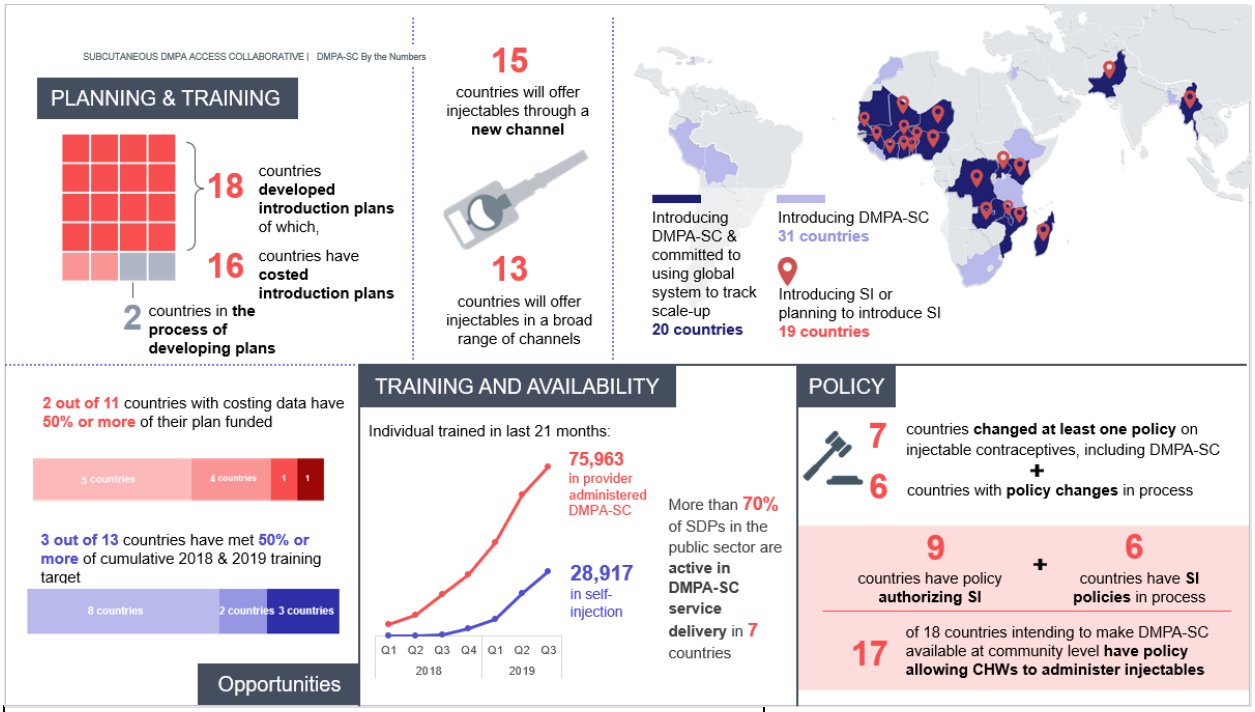
a. Integrating DMPA-SC to broaden the method mix for women and girls: Successes and challenges in scale-up

Ann-Marie Yongho of JSI opened this session with a presentation on the progress of DMPA-SC introduction and scale-up over the past several years in the countries represented at the meeting. Some of the key points covered include:

- The 20 countries represented at the meeting have a global monitoring system.
- Eighteen of the 20 countries represented have developed introduction plans and 16 of these plans are costed. The other two countries are developing plans.
- Seven countries have changed at least one policy related to injectable contraceptives, including DMPA-SC, and six additional countries have policy changes in process.
- Countries are making good progress in increasing women's access to DMPA-SC. Fifteen countries will offer injectables through a new channel and 13 countries will offer injectables through a broad range of channels, including drug shops and pharmacies in addition to facility-based delivery, social marketing organizations, and community-based delivery.
- There is still more work to do: only 2 of the 11 countries with costing data have 50 percent or more of their plan funded, and only 3 of the 13 countries with significant training targets have met 50 percent or more of their cumulative (2018 and 2019) target.

See Figure 1 for a graphical representation of these statistics.

Figure 1. The progress of DMPA-SC introduction and scale-up in countries represented at the meeting



Source: DMPA-SC Access Collaborative Country Dashboard

Successes

Access Collaborative Regional Technical Advisor for Francophone Africa Alain Kabore and Regional Technical Advisor for Anglophone Africa George Barigye discussed how country scale-up strategies have evolved over time. Mr. Kabore and Mr. Barigye agreed that strong coordination has helped countries harmonize activities to improve scale-up and encouraged partners to integrate DMPA-SC into their plans where it was not present before. Mr. Kabore also highlighted that innovative approaches like reducing self-injection training to one day enabled teams to reach providers in the biggest region of Senegal, and 4,000 providers have been trained in Burkina Faso.

Challenges

When asked about remaining challenges, Mr. Kabore and Mr. Barigye discussed that funding is a persistent challenge. Another challenge is that policy change can be a long, involved process, delaying introduction and scale-up. In the private sector, there are still challenges in increasing availability of the product, though doing this could increase access for women.

Opportunities

Despite the remaining challenges, there are clear opportunities to catalyze scale-up of DMPA-SC. Countries that have not yet started or are still in the scale-up process should feel inspired by what is

going on in other countries as demonstrated at this meeting. The donor community is very committed to scale-up, and this meeting is a unique opportunity for the 20 countries to share and learn from each other to accelerate learning.

b. Self-injection research and implementation experiences

Self-injection is key to what makes DMPA-SC an impactful innovation in contraception for women. For women to have the autonomy to use one of the most popular methods in the comfort and privacy of their own homes, without having to travel to a health facility every three months, allows them to take control of their own health. With this in mind, there were two sessions that focused on self-injection. The first session highlighted the global journey to achieving self-injection and the most recent supporting evidence, as well as country and regional perspectives on why self-injection is a game changer. The second session focused on country implementation experiences and lessons learned.

Self-injection as a game-changer: How do we ensure women's access to this important option?

Jennifer Drake, deputy director of PATH's Sexual and Reproductive Health program, highlighted the value proposition of self-injection, the most recent self-injection evidence, and program resources. Ms. Drake started by framing self-injection within the context of self-care and the World Health Organization's (WHO's) strong recommendation of self-injection in its 2019 self-care guidelines (see Box 1), proof of the strength of the existing self-injection evidence.

Box 1. World Health Organization recommendations for self-care include:

- Self-administered injectable contraception should be made available as an additional approach to deliver injectable contraception for individuals of reproductive age.
- Human papillomavirus self-sampling should be made available as an additional approach to sampling in cervical cancer screening services for individuals aged 30 to 60 years.
- HIV self-testing should be offered as an additional approach to HIV testing services.
- For women living with HIV, interventions on self-efficacy and empowerment around sexual and reproductive health and rights should be provided to maximize their health and fulfil their rights.

Ms. Drake then gave an overview of the self-injection evidence generated since 2015 from different partners in four countries (Malawi, Senegal, Uganda, and the United States), which consistently demonstrated that women who self-inject are more likely to continue using the method at 12 months than women who have DMPA injections administered by a provider. She also highlighted that at the first Evidence to Practice meeting in Nairobi, there was substantial evidence about feasibility, acceptability,

continuation, cost, and cost-effectiveness, but many questions remained about implementation. Since then, there is much more implementation information to further scale-up (a key focus of this meeting).

The value proposition for DMPA-SC and self-injection includes:

- **Expanded access.** Given the ease of use and the option for self-injection, many countries are allowing a broader range of providers, including drug shops and pharmacies, to administer or sell the product.
- **More new users.** Data collected from several countries have shown that when DMPA-SC and/or self-injection are newly introduced into the method mix, about one-third of doses are administered to first-time family planning users.
- **Higher continuation.** Studies from four countries showed that continuous use of DMPA at 12 months is significantly higher in all four countries among self-injectors than among women who receive DMPA injections from health workers.
- **An additional self-care option.** Self-injection increases women's options for non-facility-based contraceptive methods, putting more power in their hands. However, the WHO Guideline Development Group for self-care emphasized that self-injection should be made available as an *additional* approach for women, because nobody should have to self-inject due to lack of access to provider-administered injections.

Ms. Drake highlighted monitoring and evaluation insights from Uganda, which can help inform program design in other countries. Ongoing priorities also include ensuring services are consistently available when women want/need them and ensuring that self-injection is an option but that providers are supported to keep women at the center of the decision-making process (i.e., not pushing them into self-injection if it is not their choice).[1]

> "Self-injection could prevent 11,000 additional pregnancies and save $1.1 million per year in Uganda [relative to facility-administered DMPA-IM]."
>
> —PATH costing study

Ms. Drake also highlighted some tools that are available for self-injection program design and implementation, including:

- A self-injection program design guide that will be ready by the end of 2019. The design guide will cover the entire self-injection journey, including health worker training, client training, follow-up, reinjection, disposal, and resupply visits.
- Provider training module on offering self-injection (also an eLearning course).
- One-page client job aid.

[1] (PATH Costing study) Di Giorgio L, Mvundura M, Tumusiime J, Morozoff C, Cover J, Drake JK. Is contraceptive self-injection cost-effective compared to contraceptive injections from facility-based health workers? Evidence from Uganda. *Contraception.* 2018;98(5):396-404. https://www.sciencedirect.com/science/article/pii/S0010782418303901?via%3Dihub

- Client training video that can be adapted to local contexts.

After Ms. Drake's introduction, she moderated a panel of experts with experience in self-injection program design and implementation, including:

- Ndeye Sene, health post midwife, Senegal
- Dr. Fatou Ndiaye, US Agency for International Development, Senegal
- Dr. Mihayo Placid, Uganda Ministry of Health
- Fannie Kachale, Malawi Ministry of Health
- Fatimata Sy, Program Investment Committee member, Children's Investment Fund Foundation

Ms. Drake asked the panelists about their evolving perspectives related to self-injection. Responses included:

- Early questions about the feasibility of self-injection in a country like Senegal due to the high rate of illiteracy among women but finding that the results of the pilot study led to a radical change in opinion. (Dr. Ndiaye)
- Early hesitance among some patients when DMPA-SC self-injection was first offered, but others accepted the method and said it was very beneficial for them as it helped them save time in accessing contraceptives. (Ms. Sene)
- Concern about client acceptance by the Uganda Ministry of Health, particularly whether there would be a difference in receptivity to self-injection between educated and uneducated women. There had also been concern about whether safety and sterility would be observed and whether health workers would resist self-injection in fear that it could eliminate their jobs. With time and research, however, perceptions changed, and he realized women were willing to self-inject. (Dr. Mihayo)
- The importance of self-injection as a family planning option in Malawi, where women are now empowered by this option and motivated that they only have to come back for services once a year. (Ms. Kachale)
- The more contraceptive options women have, the better. However, there is a persistent barrier of the stigmatization of young people and how this impacts their access to the product and option for self-injection. (Ms. Sy)

Recommendations and next steps

The panel closed with the participants discussing their recommendations and next steps for self-injection, including:

- High-quality communication skills for counselors as they are the closest to the population and can reach the largest audience possible with self-injection information. (Ms. Sene)
- Donor collaboration with government to achieve planned objectives, and partner coordination with implementing districts to ensure that if technical or financial assistance is needed for monitoring

and evaluation that it is received, but ensuring that the districts take the lead to ensure sustainability. (Ms. Kachale)

- Governments need to work on their policies to encourage service offerings for certain groups (e.g., young people), and donors need to work with the manufacturers to provide product for social marketing and with the private sector to support trainings. (Dr. Mihayo)
- Waste management needs to be addressed, and health ministries need to give clear directives for financing in national action plans. (Dr. Ndiaye)
- When policy is created, the responsibility for implementation should be clearly indicated so that it does not rely on local implementing partners. Government funding should also be dedicated to family planning rather than relying on nongovernmental organizations and outside assistance. (Ms. Sy)

Ms. Drake concluded the session with the following main points:

- Self-injection is about convenience, autonomy, and putting power in women's hands, as well as opportunities for young people.
- There is still work to be done in the private sector and with financing.
- There is a need to foster collaboration at every level and across sectors, including with activists, to keep the conversation moving past what we are often comfortable with.
- Informed choice and client-driven decisions are key to self-injection.

Catalyzing change: Solutions to overcoming challenges to operationalizing self-injection

Rodrigue Ngouana, project director of Jhpiego's DMPA-SC Accelerating Access project in West and Central Africa, moderated this session, which focused on country implementation experiences with self-injection. He shared an anecdote from a colleague in Togo about a woman who had been trained on self-injection and was asked to try self-injecting.

> "After she injected herself, her first reaction was to jump up and hug and kiss all who were present. She was overjoyed because she realized she not only had the opportunity to manage her own health, but the capacity to do it."
>
> —Rodrigue Ngouana, Jhpiego

The panel then proceeded to discuss the solutions to the challenges faced in self-injection.

