Summary

The initiative described in the present case study was undertaken in order to reintroduce the intrauterine device (IUD) into the contraceptive method mix and to increase its uptake in Kenya. The use of IUDS was declining despite the safety, effectiveness, convenience and low cost of the device. At the same time, the use of expensive, modern family planning methods such as injectables was on the increase. The percentage of women in Kenya who used IUDs for contraception dropped from 21 per cent in 1989 to 15.4 per cent in 1993 and to 7.6 per cent in 2003. The underuse of IUDs and other long-acting and permanent methods became a cause of concern to the Government of Kenya and those who make health policy. Overreliance on relatively expensive methods burdened the National Family Planning Programme, which was already faced with budget cuts as resources were increasingly directed to HIV/AIDS programmes, and limited women's access to a full range of contraceptive options. At the same time, Kenya was undergoing serious challenges in ensuring family-planning commodity security, with recurrent stock-outs. HIV/AIDS was attracting all the focus of all the players, including the bilateral partners. It became necessary to reintroduce a method whose safety and cost benefits were well established even in the era of HIV/AIDS.
**Introduction**

The initiative described in the present case study was started to help to create demand for intrauterine devices (IUDs), enhance the quality of services, increase easy access to IUDs, reduce reliance on the relatively expensive methods that burdened the National Family Planning Programme, and increase women’s access to a full range of contraception options.

**Background: Origin, Design and Objectives of the Initiative**

**Origin and Growth**

Since 1967, Kenya has been promoting and implementing an integrated maternal and child health/family planning programme to reduce its high population growth rate and to improve the welfare of women and children. The high population growth in the country was influenced mainly by high fertility and declining mortality. Until recently, the performance of the family planning components had been rather poor. For instance, between 1978 and 1998, the proportion of married Kenyan women using modern contraceptive methods rose from only 9 per cent to 39 per cent (graph 1). It reached a plateau between 1988 and 2003, indicating a significant unmet need for family planning. Contraceptive commodity stock-out was a serious challenge. Fertility remained relatively high at about 5 children per woman.

![Graph 1](source: Kenya Demographic and Health Survey 2003.)
Moreover, the use of the IUD – one of the most reliable and cost-effective methods – dropped from 31 per cent of the modern method mix in 1984 to about 8 per cent in 2003 (graph 2). At the same time, Kenyan women began to rely almost exclusively on short-term methods, with more than 70 per cent of women who used modern contraception using injectables or pills, methods that are more costly than IUDs. In addition, IUDs have proven to be safe, effective, acceptable, and low in cost, and therefore suitable for most women in a resource setting such as Kenya. Also, the World Health Organization has shown that IUDs are also suitable for women with HIV/AIDS.

At the same time, the Ministry of Health was facing several challenges to its reproductive health programme. For example, it was facing serious challenges in ensuring family-planning commodity security, with recurrent stock-outs. Kenyan women did not have access to a full range of contraceptive methods. Kenya as a country was experiencing an increasing disease burden from the HIV/AIDS pandemic (graph 3), and the ability of the Ministry of Health to provide services was under a great deal of pressure. All the players, including the bilateral partners, were focusing only on HIV/AIDS. Amid all the challenges, an increased number of Kenyans were reaching reproductive age and requiring services, furthering demand for contraceptives.

In addition, research on IUD service delivery in Kenya showed that a combination of factors contributed to the decline in the uptake of the IUD. These included:

- poor quality of care;
- fear of HIV transmission;
- misconceptions and myths about IUDs;

**Graph 2** | Trends in the contraceptive method mix in Kenya.

![Graph](image)

*Note: BTL = bilateral tubal ligation.*

*Source: Kenya Demographic and Health Survey 2003.*
• provider bias or preference (e.g., concerns about the time and skill required to offer IUDs);
• shifting client preferences;
• lack of expendable commodities; and
• availability of Norplant and depot medroxyprogesterone acetate (DMPA).

Concerned about a contraceptive method mix skewed towards short-term methods (the most costly) and about providing a wide range of contraceptive options to Kenyan women and a more balanced and sustainable method mix, the Ministry of Health decided to reintroduce or rehabilitate the IUD. In 2001, the Ministry, in collaboration with several local and international partners, launched the initiative to promote a balanced and sustainable national family planning programme, increase client choice, and reintroduce the IUD into the Kenyan contraceptive method mix.

The initiative was phased in well. It started in two provinces – the Western and Coast provinces – and gradually some of the activities were extended to the six other provinces. The Ministry of Health AMKENI Project, a service delivery project supported by the United States Agency for International Development (USAID), was already operating in these two provinces and thus integrated the IUD reintroduction efforts into its activities.

