

REPUBLIC OF KENYA



**MINISTRY OF PUBLIC HEALTH AND
SANITATION**

DIVISION OF REPRODUCTIVE HEALTH

**KENYA COMPARATIVE
ASSESSMENT OF
LONG-ACTING &
PERMANENT METHODS
ACTIVITIES**

Final Report

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All Correspondence to:

Head, Division of Reproductive Health,
Ministry of Public Health and Sanitation
Old Mbagathi Road
P. O. Box 43319
Nairobi
Kenya

Tel: +254-20-2725105
Fax: +254-20-2716814

Kenya Comparative Assessment of LAPM Activities: Final Report

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Contributors included:

Dr Josephine Kibaru

Dr Bartilol Kigen

Jennifer Wesson

Erin McGinn

John M. Pile

Ferdinand Mose

Violet Bukusi

Marsden Solomon

Frederick Ndede

Feddis Mumba

Alyson Smith

Executive Summary

Introduction

In 1989, long-acting and permanent methods of contraception (LAPMs) accounted for 47 percent of all modern contraceptive use among currently married women aged 15-49 in Kenya. In 2003, the LAPM share of modern contraceptive use had decreased by 55 percent to 21 percent of modern contraceptive use in Kenya. In the past five years, efforts have been made to ensure a range of contraceptive choice in Kenya. The most comprehensive interventions have occurred under the leadership of the Ministry of Health's IUCD Reintroduction Task Force, which helped launch several interventions with the goal of increasing use of IUCDs and, by extension, long-acting and permanent methods of contraception (LAPMs). Three recent projects have embraced models incorporating LAPM advocacy, stable supply, and demand creation: AMKENI, AMUA, and ACQUIRE. All of these projects have similar end points (i.e., increase in LAPM use), which affords a unique opportunity to examine more closely the medium-term outcomes and impact of each intervention, and to determine which combination of these approaches might be best for increasing LAPM use.

This assessment employs a multiple-case study (comparative) approach in which each of these three major LAPM-related interventions was defined as a "case." We use pre-existing project information and data collected specifically for this purpose; the primary data used to compare the interventions were the pre- and post-intervention levels of LAPM provision at the service delivery sites. In addition, program managers, providers, and clients were interviewed in April and May 2007 at all the sites included in the study. The ultimate goal of this assessment is to inform the design of future LAPM revitalization efforts in Kenya.

Results of the interventions: LAPM uptake

Direct comparisons among the interventions are difficult because of their differing objectives and sizes; however, all three targeted the IUCD. This assessment examines a small, comparable number of sites for each intervention. The table below demonstrates that while percentage increases in IUCD uptake were impressively high at the peak of each intervention, the maximum monthly provision of IUCDs was still relatively low. At their peak, a sample of AMKENI sites provided approximately eight IUCDs per site per month. A sample of AMUA sites provided a high of five IUCDs per site per month. The six-month-period high for the ACQUIRE sites was 12 IUCDs provided per site per month.

Comparison of peak IUCD uptake among intervention sites

	% Increase in IUCD uptake at peak	Average number IUCDs per site per month at intervention's peak
AMKENI*	1187%	8
AMUA±	160%	5
ACQUIRE**	734%	12

*AMKENI peak quarter Q3 2004, 193 IUCDs in 8 sites; ± AMUA peak, Q4 2006, 143 IUCDs in 10 sites; **ACQUIRE peak Q1 2007, 484 IUCDs in 13 sites.

Beyond the IUCD, all the projects increased provision of other LAPMs, but few of these increases were sustained beyond the end of the project. AMKENI concluded in March 2006, at which time the eight sites included in this assessment were providing between four and five times the numbers of IUCDs, implants, and tubal ligations (i.e., tubal ligations [TL] = female sterilization) compared to baseline, although these increases were

smaller than the provision the project achieved at its peak. A sample of 10 clinics participating in either the AMUA network or mobile TL services nearly tripled provision of IUCDs and TL from January - June 2005 to January - June 2007. The AMUA project is on-going. Although the ACQUIRE project specifically targeted IUCDs, the district it worked in also experienced a five-percent increase in all family planning (FP) clients, and a 19-percent increase in uptake of female sterilization. As with IUCD provision, the actual numbers of clients using these LAPMs were small, despite the dramatic percentage increases, ranging from less than one client per clinic per month at baseline to a maximum of 12 clients per clinic per month.

This comparative assessment was able to address longer-term sustainability for two of the three interventions (the AMUA project is ongoing). Review of LAPM uptake in sites from the AMKENI intervention, which ended in March 2006, raises some concerns regarding sustainability. Fifteen months after AMKENI's conclusion, the number of IUCDs and implants provided remained elevated. This increase was observed in a selection of high- and low-performing AMKENI facilities, which may approximate an average level of achievement for AMKENI facilities. On the other hand, provision of TL quickly returned to baseline levels after the conclusion of the AMKENI project. In another positive finding, despite a large decrease in IUCDs provided during a district staff transfer in Kisii, the provision of IUCDs in ACQUIRE pilot sites remains elevated over one year after the intervention concluded, and indeed continues to grow.

Intervention elements and lessons learned

Ensuring an adequate supply of trained personnel

- Maintaining a trained workforce in facilities after interventions end is an ongoing issue. Respondents reported frequent transfers of trained providers to other duties where they no longer use the skills they acquired through the interventions.
- Past research demonstrated that not only provider skills, but also provider attitudes constitute a barrier to LAPM use. Attitudes may affect how providers counsel about LAPM. A large majority of providers in AMKENI and AMUA facilities said that they always counsel clients about IUCDs, implants, and TL. However, there is a gap between what providers say about their counseling, and what clients report providers tell them. Among the few clients interviewed who were coming to the facility for a new method, less than half said that the provider discussed the IUCD, TL, or vasectomy with them.
- Despite large numbers of provider trainings, provider biases against certain methods (notably the IUCD) remain. Some providers expressed unfounded concerns about the relationship between IUCD and pelvic infection, and there was some evidence among both providers and clients in former AMKENI and AMUA sites that the IUCD is perceived as ineffective at preventing pregnancy.

Making commodities, equipment, and expendable supplies available

- All of the ACQUIRE-supported facilities were fully equipped for IUCD insertion and removal when they were observed six months after the end of the ACQUIRE intervention. A year after AMKENI ended only 20 percent of AMKENI facilities were fully equipped for IUCD insertion and removal, while the AMUA project

(ongoing) has only 70 percent of its facilities equipped for IUCD insertion and removal. Only 10 percent and 20 percent of facilities respectively were equipped for implant insertion and removal at the time of facility audits.

- Ensuring adequate commodities and other consumable supplies for LAPMs (and other FP methods) is a constant challenge. Implants were stocked out nationally at least twice during the past seven years, and injectable contraceptives were out of stock during the time of fieldwork for the assessment. Among 22 AMKENI and ACQUIRE facilities examined, only two had DMPA in stock. Stock-outs can force clients to choose methods they may not originally prefer. Data from Kisii showed IUCD uptake increased when there were DMPA stock-outs. Several of the LAPM users interviewed said that they had been compelled to select another, less appealing alternative due to injectable stock-outs.

Improving knowledge and confronting myths and misconceptions to help create demand

- All three interventions included either community based distribution (CBD) agents or volunteer peer educators in their demand creation activities. Providers in all interventions agreed that CBD agents and peer educators had improved community opinions about LAPM. Both providers and clients suggested that one of the best ways to improve clients' views about specific methods was by using peer education, particularly by satisfied users of that method. CBD agents seemed to play a role in education and referral to clinics, but retaining committed volunteers over time is challenging.
- The ACQUIRE communications campaign was designed to address women's and men's views about the IUCD and to challenge myths and rumors. Using the slogan, "Now you know the truth," the campaign's goal was to improve the image of the IUCD in the community. An evaluation of this campaign in April 2007 showed that 45 percent of the district reported hearing or seeing IUCD advertising in the past six months. Nearly one in five respondents had attended a community session focused on the IUCD. Once those sessions concluded, respondents were likely to take some action about family planning, such as talking to a partner or family/friend. The ACQUIRE project concluded that while advertising encourages method awareness and consideration, community sessions are integral to driving people to action.
- Given the relatively greater achievement of IUCD provision in ACQUIRE, it appears that targeted messages were more effective than the broader information, education, and communication (IEC) messages of AMKENI and AMUA.
- Despite community outreach and mass media campaign efforts, knowledge about LAPMs was still somewhat low among family planning clients attending AMKENI and AMUA facilities (between 22 and 52 percent of clients said they did not know about each LAPM method). Among the clients interviewed, relatively large proportions of respondents reported that their knowledge about LAPM methods was insufficient to make a judgment about them.

