

ACQUIRING KNOWLEDGE

Applying Lessons Learned to Strengthen FP/RH Services

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Programming for IUD Services

Experience and Lessons Learned in Field Implementation and Global Leadership

Purpose

This brief is intended for public health professionals working to expand access to, quality of, and use of family planning (FP) methods and services, especially the long-acting reversible methods (the intrauterine device [IUD] and the hormonal implant) and permanent methods (female sterilization and vasectomy).¹ It draws upon the experience of the ACQUIRE Project in providing field-based technical assistance and global leadership for the IUD. Rather than summarize the ACQUIRE Project's results per se, the brief presents its conceptual model for IUD service provision, the programming approaches that follow from this model, some illustrative IUD-related activities that ACQUIRE undertook, the challenges met, and the lessons learned or reinforced that are relevant to planning and programming for expanded IUD and other clinical method services.

Introduction and Context

The IUD is one of the most highly effective, convenient, cost-effective, and widely used FP methods. Fewer than 10 in every 1,000 users become pregnant in the first year of IUD use, one act can confer up to 12 years of contraceptive protection,

¹ IUDs and hormonal implants (Jadelle, Sinoplant, and Implanon) are suitable for women who want to delay, space, or limit births; female sterilization and vasectomy are suitable only for clients who want to limit further childbearing. These methods all must be provided by a trained and skilled provider in a setting appropriate to the provision of clinical services.

² The IUD and the three other clinical methods comprise the most effective category of methods, with failure rates below 1% in the first year of use. By comparison, one-year failure rates with the resupply methods are 30 pregnancies per 1,000 injectable users, 80 pregnancies per 1,000 pill users, and 160 pregnancies per 1,000 condom users. The commodity cost for the Copper T-380A IUD provided through the U.S. Agency for International Development (USAID) is \$1.64 per device (MSH, 2007).



Mary provides FP counseling and services at Kisii District Hospital

and the IUD's commodity cost is the lowest of any method per year of use.² Most women can use the IUD, including young women, women who have not had children, HIV-infected women, and women with AIDS who are clinically well on treatment. The IUD is suitable for those who wish to space, delay, or limit births, and it is appropriate for women who are postpartum or postabortion (WHO, 2004; WHO, 2007).

Thirteen percent of the world's married women—more than 150 million women overall—use the IUD as their method of contraception. In developing countries, almost one out of every four women (23%) who are using contraception use the IUD, although there are wide variations among countries in IUD prevalence rates, and these aggregated figures largely reflect IUD use in a few populous countries such as China, Egypt, and Vietnam. In developing countries excluding China, 5% of



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married women use the IUD, and in Sub-Saharan Africa, 1% of married women use the IUD. While IUD use is low in most Sub-Saharan African countries, both overall and relative to reproductive intent³; nonetheless, in every country, women are using the IUD and are very satisfied with it (Salem, 2006).

When programs make an effort to increase IUD use, it generally goes up, in large part because the IUD is so highly effective, convenient, and cost-effective for clients and programs. However, limited human resources, commodity stock-outs, competing demands on health providers, and suboptimal organization of work in the health system often limit the IUD's availability in FP programs. Programs also have to work to counteract myths, misperceptions, and biases concerning the IUD, as many providers and potential clients have exaggerated concerns about the IUD's safety, especially with respect to the risk of pelvic inflammatory disease (PID), infertility, and/or HIV and AIDS. In fact, rates of pelvic infection are very low (fewer than two per 1,000 IUD users [Farley et al., 1992]); a woman's ability to get pregnant returns immediately after an IUD is removed; the risk of infertility due to tubal damage is *not* associated with previous IUD use (Hubacher et al., 2001); and use of the IUD does not increase the risks of acquiring HIV, of progressing toward AIDS (among women who are HIV-infected), or of worsening the disease (Sinei et al., 1998).

Because of this “half-full, half-empty” situation—misunderstanding and underutilization of the IUD despite its highly positive method characteristics, high user satisfaction levels, compelling health and programmatic rationales, and good prospects of successful service expansion—ACQUIRE was asked to devote resources and programmatic attention to IUD revitalization.

³ Use of the implant, female sterilization, and vasectomy is also low in Sub-Saharan Africa. A typical pattern of disconnect between reproductive intent and FP use is seen in Kenya. Although Kenya's modern method prevalence (31.5%) and level of IUD use (2.4%) each ranks among Sub-Saharan Africa's highest, among women who want to space a birth for at least two years, only one in three use modern FP, and of these, only 6% use an IUD and 5% use an implant. Only four of every seven women who want to limit further births use modern FP, and of these, only one in three uses a long-acting or permanent method (8% IUD, 5% implants, and 20% female sterilization).

