



Reintroducing the IUD in Kenya

Background

Between 1978 and 1998, the proportion of married Kenyan women using modern contraceptive methods rose from only 9 percent to 39 percent. However, use of the intrauterine device (IUD) – one of the most reliable and cost-effective methods – dropped from 31 percent of the modern method mix in 1984 to about 8 percent in 2003. At the same time, Kenyan women began to rely almost exclusively on short-term methods, and today, more than 70 percent of women using modern contraception are using injectables or pills.

At the turn of the 21st century, the Kenya Ministry of Health (MOH) was facing several challenges to its reproductive health program. An increased number of Kenyans were entering reproductive age and requiring services, furthering demand for contraceptives. Faced with the HIV/AIDS pandemic, donors decreased funding for reproductive health and contraceptive commodities. Pressure emerged for Kenya, like many developing countries, to fund the purchase of commodities from its national budget. The Kenya MOH was also interested in finding the most sustainable approach to its family planning program, while addressing this imbalance in the contraceptive method mix.

Ministry officials were encouraged by emerging global findings on the safety of IUDs, including research conducted in Kenya on the safety of IUDs for HIV-positive women. So, in 2001, the Kenya MOH collaborated with several other local and international partners and launched an initiative to promote increased client choice and a balanced and sustainable family planning program by reintroducing the IUD into the Kenyan method mix.

The Kenya MOH's partners on the IUD reintroduction initiative included: Africa Population Advisory Committee; John Snow, Inc.'s DELIVER project; the EngenderHealth-led AMKENI consortium; Family Health International; Family Planning Association of Kenya; Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ); PRIME Project of IntraHealth International, Inc.; JHPIEGO; Maendeleo Ya Wanawake Organization; Marie Stopes International; the Population Council; the U.S. Agency for International Development (USAID); the Department of Obstetrics and Gynaecology, University of Nairobi; and several Kenyan healthcare professional organizations, including the Kenya Obstetrical and Gynaecological Society, Nursing Council of Kenya, Kenya Clinical Officers Association,

National Nurses Association of Kenya, and the Kenya Medical Association.

By February 2003, the initiative was officially launched with three major objectives:

- Increase support for the IUD among policy-makers, health care professionals, and clients
- Increase the provision of quality IUD services
- Enhance demand for IUDs

Best Practices

Reintroduction of the IUD as part of a balanced and sustainable contraceptive mix in Kenya was spearheaded by the Ministry of Health, which provided political commitment and leadership. The effort involved national education and advocacy efforts as well as targeted community outreach and capacity building in pilot health facilities served by the AMKENI bilateral project in Western and Coast provinces. The holistic reintroduction process aimed to address the many factors that hinder access to and use of the IUD by building consensus at the national level, assessing client and provider knowledge, training providers, strengthening service delivery, reaching clients and communities, and improving logistics. The Kenya effort has provided adaptable lessons learned for other African countries.

Assessments

The reintroduction initiative was based on a solid understanding of client and provider knowledge, attitudes, and practices. In 1995, FHI researchers conducted an assessment to collect detailed information about clients' attitudes toward IUDs, knowledge of the method, and their use of IUDs or other family planning methods. The assessment also included provider interviews and observations at service delivery clinics to assess both provider perspectives on the IUD and service quality.

The assessment revealed a number of reasons for the steady decline in IUD use: poor quality of care, clients' and providers' fears about HIV acquisition or transmission during insertion, other safety concerns and misconceptions, provider bias, shifting client preferences, and a decline in health infrastructure. Over the years, assessments in other countries have revealed similar results; this local information contributes greatly to stakeholder involvement and buy-in.

Training

FHI's assessment also found that a lack of up-to-date pre- and in-service training left many providers ill-prepared to offer IUDs to their clients. Therefore, the national reproductive health training curriculum was updated and used to train 171 public- and private-sector family planning service providers in IUD counseling, insertion, and removal over the two-year period. Members of the MOH's recently formed decentralized training and supervision teams at the provincial and district levels also received training so that they could support IUD reintroduction.

Service delivery

During the reintroduction effort, the MOH and AMKENI deployed decentralized reproductive health training and supervision teams to provide supportive supervision to pilot health facilities in Coast and Western provinces where AMKENI worked. Their goal was to ensure that facilities were well prepared -- with sufficient training, commodities, and supplies -- to offer clients a full range of contraceptive options, including the IUD. In addition to building capacity at facilities where IUD services were already available, reintroduction partners also provided training, equipment, and supplies to increase the number of AMKENI-supported health facilities that are able to offer IUDs to their clients. A standard IUD kit endorsed by the MOH was distributed to AMKENI-supported facilities. Prior to the intervention (2001), only 18 of the AMKENI-supported sites had the capacity to provide IUDs; by 2003, this number increased to 68.