Uganda

Allen Namagembe, Uganda research and evaluation manager for PATH, presented lessons from the Self-Injection Best Practices project in Uganda. These included lessons learned about client training on self-injection, reinjection and resupply, and waste disposal:

- Client training on self-injection
    - Combining individual and group training of clients was more effective for self-injection competency than individual training alone.

    - Clients who practiced self-injection during the training were not more competent than those who did not, and shifting to provider demonstration instead (while the client followed along) can save time as well as the cost and waste of self-injection supplies used during practice.
    - Clients trained by community health workers were not significantly less competent at self-injection than those trained by facility providers, even though they were less educated.
    - About half of facility providers reported that they were sometimes too busy to train women on self-injection, compared to one-third of community health workers.
- Reinjection and resupply
    - About three-quarters (76 percent) of women continued to self-inject for one year in routine settings (in Uganda's public sector), based on follow-up interviews conducted with self-injection clients around 14 months after training. Women would have preferred a one-year supply for reinjection (i.e., three units to take home after one injection under provider supervision; instead, they were given two units to take home).
    - Less than 2 percent of the units women took home after training were wasted.
    - Some clients discontinued because of stockouts.
- Waste disposal
    - Most women were willing to return used devices to a point of service; they were more likely to return used units to a community health worker than to a health facility.

Madagascar

Dr. Noromalala Sylvie Tidahy, director of Family Health with the Ministry of Public Health in Madagascar, described the advocacy process conducted in Madagascar to obtain government approval of self-injection of DMPA-SC. The process began in April 2018 and concluded in May 2019 when they gained approval. Advocacy targets included the Ministry of Public Health, the Secretary General, and the Division of Family Health. The advocacy team included the National Madagascar Family Planning Committee, staff of the Family Planning Services department in the division of Family Health, and several partners. The experiences and evidence from countries like Senegal and Uganda were used to inform best practices and procedures for the introduction and scaling up of DMPA-SC.

Zambia

Dynes Kaluba, chief safe motherhood officer coordinating Family Planning Services with the Zambia Ministry of Health, discussed lessons learned from their approach to scaling up affordable training for self-injection of DMPA-SC for facility-based health workers. Because the health workers already knew how to administer injectables, a memo was sent to them with the DMPA-SC fact sheet, job aid, and video through the permanent secretary authorizing the scale-up of DMPA-SC administration by health care providers. This was followed with rollout of self-injection when provincial trainers were then sent

out to health facilities, where they observed a pretraining demonstration by health care providers on provision of DMPA-SC to assess knowledge and skills, which was followed up with mentorship. Three to four hours of on-the-job training on self-injection of DMPA-SC was then provided, enabling the trainers to train an average of two facilities per day. More than 900 providers were trained in almost 500 facilities. Some challenges and lessons included:

- Competing priorities of providers and short advance communication to the facilities by the districts, so facilities had difficulty adjusting schedules; advance communication of at least two weeks is needed.
- Not all providers had administered DMPA-SC prior to training.
- Costs were reduced by removing district cascade training; when training is localized to a health facility, more staff can be covered.
- Training of facility-based, public-sector providers in DMPA-SC was eliminated entirely through a memo issued in December 2018 by the Ministry of Health instructing all health facilities to start administering DMPA-SC, saving US$1.4 million. This approach made on-the-job training easier.
- Reinforcing both subcutaneous and self-injection administration is required for various degrees of competency.
- Joint training with supervisors enforces higher-quality supervision and monitoring.
- The funds saved could be used for other high-priority activities such as printing of information, education, and communication material.

Togo

Yaba Essien commented on the introduction of DMPA-SC self-injection provider training in Togo. First, health worker training was addressed in the following ways:

- Using the experience of Burkina Faso as a model, training manuals were updated with content for training of health workers on the proper administration of DMPA-SC.
- Revisions were made to the national family planning training modules to include DMPA-SC. The training module on clinical family planning was mass distributed, as were counseling materials.

Midwives were targeted first using an orientation approach rather than formal training. Sixteen master trainers were trained, and 238 midwives were oriented to DMPA-SC self-injection provision in just one month and post-training supervision was also conducted with limited initial funding. Following this, Togo drafted an action plan for the introduction and scale-up of DMPA-SC and received funding to begin the process. A lot of advocacy was needed to reach approval, and there were challenges of funding and institutional barriers. In the end, they have acquired the commitment of the Ministry, a necessary first step, and Ms. Essien concluded that the country needs to scale up self-injection training in all districts, and more partnerships are needed.

Pakistan

Dr. Talib Lashari of Pakistan mentioned that DMPA-SC is being implemented in two provinces: Sindh and Punjab. He said that the regulatory and policy environment is enabled, and DMPA-SC has been registered. The UK Department for International Development (DFID) has provided about 100,000 units to Pakistan, and the government has procured more. In Sindh, a study took place with various partners and under the leadership of the government; the results will be available in March 2020. Scale-up of DMPA-SC has begun in Sindh because of this. In Punjab, they are focusing on four districts for the pilot. DMPA-SC has acceptability among women in Pakistan.

Burkina Faso

Aguiébina Ouedraogo from the Burkina Faso Ministry of Health said that the country has already benefited from DMPA-SC and by using experiences from Senegal as a model. Burkina has seen an increase in the number of new users of DMPA-SC and had good results with 41,000 new DMPA-SC users in two years. This has encouraged them to write a strategy for implementing DMPA-SC monitoring indicators to better capture family planning data. Other plans are in place to focus on expanding self-injection in the private sector and distribution at the community level. Today there are 10 districts (out of 13 in the country) doing self-injection. He also affirmed that the country has a lot of political commitment and will focus on task-shifting of self-injection for better reach into communities and believes in using the private sector on a national level.

Panel conclusion

Mr. Ngouana concluded the panel by citing the following summary points:

- Advocacy can sometimes take time, and it must start over when there is a change of government.
- Waste management remains a challenge, but countries are working to develop innovative solutions.
- The example of Togo: with few resources, a lot of providers can be trained in self-injection.

Conclusion

The two self-injection sessions highlighted how important the generation of evidence is to self-injection policy and programming. Both the global stakeholders and the country presenters provided examples of what it takes to change the minds of those who approve new policy. Though self-injection may have seemed out of reach to some policymakers, particularly when thinking about consumers with less education, the evidence showed that there is no difference in ability to self-inject, and policy was changed. This example can be used to address other programmatic areas that were raised by panelists, such as lower-cost, time-saving provider and client training; effective client communication; innovative waste management options; and other areas for which additional evidence is currently being generated.

Can provider training be shortened to enable cost savings and more rapid implementation? Issues of quality are paramount, but innovative use of distance learning and targeted reduction of training time for certain providers may be one key to achieving this. The evidence and experience generated through countries at the forefront can help to bring these changes to other countries. For client training in self-injection, is practice injection with a provider needed? The evidence is not showing that this is needed, but policymakers are cautious given their role in ensuring that programs are of high quality. As more evidence is generated, this too may change to reduce wasted DMPA-SC units and have women self-injecting at home more quickly with the appropriate support.

c. Ensuring access to integrated sexual and reproductive health services: Understanding and integrating updated WHO recommendations on the use of contraceptive methods by women at high risk of HIV into country action plans

Mr. Petrus Steyn from WHO's human reproduction team, Reproductive Health and Research department, began the session with a summary of the key results from the Evidence for Contraceptive options and HIV Outcomes (ECHO) trial, which looked at HIV incidence and the difference in HIV risk among women using the copper intrauterine device, levonorgestrel-releasing implant, and DMPA-IM among a sample of 7,830 women in four countries. The results, released in June 2019, showed overall HIV incidence was 3.81 percent, with no real difference observed among the various contraceptive methods. Recommendations include:

- A need for stronger HIV and STI prevention and management.
- Continuation of efforts to expand access to contraceptive choices.
- Continued access to all three methods.

The study placed a renewed emphasis on HIV testing and on the integration of family planning and HIV prevention. For women at high risk of HIV, there are no medical restrictions for any contraceptive method. Mr. Steyn also reviewed the guidelines developed by the Guideline Development Group led by WHO and noted that next steps will be adaptation and implementation of those guidelines.

After Mr. Steyn's presentation, Navita Jain from AVAC, an organization that advocates for a comprehensive response to the HIV epidemic, moderated a panel of experts to discuss the importance of family planning and HIV service integration, including:

- Jacqueline Wambui Mwangi, National Empowerment Network of People Living with HIV/AIDS in Kenya
- Yuhsin Huang, International Planned Parenthood Federation
- Saad Abdulmumin, US Agency for International Development
- Petrus Steyn, World Health Organization

Ms. Jain started out by asking the panelists what we should be doing differently now that we have the results from the ECHO trial:

- Ms. Wambui Mwangi stressed that given the results that Mr. Steyn presented, we must ensure that women have the services needed to prevent pregnancy and also prevent HIV and STIs.
- Dr. Saad said that it was very important for countries to understand how to operationalize these guidelines and have country-specific action plans. Countries need national strategies so they can adopt integration models that can address their specific context. He highlighted that, for example, a study in Kenya has shown that integration of family planning and HIV is associated with increased client satisfaction, increased access to services, and increased uptake and adherence to antiretroviral drugs and contraceptives[2]—a win-win situation from family planning and HIV perspectives.
- Ms. Huang explained that International Planned Parenthood Federation (IPPF) has a working group on family planning/HIV integration that brings advocacy, communications, and service delivery experts together, and they hold webinars to help them communicate information directly to their member associations and project staff. This helps them to determine what messages they should bring to the national governments in the countries where they work.

The next question was how integration is defined. Ms. Huang said IPPF defines integration as getting the right services to the right clients at the right time. They need to ensure that their clients are receiving good quality services. She gave the example that when a woman comes to the clinic for contraception, the opportunity should also be taken to talk to her about HIV and STI prevention.

When asked how she knows if health services are being integrated at a clinic, Ms. Wambiu Mwangi, as a woman living with HIV, discussed how her personal experience of having gone to many clinics led her to define integration as when a woman is able to get everything she needs in one place. Integration is also when the service is effective, and the client has enough time with the provider so that they know what's best for her body.

Funding can be a constraint to integration, so Ms. Jain asked the donor representative on the panel, Dr. Saad, about barriers to integrated funding. He said that it is necessary to help countries understand the need for integration and for them to define their own models on how best to integrate services, but in his opinion, the most important thing is to improve quality. Integration has the ability to enhance the quality of family planning services. Dr. Saad also highlighted that countries need to understand the resources and funding needs for integration as well as the human resource needs.

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[2] Winestone LE, Bukusi EA, Cohen CR, Kwaro D, Schmidt NC, Turan JM. Acceptability and feasibility of integration of HIV care services into antenatal clinics in rural Kenya: a qualitative provider interview study. *Global Public Health*. 2012;7(2):149–163.

Ms. Jain then turned the conversation to what the community needs to know about the advocacy agenda for integration. Mr. Steyn believes that meaningful community involvement right from the start is very important, as demonstrated in the ECHO study. Also, in each of the 14 priority countries, WHO assisted the Ministry of Health to convene a task force to help plan for uptake of the ECHO results and think about guidance development at the country level; it is also important for the community to be involved. Ms. Wambiu Mwangi concurred with Mr. Steyn that community involvement in the ECHO study helped to understand what it really meant for women and showed that a method mix really is possible. She said that it is important to ask women what they want and then you can find a way to make it work; don't make a product that you think they will use without asking them.

The panel ended by discussing what they want to see happen in integration a year from now:

- When a person steps into a clinic, they should feel comfortable to ask any question without being stigmatized, and health care providers should be able to provide answers. (Ms. Huang)
- Success is responding to the need of the client and making sure there are appropriate technologies and approaches that will enable couples and individuals to prevent HIV, STIs, and unintended pregnancies. (Dr. Saad)
- Hopefully task forces will get things done at the national and subnational levels. Also, maternal health has integrated services, but they are called standard of care. Why can't we have this for HIV/family planning integration? (Mr. Steyn)
- Governments must invest more in health and human resources to prevent funding-cut excuses. Also, policies that are acceptable to the community must be implemented. (Ms. Wambiu Mwangi)

The session ended with a brief opportunity for questions and answers from the audience. A participant from Mauritania commented that the ECHO trial had brought to the fore the reality that women were more at risk of HIV acquisition and more thought must go into preventing that. Dual methods of protection are not always practical. The community must think how to enable dual protection in a logical way that an average woman can actually practice. Dr. Saad replied that the US Agency for International Development (USAID) will continue to embrace new technologies for HIV prevention, family planning, and multipurpose prevention technologies and continue to work closely with partners, including WHO.