Based on the fact that the barriers to IUD use in Kenya were many, the initiative focused on and addressed four strategic areas: consensus-building and advocacy; building capacity and improving service delivery; creation of demand;
and monitoring and evaluation and operations research.

**OBJECTIVES**

The objectives of the initiative were to:

- increase support for the IUD among policymakers, service providers and clients;
- improve the quality of IUD services;
- enhance demand for IUDs; and
- monitor and evaluate programme performance.

**MAJOR ACTIVITIES**

Although the activities followed a developmental sequence, they were in reality carried out more or less simultaneously once the stakeholders had agreed on the importance of the project and the implementation mechanisms.

**Consensus-building Activities**

At the onset, the Ministry of Health undertook several activities to cultivate ownership and consensus among various groups, including researchers, trainers, programme managers, service providers, professional associations, funding agencies and clients. This cluster of activities occurred in several steps over the course of approximately two years from late 2000 to 2002:

- In early 2001, the Ministry of Health and Family Health International hosted a panel session at the annual meeting of the Kenya Obstetrics and Gynecological Society to discuss IUD usage in Kenya. The members agreed that there was a need to convene a national stakeholders meeting to discuss matters relating to the IUD.
- Several months later, Family Health International organized a stakeholders meeting to bring together government leaders, representatives from non-governmental organizations (NGOs) and providers. The meeting served as a venue for presenting the most current IUD research and discussing a way forward. The stakeholders proposed the formation of the IUD Task Force, which the Ministry of Health adopted.
- In March 2002, the IUD Task Force, with the Ministry of Health as chair and Family Health International as secretariat, met to develop a revitalization strategy and work plan for the reintroduction of IUDs. In subsequent quarterly meetings, the group developed a work plan outlining goals, activities, indicators of success and a timeline.
- The national IUD revitalization strategy was launched at the annual conference of the East, Central and Southern Africa Association of Obstetrical and Gynaecological Societies (ECSAOGS).
- The IUD Task Force transitioned to a more streamlined implementing body under the chairmanship of the Department of
Reproductive Health in the Ministry of Health. The Department adopted a systematic approach of quarterly meetings and regular progress reports. The Ministry of Health led this group, which consisted of representatives of the Ministry, Family Health International, the AMKENI Project, Jhpiego (an international non-profit health organization) and several medical professional associations.

**Advocacy and Sensitization Activities**

Based on research findings about the causes of the decline in the use of IUDs in Kenya, the Task Force recognized that the revitalization strategy would require a strong advocacy component to combat provider bias and misinformation. Family Health International was responsible for developing the advocacy strategy. Throughout the process, it maintained strong partnerships with professional organizations and local NGOs whose members work closely with providers or are providers.

The advocacy activities included a review of Ministry of Health policies and the development of various communication efforts to raise awareness among providers, clients and the general public. As of 2004, over 2,600 advocacy briefs had been distributed, 400 programme managers and family planning service providers had been sensitized in meetings in all eight provinces in Kenya, and hundreds of others had been encouraged to take a new look at the IUD during radio programmes and presentations at regional reproductive health conferences.

In summary, the advocacy and sensitization activities included the following:

- A public call-in radio programme aired featuring IUD advocates, satisfied users and providers. During some of these programmes, professionals answered some of the frequently asked questions about IUDs. Some of the IUD clients shared their experiences with other potential clients.

- A package of IUD advocacy briefs targeting providers and policymakers was developed by the Ministry of Health, Family Health International and representatives from all the major medical professional associations in Kenya. In non-technical 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 Ministry of Health hosted district-level meetings of public-sector providers, health facility managers, and policymakers in all eight provinces. The purpose of the meetings was to disseminate the revitalization strategy and the briefs and to review information about the IUD.

- Private-sector providers across the country were invited to sensitization meetings as part of their continuing professional development.
Participants were certified and the sessions were recognized as part of their continuing medical education by their respective professional bodies. The materials for continuing professional development were adapted and used to train pre-service trainers from universities and medical training colleges.

Capacity-building and Service-delivery Activities

Capacity-building and service-delivery activities were implemented primarily by Ministry of Health teams and the Ministry of Health AMKENI Project, which was USAID-funded. Concerted efforts were made to improve the provision of quality IUD services by establishing a training system for IUD services and creating a cadre of trainers to reach IUD providers in the public and private sectors. The cluster of activities was carried out to enhance supervision capacities within the existing Ministry of Health structures, to ensure the provision of equipment and expendable supplies to AMKENI-supported clinics, to improve the infrastructure of facilities and to address infection-prevention techniques in clinics.