Client perspectives on LAPMs

- Understanding the motivations of LAPM clients may help to better promote these methods in the future. For LAPM users, the long-acting effectiveness or permanence of the methods is an important advantage. Some users emphasized the convenience

of not having to make repeated trips to the clinic. Other users said they preferred long-acting methods because they do not have to remember to take pills every day, or remember to come back for re-injections. Some users noted the lower costs associated with using a long-acting method.

- While overall use of TL has declined in Kenya, many providers interviewed noted that TL demand was not only strong, but increasing in their facilities. Current LAPM clients seemed to have a good impression of female sterilization overall, and many indicated that it would be their preferred method of contraception once they had a desired number of children. Despite the demand for TL, interventions have faced challenges in increasing access to permanent methods of contraception. Only about 20 percent and 12 percent of providers interviewed for this assessment had received any TL or vasectomy training, respectively, in the past five years. Among the facilities included in this assessment, only about half offer any permanent method of contraception (TL and/or vasectomy).

Conclusion

The interventions that were examined lasted from two to five years and attempted to address significant issues with health systems and entrenched attitudes among providers and clients. Although all three projects made progress, the magnitude of progress, in terms of the total number of clients served was relatively modest, compared to the total number of FP clients. Longer-term outcomes were mixed. In the case of AMKENI, cessation of project activities appears to have coincided with rapid returns to near-baseline levels of method provision. This failure to sustain progress could be due to staff transfers and to logistical problems with equipment, supplies, and commodities. On the other hand, the ACQUIRE project observed continuing increases in IUCD service provision several months after the project concluded. Still in progress, AMUA has increased and maintained its increase of LAPM provision. Regardless of how the intervention performed, they often had challenges with training, readiness of facilities in terms of equipment and commodities and demand creation. One single element did not stand out as the most important determinant of increased LAPM uptake.

The assessment reveals several important lessons. Implementing both supply-side and demand-side activities at the same time as conducting advocacy seems to be the best model for this kind of work. ACQUIRE, an intervention targeted at one method, seemed to yield more positive results. The implementation of the AMUA social franchising network of private providers may be a promising direction for future public-private partnership efforts, if the costs can be controlled. The costs associated with targeted IUCD or broader LAPM/FP interventions have not been examined, thus information on cost per CYP, replicability, and sustainability is lacking. Instead of primarily relying on donor funds, LAPM efforts should be mainstreamed into the MOPHS structure and funded through the annual operating plans. Finally, if they decide that LAPM efforts should continue to be prioritized, the MOPHS and donors need to take a longer term approach to promoting LAPM utilization so that progress achieved during interventions can be sustained over time.

Introduction

During the past 20 years in Kenya, the percentage of currently married women using any modern contraceptive has tripled, from 10 percent to 33 percent.¹⁻⁴ Despite the increases in contraceptive use, over 24 percent of currently married women aged 15-49 still have an unmet need for family planning.³ According to the 2003 Kenya Demographic and Health Survey (KDHS), contraceptive prevalence has plateaued after decades of steady growth, and Kenya's total fertility rate has increased slightly.³

Kenyan policy makers are concerned about how to maintain and expand reproductive health services when national and donated resources are not meeting anticipated commodity needs. Nearly half of Kenya's population (13 million) is under 15 years of age, and 100,000 young people turn 16 every year, a pattern that will continue for over a decade. Use of long-acting methods such as the intra-uterine contraceptive device (IUCD) and female sterilization (e.g. tubal ligation, TL) is decreasing, while a continuing increase in the use of injectables made it the predominant method in 2003.³ In 1989, long-acting and permanent methods of contraception (LAPMs) accounted for 47 percent of all modern contraceptive use among currently married women aged 15-49 in Kenya (20.6% intrauterine contraceptive device (IUCD); 26.2% female sterilization).^{#139} Over ten years later, the LAPM share of modern contraceptive use has decreased by 55 percent. In 2003, only 21 percent of modern contraceptive use in Kenya was attributed to LAPMs (7.6% IUCD, 13.7% female sterilization).^{#139} Male sterilization has remained almost nil in Kenya.

One concern about increasing reliance on short-acting methods is that methods like injectables and pills have been shown to have higher rates of discontinuation within a year than does the IUCD, a long-acting method.⁵ All of these trends mean that demand for family planning commodities will continue to increase. The declining utilization of long-acting and permanent methods (LAPM) occurs at a time when the total annual cost of all commodities is projected to increase from US\$16.7 million in 2004 to US\$21.7 million in 2015 just to maintain the current prevalence rate and method mix.ⁱ

Recent Kenyan interventions for LAPM and IUCD

In the past five years, several efforts have been made to ensure a range of contraceptive choice in Kenya. The most comprehensive interventions have occurred under the leadership of the Ministry of Public Health and Sanitation's (MOPHS) IUCD Reintroduction Task Force, which helped launch several interventions with the goal of increasing use of IUCDs and, by extension, LAPM. The MOPHS and other partners have also led national efforts.

ⁱ Based on a forecast done using the ACQUIRE Project Reality \sqrt Tool. The forecast used the CPR and method mix from the 2003 DHS, UN projections for the number of women of reproductive age 2003-2015 in Kenya, and ran a projection assuming no change in the CPR/method mix. See www.engenderhealth.org for more information about the tool.

National efforts

In 2002, the MOPHS, Division of Reproductive Health led a nationwide initiative to introduce Norplant© by training providers how to insert and remove the device. The MOPHS revised service provider guidelines to allow nurses and clinical officers to provide implants. Subsequently, national provider trainings and enhanced commodity and expendable supplies were provided. In 2004, Norplant© was phased out of the Kenyan FP program and replaced by Jadelle and Implanon.⁹

The MOPHS and FHI, together with professional associations (the Kenya Medical Association, the Kenya Obstetrics and Gynecological Society, the Nursing Council of Kenya, and the Kenya Medical Training College), carried out continuing professional development (CPD) sessions for public and private sector health care providers in all eight provinces, and for trainers from training institutions around Kenya in 2004 and 2005 (Table 1). The trainers (university lecturers and lecturers in private and public medical training institutions) were targeted because of their role in molding the country's pool of service providers. In total, 376 public sector providers and managers, 235 private practitioners, and 83 trainers from 39 training institutions participated.

The MOPHS updated the National Guidelines on Reproductive Health and Family planning in 2005 to reflect changes in the World Health Organization (WHO) medical eligibility criteria (MEC) for contraceptive use. These guidelines were disseminated through the CPD sessions, among other means. The CPD sessions also provided information on changing RH trends in Kenya. Although evaluation efforts of the sessions were sporadic, reports showed that levels of knowledge increased approximately 15 percentage points from pre-training to post-training tests. A mail evaluation six months after the CPDs showed that providers had retained much of that knowledge, especially about the IUCD, but the limited information available on their IUCD provision did not show increases (unpublished data, FHI).

Three large-scale LAPM interventions have also taken place in Kenya since 2000.

AMKENI Project

AMKENI was designed and funded by USAID/Kenya and operated under the auspices of the MOPHS. The goal of this five-year RH project was to increase the provision of sustainable, integrated, comprehensive RH/FP/child survival (CS) services, including HIV/AIDS prevention services, at the community level. From this goal, AMKENI formulated three objectives:

1. Increasing access to sustainable comprehensive RH/FP/CS services, including HIV/AIDS prevention services
2. Improving the quality of sustainable, comprehensive RH/FP/CS services, including HIV/AIDS prevention services
3. Increasing healthier behavior among the population

Table 1: Summary of recent major IUCD/LAPM interventions in Kenya

Name	Coordinating agencies	Geographic area	Principal sector targeted		Activities for LAPM promotion							Services targeted	Budget obligated	
			Private	Public	Policy/ guideline changes	Provider training		Commodity/ supply systems	Facility/ equipment upgrades	CBD/Peer Educator involvement	Communi- cations campaign			
						Clinical training	Sensiti- zation							
AMKENI Q1 2000- Q2 2006	EngenderHealth, Program for Appropriate Technology in Health (PATH), FHI, IntraHealth International Inc.nj	96 facilities in Coast and Western provinces		X		X				X	X		Reproductive health, all FP methods, child survival	US\$18.9 million
MOPHS Initiative to Access Norplant® Q1-Q4 2002	Ministry of Health/ Division of Reproductive Health	National		X	X	X		X					Norplant®	Not available
CPD seminars Q1 2004-Q4 2005	FHI, Ministry of Health/ Division of Reproductive Health	All 8 provinces & national trainers	X	X			X						All FP, emphasis on IUCD	US\$ 90,000
Amua Network Q2 2004- ongoing	Marie Stopes Kenya, Marie Stopes International, MOPHS	141 providers in Western, Nyanza and Rift Valley provinces	X		X	X		X	X	X	X		Tubal ligation, vasectomy, IUCD	Euros 2.0 million
Policy/ Central Level Q1-Q4 2005	MOPHS/Division of Reproductive Health, FHI, and other partners.	National	X	X	X		X						All FP, emphasis on IUCD	US\$ 50,000
ACQUIRE Q1 2005- Q2 2007	EngenderHealth	13 facilities in Kisii District, Nyanza province		X		X			X	X	X		IUCD	US\$ 650,000

