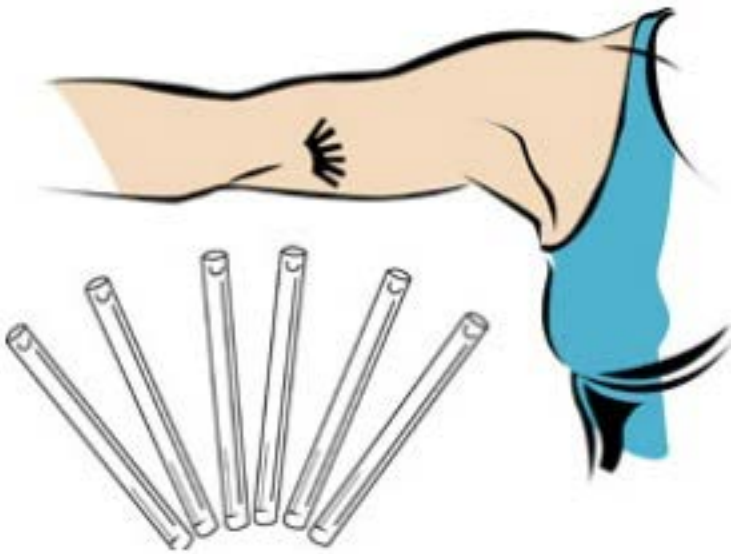
Women’s movement on Norplant

Naripokkho

- **Norplant – background**
- **Our movement**
- **Norplant – current status**
- **Human rights perspective**

Norplant I

Consists of six silicon capsules/rods containing levonorgestrel



Levonorgestrel is a synthetic progestin it alters the cervical mucus to prevent penetration by sperm; inhibits ovulation; and alters the lining of the uterus to prevent implantation

Norplant is implanted in a woman's body, just under the skin in the arm through a minor incision. Removal also requires minor surgery - incision

Side effects

- Irregular menstrual bleeding, Lack of menstruation, spotting
- Stomach upset, cramps, nausea
- Headache
- Acne
- Change in appetite
- Seating
- Weight gain

Contact doctor if -

- Irritation at insertion site – pain, redness and warmth
- Changes in vision
- Depression
- Swelling of feet and ankles
- Yellowness of eyes or skin, pale stools, dark urine

History of Norplant globally

- Norplant was approved by the FDA in 1990
- By 1996, over 6,000 complaints of “adverse medical consequences” had been filed by American women who were suffering from various Norplant-related ailments, from heavy bleeding and vision impairment to general malaise and lack of appetite.
- Some women overseas became blind and were bedridden
- In 1996 a media campaign was launched against Norplant, advising American women who were suffering serious side effects from the device to contact legal counsel. A “citizen’s petition” with the FDA to have Norplant taken off the market.
- The manufacturer, Wyeth-Aherst, in 2002 reached an out-of-court settlement with the victims and took Norplant I off the market in the U.S
- But Wyeth-Aherst continued to manufacture, and USAID continued to purchase, millions of Norplant I to use on women in the developing world.
- USAID finally ended its contract with the manufacturer in 2006.

Women’s movement on Norplant - Naripokkho

Naripokkho's approach to reproductive technologies including contraceptives

- Not against reproductive technologies but quite the reverse
- Putting women first – family planning is a national priority but it cannot take precedence over a woman's overall health
- Women's reproductive needs are not isolated from her overall health needs – holistic approach to contraceptive devices and services so that women are treated not just as reproductive beings
- Women need contraception – ones that suit her body and her needs and therefore full information, counselling and related services are essential

Naripokkho and Norplant

- 1989 campaign with Norplant started – it was around health systems delivery
- 1990 interviews with five women with complications from Norplant and 4 of whom were refused removal conducted
- 1990 Holiday newspaper article detailing these case reports – *Family Planning at the Cost of Women's Health*
- USAID investigation through an independent study started – into the study trial that was being conducted
- Technical committee formed for this - Naripokkho was a member