Conclusion

Though not a new topic, the results of the ECHO trial have highlighted the continued need for integration of different sexual health topics, including contraception, HIV, and STI information and services. Though HIV risk was not differentially increased among the contraceptive methods in the study, the results did show a high rate of STIs among women in the study, showing that women are not getting the information and/or services they need to protect their health. Government stewardship and

donor engagement are needed to help ensure that programs are able to integrate these services from a policy and financial perspective.

d. The future of Sayana® Press: A conversation with Pfizer Inc.

Daniele Russo from Pfizer provided an update on the production and distribution of DMPA-SC. Mr. Russo gave an overview of how Pfizer works to support social marketing practices, recognizing that social marketing can help maximize access to modern methods of contraception. He noted that Pfizer has developed promotional material, and he showed two pieces of these: a 12-page flipbook and a 5-page leave-behind for providers. Pfizer is working with donors and social marketing organizations to translate the documents into local languages and evaluate the creation of additional promotional pieces. Mr. Russo also mentioned that Pfizer has made investments to increase manufacturing capacity, and guaranteed pricing will stay the same until 2022. A question and answer session was then moderated by Kaitlin Christenson, PATH.

Questions and answers included:

Q: Why is DMPA-SC in a plastic vial costlier than DMPA-IM, which is in glass?
A: Plastic is more complicated from a quality perspective than glass and materials are only one component of price.

Q: What are Pfizer's conditions for allowing social marketing of DMPA-SC at the country level when repackaging can only be done with permission from Pfizer?
A: Pfizer is committed to supporting local social marketing, and the requirement was for the drug to not be repackaged locally unless there was a specific agreement in place, in order to protect Pfizer.

Q: What will Pfizer do to suggest how to differentiate the product sold in the private sector versus the public sector?
A: The plan in place is to implement product differentiation, and Pfizer's recommendation is to convey requirements to the donor consortium.

Q: Is the plastic or the glass vial more suited to tropical countries for conservation?
A: Both products are prequalified by WHO and their storage conditions are based on the country. Although DMPA meets WHO's storage conditions for prequalification, there are no data on whether a temperature of 45 degrees Celsius can damage the product.

Day 1 closing

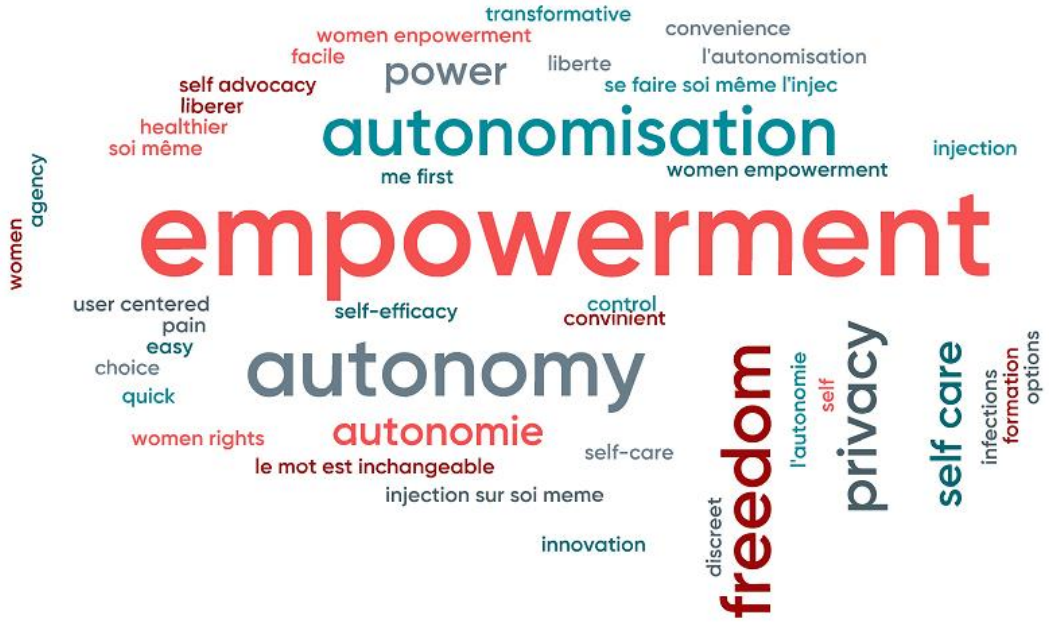
Recommendations and key takeaways based on the first day of panels were offered by the Day 1 meeting facilitators, Avotiana Rakotomanga, JSI/Madagascar, and Fiona Walugembe, PATH/Uganda:

- There is compelling evidence for self-injection, and it should be integrated as an option for women and girls in the broader method mix.
- Advocacy should continue with governments to identify internal sources of funding to sustain programs. This requires political will to identify different technical approaches.
- Collaboration between all sectors should be reinforced.
- The recommendations related to integration of family planning and HIV emerging from the ECHO study should be integrated into country plans.
- Pfizer confirmed that the price of Sayana Press will be guaranteed until 2022 and stressed its support for social marketing.
- The private sector is key to making the product more available, and work needs to continue to better integrate these channels into the scale-up of DMPA-SC.

Participants were also invited to share their thoughts. Figure 2 provides a graphical depiction of participants' views on what is the greatest opportunity for DMPA-SC. Figure 3 summarizes their thoughts on self-injection.

Figure 2. Participant responses to "What is the greatest opportunity for DMPA-SC?"

Figure 3. Participant responses to "What word comes to mind when you hear self-injection?"



Days 2 and 3

Martyn Smith, managing director of Family Planning 2020, opened the second day by providing a recap of the first day of the meeting, including the following takeaways:

- Compelling evidence exists on the value of self-injection (convenience, autonomy) and self-care for sexual and reproductive health more broadly.
- The right solution for women means the right service for the right client at the right time.
- We must increase efforts to get the private sector involved.
- Domestic funding is critical for long-term sustainability.

Matthew Rehrig from the Children's Investment Fund Foundation (CIFF) and Maryjane Lacoste from the Gates Foundation then shared some reflections on the previous day's Pfizer presentation:

- There is a contractual agreement for Pfizer to maintain the 85-cent pricing agreement through 2022. It is strongly believed that Pfizer will maintain that price beyond 2022 if market conditions continue on their current trajectory.
- To encourage healthy markets, CIFF and the Gates Foundation have been actively investing in development of a generic DMPA-SC product since 2015 and selected a manufacturing partner last year. The objective is to obtain WHO prequalification and ensure lower prices and stability of supply.

- On the demand side, the donors reinforced that:
    - Country governments are who ultimately decide which materials can be used to educate providers and women on contraceptive options, including DMPA-SC.
    - Social marketing organizations and other partners should work closely with ministries to ensure that any training and educational materials have the relevant approvals.
    - These efforts should avoid using trademarked brand names and instead emphasize education on the category of DMPA-SC and self-injectable contraception.
- There will be follow-up on the potential for packaging differentiation between the private-sector and public-sector product.

e. Self-care: The ultimate form of task-sharing or empowering women?

Shanzeh Mahmood from CIFF moderated a panel on self-care. In the context of DMPA-SC, self-care means women are able to take control of their sexual and reproductive health, and their health in general. Self-care is not a new concept, as self-care measures are already commonplace in the sexual and reproductive health space—for example, the use of pregnancy test kits and daily pills to prevent pregnancy and HIV. However, global attention to self-care has increased recently, as evidenced by WHO publishing the first-ever consolidated guidelines on self-care. Momentum and global advocacy for self-care are growing.

Ms. Mahmood began by explaining that this session was to discuss self-care within the context of self-injection and also to look more broadly at sexual and reproductive health interventions and explore efforts and actions countries can take to integrate self-care into their existing structures. The panel for the session included:

- Faridah Luyiga, White Ribbon Alliance, Uganda
- Gina Smith, Society for Family Health Zambia
- Jennifer Drake, PATH

Ms. Luyiga defined self-care as the ability for individuals to be able to manage their own health. It involves actions people can take on their own behalf but also being able to seek appropriate care. She stated that there is growing evidence that self-care helps people achieve better health every day. She discussed how advocates are looking to gather momentum on self-care and talk about their advocacy work in their country. WHO's consolidated guidelines on self-care are an opportunity for countries to engage ministries of health. Uganda is fertile ground for self-care, putting power in the hands of women and engaging partners, community members, and authorities.

Ms. Drake began by stating that while there might be many reasons for the current focus on self-care, such as increased access to health information, self-injection itself has helped contribute to galvanizing interest in self-care globally. Ms. Drake stressed that it was impossible to underestimate the novelty of

the act of moving injectable contraception from the provider to the hands of the client and how it can make life easier for women. PATH has been working for a long time on reproductive health technologies and self-care methods like the Woman's Condom and the one-size-fits-most diaphragm (Caya), because the organization believes women have the right to take informed action on their health. At the same time, the health system needs to remain involved with supporting women to use self-care methods.

Ms. Drake also discussed that the WHO self-care guidelines elevate the concept of self-care as one that requires specific attention and investment and helps formalize global thinking. In terms of self-injection, the strength of the recommendation is significant. When WHO conducts a guidelines process, it puts a lot of careful thought into it. In particular, Ms. Drake appreciated the global values and preferences survey that solicited responses from 800 people, as this highlights that users have to be at the center of self-care design interventions.

Ms. Smith spoke about how Population Services International (PSI) is applying the concept of self-care in the Zambian context as well as globally, and the opportunities she sees in this space. She said that in Zambia many different PSI interventions can be seen as self-care, including:

- Promoting HIV self-testing.
- Marketing the female condom.
- Improving awareness of emergency contraception pills.
- Scaling up the provision of family planning, including DMPA-SC.

PSI has been working on self-care for many years and has recently revised its global strategic plan with the vision of reimagining health care with a consumer-centric approach they call "consumer-powered health care." PSI also contributed to the recent WHO guidelines. Even if the term self-care is not widely used in the countries PSI works in, the concept is not new. Increasingly, PSI sees global interest in introducing HIV self-testing, and countries such as Zambia are incorporating HIV self-testing into national guidelines.

The session ended with a question and answer session:

Q: In the ECHO trial, 60 percent of women were under 25. What are we doing to target young women in regard to self-care?

A: Gina Smith replied that PSI's work differs per country. Their program Adolescents 360 has a human-centered approach targeting adolescent and young women. Jennifer Drake agreed that there is no population in the world that has so much at stake.

Q: Does education level play a role in self-care? Is there a difference between the educated and uneducated in their practices of self-care?

A: Allen Namagembe from PATH responded from the audience that those were their fears when they started with self-injection. She agreed that appropriate interventions must be designed for

the less educated—that is an example of a key role for health systems to play in supporting equitable access to self-care options.

Q: What are the criteria needed for moving forward a self-care approach, and what is an advocacy approach? What does Uganda recommend to other countries?

A: Ms. Luyiga said that a well-functioning health system with infrastructure and medicine is a reality in only a few countries. Most are struggling with staff shortages and budget reductions, and it is necessary to integrate self-care with provision of other services.

Conclusion

Self-care is not a new topic but is regaining momentum thanks in part to self-injection. Self-care has the potential to empower women and increase their autonomy. However, it should not be seen by governments and health systems as a way to decrease costs and reduce the burden on the health system. Even self-care requires guidance, appropriate support, and follow-up from the health system. It is important for women to retain that link so that when facility-based care is needed, it can be easily accessed. What self-care can provide for women is time savings, with fewer trips to a facility and more time for family or work; the cost savings of those trips; and a greater feeling of power over their health and lives.

f. Skills-building sessions

Three skills-building sessions were planned to help participants build their capacity in areas strategically selected to help with DMPA-SC and self-injection program scale-up moving forward. Experts in these three areas developed 90-minute sessions focused on activity, not presentation. Practicing these skills was expected to help participants better incorporate these activities into their action plans. Each meeting participant had the opportunity to attend two of the three skills-building sessions.

Forecasting, supply planning, and monitoring DMPA-SC supply

This supply-focused session covered a variety of topics, including:

- Key terms in quantification.
- Specific challenges related to forecasting for a new product such as DMPA-SC.
- Basic recommendations for DMPA-SC forecasting in this context.
- A small group exercise where attendees brainstormed about what types of forecasting assumptions they would need to estimate DMPA-SC needs, and what data they might draw on.
- Basics of supply planning.
- Resources available in English and French on the topic of DMPA-SC quantification.

Takeaways from the session included that estimating DMPA-SC commodity needs is challenging given that historical data are either not available or not indicative of the future given investments in training and rollout. Attendees discussed ideas for how to nevertheless prepare estimates and draw on the

available guidance documents. Routine monitoring of the forecast and supply plan in light of program progress was emphasized as the primary strategy for mitigating risk in this context.