AMKENI worked with the national Division of Reproductive Health at provincial and district levels. The implementation model stressed the importance of addressing the *demand* and the *supply* sides of the equation simultaneously and comprehensively in an integrated, coordinated manner. The AMKENI Model utilized three strategies:

1. Access and quality – improving the capacity of health facilities to provide FP/RH/CS services, including HIV- and AIDS-related services
2. Behavior Change Communication (BCC) – working with communities to promote FP/RH/CS healthier behaviors and demand for services
3. Sustainability – strengthening the MOPHS’s decentralized systems for training and supervising reproductive health service providers

AMUA Social Franchise Project

Social franchises enable distribution of products and services by harnessing unused capacity amongst entrepreneurs in the private sector.¹⁰ The AMUAⁱⁱ project is supported by the German government through its development bank, KFW (Kreditanstalt für Wiederaufbau). Marie Stopes Kenya (MSK) with cooperation from Marie Stopes International London (MSI) and the MOPHS initiated project activities in April 2004.

AMUA seeks to contribute to the improvement of the reproductive health of poorer and hard-to-reach women (aged above 25) in under-served areas of Kenya through increased utilization of modern clinical family planning methods (i.e, bilateral tubal ligation via "minilap" and IUCD). Its objectives are:

1. Increasing utilization of modern clinical family planning methods in Kenya
2. Developing/implementing social marketing procedures through training and networking of service providers
3. Improving accessibility of quality affordable clinical services through implementation of a reliable distribution system for supplied commodities
4. Increasing demand for long-acting clinical family planning methods and enhancing awareness of available networked services through implementation of a comprehensive IEC/marketing campaign

The project targeted recruitment of 70 doctors 15 clinical officers and 100 nurses for franchising. By January 2007, only seven doctors had been recruited; the targets for nurses and clinical officers were surpassed (111 and 33 trained, respectively). Anecdotal evidence suggests that doctors did not see a profit motive in providing sterilization services; this issue will be further examined by the AMUA project in their second phase. Franchisees receive subsidized supplies and equipment, and training, and benefit from AMUA demand creation activities.

ACQUIRE Project: Kisii FP Revitalization Initiative

In December 2004, the MOH Division of Reproductive Health requested the ACQUIRE Project’s technical assistance and support to expand IUCD revitalization efforts to Kisii District, in southwestern Kenya. ACQUIRE and local stakeholders applied the MOH’s

ⁱⁱ meaning “decide” in KiSwahili

national IUCD strategy (developed during the AMKENI intervention).ⁱⁱⁱ Following a stakeholder meeting, the MOH and ACQUIRE conducted a performance needs assessment (PNA) in order to identify critical issues; this consisted of a data collection exercise in 12 sites, focus group discussions, and a subsequent stakeholders' workshop. Following this assessment, the District MOH selected 13 sites in Kisii to be fully supported throughout the project cycle; however other sites in the Kisii District were supported through trainings.

Efforts were made to focus on both supply and demand side needs, while simultaneous attention was given to local advocacy among providers, stakeholders, and community members, and creating and linking the community and campaign components. The timing of each individual activity was coordinated so that the supply side was strengthened and in place before the community activities and the communications campaign were launched. Ensuring the campaign messages were consistent throughout all components of the project – both on the supply and demand sides – was important so that clients received accurate messages regarding family planning and the IUCD. Sensitizing project partners before the campaign was officially launched allowed for messages to be consistent, thus reinforcing messages of safety and uses. Peer educators, CBD, radio, and road show events delivered campaign messages.

Objectives and methods

As described above, the AMKENI, AMUA and ACQUIRE interventions embraced multi-dimensional models encapsulating issues of both supply and demand.^{iv} At the same time, the interventions have had slightly differing foci. For example, the AMUA Network works with private sector providers, while the bulk of AMKENI and ACQUIRE work was with public sector providers. ACQUIRE concentrated on efforts to revitalize the IUCD, while AMUA stresses clinical methods of contraception (IUCD and sterilization), and the AMKENI project targeted all modern forms of contraception. The presence of these projects with similar end points (i.e., increase in LAPM use) in one country affords an opportunity to examine more closely the longer-term outcomes and impact of each intervention, and to determine what combination of these approaches might be best for increasing LAPM use.

Objectives

The overall goal of this project is to inform the design of future LAPM revitalization efforts by comparing and contrasting the various interventions that have recently taken place in Kenya. This comparative assessment addresses several research objectives:

- Describe interventions conducted in Kenya from 2000-2007 as part of the initiative to increase LAPM and IUCD use, including program managers' views on the strengths and limitations of the interventions.
- Describe the pre- and post-intervention LAPM utilization levels for facilities participating in each intervention, where it is available.

ⁱⁱⁱ The Ministry's strategy has four components: 1) consensus-building and advocacy, 2) building capacity and improving service delivery, 3) demand creation, and 4) monitoring and evaluation.

^{iv} The ACQUIRE project also included elements of advocacy.

- Describe levels of knowledge and attitudes among family planning (FP) clients and providers in sites that were subject to one or more interventions about LAPM.
- Determine the key determinants influencing clients who choose LAPM.

Methods

There was no attempt to attribute results to a single intervention (due to geographic overlap of the projects), but rather we employed a multiple-case study (comparative) approach. A multiple-case study design is ideal to address these objectives because case studies provide more context than typical study designs, giving the “story behind the result.”⁶ The formal definition of a case study is “an empirical inquiry that:

- 1) investigates a contemporary phenomenon within its real-life context; when
- 2) the boundaries between the phenomenon and context are not clearly evident; and in which
- 3) multiple sources of evidence are used.”⁷

A limitation of using a case study design is that one cannot make causal conclusions based on its results. Due to varying intervention start dates, the differing lengths of time during which interventions took place, selective recall of events, the differing times required for interventions to mature into their most effective state, and the reality that the context relating to LAPM changed in the last several years as national programs expanded, no study design could address the issue of causality. Hence, we employed a study design that is exploratory instead of experimental.

Each of three major LAPM-related interventions (AMKENI, ACQUIRE, AMUA) was defined as a “case.” Each case was, in turn, examined in several sites (i.e., facilities, communities). We purposively selected 10 facility sites to represent each of the three major interventions. We asked projects to identify some sites where the interventions worked particularly well, and some where there were more difficulties. The 6 sites examined in the ACQUIRE case study were part of a larger case study on the ACQUIRE project done by EngenderHealth.

We limited site selection to the western part of Kenya, where the interventions came closest to overlapping geographically, both for logistical reasons, and to keep the areas as comparable as possible. We collected data from AMKENI sites in Western Province, ACQUIRE sites in the Kisii District of Nyanza Province, and AMUA sites in Rift Valley Province.^v Data on ACQUIRE sites were collected from February to August 2007. Data from AMKENI and AMUA sites and interviews with national and program-level stakeholders were collected in June and July 2007 (Table 1). Because the ACQUIRE case study had been designed before this comparative analysis was conceived, the types of information collected at ACQUIRE sites were slightly different than those collected at AMKENI and AMUA sites.

^v Note: two of the “AMUA” facilities are public sector facilities that participate in the TL mobile clinics with Marie Stopes Kenya. Stakeholders in the AMKENI project in Coast Province were also interviewed.

