

*Translating Research  
into Practice:  
Reintroducing the IUD  
in Kenya*

by Family Health International  
in collaboration with  
the Kenya Ministry of Health



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## INTRODUCTION

Despite the intrauterine device's (IUD's) safety, effectiveness, convenience, and low cost, the percentage of contracepting women in Kenya who use the IUD dropped from 31 percent to 2.5 percent since the 1980s. Factors contributing to the decline include provider bias, fear of HIV transmission, and myths and rumors among clients. Instead of selecting the IUD—if they actually were offered the method—Kenyan women began relying more heavily on oral contraceptives and injectables.

This underutilization of the IUD and other longer-acting and permanent contraceptive methods became a cause of concern to the Kenyan government and health policy-makers. At the same time, misconceptions about the IUD and concerns about the time and skill required to offer it diminished its appeal among providers, ultimately limiting women's access to a full range of contraceptive options. Overreliance on relatively expensive methods burdens the country's family planning program, which already faced budget cuts as limited resources were increasingly directed toward HIV/AIDS programs.

Family Health International (FHI), with support from the U.S. Agency for International Development (USAID), undertook studies to determine the causes of the IUD's decline in Kenya as well as the safety of the method for HIV-infected women. With the results of this research in hand, the Kenya Ministry of Health (MOH)—with FHI and other partners—initiated an effort to revitalize the IUD as one component of a balanced and sustainable contraceptive method mix.

This report succinctly documents the process of building consensus among numerous stakeholders and developing and implementing the reintroduction strategy. It summarizes successes, challenges, and lessons learned at each step. The document is not intended to provide exhaustive detail, but rather to highlight key actions and milestones.

## BACKGROUND

### Family Planning in Kenya

Kenya's family planning program made great strides between the late 1970s and late 1990s. By 1998, 32 percent of reproductive-aged women used modern contraceptive methods, and the average number of births had dropped from 8.1 to 4.7 per woman.

Today, despite these successes and a strong commitment by the government to provide quality reproductive health services, the country's family planning program still faces numerous challenges.

Funding for family planning has decreased as more

resources have been allocated to HIV/AIDS programs, and diminished emphasis on family planning has begun to take its toll. According to the 2003 Kenya Demographic and Health Survey (KDHS), for instance, contraceptive prevalence has plateaued and the total fertility rate has increased slightly. One-quarter of Kenya's married women still have an unmet need for family planning, and about one-half the population is under 15 years old. The millions of these young people who will reach reproductive age each year will place added burden on the country's reproductive health program. At the same time, contraception is recognized as a key strategy in preventing mother-to-child transmission of HIV/AIDS, creating further need for accessible, affordable family planning services.

While already-limited health resources are increasingly being used to address the HIV/AIDS epidemic, expensive and short-term family planning methods like injectables and oral contraceptives have come to dominate the contraceptive mix in Kenya. In 1984, the IUD, which is one of the safest and most cost-efficient methods, made up 30.9 percent of the modern method mix. That number dropped to 7.6 percent in 2003 (KDHS and Population Reference Bureau).

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*"We saw that the contraceptive mix in Kenya had become unbalanced, that long-term and permanent methods were losing ground."*

—Professor Joseph Karanja,  
Kenya Obstetrical and Gynaecological Society  
(KOGS) Chairman, 2000-2004

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## Why IUD Use Declined

Family Health International assessed IUD service delivery in Kenya and found several causes for the steady decline of the method: poor quality of care, fear of HIV acquisition and transmission, poor product image, provider bias, shifting client preferences, and decline in health infrastructure.

### Poor quality of care

- Providers were misinformed about contraindications for IUD use and its advantages and disadvantages.
- Nonmenstruating clients who were not pregnant were denied service.
- Limited clinic hours and heavy workload did not allow providers enough time to spend with clients.

### Fear of HIV acquisition and transmission

- Providers worried about contracting HIV from clients or spreading it from one client to another.
- Clients were concerned about being infected with HIV during IUD insertion.