ACQUIRE's IUD Revitalization Activities

ACQUIRE implemented a range of innovative, evidence-based technical assistance activities to help increase accurate knowledge about the IUD and expand its availability, service quality, access, and use in 10 countries across three regions: Bangladesh, Ethiopia, Ghana, Guinea, Honduras, Kenya, Mali, Nigeria, Senegal, and Uganda. The activities consisted of supply-side, demand-side, and/or advocacy interventions, as discussed below in sections devoted to each program area. A number of activities were introductory, meant to stimulate further interest in the IUD and to introduce effective service delivery and programmatic practices. ACQUIRE's technical assistance for IUD programming varied according to the source, duration, modality, and level of USAID funding, as well as the nature and duration of technical assistance desired by the respective USAID Mission and its program partners.

Some ACQUIRE IUD activities had an operations research focus (in Ghana and Honduras), some were meant to be catalytic pilot efforts (in Mali, Nigeria, and Senegal), and others entailed on-the-ground service delivery and scale-up (in Bangladesh, Guinea, Ethiopia, Kenya, and Uganda). At one end of the spectrum, ACQUIRE's engagement was brief (12–18 months), narrowly focused, and at a greater remove from ongoing implementation. At the other end of the spectrum, activities in some countries were broader (both programmatically and geographically) and were provided over a longer period of time (2–5 years), via more direct and ongoing provision of technical assistance to program counterparts. In these instances (e.g., in Bangladesh, Kenya, and Uganda), ACQUIRE worked as a bilateral Mission partner, rather than through an intermediary USAID-funded bilateral partner (as was the case in Ethiopia, Mali, and Nigeria). Table 1 presents an overview of these IUD-focused efforts.

Overall, ACQUIRE supported 3,472 sites in these 10 countries to provide and/or expand IUD (and other clinical method) services, and more than 640,000 clients received IUD services at these sites from 2003 to 2007. The majority of this service delivery output came from two countries where ACQUIRE worked on a national scale

Table 1: ACQUIRE's IUD revitalization activities, by country and type of activity

Activity	BAN	ETH	GHA	GUI	HON	KEN	MAL	NIG	SEN	UGA
Advocacy										
PNAs	X	X		X		X	X	X		X
Policy work	X	X			X	X	X			X
Male involvement/gender				X	X	X		X		X
Reality ✓ (2007–2008)	X									X
Supply										
CTUs	X	X		X	X	X	X	X	X	X
Training (clinical/counseling)	X	X	X	X	X	X		X	X	X
Site readiness	X	X		X		X	X		X	X
QI/supervision/M&E	X	X		X	X	X	X		X	X
Logistics	X	X	X			X				
Demand										
<i>Communications and media</i>										
Radio shows			X	X		X				X
IEC materials	X	X	X	X	X	X				
Launches, road shows		X	X			X				X
<i>Engaging the community</i>										
Religious/community leaders	X	X		X		X		X		
Peer educators/volunteers			X	X		X		X		
Satisfied clients		X	X	X		X		X		X

(Bangladesh and Honduras), with more than 90% of these totals coming from Bangladesh, where levels of IUD acceptance rose dramatically. Whereas approximately 50,000 clients in Bangladesh accepted the IUD in 2003–2004, this level more than doubled (to 120,000) in 2004–2005, and almost doubled again (to 235,000) in 2005–2006, before leveling off at 220,000 in 2006–2007. In the four other countries with available service data (Guinea, Ethiopia, Kenya, and Uganda), increases in IUD use were continuous during the time that ACQUIRE worked there (although such growth in IUD use cannot be attributed solely to ACQUIRE's initiatives), and numerical outputs were more modest. For example, in Ethiopia, IUD provision rose almost 10-fold, from 41 IUD insertions at ACQUIRE-supported sites in 2004–2005 to 338 in the first nine months of 2007–2008. IUD use also rose markedly in ACQUIRE-supported sites in Kenya (see page 8).

In addition to its field interventions, ACQUIRE also worked at the global level to advocate for and otherwise champion the IUD, by: developing, testing, implementing, and disseminating models and approaches for IUD service delivery; collaborating

closely with the World Health Organization (WHO) on the development of its authoritative, evidence-based, method-specific guidance documents for contraceptive use; helping to incorporate this latest WHO guidance into national policies, guidelines, and practices; serving as IUD technical experts and champions at many international, regional, and electronic forums; and spurring and informing the development of the IUD Toolkit (accessible at www.iudtoolkit.org), the definitive electronic knowledge resource that provides the latest scientific evidence and best program practices related to the IUD.

The ACQUIRE Program Model and Approach to IUD Revitalization

ACQUIRE's holistic Program Model for Family Planning/Reproductive Health Service Delivery, which became more fully articulated and elaborated in visual form over the project's period of operation, served first implicitly and later explicitly to conceptualize, organize, and guide ACQUIRE's work to improve and expand IUD services. Confirmed by ACQUIRE's programming experience in a number of countries as an accurate and helpful representation of "how the world works,"