Monitoring, learning, and evaluation

The goal of the monitoring, learning, and evaluation session was for participants to walk away with tangible resources and tools[3] for linking data to decision-making needs at the various stages of DMPA-SC introduction and scale-up and to build skills to facilitate data-driven learning. The session started with small groups brainstorming key questions that ministries of health, private-sector entities, and family planning implementing partners need to answer at various stages of introduction and scale-up, and the associated data sources to answer those questions. Participants highlighted how information needs change over the course of new product introduction, and thus how data collection efforts must be agile. Next, participants were presented with four techniques to facilitate data-driven learning processes and discussed how and when to use each approach. Participants were then given the opportunity to practice facilitating one technique—a root cause analysis—using the data sheets for their country. This practical exercise highlighted the need for continued support with using data to learn and inform adjustments throughout implementation to have the most effective and efficient scale-up process.

Policy change 101: Three things every advocate should know

During the skills-building session on advocacy, Advance Family Planning led participants in strategically planning an advocacy effort. Small groups were given a hypothetical SMART advocacy objective—one that is specific, measurable, achievable, realistic, and timebound: provision of DMPA-SC by nursing students. Groups debated which interim measures were on the critical path for achieving the advocacy objective in the short term of integration and scale-up of DMPA-SC, and in the long term, improved contraceptive method mix.

Advance Family Planning facilitators highlighted the three advocacy secrets that have resulted in increased financial and political support at the national and subnational levels: (1) build consensus, (2) focus efforts, and (3) achieve change. Through discussion and audience participation, they simplified the advocacy process in ways that both novices and experts can use to translate secrets into practice and progress.

[3] Program (re)design: Identifying, describing, and mapping key stakeholders; Prioritizing Solutions: Prioritize activities to address program challenges; Understanding the Problem: RCA Root Cause Analysis; Pause and Reflect: SWOT Strengths, Weaknesses, Opportunities, and Threats.

g. Optimizing access to family planning services through the private sector: Opportunities and challenges

Rodio Diallo from the Bill & Melinda Gates Foundation moderated a panel on issues related to improving access to DMPA-SC through the private sector. The panelists for this session included:

- Kimberly Cole, US Agency for International Development
- Serigne Kane, SHOPS Plus Senegal
- Mika Bwembya, John Snow, Inc., Zambia
- Dr. Kayode Afolabi, Nigeria Ministry of Health
- Hyacinthe Musangu, DKT International, Democratic Republic of the Congo

The panel began by discussing challenges in incorporating the private sector into scale-up of DMPA-SC. Ms. Cole began by discussing what USAID has been doing in the private sector for DMPA scale-up. USAID has been working in the private sector because it expands access, geography, and choice and increases the likelihood of sustainability. The partnership between USAID and Pfizer is what gave birth to the Sayana Press product. Ms. Cole acknowledged that USAID has learned a lot in introducing Sayana Press through the private sector and is aware of challenges around awareness-raising and data collection.

Mr. Kane gave an overview of the SHOPS Plus project (the USAID flagship global project on private-sector health) and acknowledged the extensive work of the private sector in introducing a variety of family planning options in countries. One of the challenges encountered in Senegal, where SHOPS Plus partners with ADEMAS for social marketing of DMPA-SC, is that pharmacists readily accepted the substitution of DMPA-IM with DMPA-SC, but it was quickly discovered that providers faced difficulties if they were not technically trained, causing them to stop selling the product. With the support of USAID, more than 1,000 providers have now been trained, including some pharmacists, midwives, and gynecologists in the national territory, which has led to a ten-fold increase in injectable sales in the private sector, highlighting that provider training is critical to increase access.

Mr. Musangu talked about the challenges of branding and the culture of believing that having many children is a blessing. Ms. Bwembya highlighted that in Zambia there is not an affordable DMPA-SC product available to the private sector. A policy solution is to have an implementing partner sell DMPA-SC to the commercial sector with a cost-recovery mechanism before the generic is made available. She said that it is necessary to make the product more affordable and for training approaches to be oriented to the needs of the private sector.

Next, the panel discussed opportunities to increase access to DMPA-SC through the private sector. Ms. Cole envisions that the product will be available through a range of channels as it offers a highly reliable choice for women who might not otherwise have access to family planning, and the private sector is key to that success. Ms. Bwembya said that in Zambia, following the pilot, the market is ripe in terms of taking on private-sector engagement and scaling up sustainably. Women are ready to pay, but if DMPA-

SC is also made free, no one will pay for it. As we design and implement programs, it is important to keep equity and sustainability in mind. Mr. Musangu said that the biggest priority is for the product to be packaged in pharmaceutical quality. Dr. Afolabi said the priority in Nigeria is to ensure the private sector is trained.

Ms. Diallo ended the session with some key takeaways, including:

- What is critical is how we can leverage public policies to include the private sector in a comprehensive way and include national leadership.
- We learned from USAID that the private sector can help to expand services, but they are left behind in trainings. How can we create a more enabling environment for the private sector?
- We learned from SHOPS Plus that working through private-sector alliances is key.
- How do we encourage the private sector to disclose usage data without fear of being tracked down to pay taxes? A key barrier is lack of trust.
- How can we bring the price down so there is an affordable product for the private sector to purchase?
- There is tension between private and public sector in terms of same packaging but different price.

Conclusion

There is agreement that the private sector, both not for profit and for profit, is vital to the scale-up of DMPA-SC and access to the full contraceptive method mix for women. However, there is not one answer to how to achieve effective private-sector participation. Each country will need to identify the barriers to full participation and how to find solutions for areas such as access to affordable supplies, training and supervision of providers, monitoring that is supportive and not punitive, and policy and regulation change to allow their effective participation.

h. How does training become more scalable? Lower-cost, high-quality training approaches

Provider training is a time and cost driver for countries introducing a new method. This impacts the time it takes to scale up DMPA-SC programs. Because of this, many countries are looking for options to complement or replace traditional training methods. Robin Keeley from PATH moderated a session on this topic. A list was provided in table format of provider training methods and examples of countries where those methods have been used. PATH will continue to update this resource with country experiences and new training methods developed and shared with those implementing DMPA-SC programs. Currently it is a mix of traditional in-person trainings (centralized, in-service, cluster) and eLearning (full eLearning course, provider training video, client training video).

Four examples of country experiences with innovative training methods were presented by:

- Lekia Lesor Nwidae, Clinton Health Access Initiative, Nigeria
- Joy Batusa, Clinton Health Access Initiative, Uganda
- Abdoulaye Diallo, Jhpiego, Guinea
- Avotiana Rakotomanga, John Snow, Inc., Madagascar

Ms. Nwidae spoke of Nigeria's need to develop lower-cost training approaches that still maintain quality. She discussed how the Clinton Health Access Initiative (CHAI) has developed streamlined approaches using cluster training and facility attachment to replace centralized training, which was originally in the national plan. These methods save on costs by using a free community venue or being hosted in a facility. Providers were also categorized as injection naïve or injection experienced, with injection-experienced providers receiving 1 day of training, shortened from the original 2 days, and injection-naïve providers receiving 2 days, shortened from the original 3.5 days with centralized training. Initially, a cost savings from 93 to 95 percent was observed. However, competency scores were moderate due to many logistical barriers. Since then, improvements have been made and still demonstrated a cost savings (more than 90 percent) and high competency (92 to 95 percent). More information will be available from CHAI regarding these approaches in early 2020.

Ms. Batusa presented on CHAI's work in Uganda and how training on DMPA-SC can be focused, practical, and low cost. CHAI focused on assessing the direct and indirect training costs and whether health workers become more competent with more training days. For injection-experienced providers, there was 96 percent competence observed with shorter training using facility attachment or cluster training; for community health workers, competence was 100 percent. Another change was the use of district-based trainers rather than national trainers. Previous training costs for injection-experienced providers were estimated at $469 per health worker, reduced to $58 per health worker. For community health workers, the training cost was originally $940 per worker, reduced to $150 per worker. Based on this experience, Ms. Batusa recommended the use of district trainers, a shortened number of training days, and leveraging resources to reduce training costs using facility attachment and cluster trainings. More information will be available from CHAI regarding these approaches in early 2020.

Mr. Diallo gave an overview of how Jhpiego works to make provider training more scalable through lower-cost, high-quality training approaches in eight francophone West African countries. In Togo, instead of organizing formal/traditional training sessions, Jhpiego oriented health providers during maternity staff meetings. According to district plans, meetings for midwives and nurses are organized every month or two. In 13 days, 303 providers were oriented on DMPA-SC service provision in 12 districts. The orientations sessions helped Jhpiego to save around $9,000. In Guinea, Jhpiego is planning to orient 400 providers on DMPA-SC service provision over two days in target health centers in the capital city using an on-site training approach.

Ms. Rakotomanga from JSI Madagascar presented on a lower-cost training approach in which all health workers were sent job aids with each order of DMPA-SC. They followed up with the districts to see how

they supplemented the job aid training with health workers. Supervision visits were used to orient providers on DMPA-SC, and quarterly meetings with district health leaders were used to orient them about DMPA-SC. Lead nurses would do the injections first while other health workers watched. The lead nurses would then conduct a competency assessment of health workers. It was a very low-cost approach, and the Ministry of Health is very enthusiastic about it. JSI and the Ministry of Health are planning an evaluation of this training method.

For the second half of the session, participants rotated among three stations that displayed, demonstrated, and answered questions about the three eLearning options: the eLearning course, the provider video, and the client video.

Conclusion

More evidence is needed on the efficacy of the newly developed training methods. As shown in other areas, once evidence is generated supporting a new methodology, countries are more likely to incorporate it into their plans for scale-up. With more evidence on effectiveness and cost savings, more countries may adopt non-traditional training methods or develop their own innovative training methods that can be shared with others.

i. Learning from the past: Bringing lessons on demand generation from other methods to DMPA-SC

Twebese Mugisha from CIFF moderated a session on demand generation. The panel for this session included:

- Jane Zgambo, Population Services International, Malawi
- Elisohasina Rafalimanana, Population Services International, Madagascar
- Fiona Walugembe, PATH, Uganda
- Hyacinthe Musangu, DKT International, Nigeria
- Adenike Ayodele, Centre for Communication and Social Impact, Nigeria

Ms. Mugisha opened the session by stating that empowerment doesn't happen automatically; it only starts when women are radically informed; this is when true agency occurs. The ultimate goal of demand generation is true agency for women. The goal of this session was to identify key pathways to find new strategies and present an opportunity to gather and share knowledge.

- **Drivers of social change.** Ms. Walugembe mentioned social and political structures were the drivers of social change. Ms. Ayodele said they used the Fogg model (a model of behavior change theory in which motivation, ability, and prompts must occur at the same time for an expected behavior to happen) and they are noticing a lot of women were motivated by the benefits of family planning.

- **Barriers to youth.** Ms. Walugembe described setting spaces under trees, in churches, or in schools where young people can talk about anything. Ms. Zgambo said that youth struggle to access all methods, so self-injection was a benefit as they can do it in private.
- **The role of technology.** Mr. Musangu's organization made a Facebook page to reach 15-to-25-year-olds. This page has an online doctor available at times to directly reply to users. Ms. Ayodele talked about making their social media strategies attractive to urban young people (Facebook and Instagram have different uses and clienteles according to region and age). Technology has limitations; for example, in rural areas it may not be as developed, so communication must be door to door, at "road shows," or during mass activities like a football match.
- **Provider education.** Ms. Walugembe has trained providers in interpersonal communication. Community health workers conduct visits.
- **Male engagement.** Ms. Ayodele explained how they target men to discuss family planning, such as groups of mechanics, tailors, or men in the mosques during Ramadan. Mr. Rafalimanana talked about how in Madagascar, they have a "Positive Image of the Man" campaign.
- **Biggest challenges and recommendations.** Ms. Zgambo said the involvement of community health workers created an opportunity for the acceptance of DMPA-SC. Ms. Ayodele said a persistent challenge is the misconceptions and fears of side effects that have persisted over the years; she addresses these head-on by letting women know about them in advance, which in turn reduces discontinuation rates.

Ms. Mugisha then facilitated general questions and answers:

Q: How do you balance empowerment with demand generation, which is more about marketing new products?

A: Ms. Ayodele replied that they try to keep demand generation in the frame of a rights-based approach.

Q: What recommendations are there to try and reach illiterate women, and what approaches and methodologies have been tried?

A: Ms. Walugembe replied that they use village health teams who are able to talk to the women in their local languages and via interactive radio shows.

Q: Have there been any interesting examples of how women refer to this product that might be useful from a marketing perspective?

A: Ms. Ayodele replied that women were using the local language for "the injection you can give yourself."

Q: Is there an example of an ambassador strategy that uses men to reach husbands?