### Poor product image

- Misinformation—such as the idea that an IUD can move around the body or be dislodged during sex—discouraged clients from using the IUD.

### Provider bias

- Health care workers perceived that providing the IUD required much more time than other methods. Paradoxically, despite their biases, many providers choose the IUD for themselves.
- Lack of up-to-date pre-service and in-service training left providers ill prepared to offer IUDs.
- Because the method had been falling out of favor among clients, even providers who at one time had been trained to insert IUDs were no longer confident in their skills.

### Shifting client preferences

- Longer-acting and permanent contraceptive methods declined in popularity.

### Decline in health infrastructure

- IUD insertion and removal requires more up-front investment than do injectables and pills—investment in training, supervision, infection prevention, instruments, and supplies—and health

facilities sometimes lacked even private rooms for clients. Failure of the health care infrastructure to consistently provide clinics with IUD commodities and supplies made it difficult for providers to offer the IUD and easier for them to provide injectables.

## What's Good About the IUD?

Despite persistent rumors about the IUD's safety, research-based evidence from studies conducted in Kenya indicates that the method is very safe, highly effective, an important option for some HIV-positive clients, and relatively low cost.

### The IUD is very safe

- When inserted in women who do not have cervical infection, the risk of IUD-related complications is extremely low.
- Perforation of the uterus or cervix is possible during insertion, but it is extremely rare and can be minimized further when providers are well trained in insertion techniques.
- Trained health care providers are at very low risk of being infected with HIV during IUD insertion or of transmitting HIV from an infected to an uninfected client.
- The IUD can be used safely by women for whom hormonal methods are not an option.
- The risk of pelvic inflammatory disease that can be attributed to the IUD is almost negligible. The presence of a sexually transmitted infection at the time of insertion, not the IUD itself, increases the risk of pelvic inflammatory disease.

### The IUD is highly effective

- Fewer than 1 percent of IUD users become pregnant during the first year of typical use.
- The IUD has been compared to female sterilization in its efficacy, but it is completely reversible.
- The IUD requires no daily decision or action on the user's part to ensure contraceptive effect.

### The IUD is an important option for some HIV-positive clients

- Where trained providers and clinical resources are available, the IUD can be an appropriate choice for HIV-positive women, although careful follow-up may be required.

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*“Revitalizing the IUD and bringing it back to its rightful place in the method mix is a noble cause. It’s a very effective method and cost-effective for both clients and the nation.”*

—Dr. F.X.O. Odawa, OB/GYN  
lecturer, University of Nairobi

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- HIV-positive women seem to have no greater risk of IUD-related complications than do HIV-negative users.
- Because of the health risks associated with pregnancy, it is safer for HIV-positive women to use the IUD than to use no method. However, dual method use is recommended to prevent transmission of HIV to partners or infection with a different strain of HIV.

### **The IUD is a convenient and low-cost method for women and for the health care system**

- When all program costs and the length of time each method will protect a woman from pregnancy are taken into account, the IUD proves to be the most cost-effective contraceptive method for the health care system.
- While IUD clients in Kenya may pay a higher “start-up” cost, over a period of two or more years the IUD is far more economical for clients than are pills or injectables, which require many more return visits and frequent resupply.

### **Promoting the IUD as Part of a Balanced Method Mix**

Given that the IUD had proven to be safe, effective, and affordable, Kenya’s Ministry of Health (MOH)—in an effort to meet growing need under the constraints of shrinking resources—initiated an effort to reintroduce the IUD as part of a balanced and sustainable contraceptive method mix. This reintroduction effort was supported by the U.S. Agency for International Development (USAID) through the Contraceptive Technology Research agreement with FHI and implemented by the MOH with support from partners including the EngenderHealth-led AMKENI project, JHPIEGO, the U.K. Department of International Development (DFID), Kenya Obstetrical and Gynaecological Society (KOGS), Family Planning Association of Kenya (FPAK), Gesellschaft für Technische Zusammenarbeit (GTZ), PRIME/IntraHealth International, the Africa Population Advisory Committee, and the Population Council.