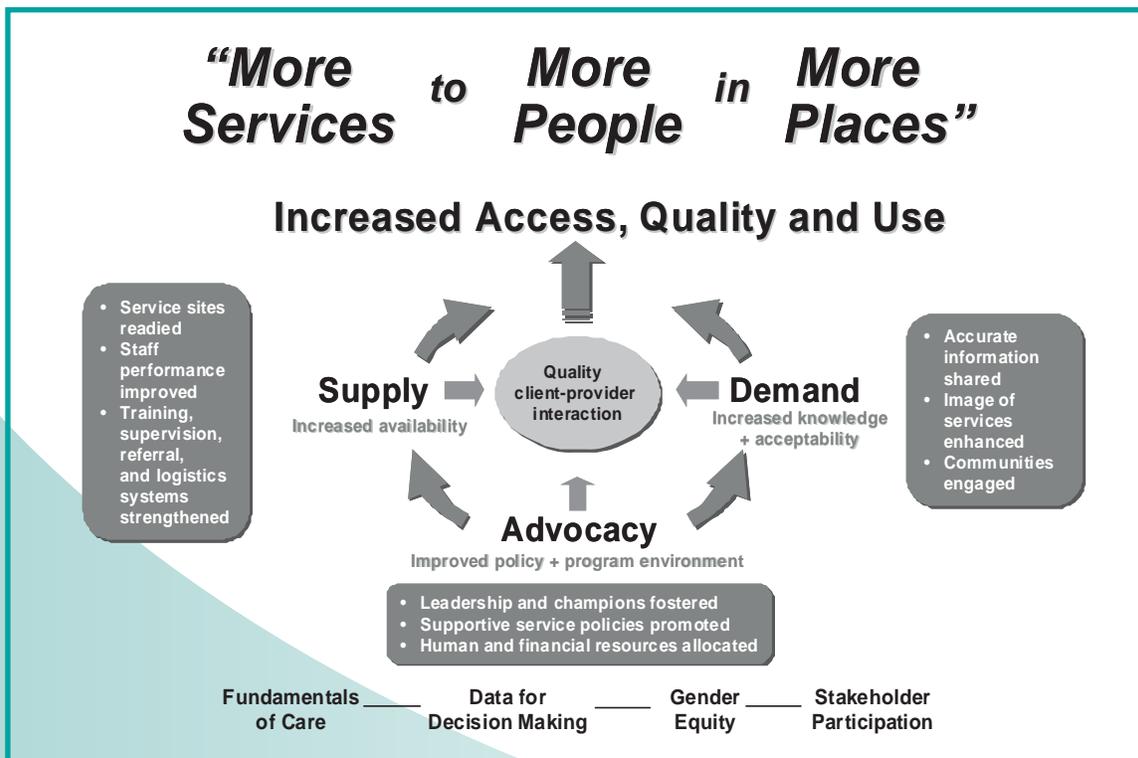
the model subdivides a service delivery system into—and emphasizes the importance of—the areas of supply, demand, and advocacy, holding that potential synergy among these program areas can be fostered in FP programs via a coordinated package of mutually reinforcing interventions (ACQUIRE Project, 2007a).

The model, depicted below, positions the client-provider interaction at its center. This interaction is crucial, especially for the IUD, as the IUD must be delivered at a clinical service site by a skilled and well-supported service provider (a midwife, nurse, clinical officer, or physician) to a knowledgeable and empowered client. The model’s four cross-cutting programmatic imperatives—to: 1) focus on the fundamentals of care (informed choice, medical safety, and ongoing quality improvement); 2) use locally relevant data for sound and realistic decision making; 3) promote gender equity (including supportive male involvement); and 4) ensure widespread stakeholder participation and ownership—are also particularly important in the provision of quality IUD services at the individual level, as well as for the effective design and implementation of IUD services within FP programs.

Advocacy, Data for Decision Making, and Stakeholder Participation

In addition to generating and disseminating its holistic program model, ACQUIRE engaged in evidence-based advocacy at both the global and the field levels to broaden the IUD’s visibility and champion its wider availability and use. ACQUIRE worked closely with WHO on its development of *Medical Criteria for Contraceptive Use*, the *Selected Practice Recommendations for Contraceptive Use*, and the *Global Family Planning Handbook*, and then facilitated the incorporation of this latest guidance into updated national service delivery policies, guidelines, and protocols in eight of the 10 ACQUIRE-supported countries. ACQUIRE also co-chaired the IUD Subcommittee of USAID’s Maximizing Access and Quality (MAQ) Initiative, whose collaborative interagency efforts resulted in the development of the highly utilized and highly regarded IUD Toolkit. In 2007–2008, the year after it became fully operational, the IUD Toolkit had received more than 100,000 visitors from 183 countries, 50,000 downloads were made, and it received very positive user feedback for its utility.

The ACQUIRE Project Supply-Demand-Advocacy (SDA) Program Model for Family Planning and Reproductive Health Service Delivery



ACQUIRE's field-based IUD advocacy activities began with stakeholder participation and use of relevant data to guide planning and implementation. ACQUIRE assisted a wide group of stakeholders, including Ministry of Health (MOH) representatives, to conduct IUD-oriented performance needs assessments (PNAs)⁴ in Bangladesh, Ethiopia, Guinea, Kenya, Mali, Nigeria, and Uganda. This type of formal needs assessment was found to be helpful in generating enthusiasm, buy-in, and ownership at project start-up. Findings from the latest Demographic and Health Surveys were analyzed, program studies were reviewed, and national policies, guidelines, and practices were examined. In conjunction with the PNAs, ACQUIRE also presented contraceptive technology updates (CTUs). A limited number of site visits were also made to assess contraceptive supply, provider and client perspectives, and the quality and extent of services being provided.