Independent study findings

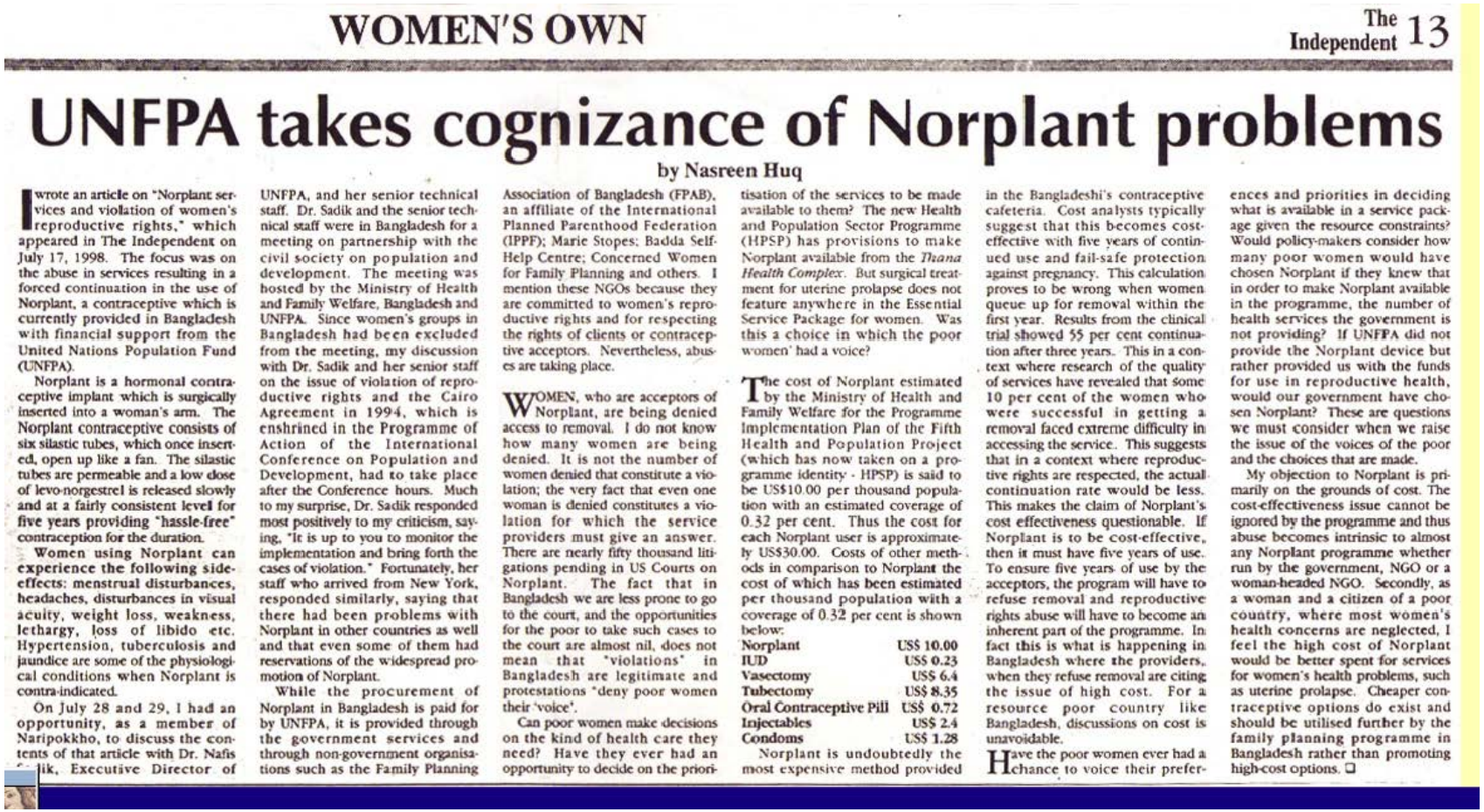
- 17% of women who accepted Norplant knew of side effects
- 15% of women knew that Norplant could be removed on request
- Most physicians and counsellors did not know about complications and contraindications of Norplant

Outcome

- GoB declared that removal was a right of the client

Further actions and findings

1994 Meeting with UNFPA executive Director Dr. Nafis Sadik who suggested monitoring Norplant services



UNFPA takes cognizance of Norplant problems

by Nasreen Huq

I wrote an article on "Norplant services and violation of women's reproductive rights," which appeared in The Independent on July 17, 1998. The focus was on the abuse in services resulting in a forced continuation in the use of Norplant, a contraceptive which is currently provided in Bangladesh with financial support from the United Nations Population Fund (UNFPA).

Norplant is a hormonal contraceptive implant which is surgically inserted into a woman's arm. The Norplant contraceptive consists of six silastic tubes, which once inserted, open up like a fan. The silastic tubes are permeable and a low dose of levo-norgestrel is released slowly and at a fairly consistent level for five years providing "hassle-free" contraception for the duration.

Women using Norplant can experience the following side-effects: menstrual disturbances, headaches, disturbances in visual acuity, weight loss, weakness, lethargy, loss of libido etc. Hypertension, tuberculosis and jaundice are some of the physiological conditions when Norplant is contra-indicated.