## IDENTIFYING ISSUES AND BUILDING CONSENSUS

The process of identifying factors that affect IUD use and building consensus among stakeholders occurred in several steps over the course of about two years:

- In early 2001, the MOH and FHI hosted a panel session at the annual meeting of the Kenya Obstetrical and Gynaecological Society (KOGS) to discuss the state of the IUD in Kenya. The members agreed there was a need to convene a meeting of stakeholders to continue this discussion.

- Several months later, FHI organized the stakeholders meeting, which brought together government leaders, representatives from nongovernmental organizations, and providers. The meeting served as a venue to present the most current research in IUDs and discuss a way forward. The stakeholders' proposal to form the IUD Task Force was adopted by the MOH.


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*“The teamwork has been wonderful. It’s not so much a competition as a synergy among partners who have different areas of expertise.”*

—Professor Joseph Karanja,  
KOGS Chairman, 2000-2004

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- In March 2002, the task force—with the MOH as chair and FHI as secretariat—met for the first time to develop a reintroduction strategy and work plan. In quarterly meetings, the group developed a work plan outlining goals and objectives, activities, indicators of success, and a timeline.
- The national strategy was launched at the annual conference of the East, Central, and Southern African Association of Obstetrical and Gynaecological Societies (ECSAOGS).
- The IUD Task Force transitioned to a more streamlined implementing body, which adopted a systematic approach of quarterly meetings and regular progress reports. This group was



composed of representatives from the MOH (lead), FHI, AMKENI, JHPIEGO, and several medical professional associations.

### ***Challenges, Successes, and Lessons Learned***

- Ownership, commitment, and leadership by the Ministry of Health proved invaluable in bringing other stakeholders to the table.
- The KOGS and ECSAOGS meetings resulted in the support of many of the country's leading reproductive health scientists and family planning providers, who have significant influence on research, policy, and service delivery.
- The collaborative process of developing the work plan was challenging and time-consuming, as is the case when any document is written by consensus. However, teamwork was essential in breaking down the project into distinct activities and securing commitment by the partners to carry them out.
- Finding the right combination of partner organizations—each with its own capabilities and complementary programs—was crucial, since partners were requested to incorporate activities into their own existing work plans without receiving additional funding.
- The scope of the reintroduction strategy included a general revitalization of family planning in Kenya, with specific focus on the IUD.

## IMPLEMENTING THE STRATEGY

The IUD reintroduction strategy consisted of four general categories of activities:

- Advocacy and sensitization
- Capacity building and service delivery
- Demand creation
- Monitoring and evaluation and operations research

### Advocacy and Sensitization

Based on research findings about the causes of declining IUD use, the task force recognized that the reintroduction strategy would require a strong advocacy component to combat provider bias and misinformation. FHI was responsible for developing the advocacy strategy, which was carried out with partners.

- Throughout the process, FHI maintained strong partnerships with professional organizations and local nongovernmental organizations whose members work closely with providers or are themselves providers.
- The MOH, with the task force's assistance, revised the *Kenya Family Planning Guidelines for Service Providers*, which now includes new medical eligibility criteria for the IUD and all other contraceptive methods.
- A call-in radio program featured IUD advocates, satisfied users, and providers.

### Advocacy Activities

Over two years, partners in the reintroduction effort:

- distributed 2,663 advocacy briefs
- directly reached 400 public-sector program managers and family planning service providers through provincial sensitization meetings
- reached 235 private-sector providers through CPD meetings
- trained 83 trainers from 39 training institutions in the new World Health Organization medical eligibility criteria for contraceptive use
- gave presentations about the IUD at regional reproductive health conferences and professional association meetings
- trained district-level supervisors and facility-level service providers on maternal and child health and family planning (including the IUD)