The findings of these PNAs were similar across countries and reflected the constellation of problems that the IUD faces: Knowledge of the IUD was low to very low, or, where higher, was associated with widespread myths and rumors; provider bias against the IUD was high; and the availability of skilled health personnel to provide IUD services was greatly constrained, especially in Sub-Saharan Africa. After analyzing the implications of these findings, stakeholders defined desired program performance, identified weaknesses in provider support systems and other root causes of low IUD access and use, established priorities, and identified resources. The PNA process culminated in the development of an IUD-specific action plan that entailed stakeholder leadership and championship and that served as the blueprint for carrying out IUD revitalization activities.

Another promising practice advanced by ACQUIRE to facilitate realistic program planning and resource allocation was the use of the Reality ✓ Family Planning Forecasting Tool (ACQUIRE Project, 2007b).⁵ Reality ✓ can assess past trends in contraceptive prevalence rates (CPRs), test the feasibility of established goals within their local context and resources,

and project additional resources that may be needed to meet these service goals. Use of Reality ✓ in Uganda enabled MOH representatives and district health management teams to use data to inform sound programming for IUDs and other FP methods at the district level. In Bangladesh, Reality ✓ training brought together multiple departments from the Directorate General of Family Planning (logistics, planning, clinical services, field services, management information systems) and the Ministry of Health and Family Welfare to plan for implementation of its FP service goals, including for the IUD. In both countries, use of Reality ✓ led the MOH to appreciate the scope of the inputs required to achieve its service delivery goals and to reassess how to achieve these goals with limited resources. Use of this tool also empowered MOH staff to become active participants in understanding and setting achievable FP service goals, rather than simply being passive recipients and conduits of service targets.

Supply

ACQUIRE provided technical assistance on the supply side in all of its IUD-focused country efforts, in accordance with PNA findings and host-country partner preferences. Consistent with the approach of the programming model, this technical assistance was directed at improving the capabilities and performance of health service providers to deliver the IUD, readying service sites to enable the IUD to be provided, and strengthening supply-side service subsystems to support continuing and expanded IUD services.

To improve providers' knowledge, skills, motivation, and performance, ACQUIRE conducted a range of information and skills-transfer activities in each country, including training in IUD

⁴ ACQUIRE adapted the PNA methodology described in the late 1990s by the PRIME II training project, enlarging it for IUD service delivery to include a focus on the fundamentals of care, perspectives from clients and communities, and consideration of both supply- and demand-side program components.

⁵ Reality ✓ is an Excel-based FP forecasting tool developed by the ACQUIRE Project. Reality ✓ examines the relationship of CPR to FP users, potential adopters, commodities, commodity costs, and service delivery capacity. It has minimal data requirements (population and CPR), allows a user to rapidly assess the implications and feasibility of alternate scenarios and goals, and provides the data needed for planning whatever service delivery expansion may be required to meet those goals.

insertion and removal, quality improvement, and facilitative supervision. CTUs were provided to many cadres of MOH service providers, managers, trainers, and supervisors, as well as to USAID and bilateral partner staff. Some training activities had a more specific and narrower focus (e.g., supportive male involvement in Nigeria; postpartum IUD services in Honduras; leadership orientation in Uganda; and the use of quality improvement tools and approaches in Bangladesh, Ethiopia, Guinea, Kenya, Mali, Senegal, and Uganda).

Overall, ACQUIRE conducted 794 training events that dealt solely or substantially with the IUD for 36,795 trainees of various classification and cadre, including nurses, midwives, physicians, community health workers, program managers and supervisors, and bilateral partner staff. All training, irrespective of the cadre of trainee, was grounded in four key considerations: the importance of the fundamentals of care for IUD services; the usefulness and components of a holistic and integrated programmatic approach (“supply-demand-advocacy”) to conceptualizing, planning for, and delivering IUD services; accurate, updated scientific evidence and proven program practices; and the principles and dynamics of fostering change, especially in medical settings and as it pertains to the IUD and to undoing misperceptions and misunderstandings about the IUD’s safety and suitability.

The aforementioned activities increased the number of and the readiness of sites to provide IUD services by increasing the number of knowledgeable and skilled IUD service providers. In addition, ACQUIRE focused on contraceptive security and logistics, since the lack of equipment, consumable supplies, and/or IUDs themselves is often a major impediment to a site’s readiness to provide IUD services on a regular and reliable basis. ACQUIRE provided project sites across all 10 countries with the essential equipment and supplies necessary to provide IUD services and improve infection prevention practices. In several of the countries, ACQUIRE also provided technical assistance to the MOH to strengthen its procurement procedures. For example, in Bangladesh, ACQUIRE collaborated with the MOH and DELIVER/John Snow, Inc., to create “medical-surgical requisite” kits for the IUD (and for tubal

ligation and vasectomy), as well as a counseling job aid that included an IUD and pelvic model.