A: Benin and Niger have both adopted ''The school of husbands.''

In closing, Ms. Mugisha addressed the tension between marketing a product and generating demand among potential users. She asked if this was really a misnomer and advocated for bringing marketing rigor into demand generation as she believes they are not really at odds.

Conclusion

Not much evidence is available on demand generation for DMPA-SC given its relatively recent emergence in the method mix and the restrictions on printed demand generation materials. However, as this session showed, there are lessons to learn from implementation experience for this product and, since DMPA-SC is one product in a broader method mix, from generating demand for family planning use generally. Generating demand does need to raise awareness of the methods available, but social norms persist that need to be changed in relation to contraception and family size/child spacing generally.

j. Donor panel

The final plenary session of the meeting was a discussion with the major donors to DMPA-SC programming. The panel was moderated by Kaitlin Christenson from PATH, and the donor representatives included:

- Maryjane Lacoste, Bill & Melinda Gates Foundation
- Matthew Rehrig, Children's Investment Fund Foundation
- Emma Foster, UK Department for International Development
- Kimberly Cole, US Agency for International Development
- Fenosoa Ratsimanetrimanana, United Nations Population Fund

The first question posed to the panel asked what they are doing to expand the method mix and how they feel investments in DMPA-SC contribute to the method mix. Ms. Lacoste said that bringing a new product into the method mix provides an opportunity to catalyze the system. The Gates Foundation has priority countries in which they target youth access to family planning, and DMPA-SC is an important component of this. She also stated that the Gates Foundation was continuing to work in contraceptive technologies, and new products are in the pipeline. She acknowledged that side effects are still a big issue for women, and she wants to ensure women have the widest possible access to the broadest range of methods. The donor community is working with Pfizer to ensure there is as much product as necessary to meet the demand.

Mr. Rehrig said that CIFF sees their work on access to self-injection in the broader context of self-care and is investing in other self-care technologies like HIV self-testing and tools to prevent unsafe abortions. He asserted that CIFF wants to strengthen the broader context around the product. The Gates Foundation and CIFF entered into an agreement with Pfizer in 2017 that it would scale up DMPA-SC and maintain the 85-cent price until 2022. The sustainability of Pfizer's price is just one small piece of the puzzle. Donors are also committed to bringing a generic product to market.

Ms. Foster stated that DFID was highly committed to expanding method choice in countries because when that happens, women are much more likely to take up family planning. At the 2019 UN General Assembly, the British secretary of state announced a flagship reproductive health supplies program, which will provide more than 20 million women with family planning until 2025. DFID intends to work more with the private sector and with partners.

Ms. Cole from USAID said they focus on client-centered counseling around the product and will be making changes to the Demographic and Health Survey questionnaire to find out if women are using DMPA-SC or DMPA-IM and whether they are self-injecting.

Mr. Ratsimanetrimanana, United Nations Population Fund regional advisor for West and Central Africa, affirmed that the wider the options, the more choices women have, and that access is a human right. He reinforced that one has to offer clients the best quality and have transparency between donors and governments.

When asked about priorities for a total market approach, Ms. Foster declared that expanding access to new channels for DMPA is critical. If we introduce subcutaneous where intramuscular is already available, only small gains will be seen. What they're most excited about is the potential of DMPA-SC to revolutionize the family planning sector and harnessing the resources and capabilities and geographical scope of health care providers.

Mr. Rehrig considers it necessary to think more proactively about demand generation and normalizing self-injection. He noted that 40 years ago, it was not conceivable for women to have a pregnancy test. One challenge for the meeting participants is to think about how we talk about the option of self-injection and how countries are describing the act of self-injection in local terms.

A question was raised in relation to demand generation via social marketing, where there have been delays in the ability to develop materials to enable effective communication on DMPA-SC. The response from the panel was that the ministries of health know best and that materials must be developed in consultation with them. It was stated that they should avoid using brand names as the goal is to promote a contraceptive category, not a brand.

Conclusion

The donor organizations continue to support DMPA-SC as an innovative contraceptive product, particularly because of the option for self-injection and women's ability to access more methods that can increase their autonomy and empowerment through self-care. However, several critical issues were discussed that still need donor support, including development of a generic DMPA-SC that can help make it more available and affordable, demand generation given the restrictions in place, and greater inclusion of the private sector in provision of the product. Donors continue to look for ways to invest strategically in advancing DMPA-SC as part of the broader method mix, including CIFF's investments in demand generation, DFID's investments that will specifically include increased access through the

private sector, and USAID's changes to the Demographic and Health Survey that will help to better monitor use of DMPA-SC, DMPA-IM, and self-injection.

Country group work

Prior to the meeting, each country delegation prepared their goals, successes, and key remaining challenges to the scale-up of DMPA-SC and self-injection. At the country group work sessions held during the meeting, delegations reviewed and revised their goals and challenges based on the sessions they attended and then worked together to develop action items to address each challenge. The delegations will operationalize these action items after the meeting. Some common goals that emerged from the group work included:

Provider training

- Integration of self-injection into provider training guides.
- Advocacy for pre-service training on DMPA-SC.
- Integration of innovative distance learning platforms and other ways to save training time and costs.

Data

- Integration of self-injection indicators.
- Distinguishing between provider administration and self-injection.
- Revision and distribution of data collection tools.

Improving private-sector provision

- Advocacy/regulations to enhance engagement.
- Working with private-sector stakeholders to determine the means of engagement.

Demand-generation/social and behavior change

- Communications materials.
- Engagement with community leaders.
- Community education.

Meeting closing

Ms. Christenson and Ms. Keddem closed the meeting by highlighting that as a community, everyone has progressed since the Nairobi meeting. (See Figure 4 for key words or phrases participants used to summarize the meeting.) They asked some meeting participants to highlight key lessons they took away from the meeting. These included:

- The Democratic Republic of the Congo said they will adopt the innovative training approaches for self-injection.
- Malawi said they would adopt the different training models to maximize efficiency of resources.

- Mozambique hoped that one year from now they will have expanded access to Sayana Press and will continue to apply the lessons learned in Nairobi.
- Nigeria hoped to move DMPA-SC forward to the point that they have a lot of best practices to share with the community.
- Jacqueline Wambui Mwangi from Kenya, as someone who comes from the HIV advocacy community, commented that this was a nice experience to see there's so much going on in family planning and that it was important not to leave here only thinking about the particular products but how to give women family planning options.
- Finally, Rodrigue Ngouana from Jhpiego commented that the countries in attendance had made a lot of progress and hoped in the next year they will be talking about full implementation in the countries. In particular, he expressed his wish that by 2021 the eight francophone countries he supports will be really advanced in self-injection.

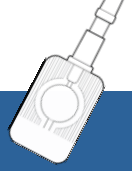
Figure 4. Participant responses to "One word or phrase that summarizes our time together."

Outcomes

Table 1 provides a summary of the meeting objectives, related work, and recent wins.

Table 1. Overview of meeting objectives and how they were or will be met.

Objective	How it was or will be met
1. Identify country-specific barriers and solutions to scale-up of DMPA-SC within the contraceptive method mix, including self-injection.	Through the country prework and group work, all 20 countries identified and refined their specific barriers to scale-up and developed solutions using the new information that was presented at the meeting or skills developed during the skills-building sessions. These solutions were integrated into the country action plans developed at the meeting.
2. Enhance awareness of tools, resources, and evidence to aid the development of comprehensive family planning programs, including their effective integration with HIV prevention programs.	A wide variety of advocacy and implementation resources were highlighted during the meeting. These tools will be updated as needed and are available for countries to use in their programming, with some available for adaptation into local languages and to local context.
3. Develop or update country-specific commitments and action plans to scale up rights-based, high-quality, total market family planning programs, including DMPA-SC and self-injection.	Twenty country action plans were developed by meeting participants. The Access Collaborative is coordinating follow-up with each participating country, in collaboration with Jhpiego, Clinton Health Access Initiative, and RIZ Consulting, to track progress in achieving the next steps outlined at the meeting. The Access Collaborative, partners, and donors will continue to follow up to track progress in assigned countries. Since the meeting, two countries have already had advocacy wins, with self-injection scale-up being approved in both Uganda and Madagascar.
4. Strengthen two regional Learning and Action Networks that promote continued cross-country sharing of experiences, dissemination of evidence, and collaboration on scale-up of DMPA-SC.	The Learning and Action Networks will host a series of webinars on topics of import that emerged from the meeting, including the private sector, monitoring, lower-cost training methods, and self-injection, among others. The Learning and Action Networks will also host topical discussion groups to facilitate further opportunities for information sharing across countries.



Moving forward

The second Evidence to Practice meeting demonstrated that countries have embraced the addition of DMPA-SC to the contraceptive method mix, including self-injection. DMPA-SC's unique value proposition includes that it is easy to transport and use, gives women more autonomy in the care of their health, and provides more access points from which women can obtain their contraceptive methods. The questions emerging from this meeting were not focused on whether to scale up DMPA-SC but rather on how to resolve operational issues such as lower-cost provider training, better incorporating the private sector, generating awareness of and demand for the product, and including the product in monitoring systems.

The meeting also demonstrated the continued commitment of donors and partners to helping countries effectively integrate this product into the broader method mix to enhance women's contraceptive options. The DMPA-SC Access Collaborative (PATH and JSI), Jhpiego, CHAI, and RIZ Consulting will continue to provide technical assistance to their assigned countries after the meeting. Action plans coming out of the meeting will help to inform the assistance needed and who is best placed to provide this assistance. Country coordinators will be following up with the delegations from each country to help with the assessment. This can include help in identifying funding, determining what technical assistance is needed and who is best placed to provide it, identifying and accessing tools for advocacy or implementation, or other needs.

Resources from the meeting, as well as links to other DMPA-SC resources, can be found on the PATH website.

Annexes

A. Steering Committee list
B. Agenda
C. Group Work form
D. Participant list

A. Steering Committee List

Name	Organization
Jenny Liu	UCSF
James Kiarie	WHO
Farouk Jega	Pathfinder
Martyn Smith	FP2020
Leigh Wynne	FHI360
Sada Danmusa	M-Space
Mbogo Bunyi	SHOPS Plus
Rebecca Husband	PSI
Rodrigue Ngouana	Jhpiego
Raveena Chowdhury	MSI
YuHsin Huang	IPPF
Roy Jacobstein	IntraHealth
Beth Frederick	AFP
Julie Hernandez	Tulane
Margaret Happy	ICWEA, Uganda
Jacque Wambui	NEPHAK, Kenya
Caitlin Glover	CHAI
Leslie Patykewich	JSI
Ami Sar	PATH
Maymouna Ba	PATH
Alain Kabore	PATH
George Barigye	PATH
Dr. Norbert Coulibaly	Ouagadougou Partnership
Dr. Serem	Kenya MOH

B. Agenda

DMPA-SC Evidence to Practice
Working Meeting

Radisson Blu Hotel
Dakar, Senegal
28-31 October 2019

GOAL AND OBJECTIVES

GOAL

Catalyze scale-up of DMPA-SC to improve women's awareness of and access to an expanded range of high-quality family planning products and services.

OBJECTIVES

- ***Identify*** *country-specific barriers and solutions to scale-up of DMPA-SC within the contraceptive method mix, including self-injection.*
- ***Enhance*** *awareness of tools, resources, and evidence to aid the development of comprehensive family planning programs, including their effective integration with HIV prevention programs.*
- ***Develop or update*** *country-specific commitments and action plans to scale-up rights-based, high-quality, total market family planning programs, including DMPA-SC and self-injection.*
- ***Strengthen*** *two regional Learning and Action Networks that promote continued cross-country sharing of experiences, dissemination of evidence, and collaboration on scale-up of DMPA-SC.*

EXPECTED OUTCOME

Country commitments made and documented in action plans to expand contraceptive method mix, including through the scale-up of high-quality DMPA-SC provision.

Simultaneous English-French interpretation services will be available throughout the meeting.

MONDAY, October 28, 2019

18:00 – 20:00	WELCOME RECEPTION *Welcome remarks* • Dr. Omar Sarr, Senegal Ministry of Health and Social Action • Dr. Fatoumata Haidara, Ouagadougou Partnership Coordination Unit • Aminatou Sar, PATH Senegal Each country will be offered the opportunity to host a table at which country delegations (i.e., government officials, implementing partners, and donors) would jointly identify DMPA-SC-related tools, resources, and success stories to display.