- A package of IUD advocacy briefs targeting providers and policy-makers was developed by the MOH, FHI, representatives from all the major medical professional associations in Kenya, and other partners. In nontechnical language, these briefs addressed the issues of concern identified in the IUD assessment and stakeholders' meeting: safety, efficacy, cost, convenience for clients and providers, eligibility criteria, and potential as a safe method for HIV-positive women.
- The MOH hosted district-level meetings of public-sector providers, health facility managers, and policy-makers in all eight provinces. The purpose of the meetings was to disseminate the reintroduction strategy and the briefs and to review information about the IUD.
- Private-sector providers across the country were invited to sensitization meetings offered as continuing professional development (CPD). Participants were certified, and the sessions were recognized as part of their continuing medical education by providers' respective professional bodies.
- The CPD materials were adapted and used to train pre-service trainers from universities and medical training colleges.

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*"I had not received an update in family planning since 1989. This training was a good opportunity to be updated. I intend to share this information with colleagues when I get back to my facility."*

—Service provider, North Rift Valley

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### ***Challenges, Successes, and Lessons Learned***

- The process of writing and designing the advocacy briefs was inclusive and participatory, generating ownership among professional associations involved in writing the briefs and confidence in the material they contained.
- The briefs distilled research conducted not only at an international level but locally as well, ensuring that they were relevant to the Kenyan context.
- The MOH's role as host of the sensitization meetings made a strong impression on local providers and program managers in both the public and private sector.
- Holding sensitization meetings for private-sector providers within the context of CPDs made it more attractive for them to attend.
- The national scope of the CPDs provided an extensive and effective means of disseminating information.
- Participation by different cadres of service providers (e.g., clinical officers, nurses, doctors) provided a forum for sharing information and reducing communication barriers.

## Capacity Building and Service Delivery

Capacity building and service delivery were primarily implemented by MOH teams and the USAID-funded, EngenderHealth-led AMKENI project, which works to improve reproductive health service delivery at 97 MOH-supported sites in Kenya's Coast and Western provinces. To fit the reintroduction effort into AMKENI's work plan, pilot facilities were selected from these two provinces.

- With leadership from AMKENI, the MOH and the rest of the IUD task force revised the national reproductive health curriculum. Previous training materials were piecemeal and had become out of date. The new curriculum was standardized, with updated information about reproductive health and family planning.

### Capacity-Building Activities

Over two years, reintroduction partners:

- distributed 581 IUD kits with necessary equipment and start-up supplies
- trained 171 family planning service providers in IUD counseling, insertion, and removal
- provided 50 new sites with the capacity to provide the IUD
- developed a national reproductive health training curriculum
- continue to provide ongoing supportive supervision to trained providers

- AMKENI held facility-level orientation meetings to introduce IUD revitalization in ten districts in Coast and Western provinces. These meetings included the entire staff of the facilities, not just the providers.
- AMKENI provided clinical, in-service IUD training and refresher courses to public and private providers in eight districts and, with the MOH's newly formed, decentralized reproductive health training and supervision teams, continues to provide supportive supervision. The goal of supportive supervision is to ensure that facilities are well prepared—with sufficient training, commodities, and supplies—to offer IUDs to their clients.
- 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 make sure there are sufficient numbers of IUDs and related supplies available at the facilities.
- FHI developed, and field-tested in Kenya, a checklist designed to help providers establish whether clients are medically eligible to use the IUD. During four focus groups, Kenyan providers reviewed and endorsed use of the checklist.



### ***Challenges, Successes, and Lessons Learned***

- Stock of IUDs and related supplies continues to be sporadic. Problems include:
  - ◆ reliance on shifting levels of donor support
  - ◆ unreliable transportation for delivering supplies
  - ◆ facilities' failure to maintain a supply buffer
  - ◆ inadequate record-keeping—without the ability to report the number of IUDs provided, facilities have difficulty requisitioning more
- High turnover of staff sometimes leaves facilities without well-trained providers.
- The MOH was quite clear that it wanted the IUD promoted in the greater reproductive health context. Doing so was important for several reasons, not least of which was gaining the trust of providers who, from past experience, were wary of programs that endorsed one method over another.