ACQUIRE worked in various ways to improve the training, supervision, referral, and logistics subsystems of the larger service delivery system, so that its capacity to provide IUD services could be enlarged and improvements could be sustained. ACQUIRE conducted three IUD standardization workshops in East Africa, Anglophone West Africa, and Francophone West Africa, in partnership with AMKENI (the USAID bilateral project in Kenya) and AWARE (the USAID regional West African project). The purpose of these standardization workshops was to ensure consistency at the national level in training for IUD service provision and to otherwise strengthen national training capacity for IUD revitalization activities. Sixty-eight senior program leaders, medical trainers, and other key stakeholders from 18 countries analyzed their national policies, guidelines, training curricula for IUD insertion and removal, and program practices in the light of the latest scientific information and international guidance, identifying those in need of revision and updating.

The supervision system was strengthened in a number of ways. Assistance was given in Bangladesh, Ethiopia, Guinea, Kenya, Mali, Senegal, and Uganda to incorporate quality improvement tools and facilitative supervisory approaches into the ongoing FP program, to strengthen the fundamentals of IUD service delivery. In Uganda, leadership orientations for senior managers and supervisors from the MOH Reproductive Health Division and District Health Management Teams were also provided prior to the introduction of facilitative supervision activities, as a way of ensuring their involvement and continued support to providers. Because poor-quality service statistics and a lack of ongoing monitoring and support often present a challenge to the provision of good-quality IUD services, ACQUIRE provided technical assistance in both site data collection and medical monitoring of facilities and services in Bangladesh, Ethiopia, Ghana, Guinea, Honduras, and Kenya, including working with clinical supervisors to incorporate IUD-related checklists into their routine facility assessment reviews.

Demand

Demand-side activities featuring IUD-specific behavior change communication (BCC) were a part of almost all of ACQUIRE’s IUD programs (see Table 1). Demand-side activities varied in range, intensity, and extent of formal coordination with supply-side elements, depending on available resources and partner priorities. These activities flowed from marketing and communications strategies that were built on PNA and survey findings, as well as on formative research and on interviews with influential leaders. For example, in Ethiopia, Guinea, Honduras, Kenya, Mali, and Nigeria, religion and culture were cited as barriers to IUD revitalization, and specific aspects of these barriers were incorporated into communications messages. Clients and communities comprised the primary audience for BCC activities, the purposes of which were to increase accurate knowledge, counteract myths and misunderstandings, improve the IUD’s image, and link to the supply-side referral system. Information, education, and communication (IEC) materials, such as posters, brochures, and leaflets, were developed to convey positive images of IUD users, providers, and families (see below for examples from Guinea, Kenya, and Uganda, in English, French, and local languages). Key messages included: “The IUD is a very good method for spacing births”; “The IUD is quickly and easily reversible”; “The IUD does not interfere

with work or sexual pleasure”; and “Men are supportive of women who use the IUD.”

Multiple channels and methodologies of communication were used, including mass media (radio), community mobilization, and interpersonal communication (e.g., “road shows,” orientation of religious leaders, and use of community peer educators as mobilizers and referral agents). Marketing efforts used testimonials from satisfied “early adopter” clients and provider champions. Demand creation campaigns of varying length and scope⁶ were mounted in Ethiopia, Guinea, Honduras,

⁶ These campaigns had relatively limited budgets: \$30,000 for a region of Ethiopia, \$50,000 for two districts in Uganda, and \$60,000 for one district in Kenya. The cost of the communications effort in Kenya—mass media, print, public relations, community activities, and peer educators—was approximately US\$76,500.



These IUD-specific posters and brochures were developed for use in Guinea, Kenya, and Uganda

Kenya, and Uganda. The reach of the radio campaigns proved to be extensive, ranging from an estimated 12,000 people in Guinea to as many as 240,000 or more in Kisii District, Kenya, which had the broadest and most complete range of information and demand creation activities, including mass media, experiential marketing, and many various community-level BCC/IEC activities.