TUESDAY, October 29, 2019

08:30 – 09:00	**WELCOME REMARKS AND INTRODUCTIONS** **Speakers:** • Alassane Mbengue, Secretary General of the Senegal Ministry of Health and Social Action • Kaitlin Christenson, PATH • Carmit Keddem, JSI
09:00 – 10:00	**Seizing the opportunity to ensure comprehensive sexual and reproductive health services and a broad contraceptive method mix for women** **Moderator**: Beth Fredrick, AFP **Panelists**: • Chilufya Kasanda, Treatment Advocacy and Literacy Campaign, Zambia • Roy Jacobstein, IntraHealth • Dr. Mareme Ndiaye, Senegal Ministry of Health and Social Action • Aminatou Sar, PATH Senegal • Maryjane Lacoste, Bill & Melinda Gates Foundation **Description**: This session will focus on DMPA-SC within the context of a broad and accessible method mix and sexual and reproductive health (SRH) options, and lay the foundation for the larger meeting discussion. This session will include a discussion of: – Improving women's access to and information about all available contraceptive options and affirming the strong commitment of the meeting participants to that concept. – Clarifying the value proposition for DMPA-SC, including self-injection, and how it fits into the method mix and helps women access an increased range of options to meet their needs. – Integrating FP into other SRH services, HIV prevention, and connection to self-care.
10:00 – 10:30	**Integrating DMPA-SC to broaden the method mix for women and girls: Successes and challenges in scale-up** **Host:** Ann-Marie Yongho, JSI **Guests**: • George Barigye, PATH Uganda • Alain Kabore, PATH Senegal **Description**: This session will set the stage for the main themes of the meeting and ensure that participants have the needed evidentiary background on DMPA-SC and the progress that has been made. It will also ensure that participants understand: – The state of global scale-up.

	– The scale-up challenges that continue. – The future of DMPA-SC and self-injection scale-up.
10:30 – 10:45	**GROUP PHOTO**
10:45 – 11:15	**BREAK**
11:15 – 12:25	**Self-injection as a game-changer: How do we ensure women's access to this important option?** **Video:** The Power of Self-Injectable Contraception (7 minutes) Shot in May 2019, this video tells the self-injectable contraception research-to-practice story of a study in Malawi led by FHI 360 and the University of Malawi, funded by USAID and CIFF, which investigated the effectiveness of self-injected DMPA-SC in comparison to receiving DMPA-SC from a provider. **Presenter & Moderator:** Jennifer Drake, PATH (20 min) The moderator will highlight the self-injection value proposition, emerging evidence, and program resources through a short presentation. **Panelists:** (40 min) • Ndeye Sene, heath post midwife, Senegal • Dr. Fatou Ndiaye, USAID Senegal • Dr. Mihayo Placid, Uganda Ministry of Health • Fannie Kachale, Malawi Ministry of Health • Fatimata Sy, CIFF Program Investment Committee **Video:** A portable solution (1.5 minutes) This brief video from 2016 tells the story of Sunday, a 32-year-old woman in Uganda who uses family planning as a way to ensure her children's future. Sunday was one of the first women in Uganda to try contraceptive self-injection as part of a study supported by PATH and Uganda's Ministry of Health. **Description:** During this panel, global and country-level champions will discuss the importance of self-injection as an additional option for women within the broader method mix. Panelists will describe DMPA-SC and self-injection scale-up experiences, share successes and challenges, and offer priorities for expanding access.
12:25 –13:35	**Catalyzing change: Solutions to overcoming challenges to operationalizing self-injection** **Moderator:** Rodrigue Ngouana, Jhpiego **Presenters/Panelists:** (40 min) • Allen Namagembe, PATH Uganda • Dr Noromalala Sylvie Tidahy, Madagascar Ministry of Health • Dynes Kaluba, Zambia Ministry of Health • Yaba Essien, Jhpiego Togo

	Panel: The moderators will ask questions of the country panelists to learn about successes and challenges of operationalizing self-injection in their countries. **Small-group discussion and Q&A** (30 min) Each table will have 10 minutes to discuss what they've heard, including outstanding challenges and/or questions in their country, and pose a question to panelists using the polling software. There will be 10 minutes for a selection of those questions to be answered by the panel. Unanswered questions can be answered later and posted to the Learning and Action Network (LAN) online forum. There will be a short demonstration of the LAN online forum at the end of this session showing participants how to log in to the forum and post questions. **Description:** This session will look at four countries that are in different phases of the process of scaling up self-injection. Each country will talk about a unique perspective they have or challenge that they have faced in operationalizing self-injection and the lessons learned. In small group discussion, country groups can then discuss what they have heard, how it applied to their country situation, as well as other common challenges (i.e. cost, concerns about misuse, balance with IM, policy, guidance, waste disposal and management, task shifting, etc.).
13:35– 14:35	**LUNCH** **Optional Table Topics (each topic will have a French table and an English table):** • Continuing the conversation: Self-injection as a game-changer • Reaching adolescent girls and young women: Youth access to family planning services and DMPA-SC • Policies and programs in decentralized settings: Best practices in sub-national implementation
14:35 – 15:45	**Ensuring access to integrated SRH services: Understanding and integrating updated WHO recommendations on the use of contraceptive methods by women at high risk of HIV into country action plans** **Presenter:** Petrus Steyn, WHO (10 min) **Moderator:** Navita Jain, AVAC **Panel discussion** (40 minutes) • Jacqueline Wambui Mwangi, NEPHAK Kenya • Yuhsin Huang, IPPF • Saad Abdulmumin, USAID • Petrus Steyn, WHO **Question and answer** (20 min) **Description:** This session will provide an overview of new WHO recommendations for integrating HIV and FP programming and answer questions from countries about

	implementation of those recommendations. Key stakeholders will share experiences and lessons learned.
15:45– 16:15	**BREAK**
16:15-17:15	**The future of Sayana® Press: A conversation with Pfizer Inc.** **Presenter**: Daniele Russo, Pfizer Inc. **Discussion Moderator:** Kaitlin Christenson **Description**: A Pfizer representative will present updates on the branded product Sayana Press and meeting participants will have the opportunity to ask questions. *Sayana Press is a registered trademark of Pfizer Inc.*
17:15-17:30	**REVIEW OF DAY AND EVALUATION** Through the LAN online forum, participants will share: • One key lesson learned that they will incorporate into their work. • One thing that went well. • One thing to change for tomorrow.
	DINNER ON YOUR OWN

WEDNESDAY, October 30, 2019

08:25 – 08:35	**DAY ONE RECAP**
08:35 – 09:15	**Self-care: The ultimate form of task-sharing or empowering women?** **Host:** Shanzeh Mahmood, CIFF **Guests:** • Faridah Luyiga, White Ribbon Alliance Uganda • Gina Smith, Society for Family Health Zambia • Jennifer Drake, PATH **Discussion** (30 min) **Question and answer** (15 min) **Description:** This discussion will provide an overview of self-care, including the WHO's new guidance on self-care, within the context of self-injection of DMPA-SC and other SRH interventions. The discussion will also include actions that countries can take to integrate self-care into their existing policies and programs. A member of the Self-care Trailblazers Group will discuss a joint advocacy roadmap for self-care, which is being developed through country consultations and will be launched at ICPD25.
09:15 – 09:20	**Transition to break out rooms**
09:20 – 10:35	**SKILLS BUILDING SESSION I:** **i. Forecasting, supply planning, and monitoring DMPA-SC supply** Jane Feinberg, JSI Laila Akhlaghi, JSI Dana Aronovich, JSI Ensuring an uninterrupted supply of product can be challenging in the new product introduction context. This interactive session will cover strategies and considerations for national level DMPA-SC forecasting, supply planning, and supply monitoring. **ii. Monitoring, learning, and evaluation** Ann-Marie Yongho, JSI Nicole Danfakha, JSI In this session, participants will identify how data needs evolve over the course of product introduction and the key questions and decisions associated with each stage of introduction and scale-up. They will link key questions and information needs to data sources and learn tools and techniques for facilitating data use to inform decision-making. **iii. Policy Change 101: Three Things Every Advocate Should Know**

	Beth Fredrick, Advance Family Planning Sam Mulyanga, Jhpiego This hands-on session will cover the essential elements of a successful advocacy effort to move policy forward. The session will cover: 1. Building consensus—from setting a common goal to setting SMART objectives; 2. Focusing efforts—from knowledge to action; and 3. Achieving change—how sustained advocacy can support DMPA-SC's scale-up, integration, and access to the full range of contraceptive methods. The session builds on the AFP SMART approach of the Advance Family Planning initiative of the Bill & Melinda Gates Institute of the Johns Hopkins Bloomberg School of Public Health. **Description**: Three skills-building sessions of 75 minutes each will be held concurrently. Participants will be able to attend two of the three available sessions.
10:35 – 11:05	**BREAK**
11:05 – 12:20	**SKILLS BUILDING SESSION II:** **i. Forecasting, supply planning, and monitoring DMPA-SC supply** Jane Feinberg, JSI Laila Akhlaghi, JSI Dana Aronovich, JSI Ensuring an uninterrupted supply of product can be challenging in the new product introduction context. This interactive session will cover strategies and considerations for national level DMPA-SC forecasting, supply planning, and supply monitoring. **ii. Monitoring, learning, and evaluation** Ann-Marie Yongho, JSI Nicole Danfakha, JSI In this session, participants will identify how data needs evolve over the course of product introduction and the key questions and decisions associated with each stage of introduction and scale-up. They will link key questions and information needs to data sources and learn tools and techniques for facilitating data use to inform decision-making. **iii. Policy Change 101: Three Things Every Advocate Should Know** Beth Fredrick, AFP Sam Mulyanga, Jhpiego This hands-on session will cover the essential elements of a successful advocacy effort to move policy forward. The session will cover: 1. Building consensus—from setting a common goal to setting SMART objectives; 2. Focusing efforts—from knowledge to action; and 3. Achieving change—how sustained advocacy can support DMPA-SC's scale-up, integration, and access to the full range of contraceptive methods.

	The session builds on the AFP SMART approach of the Advance Family Planning initiative of the Bill & Melinda Gates Institute of the Johns Hopkins Bloomberg School of Public Health. **Description**: Three skills-building sessions of 75 minutes each will be held concurrently. Participants will be able to attend two of the three available sessions.
12:20 – 12:25	**Transition to plenary room**
12:25 – 13:35	**Optimizing access to family planning services through the private sector: Opportunities and challenges** **Moderator:** Rodio Diallo, BMGF **Panelists:** • Kimberly Cole, USAID • Serigne Kane, SHOPS Plus Senegal • Mika Bwembya, JSI Zambia • Dr. Kayode Afolabi, Nigeria Ministry of Health • Hyacinthe Musangu, DKT DRC **Description**: During this session, panelists will share experiences in providing DMPA-SC through the private sector. They will review what has been feasible and why; what the key challenges have been; and 3 to 5 key priorities for gaining traction on DMPA-SC in the private sector in 2020. This session will also address concerns about expanding task-shifting policies; market barriers, including private sector in monitoring and supportive supervision; overbranding of DMPA-SC; training of providers; and pricing of DMPA-SC in the private sector.
13:35 – 14:35	**LUNCH** **Optional Table Topics (each topic will have a French table and an English table):** • Humanitarian settings: Ensuring sexual and reproductive healthcare, including DMPA-SC, reaches the most vulnerable • Continuing the conversation: Engaging the private sector in DMPA-SC provision • Capturing DMPA-SC and self-injection in routine data systems: What are we learning?
14:35 – 15:50	**GROUP WORK** **Description**: Country delegations will reflect on the content of the past two days and discuss lessons learned that can be applied to their context. Drawing from barriers and challenges identified in pre-work, as well as country scale-up status and country-specific learning agendas, the country delegations will begin to discuss up to six priority actions for addressing and overcoming their specific barriers in order to catalyze scale-up of DMPA-SC as part of the broader method mix, including self-injection. This may focus on evidence generation, programmatic priorities, and/or advocacy and policy change, and each country delegation's work will be tailored to that country's specific needs and scale-up status. Delegations will also be asked to reflect on new WHO guidelines for HIV/FP program integration and self-care

	and discuss incorporation of these items into country plans. Group facilitators will provide templates and guidance for discussion.
15:50 – 16:20	**BREAK**
16:20 – 17:15	**CONCURRENT SESSION I:** **Francophone: How does training become more scalable? Lower-cost, high-quality training approaches** **Moderator:** Robin Keeley, PATH (5 min) Review "menu" of training options **Rapid fire/flash talks (20 minutes)** • Lekia Lesor Nwidae, CHAI Nigeria • TBD, CHAI Uganda • Abdoulaye Diallo, Jhpiego Guinea • Avotiana Rakotomanga, JSI Madagascar **Audience questions (5 minutes)** **Training station rotation (25 minutes)** eLearning course Provider training video Client training video **Description**: A menu of training options will be presented to the plenary group, followed by brief "flash" presentations; then participants will rotate through stations with demonstrations and discussion of how to use the different training approaches, including innovative techniques to disseminate and use the training tools. **Anglophone: Learning from the past: Bringing lessons on demand generation from other methods to DMPA-SC** **Moderator:** Twebese Mugisha, CIFF **Introduction (10 minutes)** **Rapid fire/flash talks (15 minutes)** • Jane Zgambo, PSI Malawi • Fiona Walugembe, PATH Uganda • Hyacinthe Musangu, DKT Nigeria • Adenike Ayodele, CCSI Nigeria **Structured Q&A (20 minutes)**