The AMKENI Project worked to improve reproductive health service delivery at 97 Ministry of Health-supported sites in the Coast and Western provinces. To fit the revitalization effort into the AMKENI work plan, pilot facilities in these two provinces were selected. Activities included the following:

- With leadership from the AMKENI Project, the Ministry of Health and the rest of the IUD Task Force revised the national reproductive health curriculum. Previous training materials were piecemeal and out of date. The new curriculum was standardized, with updated information about reproductive health and family planning.

- The AMKENI Project held facility-level orientation meetings to introduce IUD revitalization in 10 districts in the Coast and Western provinces. These meetings included the entire staff of the facilities, not just the providers. This gave all the staff an opportunity to understand the programme and their future roles in it.

- The AMKENI Project provided clinical, in-service training and refresher courses to public and private providers in eight districts on all aspects of IUD service provision.

- The AMKENI project also distributed nearly 600 kits for IUD insertion and removal to trained providers and it continues to work with the USAID-supported DELIVER PROJECT implemented by John Snow, Inc. to make sure that sufficient numbers of IUDs and related supplies are available at the facilities.

- Family Health International developed a checklist to help providers to determine if clients are medically eligible to use the IUD. The
checklist was partially field-tested in Kenya. During four focus-group discussions with providers, Kenyan providers reviewed and endorsed the use of the checklist.

The newly formed, decentralized, reproductive-health training and supervision teams of the Ministry of Health continue to provide supportive supervision. Their goal is to ensure that facilities have sufficient training, commodities and supplies to offer IUDs to their clients.

**Demand-creation Activities**

The IUD suffered from a poor reputation among family planning clients, who were rarely offered the method and often discouraged from using it by persistent rumors about its safety and by providers’ attitudes. The providers’ attitudes were influenced by many factors: lack of infrastructure, provider skills, equipment and supplies. The IUD Task Force (mostly implemented by AMKENI) undertook a campaign in the two focus provinces of AMKENI to dispel myths and to inform potential clients about the benefits of the IUD and all modern family planning methods.

Under Family Health International leadership, Task Force members developed two brochures (each produced in English and Swahili) for clients of reproductive health services. One brochure discusses the IUD, explaining what it is, who can use it, and its benefits and side effects. The other brochure provides information about all modern family planning methods, including the IUD.

AMKENI incorporated a new IUD emphasis into its existing behaviour change communication (BCC) programme. It trained more than 500 BCC agents, mostly volunteers who live in the communities that 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. They distributed the IUD and general contraception pamphlets.

The AMKENI behaviour change communication (BCC) strategy worked with communities around the targeted health facilities to increase demand for services, foster women’s empowerment and participation in reproductive health/family planning decisions, and promote healthy behaviour. A hallmark of the AMKENI approach was to engage the community surrounding each facility to put people “in the driver’s seat” for bringing about desired change. AMKENI mobilized 754 villages to form village health committees or health-facility management boards. More than 2,218 volunteer field agents were trained to provide information and mobilize community involvement in reproductive health/family planning. Approximately 51,000 members from over 2,700 community groups were engaged in regular BCC activities, reaching more than 2.8 million people.

In summary, clients’ awareness of the existence and advantages of the IUD was a major determinant of demand. Research showed that often clients were not aware of the IUD as a contraceptive option or they had misconceptions about the
An Innovative and Integrated Initiative to Reposition Intrauterine Contraceptive Devices in the National Family Planning Programme – Kenya

To raise awareness, the initiative developed information, education and communication materials and initiated public education campaigns through the extensive network of field agents of the AMKENI Project. As of March 2004, nearly 12,000 community members had been reached through educational sessions on the IUD.

Documentation
The process of documenting all the activities of the initiative was put in place as part of facilitative support supervision. Data and information were available in the implementing facilities. The documentation enabled participants to share programme information and made it easy to monitor and evaluate the progress and success of the programme based on the initial baseline survey.

Monitoring and Evaluation and Operations Research
From the start, monitoring and evaluation were considered vital to implementing the initiative and gauging its success. Family Health International was designated to lead the monitoring and evaluation process. During the monitoring and evaluation planning, it put measures in place to ensure appropriate documentation of all activities throughout the life of the project. These measures included the following:

- Family Health International developed a monitoring and evaluation plan that listed project objectives and the activities required to meet them, indicators to be measured, target goals and the partners responsible for collecting data on progress.
- Family Health International also coordinated and documented the IUD Task Force meetings and prepared quarterly reports with updates on progress and results. The AMKENI Project is collecting data in two provinces on the increase in IUD users, which will be an important indicator of success.