Table 2: Data collected at 26 sites included in the comparative assessment

	AMKENI (N=10 sites)	AMUA (N=10 sites)	ACQUIRE (N=6 sites)	Type of data
Stakeholder interviews	26			In-depth interviews
Provider interviews	26	14	6	Closed-ended questions
Facility in-charge interviews	9	10	n/a	Closed-ended and open-ended questions
Client exit interviews	60	28	6	Closed-ended questions
Facility audits	10	10	6	Facility infrastructure and stocks
Champions	n/a	n/a	8	In-depth interviews
CBD agents	0	0	12	In-depth interviews
Peer educators	0	0	16	In-depth interviews
LAPM user interviews				
IUCD users	16	9	4	In-depth interviews
Implant users	8	14	n/a	In-depth interviews
Tubal ligation users	18	7	n/a	In-depth interviews
Vasectomy users	3	0		In-depth interviews
<i>Total LAPM users</i>	<i>45</i>	<i>30</i>	<i>4</i>	
Pre and post-intervention FP provision				
	8 sites	10 sites	13 sites*	Service statistics

* Service statistics were available for all 13 of the ACQUIRE pilot sites, but the interviews only took place in 6 pilot sites.

The primary data used to compare the interventions were the pre- and post-intervention levels of contraceptive provision at the service delivery sites (Table 1). In addition, program managers, providers, and clients were interviewed at all the sites included in the study. Secondary data were examined through project reports (see Appendix for list of documents reviewed). Family Health International (FHI) led data collection efforts at the AMKENI and AMUA sites. EngenderHealth led data collection efforts at the ACQUIRE sites. One weakness of this study is that peer educators and community-based distribution agents were not interviewed at the AMKENI and AMUA sites. It is also important to note that with small sample sizes and purposive selection of facilities, this assessment can only be generalized to the few facilities and clients included in the data collection. This report is not meant to be a definitive representation of the experiences in the three interventions, but rather is meant to highlight differences, similarities and recommend the direction of future LAPM interventions.

Data from knowledge, attitude and practice (KAP) questionnaires of clients, providers and program managers, and service statistics were entered into a quantitative database in the FHI office in Nairobi, using EpiInfo software. The quantitative data were compiled into descriptive tables and stratified by the intervention type. In-depth interviews were recorded and transcribed into English in Nairobi. Transcripts were then analyzed for common themes.

Results of the interventions: LAPM uptake

All three interventions observed increases in LAPM utilization. In its 96 facilities, the AMKENI project achieved a 129 percent increase in annual IUCD insertions from baseline to the end of the project, a 48 percent increase in implant provision (although utilization varied significantly depending upon available stock), and a 363 percent

increase in annual TLs performed. At 36 months into its intervention, the 141 AMUA Network franchisees had provided 20,514 TLs to women seeking FP, and inserted 15,020 IUCDs in family planning clients. The ACQUIRE project observed a 122-percent increase in IUCD use overall in Kisii District between January 2005 and December 2006 and a 403-percent increase in the 13 ACQUIRE-supported facilities.

Direct comparisons among the interventions are difficult because of their differing objectives and sizes. However, all three interventions targeted the IUCD. To facilitate comparisons, this assessment examined a small, comparable number of sites for each intervention. Table 3 demonstrates that while percentage increases in IUCD uptake were impressively high at the peak of each intervention, the maximum average monthly provision of IUCDs in each facility was still relatively low. At their peak, the eight AMKENI sites provided approximately six IUCDs per site per month. The 10 AMUA sites provided a high of three IUCDs per site per month. By contrast, the six-month period high for the 13 ACQUIRE pilot sites was 12 IUCDs provided per site per month.

Table 3: Comparison of LAPM uptake at peak among interventions

	IUCD		Sterilization*		Implants	
	% Increase in uptake	Average number per site per month	% Increase in uptake	Average number per site per month	% Increase in uptake	Average number per site per month
AMKENI	1187	6	685	8	2592	7
AMUA	160	3	477	6	n/a [±]	n/a
ACQUIRE	734	12	**	1	168	4

* Sterilization includes both female and male sterilization, but the vasectomy numbers were negligible.
[±] Implants were not available in the AMUA Network at the time of data collection.
^{**} Unable to calculate percentage increase, since provision at baseline was 0; peak provision was 45 sterilizations performed in 13 sites in quarter 2 of 2007.

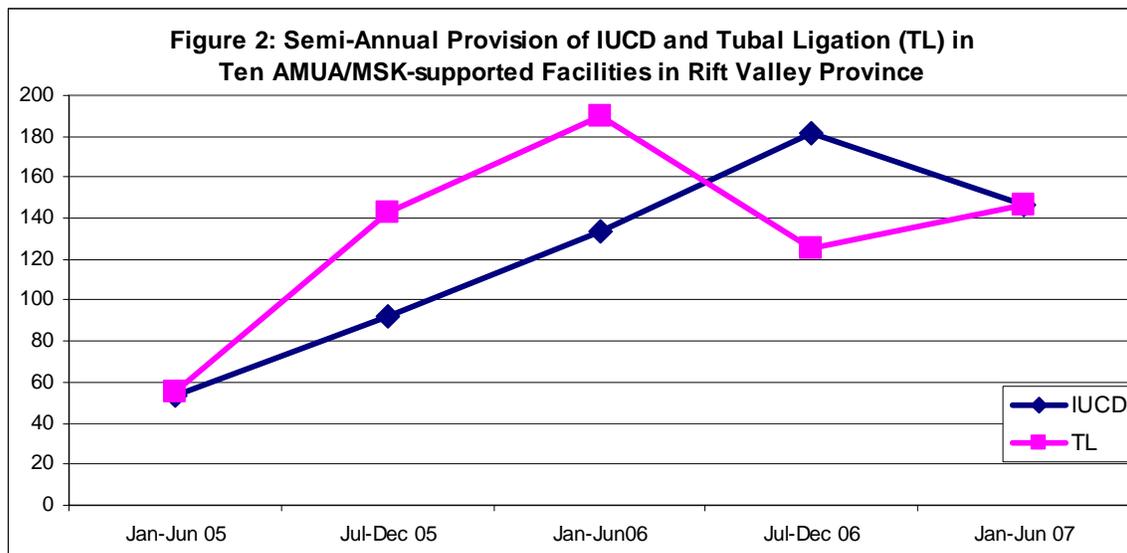
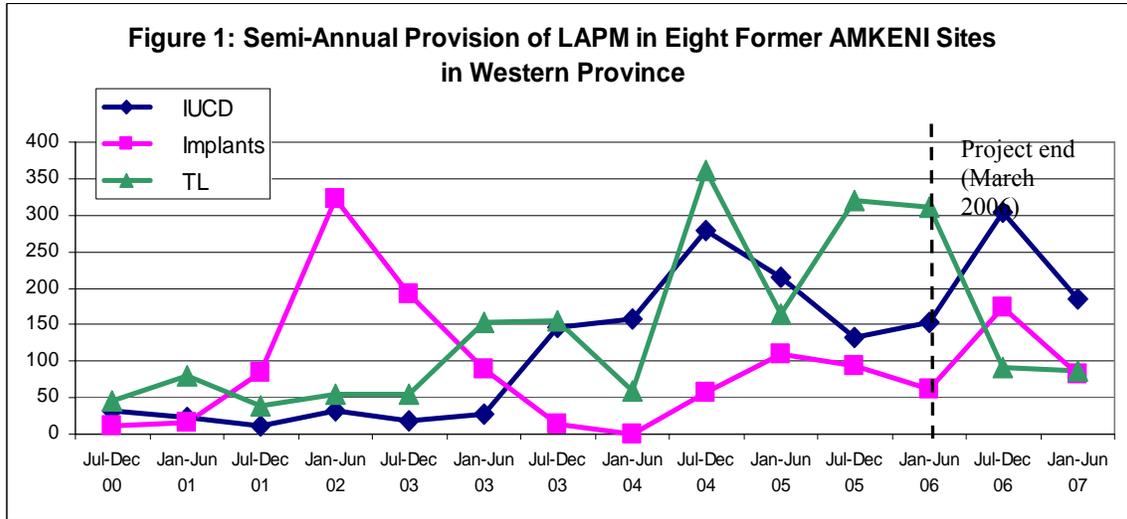
The assessment collected utilization data for eight AMKENI sites 15 months after the end of the intervention, allowing an examination of the intervention’s longer-term results (Figure 1).^{vi} AMKENI concluded in March 2006, at which time the eight sites were providing increased numbers of IUCDs, implants and TLs as compared to July-December 2000. Since the project concluded, the number of TLs provided has dropped to near-baseline levels, but the number of IUCDs and implants provided remains elevated. This provides some evidence that the AMKENI project had a modest sustained impact on LAPM provision, especially IUCDs.