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*“We sensitize everyone in the facility, even the guards. After all, these are the first people clients come into contact with. And the staff are also members of their communities, and they can speak positively about family planning and the IUD and become activists in their own way.”*

—Dr. Job Obwaka, AMKENI

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## Demand Creation

The IUD suffered from a poor reputation among family planning clients, who were, at best, rarely offered the method or, at worse, discouraged from using it by persistent rumors about its safety and by provider attitudes. The task force, mostly with implementation by AMKENI, undertook a campaign in AMKENI's two focus provinces to dispel these myths and inform potential clients about the benefits of the IUD—and of all modern family planning methods.

### Demand Creation Activities

Over one year, AMKENI:

- sensitized 500 behavior change communication agents about IUD reintroduction
- distributed 21,000 family planning and IUD-specific brochures
- reached 11,908 people in community-level meetings about the IUD and family planning

- Under FHI leadership, task force members developed two brochures (each produced in English and Swahili) for clients of reproductive health services. One brochure presents the IUD—what it is, who can use it, and what its benefits and side effects are—and the other provides information about all modern family planning methods, including the IUD.
- AMKENI incorporated a new IUD emphasis into its existing behavior change communication (BCC) program. They trained more than 500 BCC agents, mostly volunteers who live in the communities they serve, to provide information about the IUD and family planning in general. The BCC agents met with village health committees, women's groups, men at worksites, youth groups, and families, and distributed the IUD and general contraception pamphlets.

- FHI's journal, *Network*, reported on the IUD initiative. The journal reached 1,000 readers in Kenya alone, and the article was downloaded by 4,300 visitors to FHI's Web site.

### Challenges, Successes, and Lessons Learned

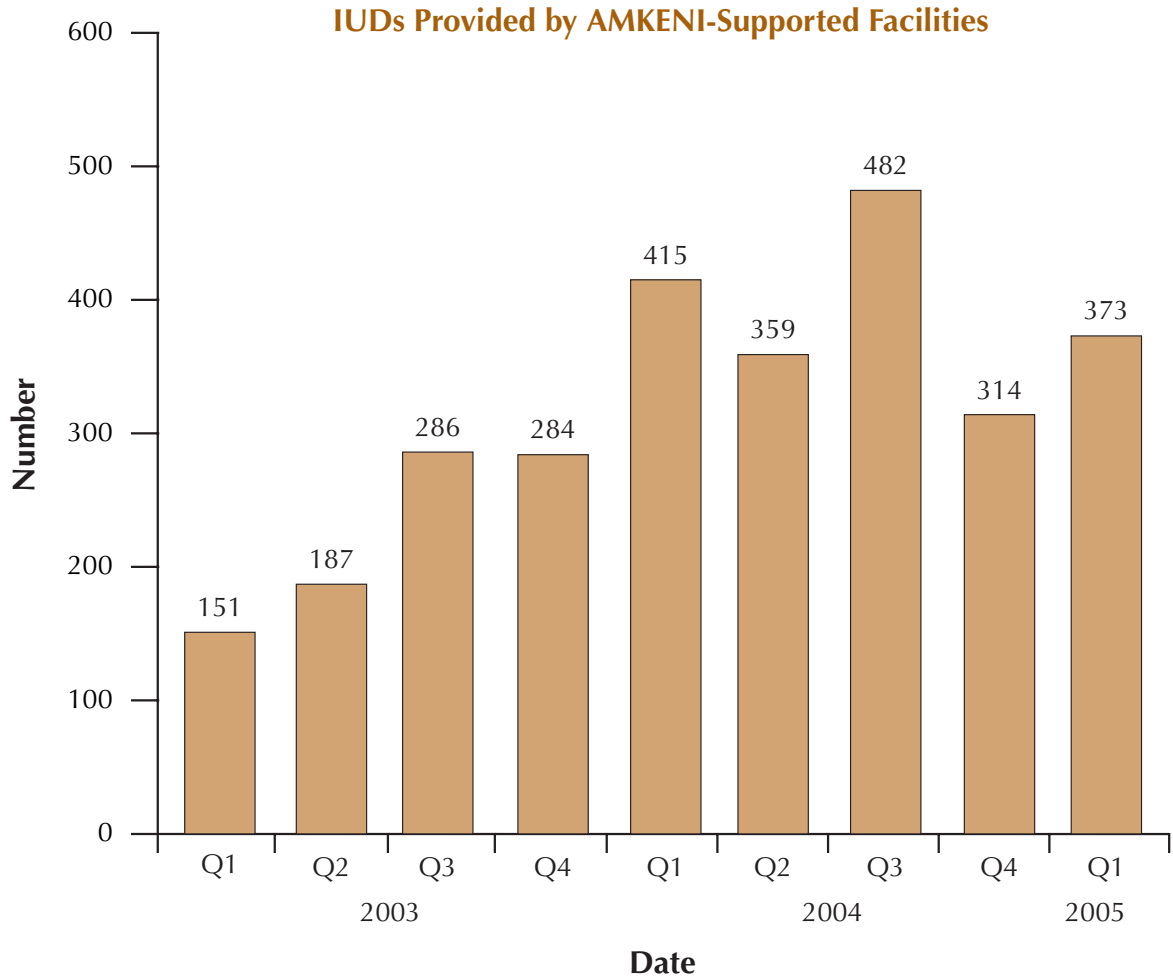
- Given the project's funding levels, it was especially fortunate that AMKENI had such an extensive, existing BCC program. Partnership with AMKENI allowed for IUD information to be distributed and for demand to be created at the grassroots level.
- Following AMKENI's BCC work on the IUD, AMKENI-supported facilities experienced an 80 percent increase in IUD provision the next quarter.
- Development and distribution of the general family planning brochure helped mitigate concerns of the MOH and AMKENI that only IUD messages would be promoted at the expense of a comprehensive discussion of family planning.