Implementation

The initiative was a collaborative effort that involved the Ministry of Health (prime mover), EnGender Health, Family Health International, IntraHealth International and the Program for Appropriate Technology in Health (PATH).

The Director of the Division of Reproductive Health had the overall coordination role and ensured that the resources needed for the various activities were made available to the implementers.

Involvement of professional health associations and training institutions in the project activities was ensured throughout the life of the project. In addition, private-sector providers across the country were invited to sensitization meetings as part of their continuing professional development. Participants were certified and the sessions were recognized as part of their continuing medical education by their respective professional bodies. The materials for continuing professional development were adapted.
and used to train pre-service trainers from universities and medical training colleges.

Each partner had a clearly defined role based on its comparative advantage and was responsible for implementing the assigned project activities in close collaboration with other stakeholders.

Joint planning and review meetings were held by a representative task force. During these review meetings, progress was assessed, challenges were discussed, and, in certain instances, workplans were modified to reflect the reality on the ground.

Funding was provided by USAID and the Government.

Supervisory teams from the Division of Reproductive Health of the Ministry of Health were formed. As indicated earlier, these teams ensured that all the facilities had sufficiently trained staff, adequate IUDs and other contraceptive commodities to offer to clients. They also ensured that all the facilities had the checklists and that high standards were being followed and maintained.

Family Health International had developed a monitoring and evaluation plan that listed all the project objectives and the activities required to achieve them, indicators to be measured, target goals and the partners responsible for collecting data on progress. The implementation of the project activities was closely monitored and all the activities were documented throughout the life of the project.

**Results and Achievements**

The results described in the following sections are based on the project documents as well as assessment and evaluation.

**Sustainability**

The initiative was sustainable because it was mainstreamed into the Ministry of Health Family Planning Programme and into each partner’s programme activities.

**Increased Utilization of the IUD**

Under the Ministry of Health AMKENI Project, which ended in 2005, the number of new users in the 97 facilities supported by AMKENI increased from 151 per quarter at the baseline in early 2003 to 373 per quarter in early 2005. The cumulative number of IUD users in AMKENI Project sites over the two-year intervention period was approximately 2,800 women.

AMKENI Project achievements have had a significant impact on the access to, quality of, and use of reproductive health services in the Coast and Western provinces. People now can choose from an increased range of family planning methods, and more people are using more methods. At the baseline, most facilities could offer only short-term methods, such as the pill, injectables and condoms, and the number of clients was low.
**Increased Access to Quality Family Planning Services**

AMKENI enabled the facilities to provide a range of methods, strengthening the capacity to provide long-acting and permanent methods in particular. For example, the number of facilities that could provide IUDs rose from 5 per cent at the baseline (2001) to 35 per cent by the end of 2005, and reported IUD insertions rose from 510 in 2001 to 1,169 in 2005. During the same period, acceptance of all long-acting and permanent methods rose by 152 per cent, and the number of new family planning users increased by 65 per cent.

AMKENI Project staff formed a true partnership with Ministry of Health staff, jointly planning and implementing projects in eight provinces, and this was piloted successfully down to the health-facility level in two districts. The Ministry of Health intends to roll out the system nationwide.

**Effective Supervision of Service Delivery**

By the end of the project in 2005, each of the eight provinces in Kenya and the 10 districts within the AMKENI Project area had members of the reproductive-health training and supervision team who had been updated in their clinical skills, exposed to supportive supervision procedures, and instructed in clinical training skills and on-the-job training techniques.

**Standardization of Reproductive-Health Training Materials and Their Use in Training Staff**

The staff had their knowledge and skills updated using standardized training manuals. The project also included pre-service trainers from various Kenyan medical training colleges in its training support. This assistance created a large reserve of high-quality, local experts in training and in supervision.

**Lessons Learned**

The following lessons were learned in the course of implementing the project:

- High-level political commitment is crucial for successful programme implementation. Programme commitment to intervention by the Ministry of Health and all the partners is essential for successful implementation and its sustainability. In addition, leadership by the Ministry ensured a commitment by all involved to undertake necessary policy and programmatic changes.

- Building activities on evidence (especially synthesis and discussion of local evidence) is more effective than not using an evidence-based approach. Synthesis and incorporation of valid research
findings are required to inform action. Succinct and accessible evidence makes busy policymakers, programme managers and service providers take notice.

- A review of existing policy and guidelines to ensure appropriate content is necessary. For instance, the guidelines on family planning were revised and a new *Kenya Family Planning Guidelines for Service Providers* was issued, which now includes the new medical eligibility criteria for the IUD and all other contraceptive methods.