The Supply-Demand-Advocacy Model in Action

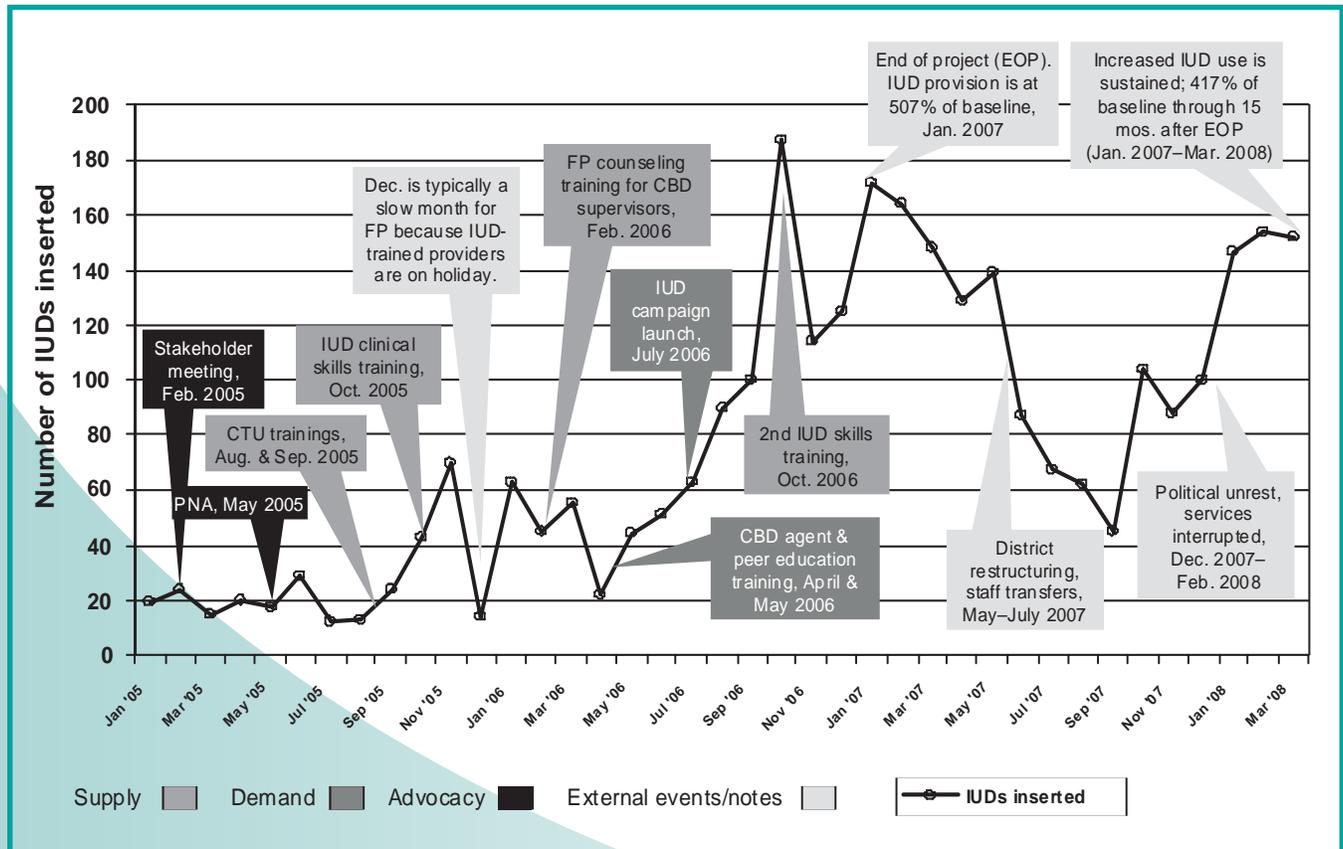
Background and Context

ACQUIRE's holistic program model was most fully and explicitly implemented in Kenya. There, the MOH had launched a national initiative in 2003 to revitalize the IUD as part of a balanced method mix, out of concern that use of the IUD (and of the other clinical FP methods) had fallen, despite a high unmet need for effective FP. The IUD's share of overall contraceptive prevalence in Kenya, which had been 33% in 1984, had declined

to less than 8% in 2004, at which time 1.2 million married women reported having an unmet need for modern FP. IUD use in Nyanza Province was even lower than the national IUD prevalence (0.5% vs. 2.5%), while unmet need for FP was higher in Nyanza than nationally (35% vs. 25%). In December 2004, the MOH therefore requested ACQUIRE to provide technical assistance in Nyanza's Kisii District.

From February 2005 to January 2007, ACQUIRE provided IUD-specific demand, supply, and advocacy assistance and support in Kisii District, closely linking and coordinating activities within these three components (ACQUIRE Project, 2006; IBP, 2007). Bimonthly service results were monitored and correlated with key program inputs, as well as with major external events that disrupt services, such as stock-outs, serious political unrest, transfer of staff trained in IUD service provision to other duties and locations, and health system restructuring (see Figure 1). Results were tracked not only during the project, but for 14 months after project

Figure 1: Number of IUDs inserted at ACQUIRE-supported sites, by time, key program inputs, and external events, Kisii, Kenya, January 2005–February 2008



support to the 13 project sites ended, thus affording a sense of the longer lasting change that arose.

What Was Done: Key Activities, by Component

After an initial stakeholder meeting in February 2005, a PNA was conducted in May 2005 in collaboration with the Kisii District Health Management Team, service providers and managers, and other stakeholders. The PNA obtained baseline data from facility audits of each service site, interviews with providers and clients, and nine focus group sessions with men and women in the sites' catchment areas. The PNA garnered consensus that deficiencies in all three components (supply, demand, and advocacy) were limiting IUD access and use and also generated partner commitment and engagement to address these deficiencies. Areas for program intervention within each component were identified and prioritized. Because significant advocacy efforts had already been undertaken at the national and provincial levels—including sensitization workshops, dissemination of IUD advocacy briefs, and updating of Kenya's FP service guidelines—ACQUIRE's advocacy effort in Kisii focused on identifying and nurturing IUD champions at the district and community levels, as well as ensuring that the updated policies and guidelines not only were in place, but also were being followed.