## Monitoring and Evaluation and Operations Research

Monitoring and evaluation (M&E) was, from the start, considered vital to successfully implementing the initiative and gauging its success. FHI was the partner designated to coordinate the M&E process.

- FHI developed an M&E plan that listed project objectives and the activities required to meet them, indicators to be measured and target goals, and the partners responsible for collecting data on progress made toward reaching these goals.
- FHI coordinated and documented the IUD task force meetings and prepared quarterly reports with updates on progress and results.
- An important indicator of success will be an increase in IUD users, data about which is being collected by AMKENI in two provinces. To assess national-level data, the DELIVER project will report on the current supply of IUDs, which will indicate how many have been provided to clients.



Programmatic research to test a promotional intervention model called “academic detailing” recently concluded in Kenya. Based on methods employed by representatives of pharmaceutical companies, detailing involves regular visits by trained health staff to service providers in order to promote the IUD, provide updates and refresher training, address lingering provider bias, and assist in commodities management. FHI and the MOH were focused on creating a model that could be replicated using as many existing resources as possible. Thus, MOH supervisory staff at the district level were trained to serve as “detailers” to both clinic-based supervisors and community-based distribution (CBD) agents. Preliminary results show that the detailing intervention had a modest effect in increasing IUD uptake in the intervention clinics. Providers’ lack of technical skills and confidence in their ability to insert and remove IUDs are major obstacles to increased uptake of the method. The detailing was most effective when both clinic-based providers and CBD agents were targeted, addressing service provision and client demand at the same time. To maintain increased IUD provision, stakeholders recommended that the detailing model should be incorporated into existing supervisory duties so that it can be sustained over time.

### ***Challenges, Successes, and Lessons Learned***

- The number of new IUD acceptors in the 97 facilities supported by AMKENI increased from 151 per quarter at baseline in early 2003 to 373 per quarter in early 2005. The cumulative number of IUD acceptors in AMKENI sites over the two-year intervention period was approximately 2,800 women.
- Working with multiple partners—each with its own monitoring and reporting conventions—complicated the M&E plan, but also guaranteed a variety of resources and assistance sharing the workload.
- The initiative had no budget for creating a project-specific method of collecting data and managing information, so the task force relied on data that partners were already collecting for their own programs.
- Only AMKENI sites are currently being monitored. However, sensitization activities were implemented on a national level and the national curriculum now contains updated information on the IUD. The full extent of the program’s impact will not be known until the release of the next KDHS in 2008.