Figure 2 presents data from eight AMUA facilities and two MOPHS facilities that participate in the MSK TL mobile outreach. More clients have received TL services in these facilities in the past three years than have received IUCDs. Indeed, MSK did not meet its mid-term targets of couple-years of protection (CYP) provided because of lower than expected IUCD uptake.^{vii} Low uptake also resulted in the cost per CYP exceeding

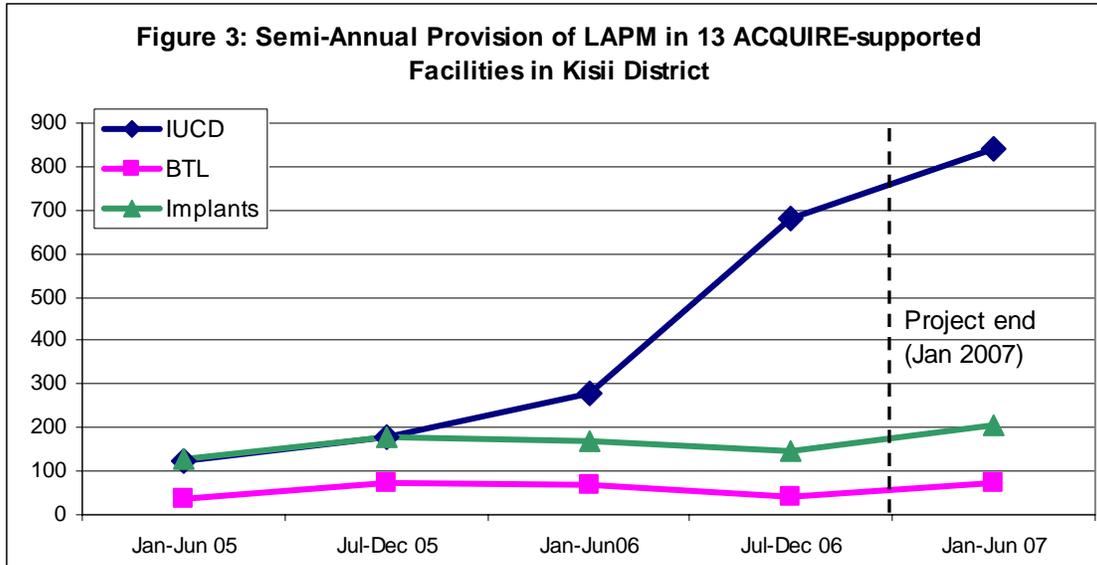
^{vi} Unable to obtain data for 2 of the 10 AMKENI sites in this assessment. There were also data missing for Q2 2006, Q3 2006, and Q2 2007. These quarters were estimated based on available data.

^{vii} CYPs were calculated using standard conversion factors specified by the United Nations Population Fund.

the target of €4 per CYP. At mid-term each CYP cost approximately €24. Since the other two interventions studied did not calculate this important indicator, we are unable to compare the relative costs of the interventions.



The ACQUIRE project achieved dramatic increases in IUCD provision from the start of the project in early 2005 to the end of the project in January of 2007, and provision continued to increase even after the project end (Figure 3). Conversely, in the ACQUIRE supported facilities there appeared to be little change in provision of TL and implants. Although the project specifically targeted 13 facilities and the IUCD, Kisii District as a whole also experienced a five-percent increase in all FP clients, and a 19-percent increase in uptake of female sterilization (data not shown).



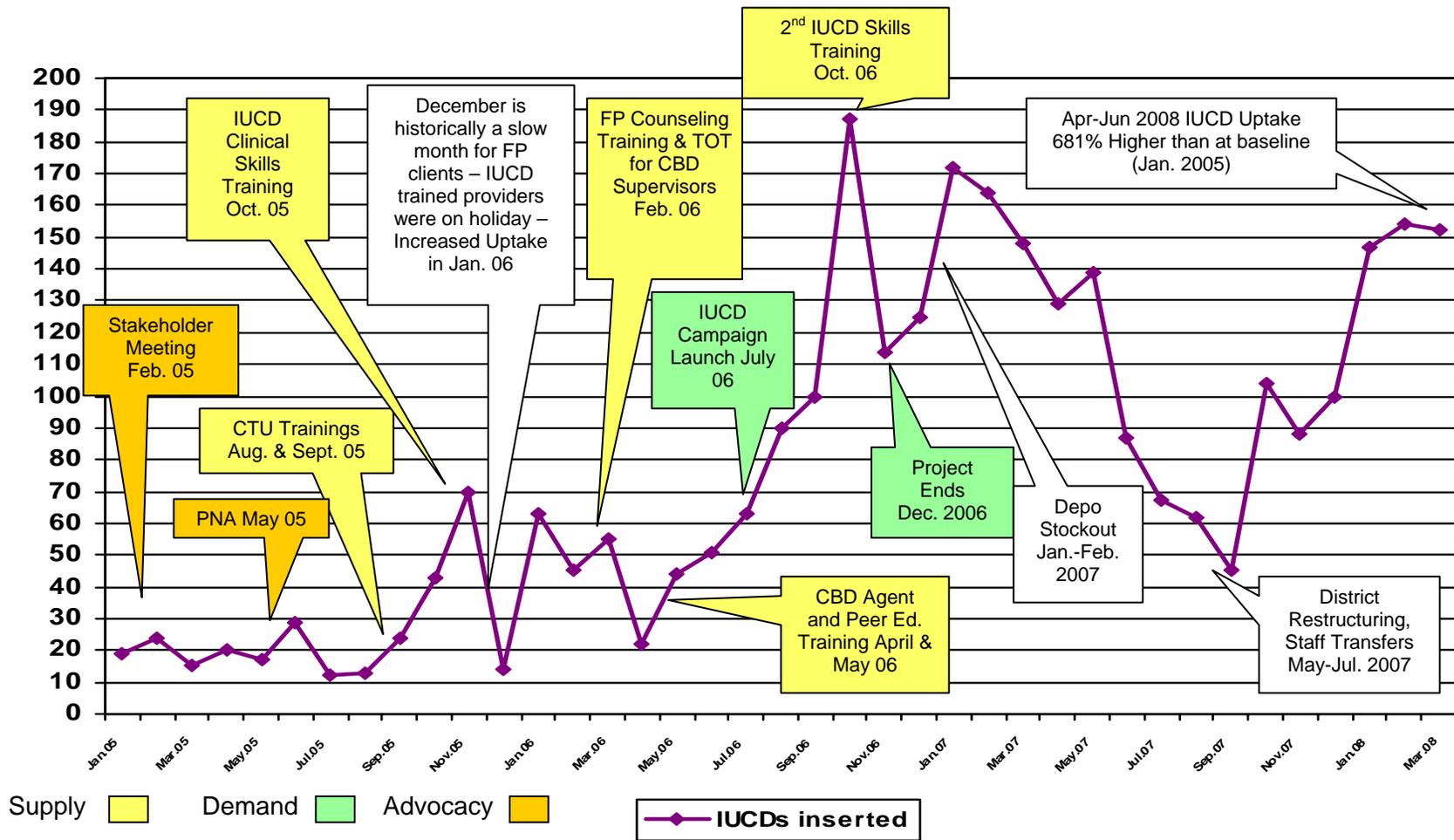
Short-term reactions to intervention activities

It is also useful to examine monthly variations to observe how sensitive uptake is to supply-side and demand-side interventions. Figure 3 smoothes out monthly variations by showing six-month totals for ACQUIRE sites, and only presents data through June 2007. Figure 4 depicts the monthly statistics for IUCD insertions in 13 ACQUIRE sites in Kisii District from January 2005-August 2007, and reveals a more complex picture.

Both training events and demand creation activities resulted in immediate spikes of IUCD uptake. For example, following the contraceptive technology update (CTU) trainings of August and September 2005, and the October 2005 IUCD clinical training, the number of IUCDs inserted at the intervention sites increased. In October 2006, a second IUCD skills training prompted a 47-percent increase in uptake from the previous month. This increase might also be linked to the fact that peer educators and CBD agents informed community members that IUCD training would take place, so clients could go to a specific location where many providers would be available to provide IUCD services. On the demand creation side, following the IUCD campaign launch in July 2006, there was a 43-percent increase in the number of insertions the following month.

Likewise, outside influences were able to spur dramatic drops in uptake. For example, the number of monthly IUCD insertions in ACQUIRE sites dropped precipitously following staff transfers and restructuring of the district in July 2007. IUCD insertions recovered after the staff transfers, and have continued to increase even after ACQUIRE support of the facilities ended.