On July 28 and 29, I had an opportunity, as a member of Naripokkho, to discuss the contents of that article with Dr. Nafis [illegible]lik, Executive Director of UNFPA, and her senior technical staff. Dr. Sadik and the senior technical staff were in Bangladesh for a meeting on partnership with the civil society on population and development. The meeting was hosted by the Ministry of Health and Family Welfare, Bangladesh and UNFPA. Since women's groups in Bangladesh had been excluded from the meeting, my discussion with Dr. Sadik and her senior staff on the issue of violation of reproductive rights and the Cairo Agreement in 1994, which is enshrined in the Programme of Action of the International Conference on Population and Development, had to take place after the Conference hours. Much to my surprise, Dr. Sadik responded most positively to my criticism, saying, "It is up to you to monitor the implementation and bring forth the cases of violation." Fortunately, her staff who arrived from New York, responded similarly, saying that there had been problems with Norplant in other countries as well and that even some of them had reservations of the widespread promotion of Norplant.

While the procurement of Norplant in Bangladesh is paid for by UNFPA, it is provided through the government services and through non-government organisations such as the Family Planning Association of Bangladesh (FPAB), an affiliate of the International Planned Parenthood Federation (IPPF); Marie Stopes; Badda Self-Help Centre; Concerned Women for Family Planning and others. I mention these NGOs because they are committed to women's reproductive rights and for respecting the rights of clients or contraceptive acceptors. Nevertheless, abuses are taking place.

WOMEN, who are acceptors of Norplant, are being denied access to removal. I do not know how many women are being denied. It is not the number of women denied that constitute a violation; the very fact that even one woman is denied constitutes a violation for which the service providers must give an answer. There are nearly fifty thousand litigations pending in US Courts on Norplant. The fact that in Bangladesh we are less prone to go to the court, and the opportunities for the poor to take such cases to the court are almost nil, does not mean that "violations" in Bangladesh are legitimate and protestations "deny poor women their 'voice'".

Can poor women make decisions on the kind of health care they need? Have they ever had an opportunity to decide on the prioritisation of the services to be made available to them? The new Health and Population Sector Programme (HPSP) has provisions to make Norplant available from the *Thana Health Complex*. But surgical treatment for uterine prolapse does not feature anywhere in the Essential Service Package for women. Was this a choice in which the poor women had a voice?

The cost of Norplant estimated by the Ministry of Health and Family Welfare for the Programme Implementation Plan of the Fifth Health and Population Project (which has now taken on a programme identity - HPSP) is said to be US$10.00 per thousand population with an estimated coverage of 0.32 per cent. Thus the cost for each Norplant user is approximately US$30.00. Costs of other methods in comparison to Norplant the cost of which has been estimated per thousand population with a coverage of 0.32 per cent is shown below:

Norplant	US$ 10.00
IUD	US$ 0.23
Vasectomy	US$ 6.4
Tubectomy	US$ 8.35
Oral Contraceptive Pill	US$ 0.72
Injectables	US$ 2.4
Condoms	US$ 1.28

Norplant is undoubtedly the most expensive method provided in the Bangladeshi's contraceptive cafeteria. Cost analysts typically suggest that this becomes cost-effective with five years of continued use and fail-safe protection against pregnancy. This calculation proves to be wrong when women queue up for removal within the first year. Results from the clinical trial showed 55 per cent continuation after three years. This in a context where research of the quality of services have revealed that some 10 per cent of the women who were successful in getting a removal faced extreme difficulty in accessing the service. This suggests that in a context where reproductive rights are respected, the actual continuation rate would be less. This makes the claim of Norplant's cost effectiveness questionable. If Norplant is to be cost-effective, then it must have five years of use. To ensure five years of use by the acceptors, the program will have to refuse removal and reproductive rights abuse will have to become an inherent part of the programme. In fact this is what is happening in Bangladesh where the providers, when they refuse removal are citing the issue of high cost. For a resource poor country like Bangladesh, discussions on cost is unavoidable.

Have the poor women ever had a chance to voice their preferences and priorities in deciding what is available in a service package given the resource constraints? Would policy-makers consider how many poor women would have chosen Norplant if they knew that in order to make Norplant available in the programme, the number of health services the government is not providing? If UNFPA did not provide the Norplant device but rather provided us with the funds for use in reproductive health, would our government have chosen Norplant? These are questions we must consider when we raise the issue of the voices of the poor and the choices that are made.