## CONCLUSIONS AND THE FUTURE

The IUD reintroduction initiative has been successful on several levels:

- The process has brought together a diverse range of stakeholders—government, public- and private-sector providers, professional associations of doctors and nurses, and nongovernmental organizations—to work in partnership, not in competition, toward a common cause.
- Advocacy efforts with a focus on IUDs as part of a balanced method mix have raised awareness about the IUD, and family planning in general, from the highest levels of government to villages and families across Kenya.
- Training and other capacity-building activities have improved service delivery and access to the IUD in AMKENI sites.
- Data available so far show that IUD uptake has increased in the AMKENI districts in Coast and Western provinces. The largest increase in IUD uptake took place after an intensive community education program, indicating that in addition to provider skills and knowledge updates, demand creation is essential for increasing IUD uptake. FHI will continue to work with AMKENI to monitor IUD uptake in these sites.
- Several other countries have shown considerable interest in revitalizing longer-acting and permanent methods, especially the IUD, and are looking to Kenya to see what elements of its program can be adapted or replicated:
  - ◆ In Ghana, the Population Council adapted Kenya’s IUD advocacy materials to promote the method.
  - ◆ In Ethiopia, FHI, EngenderHealth, and Pathfinder conducted assessments to inform an IUD strategy there.
  - ◆ In Uganda, ACQUIRE/EngenderHealth is working with FHI, the MOH, and local partners to revitalize longer-acting and permanent methods in four districts.

- ◆ Other strategies to revitalize longer-acting and permanent methods are under way in Tanzania, Mali, Guinea, and Ghana.

However, many challenges remain:

- MOH officials cite an acute shortage of staff in health facilities in many parts of the country. When staffing is low, methods that require a greater investment in time and training are the first to suffer.
- The decline in IUD use occurred over two decades, and while there is currently a gradual upward trend in new IUD acceptors, change is incremental. The reintroduction process is time-consuming and although two years have passed since the intervention began, only recently have data on the impact of the initiative become available. There must be a concerted effort to sustain momentum for the project by securing ongoing funding, by maintaining stakeholders' interest, and by continuing training and supportive supervision for providers.
- It will be important to monitor whether increased IUD use is actually contributing to increased contraceptive prevalence or whether IUDs are merely taking the place of other methods.
- Work remains to determine why some sites are more successful than others in increasing acceptance and uptake of the IUD.

USAID's ambitions for the future of this initiative include continued monitoring and evaluation, expanded demand creation activities, and more contraceptive technology updates in pre- and in-service training. Ultimately, donors hope for a substantial increase in the use of permanent and longer-acting contraceptives in Kenya.

There are ongoing opportunities to work toward achieving these goals. For instance, the IUD reintroduction project has been rolled into Kenya's Implementing Best Practices (IBP) initiative, which is led by the MOH and currently coordinated by FHI and involves numerous reproductive health experts and stakeholders. The main components of IBP/Kenya are (1) advocacy to revitalize family planning and create demand at the community level; (2) contraceptive technology updates for service providers through the MOH's structure of cascade training; and (3) training of service providers in logistics and commodities management. ACQUIRE/EngenderHealth has received USAID funding to expand IUD activities to the district of Kisii in Nyanza Province, and Marie Stopes/Kenya has begun an IUD social franchising project, which involves 185 private providers in two provinces.



The IUD revitalization initiative has brought national and international attention to the IUD as a safe and effective but underused method. More cooperating agencies are expressing interest in working on IUDs, and more countries are beginning to replicate this process, using Kenya as a model. This is creating momentum to continue monitoring and evaluating the work in Kenya and looking at opportunities to leverage existing investments to improve IUD use and contraceptive choice.



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