On the supply side, the PNA found that provider capacity was insufficient and that IUD service provision practices were often substandard, with biases against the IUD widespread, training outdated, and equipment and supplies for insertions lacking.

Thus, with a focus on the fundamentals of care, ACQUIRE provided CTUs and trained providers in IUD insertion and removal, FP counseling, and infection prevention. Supervisors were trained in facilitative supervision, gaps in needed equipment were filled, and systems for procuring commodities and expendable supplies were strengthened. Periodic monitoring visits were also conducted, and quarterly reports to the MOH were made; thus, attention to service system factors and dynamics, as well as to service outputs, was continual.

Overall, 555 providers were trained at 34 events, including 28 providers who received skills updates, 72 male and female peer educators from faith-based organizations, women's organizations, and youth groups, and 388 community-based distribution (CBD) agents and supervisors.

The demand-side effort focused on three aspects: improving accurate knowledge of clients, communities, and providers, by directly counteracting myths, misunderstandings, and misperceptions; improving the image of the IUD; and informing the public about where quality services could be accessed. Mass media and community outreach interventions were integrated, sequenced, and paced with increases in supply-side (service) capacity. A demand creation campaign was formally launched in July 2006 and was conducted for six months, centering on the pretested slogan "Now you know the truth." The campaign used local, regional, and national radio and was supported by 10,000 leaflets and 1,200 posters. Positive images conveyed concepts such as the convenience, safety, and effectiveness of the IUD; the physical stamina and well-being of users; a satisfied couple's happy and mutually supportive involvement; and a friendly and motivated female IUD provider. Ads were broadcast in local languages during peak listening periods, and a weekly talk show featured IUD advocates (doctors, peer educators, and satisfied IUD clients and their husbands) and offered listeners an opportunity to phone in.

Overall, this multifaceted communications campaign delivered approximately 250,000 exposures to IUD-related messages among the people living in Kisii District, 45% of whom reported hearing or seeing an IUD-related message. Approximately 50,000 people, including 21,000 men, were informed about the IUD by male and female peer educators from faith-based organizations, women's organizations, and youth groups at 2,700 community events. Additionally, CBD agents from the MOH served as referral links between women, communities, and the newly strengthened FP service sites. Nearly one in five residents of Kisii District reported having attended a community session focused on the IUD (ACQUIRE Project, 2008).

What Was Achieved: IUD Service Utilization and Other Sustained Changes

Although this effort was a modestly funded⁷ pilot project of relatively short duration, entailing provision of an underutilized and widely misunderstood clinical FP method in a geographically circumscribed area, project outputs were not inconsiderable, and positive service dynamics were generated and maintained. Knowledge of and positive attitudes toward the IUD increased, with 93% of women reporting knowledge (versus 68% nationally) and with one out of three women exposed to the IUD communications effort reporting that they would consider using an IUD in the future. IUD service utilization also increased across all 13 project sites. The number of IUD insertions during the second project year (959 in 2006) almost tripled compared with the baseline (338 IUD insertions in 2004). IUD utilization spiked after each set of key program interventions. After the initial training and other supply-side inputs, monthly IUD insertions rose steadily, from 28 insertions per month at baseline to 47 insertions per month. IUD use increased even more dramatically during and after the mass media demand creation campaign.

The level of IUD provision at project sites at the end of the project (142 insertions per month during the last quarter of 2006) was more than five times (507%) the level provided at baseline (28 insertions per month during 2004). Increased levels of IUD provision were sustained for at least 15 months after the end of the project, despite an intermediate four-month decline in services due to district restructuring and transfer of skilled staff. In 2007 and the first quarter of 2008, the monthly number of IUD insertions (1,305 per year) was more than quadruple (417%) the monthly number provided during the baseline year 2004. Positive changes in service provision extended beyond the IUD as well: Visible improvements were made in the supervision system; a CBD program was implemented, with linkages between the community and the project sites increasing; male engagement in FP increased; and project sites reported having served 33% more new FP clients (for all methods) in the first quarter of 2008 compared with the same time in 2007.

⁷ The project had a two-year budget of approximately \$630,000.

Lessons Learned or Confirmed, Effective Practices, and Challenges

ACQUIRE learned or confirmed a number of lessons about effective programming for IUDs. These lessons extend beyond the provision of the IUD per se, and also are relevant and applicable to the other FP methods that also have a substantial medical/ clinical dimension to their provision (implants, injectables, vasectomy, and female sterilization).