Figure 4: Monthly Provision of IUCD in 13 ACQUIRE-supported Facilities in Kisii District



General sustainability of the interventions

This comparative assessment does not explicitly address the long-term sustainability of these interventions, given that the AMUA project is ongoing, and the follow-up periods for AMKENI and ACQUIRE were different. However, a review of LAPM uptake in sites from the AMKENI and ACQUIRE interventions is possible. Examining LAPM provision over a seven-year period in several former AMKENI facilities showed mixed results. The number of clients receiving some types of LAPM (including IUCD) did not return to baseline levels, but remained elevated over one year after the project ended. This increase was observed in a selection of high- and low-achieving AMKENI facilities, which may approximate an average level of achievement for AMKENI facilities. Yet provision of TL quickly returned to baseline levels after AMKENI ended. Trends in ACQUIRE-supported sites were different, where provision of IUCDs continued increasing post-intervention. TL and implant provision remained fairly steady throughout the intervention period, which was unsurprising as the demand creation activities focused on the IUCD.

The remaining sections of this report detail the various activities of each intervention, and the output data associated with these dimensions of LAPM provision. Three major types of activities were conducted: activities to ensure an adequate supply of trained personnel; efforts to make equipment, supplies, and commodities available; and efforts to increase demand for LAPM by confronting myths and misperceptions and increasing knowledge among potential LAPM clients. Finally, the report discusses promising directions for future LAPM interventions revealed through the comparative assessment.

Intervention design

Although both the AMKENI and ACQUIRE projects selected facilities in coordination with the MOPHS and conducted onsite assessments of those facilities' needs, some AMKENI participants noted that they were only passive acceptors of the intervention, rather than active participants in it. As one AMKENI clinic manager said, "We never selected...it just rolled down to us. So [the MOPHS] was just coming with issues. We never sat down to select, we were just receiving them from above."

By contrast, ACQUIRE staff frequently mentioned the importance of obtaining stakeholder buy-in and participation from the onset as a best practice. The PNA and stakeholder workshops were seen as critical activities in gaining buy-in. A supervisor in an ACQUIRE pilot site noted that decisions were taken in partnership with providers at the facility; he noted that ACQUIRE "... did not come in and say 'do this, do this.'" It appears that top-down approaches are less accepted than participatory approaches, such as that used in the ACQUIRE project, where ownership is mainstreamed at all levels.

Ensuring an adequate supply of trained personnel

Since LAPMs are clinical methods, special attention must be paid to training; all three major interventions included large provider training components. In the first years of the AMKENI project, tutors and lecturers from Kenya's medical training colleges were

trained to strengthen the knowledge base of the pre-service trainers. In addition, 3,086 providers attended AMKENI-sponsored training in clinical and counseling topics. The range of services at AMKENI-supported sites expanded significantly during the project's lifetime. District level officers and the decentralized reproductive health training and supervision teams were targeted in trainings to improve supervision and training skills.

AMUA franchisees received comprehensive training in counseling for IUCD and TL, and insertion techniques of IUCD, as well as general reproductive health technical updates. Franchisees were also invited to attend Continuing Medical Education (CME) sessions, and AMUA trainers make occasional visits to offer technical assistance concerning any queries and problems that might arise. The ACQUIRE project also conducted provider clinical and FP counseling training, focusing on the IUCD, and general contraceptive technology updates.

Provider training experiences

When providers were surveyed in 26 facilities —10 AMKENI, 10 AMUA, and 6 ACQUIRE— more than half said they had been trained on IUCDs and implants in the previous five years (Table 4). Only about one in five had received TL training, and only five of the 46 providers interviewed had received any training about vasectomy in the past five years. It is important to note that it might not actually be appropriate to train these providers on these services, either because the health site is not equipped to provide them, or they are not in the cadre of providers allowed to provide them.

A higher percentage of providers in ACQUIRE sites received FP counseling training than in AMKENI and AMUA sites. A majority of providers in AMKENI and AMUA sites said they had attended a contraceptive technology update. Similarly, 51 providers from 26 sites in Kisii received a contraceptive technology update from ACQUIRE. By comparison, the Kenya Service Provision Assessment of 2004 found that only about one-quarter of providers or fewer had received an update on FP methods in the past 35 months in the provinces covered by these interventions (Western 23%, Rift Valley 28%, Nyanza 19%).¹¹

Table 4: Percent of providers who received training in the past five years, by training type

	AMKENI (N=26 providers)	AMUA (N=14 providers)	ACQUIRE* (N=6 providers)
IUCD	65	79	83
Implants	54	71	n/a
Tubal ligation**	16	29	n/a
Vasectomy	0.1	0.2	0
FP counseling	54	50	83
Contraceptive technology update	73	64	67
Facilitative/Supportive supervision	30	50	83

n/a= not available

*Kisii providers were asked if they received training in the past two years

**Only facilities that have surgical capability can offer tubal ligation; however providers in all facilities were queried about recent TL training.

Providers almost universally said that they applied what they learned in the trainings to their current work, and many facility in-charges emphasized that providers need

continuous training to stay up-to-date with current medical evidence. For example, one facility in-charge said, “If the staffs are not updated from time to time, they tend to go with the old information...” Another said: “Some people who have been in the field for long and have not had refresher courses have even forgotten...If they are reminded, they can improve the service. Seminars are very important, actually.”

A provider in an ACQUIRE site explained the impact of the counseling training this way: “[I] tried to identify which clients wanted to space, delay, become pregnant ... [so I] created a rapport with clients.” This provider noted that, in the past, she did not provide a lot of information to clients, but because of the training, she now talks to clients more, and fills in the gaps where they do not have information.

On average, about half of providers said they had received training on facilitative/supportive supervision in the past five years, although this varied by intervention (Table 4). Nearly all of those who underwent supervision training said they were able to apply what they learned to their job. Providers most often said the training resulted in them supervising their staff more frequently, and instructing their staff members better.

Availability of LAPM services

Despite many provider trainings on LAPM, access to these services is not universal. Although all facilities in the assessment should technically provide IUCD services, only about three-quarters of providers reported that they had ever personally inserted an IUCD (Table 5). A similar number of providers said they were trained to provide implants. Only about half of facilities included in the assessment provided TL services in their facility,^{viii} although it is likely that in many facilities, the only TL services are provided by a Marie Stopes Kenya (MSK) mobile clinic. All of the AMUA sites and seven of 10 AMKENI sites participate in MSK’s mobile outreach. Fewer than half of providers said their facility offers vasectomy services.

	AMKENI (N=26 providers)	AMUA (N=14 providers)	ACQUIRE (N=6 providers)
Provider ever personally inserted an IUCD	72	79	83
Provider trained to provide implants	70	83	n/a
Provider said facility provides TL*	42	64	n/a
Provider said facility provides vasectomy	42	43	n/a

n/a= not available

*Only facilities that have surgical capabilities can offer tubal ligation.

Training of private sector providers

The proportion of Kenyan FP users receiving their methods from the private sector has increased in recent years. In 1988, 27 percent of FP users in Kenya said their source of FP was the private sector; in 2003, this had increased to 41 percent.^{3,4} Although the purview of the MOPHS includes both the public and private health sectors, private sector providers have not always been included in MOPHS activities (e.g., trainings). Many

^{viii} Ten of the 12 ACQUIRE sites were dispensaries or health centers where TL services are not provided.

private sector providers participating in the AMUA project expressed gratitude for being included in MOPHS activities again. As one private sector provider said, “Another success [of AMUA] is the training of the personnel. [Staff members] go for short-term courses in the MOPHS. [But] ... in [the] private [sector], there is none unless maybe you go back to school. Anyway, it is difficult, because you cannot, it will mean closing [the clinic]. So, when they come and provide these short courses which take a short time, actually I think they have really helped the providers.”

As the quote above implies, training activities for private sector providers must also take into account their working hours and identify the most convenient times for them. For example, the continuing professional development (CPD) workshops organized by the MOPHS and FHI for private sector providers took place on Friday evening and Saturday morning to minimize the time that providers would be absent from their facilities.

Maintaining a trained workforce

Maintaining a trained workforce in facilities following training interventions is an ongoing issue. Respondents reported frequent transfers of trained providers to other departments or facilities where they no longer use the skills they acquired through the interventions. A respondent from Coast General Hospital illustrates these concerns: “One thing you should be aware is that there is very high job staff mobility. [Providers] don’t seem to stick in one facility for long..., the new who are being employed are very mobile. Our doctors, our nurses are very ambitious; they don’t want to be in one place for a long time. If you try to trace some of the few who were trained two or three years ago, you’ll find that they are all over — one is in Australia, one in America, one is in another place — it’s very disturbing, and that’s why we will never be able to fully train people ... to our satisfaction.” Demonstrating this point, the provision of IUCDs in ACQUIRE sites dropped sharply after staff transfers in July 2007 (Figure 4).