	Audience questions (10 minutes) **Description**: This session will focus on behavior change to normalize the self-care practice of self-injection at the community level and how to "make the case" for self-injection to those who provide it. This session will also explore experiences of behavior change and demand generation for a newly introduced product through novel channels through experiences with this and other products at introduction.
17:15 – 17:30	**REVIEW OF DAY AND EVALUATION** Through the LAN online forum, participants will share: • One key lesson learned that they will incorporate into their work. • One thing that went well. • One thing to change for tomorrow.
	DINNER ON YOUR OWN

THURSDAY, October 31, 2019

08:30 – 08:35	**DAY TWO RECAP**
08:35 – 09:30	**CONCURRENT SESSION II:** **Francophone: Learning from the past: Bringing lessons on demand generation from other methods to DMPA-SC** **Moderator:** Twebese Mugisha, CIFF **Introduction (10 minutes)** **Rapid fire/flash talks (15 minutes):** • Eliso Rafalimanana, PSI Madagascar • Fiona Walugembe, PATH Uganda • Hyacinthe Musangu, DKT Nigeria • Adenike Ayodele, CCSI Nigeria **Structured Q&A (20 minutes)** **Audience questions (10 minutes)** **Description**: This session will focus on behavior change to normalize the self-care practice of self-injection at the community level and how to "make the case" for self-injection to those who provide it. This session will also explore experiences of behavior change and demand generation for a newly introduced product through novel channels through experiences with this and other products at introduction. **Anglophone: How does training become more scalable? Lower-cost, high-quality training approaches** **Moderator:** Robin Keeley, PATH (5-7 min) Review "menu" of training options **Rapid fire/flash talks (15 minutes)** • Lekia Lesor Nwidae, CHAI Nigeria • TBD, CHAI Uganda • Abdoulaye Diallo, Jhpiego Guinea • Avotiana Rakotomanga, JSI Madagascar **Training station rotation (35 minutes)** eLearning course Provider training video Client training video

	Description: A menu of training options will be presented to the plenary group, followed by brief "flash" presentations; then participants will rotate through stations with demonstrations and discussion of how to use the different training approaches, including innovative techniques to disseminate and use the training tools.
09:30 – 09:35	**Transition to plenary room**
09:35 – 10:40	**Donor Panel** **Moderator:** Kaitlin Christenson, PATH **Panelists** • Maryjane Lacoste, Bill & Melinda Gates Foundation • Matthew Rehrig, CIFF • Emma Foster, DFID • Kimberly Cole, USAID • TBD, UNFPA **Description**: This session will be a facilitated discussion with the five donor representatives in which participants will learn the short-term and long-term vision for DMPA-SC and method mix from the donor perspective and what next steps the donor community sees based on the first two days of the meeting. This discussion will incorporate questions from the plenary. Topics may also include a discussion of funding silos, integration of family planning and HIV services, DMPA-SC price guarantee, generic versions of DMPA-SC, sustainability, supply chain, and an update on DFID Ring Fence Funding. Perspectives will also be brought in from other donor representatives (such as those from the country level) about how global donor priorities are playing out in countries and/or mission-level priorities and investments.
10:40 – 11:10	**BREAK**
11:10 – 13:30	**GROUP WORK** **Description**: Country delegations will continue their discussions from yesterday and reach consensus on up to six priority actions. They will develop an action plan to catalyze the scale-up of DMPA-SC and/or self-injection and broaden the method mix. This will include roles, responsibilities, timelines, and any support needed from partners. If policy change or domestic financing are identified as priorities, delegations will also identify the decision-maker(s), detail the policy pathway, and develop an abridged advocacy strategy. Resulting action plans and advocacy strategies should align with and be incorporated into country scale-up plans for DMPA-SC. Group facilitators will provide templates and guidance for discussion.
13:30 – 14:30	**LUNCH**
14:30 – 15:30	**GROUP WORK REPORT-OUTS IN SMALL GROUPS** • Francophone Africa (4 groups) • Anglophone Africa (3 groups)

	• Asia (1 group) **Description**: In regional groups of two to three country delegations each, countries will share their introduction/scale-up action plans developed during the meeting, including key next steps, and discuss additional information and resource needs. This session provides an opportunity for countries to share experiences and scale-up status, ask questions about overcoming barriers, and identify potential collaboration.
15:30 – 16:00	**BREAK**
16:00 – 16:55	**GROUP WORK REPORT-OUTS IN SMALL GROUPS** • Francophone Africa Group 1 (4 groups) • Anglophone Africa Group 1 (3 groups) • Asia (1 group) **Description**: In regional groups of two to three country delegations each, countries will share their introduction/scale-up action plans developed during the meeting, including key next steps, and discuss additional information and resource needs. This session provides an opportunity for countries to share experiences and scale-up status, ask questions about overcoming barriers, and identify potential collaboration.
16:55 – 17:00	**Transition to plenary room**
17:00 – 17:30	**REPORT-OUT, REFLECTIONS, AND CLOSE** Expected outcome: Summary of main points, clarity on next steps, and opportunity for participants to reflect on the meeting.

C. Group Work form

Group Work Instructions

The countries attending this meeting are at different stages of DMPA-SC scale-up and introduction and scale-up of self-injection. The goal of this group work is to guide country groups through an individualized process of identifying specific actions that will catalyze progress to operationalize existing DMPA-SC and self-injection scale-up plans. Actions identified here should include next steps and responsible parties for each action. All actions identified should align with/complement existing DMPA-SC action plans, country FP commitments, and FP2020 (or other) action plans.

You have a copy of the country pre-work and a visual overview with your country's relevant data on the DMPA-SC introduction and scale-up process on your table. Please reference these as you create your action items.

Wednesday October 30th

1 hour 20 minutes

1) Make introductions within your country group and select an official note taker. If possible, plan to document your group work using a computer in the document on the flash drive. Group work will be collected at the end of the meeting. **(5 minutes)**
2) With your group, review your pre-work and discuss the self-injection sessions from the previous day. Review the key takeaways, and how they may impact your identified barriers or opportunities. Document these takeaways and their potential impact in your country in the table below. **(20 minutes)**

Key self-injection takeaways	Potential impact in your country

a. Has your country started introducing self-injection yet?
    i. if yes, move to item 2b.
    ii. If no, what are the barriers to introducing self-injection or the opportunities to introduce self-injection? Are these already reflected in the barriers/opportunities identified in your pre-work? If not, use the space here to write down any additional barriers or opportunities you may want to discuss as a group.

b. Do the self-injection evidence and experiences you heard yesterday and today change the list of barriers/opportunities that your country delegation identified in advance of the meeting? Consider additional topics covered by speakers today and yesterday such as the private sector, forecasting and supply monitoring, and self-care.
c. If so, revise the barriers/opportunities in the space provided (add more rows if needed).

Revised Barriers or Opportunities (if applicable)

3) Prioritize the order in which you will address your barriers/opportunities and list them in the action item table below. **(10 minutes)**
4) Spend time discussing the first two barriers/opportunities in the action planning table. **(45 minutes)**
    a. Fill in each cell in the row to elaborate how you can move the action item forward in implementation, overcoming barriers and taking advantage of identified opportunities.
    b. Consider how to integrate skills you learned in the skills building sessions from earlier today (advocacy, monitoring and evaluation, and forecasting and supply monitoring).
    c. When you are done with each row, you will have established timeline, barriers preventing scale-up, opportunities to move this forward, responsible people to lead the action, specific opportunities to help move this forward, and any key authorized decision makers and resources that are needed for success of this action item.

Questions to consider for the action planning exercise:

- Is there a local or international organization or government entity that is particularly skilled in an area related to your action item?
- What existing resources can you take advantage of and use or adapt for your context?
- Is policy change needed? Can policy be amended, or a waiver obtained? Do service delivery guidelines need to be changed? Is there policy change already in the works or recently achieved?
- Is there high-level political support for DMPA-SC and/or self-injection? Are there higher levels of government buy-in or support needed (consider DMPA-SC and self-injection)?
    a. How can this be achieved? What needs to be overcome?
- Do training packages need to be developed or adapted?
- Do you have ways to learn from past experiences?
- Are there areas where cross-country exchange could be particularly helpful?
- Are there areas where new evidence or data is needed (could include secondary analysis of existing data, evidence)?
- What are the factors that can prevent achievement of the action item?
- Are there funding gaps or constraints?
- Is there stakeholder resistance?
- How does product supply/supply chain challenges or opportunities relate to the barrier or opportunity you've identified?

Use each row to elaborate an action plan for each barrier/opportunity:

Barriers/Opportunities	Solution(s)/Action item	Who has the authority to make this decision or take this action?	What additional stakeholders need to be engaged and how will this be done?
1.			
2.			
3.			
4.			
5.			
6.			

Barriers/Opportunities (repeat from above)	Who will lead the action item and who will work on each sub-step?	What resources do you have? What resources do you need?	How will you measure/monitor implementation? What is the expected date of completion?
1.			
2.			
3.			
4.			
5.			
6.			

Thursday October 31st

2 hour 25 minutes

1. As a group, reflect on the information you have heard over the past day. **(25 minutes)**
    a. Use the space below to write down any key takeaways on the following topics: Lower-cost, high-quality training approaches, demand generation, donor perspectives/opportunities
    b. Is there any new information you learned since the last group work session yesterday that you want to incorporate into the barriers/opportunities you have already worked on?

Key takeaways	Potential impact on your action planning

2. Continue working on the remaining identified barrier/opportunity in the table, integrating any of the key takeaways that you wrote down above. **(1 hour 30 minutes)**

To prepare for small group report out, as a group decide the top three action items you will share for discussion. Small group report out will provide the opportunity to get feedback or information from other country groups on your plans and to also share your lessons or experiences that might help to inform plans of the other countries in your small group. **(30 minutes)**

D. Participant list

Country	Name	Title	Organization
Benin	Aminatou Baco	Family Planning Trainer	MOH
Benin	Ando Raobelison	Deputy Director - Programs	ABMS
Benin	Fréjus Goudjo	Medecin Coordonnateur De Zone Sanitaire	MCZS ABD
Benin	Gaston Ahounou	Chef Service Planification Familiale, Santé des Adolescents et Jeunes	MOH
Benin	Justin Y Tossou	Head of the Reproctive Health and HIV/AID's Department	ABMS/PSI
Benin	Pulchérie Atachade		OSV JORDAN
Benin/Togo	Emmanuel Houndekon	Programme Initiative Manager	CARE
Burkina Faso	Aguiebina Ouedraogo	Charge de programme	MOH
Burkina Faso	Fatoumata Haidara		Ouagadougou Partnership
Burkina Faso	Mathieu Bougma	Chef de service Planification familiale / Direction de la santé de la famille	MOH
Burkina Faso	Nicolas Ouedraogo	Directeur Marketing	PROMACO
Burkina Faso	Tana Bagnoa	Responsable Des Ms Ladies/Men	Marie Stopes
Burkina Faso	Zanré Yacouba	Point focal pays du projet "DMPA-SC"	Jhpiego
Cambodia	Forum Mistry	Senior Associate, SRH	CHAI
Cote d'Ivoire	Armand Dakouri		ACPCI
Cote d'Ivoire	Khalil Sanogo	Epidémiologiste, point focal TRACK20 et DMPA-SC	MOH
Cote d'Ivoire	Nathalie Akissi	Directrice Des Programmes	AIBEF
Cote d'Ivoire	Patricia Kone		PSI
Cote d'Ivoire	Seidou Kone	Directeur Coordonnateur du Programme National de Santé de la Mère et de l'Enfant (PNSME)	MOH
Cote d'Ivoire	Touré Oumar	Senior Technical Advisor RH/PF	Jhpiego
Côte d'ivoire	Rodrigue Ngouana	Regional Director	Jhpiego
DRC	Bibi Mboma	Chef de Division Planification Familiale	MOH
DRC	Bibiche Izale	DMPA SC Scale Up Country Coordinator	Pathfinder

DRC	Hyacinthe Musangu	Head of Family Planning & Drug Regulatory Affairs	DKT International
DRC	Justin Kumpel	Chef de Division a.i Planification Familiale	MOH
DRC	Paola Mupwapwa	FP Focal Point Kinshasa	DKT International
Ethiopia	Michael Yihdego	FP/RHCS Technical Specialist	UNFPA
Ghana	Angela Boateng	Programme Officer FP/M&E	MOH
Ghana	Claudette Diogo	Family Planning Prog/ Logistics Officer	MOH
Ghana	Daniel Mensah	Executive Director	Health Keepers Network
Ghana	Demi Duah	Technical Director	TFHP
Ghana	Isaac Lamptey	Assist General Manager Programs	DKT International
Ghana	Joseph Adu	Medical Director	MSI
Ghana	Joyce Amedoe	Country Manager	CHAI
Ghana	Mario Alvarez	Country Director	DKT International
Ghana	Yaa Bonsu Asante	Family Planning Program Manager	MOH
Guinea	Abdoulaye Diallo	Monitoring Evaluation and Research Advisor	Jhpiego
Guinea	Golé Béavogui	Président	ACPG
Guinea	Hadja Bamba	Présidente de la société civile	CSO
Guinea	Madina Rachid	Directrice Nationale Adjointe Santé Familiale et Nutrition	MOH
Guinea	Mamadou Diallo	Representant Marketing social DMPA-SC	DKT/Vision Smart
Guinea	Nagnouma Sano	Responsable Logistique Pharmaceutique, Point Focal SPSR	MOH
Kenya	Denise Murekatete	Technical Advisor RHCS & Task shifting	IPPFAR
Kenya	Irene Obiero	Senior Associate, SRH	CHAI
Kenya	Issac Malonza	CEO and Technical Director	URADCA
Kenya	Jacqueline Mwangi	Program Officer	NEPHAK
Kenya	Judith Anyona		John Snow, Inc.
Kenya	Malyse Uwase	Director Health & Impact	Kasha
Kenya	Melissa Wanda	Advocacy Assistant	PATH
Kenya	Sam Mulyanga	Project Director AFP	Jhpiego
Madagascar	Avotiana Rakotomanga	Country Coordinator	John Snow, Inc.