- Partnerships with key stakeholders at all levels of implementation are critical. Each partner should be assigned responsibilities based on its comparative advantage and track record. The assignment of responsibilities should be done in a democratic and transparent manner. Collaboration leads to ownership and more effective project implementation.

- Community initiatives and partnerships are key to service and commodity uptake. Village-based health structures such as village health committees are essential for reaching people with appropriate information and for creating demand for health services and are critical for ownership and sustainability of health initiatives.

- Collaboration and leveraging of resources by implementing agencies are feasible. Organizations, with common goals, are coordinated and bring a variety of skills to the project.

- Credible spokespeople are important advocates in that they can help to bridge the worlds of research, policy and programmes.

**Challenges**

During the course of implementing the programme, several challenges were encountered:

- weak health infrastructure;
- bureaucracy in the decision-making process of government agencies;
- inadequate and erratic supplies of contraceptive commodities;
- inadequate support by service providers;
- competition from other short-acting contraceptives (e.g., DMPA);
- lack of continuity in facilities’ commitment to the IUD and the provision of IUD services; and
- insecurity among clients as to whether the services would be maintained.

**Suitability and Possibility of Scaling Up (Replicability)**

The model according to which the initiative was executed has been replicated both locally (in the country) and internationally.
• The initiative has been scaled up and is being implemented in all eight provinces of Kenya. As was indicated earlier, the Ministry of Health teams trained family planning staff of all the major health facilities in the eight provinces to provide IUDs among other family planning methods. A number of health facilities have also been upgraded and strengthened to provide a variety of family planning methods including IUDs. IUDs are now routinely included in the contraceptive commodities supplied to all the health facilities in the country. This is clear evidence that the initiative has been incorporated into national health decision-making and planning processes.

• The implementation of project activities was closely monitored and all the activities were documented throughout the life of the project. The lessons learned in the project have been used in the AMUA and ACQUIRE Projects to increase the usage of IUIDs. In Kisii District, with support from ACQUIRE\(^2\) and using lessons learned from the AMKENI Project, the Ministry of Health held community linkage meetings to bring together providers and community members. These meetings provided an opportunity for community members to express their concerns regarding family planning services and for providers to meet. They resulted in increased use of IUIDs between 2005 and 2006 in Kisii District.

 Remarkable progress in IUD insertions was recorded by the AMUA\(^3\) Project. This social franchising project targeting the rural private sector with particular emphasis on long-acting and permanent methods was conducted in Rift Valley Province from 2004 to 2007 using some of the lessons from the AMKENI Project.

• The Population Council adopted and produced 500 copies of the IUID advocacy kit for Ghana Health Services (i.e., the Ghana Ministry of Health) at a cost of approximately US$1,500.

• Ghana Health Services used advocacy kits to help to sensitize 153 Family Planning Programme managers and service providers.

**Recommendations**

The recommendations listed below should be followed to successfully reposition the IUID or any similar initiative in Kenya or in countries with similar conditions:

• Partners and stakeholders who support the Ministry of Health of

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\(^2\)The ACQUIRE Project (Access, Quality, and Use in Reproductive Health) is a global initiative supported by USAID and managed by EngenderHealth in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA).

\(^3\)Meaning “decide” in Swahili.
Kenya should work within the existing structures of the Ministry.

- Stakeholders on a project should consult with one another regularly.
- Advocacy, sensitization and consensus-building should be encouraged.
- Regular supportive supervision should be maintained.
- Advocacy should be undertaken for inclusion of the project in the annual operating plan of the Ministry of Health.
- Advocacy should also be undertaken for a line in the Ministry of Health budget covering all the components of IUD services to ensure that they will be continuous.

**Conclusion**

This initiative was a best practice because it increased the uptake of IUDs in the project provinces as shown by the service statistics; it contributed to the strengthening of the capacity of various stakeholders and health facilities; it built strong partnerships; and it was sustainable (use of existing health facilities and local resources, community participation). In addition, it is replicable (it has already been used to reintroduce the IUD in all eight provinces of Kenya and has been used in Ghana). Furthermore, the initiative was based on research and it integrated operations research and involved professional associations in a very innovative way.

The initiative worked well because of the innovative design and strategy implementation that entailed wide consultation among key stakeholders, use of research, consensus-building and advocacy, strong government commitment and leadership, capacity-building, involvement of carefully selected implementing partners that were assigned responsibilities democratically and on the basis of comparative advantage and proven track record, and well-thought-out monitoring and evaluation arrangements. It further involved a well-coordinated flow of resources from USAID, the Government of Kenya and a variety of other development partners and integration of the initiative activities into ongoing activities of the implementing partners.

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