Provider behavior and attitudes

Past research demonstrated that both provider skills and attitudes constitute a barrier to LAMP use.^{12;13} Most providers said their opinion about IUCDs has changed in the last five years, although we did not ask them to specify why or in what direction the change had occurred (Table 6). All the interventions updated providers on the new medical eligibility criteria (MEC) for IUCD use, which open the way for many more women to use the method. While more than 80 percent (81%, 86%) of providers involved in

AMKENI and AMUA interventions correctly thought that the IUCD could be an appropriate method for young women, only about half (52%) of providers in AMKENI facilities, and

71 percent of providers in AMUA facilities, thought that the IUCD was an appropriate method for nulliparous women, despite the fact that the MEC state that nulliparity should

Table 6: Percent of providers whose opinions about LAMP changed

	AMKENI (N=26 providers)	AMUA (N=14 providers)
Opinions changed in past five years about...		
IUCDs	85	86
Implants	69	64
Tubal ligation	77	71
Vasectomy	65	43

not be a contraindication for IUCD use. The differences between AMKENI and AMUA sites may be reflective of the differing training components of the interventions.

Over half of the providers interviewed for this assessment said their opinions about implants had changed in the past five years, and almost three-quarters had changed their opinion about TL (Table 6). Only about half said they had changed their opinions about vasectomy. Providers said that the long-acting effectiveness of TL is both its greatest advantage and disadvantage for clients. This belief was mirrored by clients who said that TL was a good method for women, but only when they had borne their desired number of children. Providers had similar praise and complaints about vasectomy being a permanent method, but were less likely to report always counseling clients about vasectomy compared to TL. (Table 7) The long-acting effectiveness of the method, and the fact that it required clients to come to the clinic less frequently, were the most oft-cited advantages of implants.

Attitudes may affect how providers counsel about LAPM. Following the interventions, providers in AMKENI and AMUA sites were asked their attitudes about LAPM and their counseling behaviors. A large majority of providers said that they always counsel clients about IUCDs, implants, and TL (Table 7). However, there is a gap between what providers say they give counseling about, and what clients report that providers do. Among the few clients interviewed who were coming to the facility for a new method (AMKENI N=19, AMUA N=5), fewer than half said that the provider discussed the IUCD, TL, or vasectomy with them. Clients were more likely to report that providers discussed implants with them (AMKENI 74%, AMUA 60%).

Table 7: Percent of providers who say they counsel about LAPM

	AMKENI (N=26 providers)	AMUA (N=14 providers)
Always counsel clients about...		
IUCDs	92	86
Implants	81	93
Tubal ligation	85	86
Vasectomy	39	71

A smaller fraction of providers said they always counsel clients about vasectomy, mainly because men don't come to their facilities, and clients don't ask for the method. We were not able to determine whether providers were neglecting LAPMs in their counseling sessions, or simply using targeted counseling with their clients.

Provider biases remain, particularly about the IUCD

In order to change provider behaviors, ongoing training should be matched with advocacy efforts that address biases that are a function of long-held, but erroneous beliefs. Provider biases against certain methods (notably the IUCD) remain. For example, providers continue to worry unnecessarily about facilitating infections in their clients through IUCD provision. Over half of the providers in AMUA facilities said they were concerned about the association between IUCD and infections (57%). It seems logical that continuing education of providers and improving pre-service training on LAPMs could help to address some of these problems in the future.

More providers in AMKENI sites thought that clients were not receptive to the IUCD than in AMUA or ACQUIRE sites (AMKENI 42%, AMUA 14%, ACQUIRE 11%). All providers agreed, however, that what prevents clients from desiring the IUCD are the rumors and myths prevalent in the communities. Providers also felt that clients who are receptive to the IUCD are those who listen to what their providers say, indicating that providers believe they have great influence over the methods chosen by their clients.

There was also some evidence among both providers and clients in AMKENI and AMUA sites that they do not perceive the IUCD as being effective at preventing pregnancy. One in-charge of a former AMKENI site said “I know of three cases — two are my sister-in-laws, and one was just a staff [member] — who complained that...they conceived with the coil [IUCD]. So I tend to think that possibly the coil could not be doing so well.”^{ix} This adverse experience could be related to the quality of provision. If inexperienced providers are not placing IUCDs properly within the uterus, clients could be experiencing high rates of expulsion that would leave them vulnerable to unwanted pregnancies. Another in-charge noted that providers need to improve their insertion skills: “It comes back to us, the service providers, to have the skills in fixing long-acting methods to these clients so that we do not have the failure rate.”

Facility and provider incentives

In both the private and public sectors, interventions need to consider how to motivate providers to interest them in LAPM provision. The AMUA Project intended to include doctors in the network so that they could perform sterilizations. They were unable to recruit doctors, however, because they did not see any monetary benefit in providing sterilizations.

The time required to provide a clinical method may also serve as a disincentive. One AMUA in-charge noted that some providers “try to de-motivate the clients from using the IUCD” because of the effort that goes into its provision. An AMUA program officer explained in more detail, “For the providers, they are doing [IUCDs] though with a lot of difficulty. They see the procedure as somehow very long, and ... they are spending a lot of time and resources while the income is not coming in the process.”

Although its role as a possible provider disincentive in the public sector is often ignored, public sector providers also noted the cost of LAPM provision. As a public sector facility manager said, “If TL is provided for free, who will bear the cost of the TL to the institution? Institutions are told to look for ways of generating income ... 150 shillings is just for sutures, what about the blade? What about the consumables? How do we meet the cost in between? From an administrative perspective, I think TL is not the best operation to take to theatre. Why? Because it saps on the resources.”

Beyond the issue of cost-recovery, providers in both sectors might be amenable to motivation from non-monetary sources. For example, providers who participated in the ACQUIRE project expressed satisfaction at having been thanked by their clients. Also, some providers noted that increasing the number of clients using LAPM had reduced

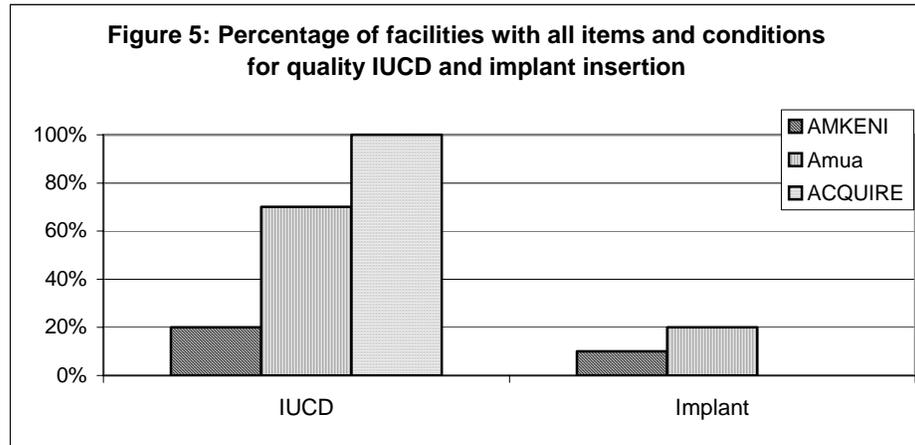
^{ix} It is possible that this facility manager was not trained under the AMKENI project.

their FP client load, which could be a strong motivation in facilities with long queues of clients. If providers are not rewarded somehow for giving LAPM, their motivation to supply these more labor intensive methods may remain small.

Making commodities, equipment and expendable supplies available

In addition to training providers in the provision of LAPMs, the projects pursued diverse strategies for making commodities, equipment, and expendable supplies available in their sites. With its larger budget, AMKENI was able to address clinic infrastructure and conducted 56 renovation projects at AMKENI-supported health facilities. Both AMKENI and ACQUIRE provided essential equipment at their sites. The equipment provided to AMKENI sites ranged from basic items such as blood pressure machines, minilap/TL set, vasectomy set, lantern/torches, sign boards, examination couches, fridge, as well as IUCD kits^x with specialized equipment, such as autoclave sterilizers,

anesthetic machines, oxygen concentrators, and operating tables. The ACQUIRE project worked to ensure that sites were ready for IUCD provision, and thus distributed IUCD supplies (two complete IUCD kits per site) and sterilization equipment distribution where needed, including non-electric autoclaves. ACQUIRE sites with high client load were supplied an additional autoclave to help reduce waiting times between IUCD clients.