My objection to Norplant is primarily on the grounds of cost. The cost-effectiveness issue cannot be ignored by the programme and thus abuse becomes intrinsic to almost any Norplant programme whether run by the government, NGO or a woman-headed NGO. Secondly, as a woman and a citizen of a poor country, where most women's health concerns are neglected, I feel the high cost of Norplant would be better spent for services for women's health problems, such as uterine prolapse. Cheaper contraceptive options do exist and should be utilised further by the family planning programme in Bangladesh rather than promoting high-cost options. ❑

Findings from Interviews with 60 Norplant Acceptors:

- Improvement in access to removal
- Counselling cursory
- Inadequate information provided to clients
- Variable quality of health check ups
- Serious side effects such as blurring of vision and dizziness often ignored. Services providers response to side effects were limited to providing assurance and nutritional advice
- Inadequate training on insertion and removal
- Negative attitude of providers

Current status – Norplant II

- **Implants are available from three main manufacturers,**
  - **Bayer Pharma AG (Germany)**
  - **Merck/MSD Inc (USA)**
  - **Shanghai Dahua Pharmaceuticals Co., Ltd (China)**

- **The most common types include**
  - **Jadelle (two rods each containing 75 mg of levonorgestrel, effective for five years)**
  - **Sino-implant (II), which is currently marketed under various trade names including Zarin, Femplant and Trust (two rods each containing 75 mg of levonorgestrel, effective for at least four years)**
  - **Implanon and Nexplanon (both with one rod containing 68 mg of etonogestrel, effective for three years).**

Jadelle

- Jadelle has been approved by FDA to be effective for 5 years in November 2002
- Is the successor to Norplant I and has replaced the contract with USAID since January 2007

WHO Essential Medicines list (2011)

Implants specified as the two- rod levonorgestrel-releasing implant, each rod containing 75 mg of levonorgestrel (150 mg total) are included

One rod implants are still not included

- ***It is crucial that policymakers, donors and service delivery groups work together to guarantee that women have access to reliable, affordable implant removal services.***
- **This includes**
  - **providing information about removal services at the time of insertion;**
  - **ensuring adequate training of providers and sufficient commodities to support same-day removals when requested;**
  - **establishing adequate referral systems especially for women who receive implants through mobile services or community-based programmes.**

Use of human rights to meet the unmet need for family planning

Jane Cottingham, Adrienne Germain, Paul Hunt
Lancet 2012

crucial importance of accountability of states: priorities for making family planning available that are mandated by human rights.

Panel: Priority measures required by human rights standards and principles for governments to eliminate the unmet need for family planning

National and sub-national plans for sexual and reproductive health education, information, and services, including family planning
Design plans, through a participatory process, to provide universal access (not only for married but also for unmarried people, adolescents, others marginalised by income, occupation, or other factors); to encompass all appropriate public, private, national, and international actors; and to include certain features, such as objectives and how they are to be achieved, timeframes, a detailed budget, financing, reporting, indicators, and benchmark measures[70]

Removal of legal and regulatory barriers
Remove barriers that impede access to sexual and reproductive health education, information, and services, including family planning, particularly by disadvantaged groups[42]

Commodities
Make available the widest feasible range of safe and effective modern contraceptives, including emergency contraception, as enumerated in a national List of Essential Medicines based on the WHO Model List and delivered through all appropriate public and private channels[25,49]

Community-based and clinic-based health workers
Train adequate numbers of health workers who are skilled and supervised to provide good quality sexual and reproductive health services, including full and accurate contraceptive information and modern contraceptives, using the local language and exercising respect for privacy, confidentiality, diversity, and other basic ethical and human rights values[25]

Health facilities
Provide health facilities that are clean, provide seating and privacy for user–provider interaction, are adequately stocked and equipped,[25] adhere to published hours of services, and inform users of their rights

Financial access
Provide state subsidies and community insurance schemes to allow access for people who would not otherwise be able to afford services[25,94]

Monitoring and accountability
Establish mechanisms that provide effective, accessible, transparent, and continuous review of the quality of services; assess progress toward equitable access and other objectives; and check that the commitments of all stakeholders are met[5,71]

Whose unmet need?

- **The human rights principle of non-discrimination leads us to examine who is included in prevailing definitions of unmet need by policy makers, programme managers, service providers, and demographers.**
- **The sources used to estimate unmet need generally include only married or cohabiting women of reproductive age who do not want to become pregnant, but who are not currently using a modern method of contraception.**
- **However, as data have become available from some countries for sexually active unmarried women, the most recent unmet need estimates include unmarried women. About 215 million women in developing countries are estimated to have an unmet need for family planning**

Thank you