In addition to improving service delivery capacity, FHI and local partners field-tested a new IUD screening tool or “checklist” in Kenya as part of IUD reintroduction, to help providers determine quickly and easily whether their clients are medically eligible to use the IUD. The job aid has now been endorsed by the Kenya MOH and will be implemented in trainings and disseminated to service delivery sites as needed.

Policies and Guidelines

By 2004, the Kenya Family Planning Guidelines for Service Providers was out of date and included old information on the IUD. Revised guidelines incorporated changes from the World Health Organization’s new (2004) criteria for contraceptive use, which expanded eligibility for IUDs. The new national guidelines were printed in 2005 and dissemination is ongoing.

Marketing, Communication, and Advocacy

Research findings pointed to the need to address provider and client bias and misinformation about IUDs. The Kenya IUD reintroduction addressed this at several levels.

First, a national advocacy effort was undertaken to educate policy-makers, program managers, and providers. FHI, the MOH, and partners worked with all the major medical professional associations in Kenya to develop a package of advocacy and information briefs geared toward policy-makers and providers. These briefs were distributed to more than 2,600 providers, health facility managers, and policy-makers, 400 of whom attended district-level IUD reintroduction meetings hosted by the MOH. To raise public awareness around Nairobi, a radio call-in show featuring IUD advocates and satisfied users was organized.

Second, provider sensitization efforts were undertaken, the goal of which was to raise awareness among providers regarding the family planning and reproductive health context in Kenya, current trends, and the new WHO Medical Eligibility Criteria updates. Evidence-based information on the IUD, and the MOH’s IUD reintroduction strategy were also highlighted. These efforts reached both the private and public sector and were conducted

as professional development/continuing medical education sessions at the provincial and national level. Eighty three trainers from 39 training institutions, 235 private-sector providers, and 367 public sector providers were reached.

Third, at the facility level, AMKENI held IUD reintroduction orientation meetings for all staff in conjunction with provider training on IUD insertion and removal. Once improved services were in place, a communication campaign was implemented to increase local demand for IUDs by dispelling myths and informing potential clients about the benefits of the method. The campaign relied on AMKENI's 500 behavior change communication (BCC) agents – mostly volunteers living in their communities – who were trained to provide information about IUDs. These agents reached almost 12,000 people through meetings with village health communities, women's groups, men at worksites, youth groups, and families. Their efforts were reinforced by the distribution of 21,000 copies of two brochures: one on the IUD and one about all modern family planning methods.

Finally, an operations research project was initiated to test the effect of academic detailing on provider perspectives of and client interest in the IUD. Unfortunately, as measured by IUD uptake, detailing seemed to have no or little effect.

Logistics

AMKENI distributed nearly 600 kits for IUD insertion and removal to trained providers and continues to work with the USAID-supported DELIVER project of John Snow Inc. to ensure that sufficient numbers of IUDs and related supplies are available at facilities. Nevertheless, ensuring reliable supplies remains a challenge. Reliance on shifting levels of donor support, unreliable transportation for delivering supplies, and facilities' failure to maintain a supply buffer and keep adequate records all pose logistical difficulties. Yet, there is political commitment to ensuring access to contraceptives; recently the Kenya government approved a line item in the national budget for family planning commodities and supplies.

Results

Reintroduction advocacy efforts raised awareness about IUDs as part of a balanced method mix for family planning among policy-makers, program managers, health providers, and potential clients throughout Kenya. At the same time, training and other activities to build capacity in IUD service provision improved contraceptive access and the overall quality of services at the 97 facilities supported by AMKENI in Coast and Western provinces.

At the AMKENI facilities, the number of IUD acceptors per quarter rose from 151 in early 2003 to 373 in early 2005, for a cumulative total of about 2,800 new users in two years. The largest jump in IUD uptake – an 80 percent increase over the previous quarter's total -- occurred in the three months after an intensive community education program by BCC agents.

FHI continues to work with AMKENI to monitor IUD uptake in the project sites. The full extent of national-level advocacy and the updated national training curriculum will not be known until the next Kenya Demographic and Health Survey in 2008.

Meanwhile, IUD reintroduction activities that were built into existing services and training programs continue. The reintroduction project has been rolled into Kenya's Implementing Best Practices initiative, through which the MOH and its partners will continue family planning advocacy, provide contraceptive technology updates to service providers, and train providers in logistics and commodities management. USAID is supporting expansion of IUD activities to other provinces through the ACQUIRE project (managed by EngenderHealth), and Marie Stopes/Kenya is working with 185 private providers in two provinces to expand access to IUDs. Several other countries –including Ghana, Ethiopia, and Uganda – have considered adapting aspects of Kenya's program to help revitalize interest in the IUD and other long-term contraceptive methods.