Madagascar	Dr Noromalala Sylvie Tidahy	Directeur de la Santé Familiale	MOH
Madagascar	Elisohasina Rafalimanana	Gestionnaire de Programme PF Stratégie mobile	PSI
Madagascar	Faramalala Rahelinirina	Chargée de Programme en Planification Familiale	UNFPA
Madagascar	Odile Hanitriniaina	Senior Research and Data Manager	MSI
Madagascar	Romy Andrianarintsalama	Health Financing Advisor	WISH2ACTION
Madagascar	Tsirihanitra Rakotoarinivo	Directeur de Distribution	PSI
Madagascar	Vololoniaina Rasoanandrasana	Responsable de la gestion logistique des produits contraceptifs	MOH
Malawi	Ann Phoya	Clinical Director	MSH ONSE Health Activity
Malawi	Bagrey Ngwira	Senior Lecturer	University of Malawi Polytechnic
Malawi	Fannie Kachale	Director, RHD	MOHP
Malawi	Frehiwot Birhanu	Program Manager	CHAI
Malawi	Gracious Ali	Program Associate	CHAI
Malawi	Jane Zgambo	Service Delivery Manager	PSI
Malawi	Jessie Chirwa	Program Officer, RHD	MOHP
Malawi	Milika Mdala	RHCS FP Focal point	UNFPA
Malawi	Mrs. Pester Siraha	Senior Operations Director	Banja La Mtsogolo (MSI)
Malawi	Premila Bartlett	Senior RH/FP Advisor	USAID
Malawi	Rose Chikumbe	Pharmacist	MOHP
Mali	Aliou Bagayoko	Country Coordinator	Jhpiego
Mali	Aoua Guindo	Point focal Planification familiale	MOH
Mali	Kassoumou Diarra	Pharmacien, Responsable de la Gestion des Approvisionnement et des Stocks des produits SR/PF	MOH
Mali	Patrice Coulibaly	Family Planning and Health Reproductive Advisor	USAID
Mauritania	Ahmed Mohamed	Chef service approvisionnement au Programme national de la santé de la Reproduction	MOH

Mauritania	Boye Salimata	Chef service adjoint PF/Sage femme	MOH
Mauritania	Youssef Limame	Point Focal Jhpiego Mauritanie	Jhpiego
Mozambique	Alda Govo	Chefe do Programa Nacional de PF	MOH
Mozambique	Clara Jaime	Ponto Focal de PF- Niassa	MOH
Mozambique	Ivandra Libombo	Planification	MOH
Mozambique	Ryan Kelley	Country Representative	PSI
Myanmar	Chan Maung	Deputy Regional Health Director	MOH
Myanmar	Hnin Lwin	Deputy Director, Maternal and Reproductive Health	MOH
Myanmar	Htwe Soe	Assistant director,Maternal and Child Health/School Health/Nutrition,Taninthary Regional Public Health Department.	MOH
Myanmar	Myint Win	Program Manager	PATH
Myanmar	Ohnmar Myint	Head of Operations (Upper Myanmar)	PSI
Myanmar	Thant Thant Sin	Senior Associate	CHAI
Myanmar	Thiri Kyaw	Program Officer	CHAI
Niger	Aissata Alassane	Master II en Sante de la Reproduction	MOH
Niger	Djibo Hama	Manager de la Sante de la Reproduction	PSI
Niger	Harou Issoufa	Director of Family Planning	MOH
Niger	Ibrahim Innocent	Country Focal point	Jhpiego
Nigeria	Abdulhameed Adediran	Programme Manager	ARFH/BMGF
Nigeria	Adenike Ayodele	Programme Officer	CCSI
Nigeria	Adewole Adefalu	Country Coordinator	John Snow, Inc.
Nigeria	Ijeoma Nwankwo	Program Officer	DRPC PACFAH Project
Nigeria	Jennifer Anyanti	Deputy Managing Director	SFH
Nigeria	Kayode Afolabi	Director, Reproductive Health	FMOH
Nigeria	Lawrence Anyanwu	Deputy Director, Population Programme	FMOH
Nigeria	Lekia Nwidae	Senior Analyst	CHAI
Nigeria	Olajimi Latunji	Program Officer	John Snow, Inc.
Nigeria	Rodio Diallo	Senior Program Officer, Family Planning	Gates
Nigeria	Sada Danmusa	CEO	M-Space

Pakistan	Akhtar Rashid	Technical Advisor	Government of Punjab
Pakistan	Fauzia Assad	Country Director	Jhpiego
Pakistan	Mohiuddin Mohammad	Project Director- Family Planning	RIZ Consulting
Pakistan	Muhammad Iqbal	Secretary to Government of the Punjab	Government of Punjab
Pakistan	Muhammad Rafiq	Technical Specialist	UNFPA
Pakistan	Roshan Fida	Technical Advisor-Family Planning	RIZ Consulting
Pakistan	Syed Azmat	Chief Technical Officer	Greenstar Social Marketing Pakistan
Pakistan	Talib Lashari	Focal Person FP2020 Working Group/Technical Advisor to the CIP secretariat	Government of Sindh
Rome	Daniele Russo	Director, Global Health Partnerships	Pfizer
Senegal	Adama Faye	Executive Director	ADEMAS
Senegal	Adjaratou Sow Diallo	Economiste de la sante	MOH
Senegal	Alain Kabore	Regional Technical Advisor	PATH
Senegal	Aminatou Sar		PATH
Senegal	Awa Dieng	Country Program Manager	Abt Associates
Senegal	Coudou Sow	Social Marketing Advisor	ADEMAS
Senegal	Dominique Gomis	Sociologist	UNFPA/WCARO
Senegal	Farmata Seye		PATH
Senegal	Fatimata Sy	Senior Health Advisor	CIFF
Senegal	Fatou Diaw		UNFPA
Senegal	Fatou Sarr	Conseillère technique/ Santé maternelle néonatale et infantile	IntraHealth
Senegal	Fatou Ndiaye	Senior Maternal Child Health and Family planning Specialist	USAID
Senegal	Fenosa A. Ratsimanetrimanana	Family Planning Advisor	UNFPA/WCARO
Senegal	Hawa Talla	Director- The Challenge Initiative Francophone West Africa	Intrahealth
Senegal	Ida Ndione	Project Manager	Path
Senegal	Khady Seck	Coordonnatrice	MOH

Senegal	Lala Sow	Direction de la Sante	Direction de la Sante, de la Mere et de l'Enfant
Senegal	Louise Coskeran	Reproductive Health and Demography Representative	DFID
Senegal	Mareme Ndiaye	Division Chief, Direction of Family Planning (DSME/DPF)	MOH
Senegal	Mareme Dabo	Technicienne superieur en enseignement administration	MOH
Senegal	Marie Ba	Deputy Director	Ouagadougou Partnership
Senegal	Maymouna Ba		PATH
Senegal	Mbayam Gueye	Country Brand Manager	Pfizer
Senegal	Ndeye Magatte Diop		MOH
Senegal	Ndiaye Sene	Midwife	MOH
Senegal	Norbert Coulibaly	Senior Technical Manager	Ouagadougou Partnership
Senegal	Salimata Cisse		MSI
Senegal	Serigne Kane	M&E Manager	Abt Associates
Senegal	Soda Niang	Coordinate/PF	UNFPA/WCARO
Switzerland	Petrus Steyn	Scientist	WHO
Tanzania	Ninabina Kitururu	Member	IYAFP
Togo	Anita Eklu	Technicienne supérieure de santé gestionnaire projet Distribution à Base Communautaire	ATBEF
Togo	Dédé Ajavon	Gynécologue obstétricienne	MOH
Togo	Kossivi Kanyi	Gynecologue-obstetricien	MOH
Togo	Nabissan Kenkou	Medical Director	Santé Intégrée
Togo	Yaba Essien	Chargée DMPA-SC	Jhpiego
Uganda	Allen Namagembe	M&E Officer	PATH
Uganda	Christopher Arineitwe	Senior Technical Advisor - Family Planning	FHI 360
Uganda	Faridah Luyiga	Regional Communication Advisor	WRA
Uganda	Fiona Walugembe	Country Coordinator	PATH
Uganda	George Barigye	Regional Technical Advisor	PATH
Uganda	Joy Batusa	Associate Director	CHAI

Uganda	Lillian Sekabembe	Director Programs	PSI
Uganda	Livingstone Makanga	Assistant Commissioner of Infant and Reproductive Health	MOH
Uganda	Placid Mihayo	Senior Consultant O&G/Family Planning Focal Person	MOH
Uganda	Thomas Obua	Senior Pharmacist	MOH
UK	Emma Foster	Senior Programme Manager	DFID
UK	Matthew Rehrig	Director	CIFF
UK	Raveena Chowdhury	Head of CIFF Projects	MSI
UK	Shanzeh Mahmood	Analyst, Adolescent Sexual Health	CIFF
UK	YuHsin Huang	Senior Technical Advisor for Comprehensive Service Delivery	IPPF
USA	Ann-Marie Yongho		John Snow, Inc.
USA	Beth Balderston		PATH
USA	Beth Frederick	Senior Associate, Executive Director, Advance Family Planning	Johns Hopkins University
USA	Bhavya Gowda		PATH
USA	Carmit Keddem		John Snow, Inc.
USA	Catherine Packer	Research Associate II	FHI360
USA	Chloe Morozoff		PATH
USA	Clea Finkle	Program Officer	Gates
USA	Dana Aronovich		John Snow, Inc.
USA	Holly Burke	Scientist	FHI360
USA	Jane Cover		PATH
USA	Jane Feinberg		John Snow, Inc.
USA	Jen Drake		PATH
USA	Julie Heinsen		PATH
USA	Kaitlin Christenson		PATH
USA	Katie Gray		PATH
USA	Kelsey Holt	Assistant Professor	UCSF
USA	Kimberly Cole	Technical Advisor	USAID
USA	Laila Akhlaghi		John Snow, Inc.
USA	Lila Cruikshank	Consultant	GIA
USA	Marty Mukasa		PATH
USA	Martyn Smith	Managing Director	FP2020

USA	Maryjane Lacoste	Senior Program Officer, Family Planning	Gates
USA	Megan Christofield	Technical Advisor	Jhpiego
USA	Megan Shawcross		PATH
USA	Navita Jain	Senior Program Manager	AVAC
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USA	Rachel Simon		John Snow, Inc.
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USA	Roy Jacobstein	Global Technical Lead for FP	IntraHealth
USA	Saad Abdulmumin	Senior Epidemiologist and RH Advisor	USAID
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Zambia	Chilufya Kasanda	Project Coordinator	TALC
Zambia	Dyness Chinyama	Chief Safe Motherhood Officer	MOH
Zambia	Gertrude Nanyangwe	Registered Nurse	MOH
Zambia	Gina Smith	Acting Country Representative/Chief of Party SARAI	PSI/SFH
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Zambia	Thandiwe Sibulinjase		PATH