Overall

- An FP service system is like a chain, composed of interlocking and interacting parts and only as strong as its weakest link. Thus, a **holistic approach** to IUD revitalization, with integrated and mutually reinforcing supply-side and demand-side programming, is more likely to be efficacious than is a more narrowly focused effort that may well not have all of its important components functioning at the same time.
- **Greater access**, within the context of a **wide choice of methods**, is the outcome that IUD service activities must work toward. *Access* (the degree to which a method can be obtained at an effort and cost acceptable to and within the means of most women) includes cognitive, sociocultural, geographic, financial, and health care system factors. Barriers to these aspects of access are common, and any one barrier can prevent even a motivated client from obtaining an IUD.
- **Change takes time**, especially in the overburdened and resource-strapped clinical settings where IUDs must be provided. There is no “quick fix,” but the sustained effort needed to make IUD services available is worthwhile, as it can result in the IUD’s wider use.
- **Repetition** of effort, message, and/or intervention is the key to generating and sustaining programmatic change, especially for clinical methods such as the IUD. **“One-off” interventions are generally insufficient and minimally effective**, whether that intervention is aimed at changing policies, increasing resources, improving program practices, or generating more accurate provider, client, and community knowledge.

- **Even modestly resourced interventions can generate noteworthy improvements** in IUD services that last beyond a project's life.

Advocacy-Related

- **Champions** at every level—provider, program manager, facility, policymaker, donor, client, and community—can and should be identified, supported, and otherwise "nurtured" to advance the knowledge, acceptability, image, and use of the IUD.
- Advocacy efforts to foster a supportive policy, program, and resource environment should be **informed by locally generated, relevant, context-specific data** and other evidence about the need for, and the cost, acceptability, and safety of, the IUD. This information should also inform strategies, service policies, and program designs and interventions. The Reality ✓ tool can be very useful in such advocacy, planning, and programming.
- **Stakeholder participation** is critical to fostering broader engagement, ownership, and sustainability of IUD services. It can be stimulated by stakeholder involvement in formal **needs assessments** that address root causes, identify sound strategies, and establish realistic service goals. Key stakeholders include political, religious, and other opinion leaders; the medical community; program managers and service providers; and community organizations.
- **Health system policies** greatly influence clients' access to the IUD, since the IUD is a provider-dependent method. Policies unnecessarily restricting which cadres of providers can provide the IUD and which categories of clients may receive it are common programmatic challenges that inappropriately limit clients' choice of the IUD.

Demand-Related

- **Method-specific demand creation efforts are effective** in increasing accurate knowledge and use of the IUD, especially when information is conveyed via **multiple channels and methodologies** and when rumors and myths are addressed directly and candidly.

- **Consumer and provider research should be used to clarify barriers to IUD uptake.** Programs should not assume that the specific barriers to IUD uptake are "known" for any given community or set of providers. Such assumptions may be erroneous.
- **Demand creation campaigns need to be conducted for an adequate length of time,** as repeated messaging leads to repeated increases in method uptake. In addition, when messages are "pulsed" over time, economies of scale can accrue, as funds invested for initial message and materials development do not need to be expended again.
- **Communications efforts should promote male involvement,** using gender-appropriate messages that engage men (who are often "gate keepers") as supportive partners in FP decision making, including adoption of the IUD.
- **Use of satisfied clients and provider champions** in demand creation campaigns and interpersonal communication efforts is an effective strategy to model positive attitudes and behavior among providers, improve the image of the IUD, and promote its choice and use.

Supply-Related

- Continuous attention to the **fundamentals of care**—informed choice, medical safety, and ongoing quality improvement and management—must be the bedrock principle of all IUD and other clinical method services.
- **Service programs need to adopt "a provider perspective"** in addition to "a client perspective," because provision of the IUD depends upon a skilled and motivated provider. Supervision, quality improvement, and management efforts should thus focus on understanding providers' needs and improving providers' knowledge, skills, motivation, and performance. This includes ensuring an appropriate reward system for quality IUD service provision.⁸

⁸ Too often, provision of the IUD simply represents "more work" for an already overburdened provider and system—even though over time the use of IUDs (and other clinical methods) would reduce those burdens. Rewards do not need only to be monetary: Successful nonmonetary rewards include professional and/or community recognition for productivity and expertise and opportunities for additional training.

- **Provision of CTUs** can be used strategically as a “hook” to stimulate provider and program interest and engagement in updating IUD service policies and revitalizing IUD service provision, as well as a means to reduce provider bias against the IUD.⁹
- For IUD services to be programmatically sustainable, they need **ongoing, well-functioning training, supervision, and supply and logistics systems**, informed by updated standards, norms, guidelines, and protocols geared to meeting clients’ needs.
- **Contraceptive security** is critical to ensuring reliable IUD service provision in programs. It requires an adequate stock of IUDs, equipment, and supplies and an adequate complement of regularly available, skilled providers. Maintaining skilled and active IUD providers in the health workforce in the face of frequent transfer or reassignment of duties is a continual challenge that must be met, as their availability is a “rate-limiting step” in IUD service provision.

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⁹ This should go beyond passive “knowledge presentation.” Champions—committed and locally respected medical leaders and active IUD service providers—can present the latest IUD-related scientific information and program guidance, engage in dialogue about provider concerns and misconceptions, and provide the latest IUD-related job aids (e.g., handbooks, algorithms, and checklists).

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