The AMUA project provided equipment to its franchisees on a cost-sharing basis. Each franchisee could request the equipment it needed (i.e., autoclave, examination bed, portable light source, etc) and receive it directly from AMUA. The franchisee was then responsible for paying back half the cost of that equipment, upon which time it would be wholly owned by that facility. In addition, the AMUA project facilitated private sector provider access to public sector commodities, and ensured product supplies if the public sector system should stock-out. An AMUA project manager noted that it is important that the MOPHS recognizes private sector members of the AMUA network as partners and not competitors. Through the efforts of AMUA, franchisees were able to obtain free FP commodities from the public stores in their districts.

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^x The IUCD kit was a minimum package required for IUCD provision as agreed upon by the MOPHS IUCD task force. It contains a deep, large oblong/rectangular tray with lid, sponge holding forceps, speculum (medium size), 2 gallipots, 1 medium 120ml and 1 small, Simsons 9" graduated uterine sound, curved long scissors, long straight artery forceps, and alligator forceps

All of the Kisii facilities (13/13) were fully equipped for IUCD insertion and removal when they were observed a few months following the ACQUIRE intervention. However, only 2/10 and 7/10 of the former AMKENI and AMUA facilities, respectively, were fully equipped for IUCD insertion and removal, and only 1/10 and 2/10 facilities, respectively, were equipped for implant insertion and removal at the time of facility audits (Figure 5; implant data not available for ACQUIRE). The most commonly missing elements were a portable light source or adequate lighting and clean running water, but many other elements were also missing in at least one facility. A 2004 service provision assessment (SPA) in Kenya found that country-wide, only 50 percent of facilities had both IUCDs and the basic equipment necessary for IUCD removals and insertions.¹¹

At the time of auditing the 26 facilities examined for this assessment, there were several stock-outs of contraceptive methods, mostly DMPA (injectable). Among the 22 former AMKENI and ACQUIRE facilities, only two had DMPA in stock. Nine of the 10 AMUA facilities had DMPA in stock. This is perhaps because AMUA provided contraceptive stocks to its franchisees from a central stockpile at the Marie Stopes Kenya offices in Nairobi in the case of stock-outs from their regular district-level sources of commodities.

Other contraceptive methods that were out of stock during the facility audits included female condoms (available in 4/10 AMKENI and 8/10 AMUA facilities), and combined oral contraceptive pills (available in 7/10 AMKENI and 9/10 AMUA facilities). Emergency contraceptive pills were available in 6/10 AMKENI and 6/10 AMUA facilities.

Commodities, equipment and expendable supplies remain a problem

Ensuring adequate commodities and other consumable supplies for LAPMs is a constant challenge, and one shared with other FP methods. Implants were stocked out at least twice over the past seven years, and during the assessment's fieldwork period, injectable contraceptives were out of stock. Stock-outs force clients to choose methods they did not originally prefer. Several LAPM users interviewed said that they had chosen their method because of the injectable stock-outs. A 20-year-old mother of two who chose an implant rather than the injectable she preferred said, "If you come for something like an injectable, you are told that it is not available. Alternatively, if you ask for injectable you are given [it], but when you are given an appointment for the next visit, you don't find [the injectable] there. I thought that can affect me, so I decided to go for [Norplant]." Similarly, ACQUIRE's Performance Needs Assessment in Kisii District also found that some FP clients used DMPA because other methods were not available.

As mentioned above, AMUA franchisees were eligible to purchase subsidized equipment for the provision of IUCD at a cost of 50 percent less than the market price. It may be that owning the equipment led private sector providers to utilize it more carefully. The fact that AMUA and ACQUIRE facilities are more likely to have all the elements needed for IUCD provision could also reflect the recency of those projects, as compared to AMKENI. Data collection took place approximately 15 months after the end of the AMKENI project, and only 20 percent of those facilities had all the elements required for IUCD provision. Assuming that the AMKENI facilities were fully provisioned until the

end of the project in March 2006, it seems that improved systems are needed to ensure that equipment and supplies remain available after an intervention has ended.

Improving knowledge and confronting myths to help create demand

Counteracting myths and misconceptions and providing clients with factual information about LAPMs were the goals of the community outreach and demand creation activities of the three projects. Where the AMKENI project focused principally on community outreach for demand creation, both ACQUIRE and AMUA also included mass media elements in their demand creation activities.

Community-based distribution agents and peer educators

All three interventions included community-based distribution (CBD) agents and volunteer peer educators in their demand creation activities. AMKENI's behaviour change communication (BCC) component worked with communities to increase demand for LAPM. The project held direct outreach activities targeting families, men, women, and youth through traditional media and established discussion networks. From 2001 until 2006, AMKENI worked with approximately 1,000 volunteers and 3,000 community groups in long-acting, continuous BCC activities. More than 600,000 community members participated in various BCC and health education activities (i.e., Health Action days, Mothers Days, and Female Sterilization outreaches).

The AMUA franchising network adopted a commission system to encourage approximately 250 CBD agents to work with the project. When a CBD agent brings a client to a TL clinic, she receives Ksh100 (approximately US\$1.50). The CBD agent accompanies the client to her appointment, takes care of her baby during the procedure (if necessary), takes the client home, and looks after her post-operatively.

A total of 72 male and female peer educators were recruited from faith based organizations, women's organizations, and youth groups, and were trained as part of the integrated ACQUIRE communication campaign. From August 2006 - December 2006, peer educators reported meeting with approximately 50,000 people throughout Kisii District at approximately 2,700 community events. The events included weddings, funerals, PTA meetings, church meetings, women's groups, youth groups, and barazas. CBD agents were also directly linked to each of the 13 sites participating in the pilot to help facilitate community access to FP methods and information.

Figure 6: Peer educators and CBDs from ACQUIRE Project



When interviewed for the assessment, providers at the AMKENI, AMUA, and ACQUIRE facilities agreed that CBD agents and peer educators had improved

community opinions about LAPM. Ten of 30 FP clients at the AMKENI facilities who had heard about the IUCD in the past six months received this information from CBD agents, whereas only 1/9 AMUA clients reported the same (information not available for clients at ACQUIRE sites). Nonetheless, CBDs were considered by program managers to be an integral part of the AMUA intervention, and perceived as responsible for most of the promotional work in the project. An earlier operations research study in Western Kenya found that including CBD agents in IUCD promotion activities was more effective than using providers only, although the intervention was not cost-effective, since the cost per 3.5 years of pregnancy protection associated with additional IUCDs provided was \$49.57 per IUCD client as compared to \$15.19 for the same years of pregnancy protection for a DMPA client.⁽¹²⁾

Both providers and clients suggested that one of the best ways to improve clients' views about specific methods may be by using peer education, particularly satisfied users of that method. Providers at ACQUIRE sites noted that peer educators served several functions, including removing client fear of providers; giving messages in villages and bringing clients; removing myths; and creating a link between providers and the community at large. A 44-year-old vasectomy user said, "Those who have done [vasectomy] should be identified as role models for those who don't know its importance. They should be in touch through family planning and NGOs dealing with FP." And an AMUA facility in-charge noted, "When we started off, [acceptance of the IUCD] was very poor. After those clients who had accepted the method talked to others, the numbers came up." The ACQUIRE project featured satisfied users in some of its radio shows, but no specific data were gathered on their effect.

Media campaigns

ACQUIRE designed a communications campaign based on data from the 2003 DHS and focus group discussions to address women's and men's views about the IUCD. Using the slogan, "Now you know the truth," the goal was to challenge myths and rumors head-on in order to improve the image of the IUCD in the community. Posters were designed to convey key messages to challenge myths and rumors about the IUCD directly, and poster target locations included health care sites throughout Kisii District, pharmacies, and public spaces. A local media organization was contracted to conduct outreach events, including four road shows, approximately 30 Ladies Clubs, and 10 Chief's Barazas. Roughly 11,000 people attended the four road shows.

A brochure of in-depth technical information on the IUCD was also created as part of the ACQUIRE campaign. Peer educators and providers were the primary media for brochure distribution. A leaflet was also created for distribution at large audience events. Two different radio advertisements were created in Kiswahili: One advert addressed the fact that the IUCD does not negatively affect a couple's love life; the second ad addressed the fact that using the IUCD does not negatively affect a woman's ability to work. The advertisements ran on Citizen Radio, a national radio station, Kisii Service Radio, and Egesa FM, a local Kisii station. As part of the radio campaign, 10-minute informational call-in shows were also conducted on Friday mornings on Egesa radio. These programs

hosted guest speakers who provided information on a range of topics, including general FP, IUCD, and the importance of male engagement in FP.

After implementing its marketing strategy, the ACQUIRE project implemented a household survey in Kisii District in April 2007, to obtain more information on the impact of their communications and community initiatives. The survey involved interviewing 346 married or cohabiting adults aged 20 - 49, with a gender breakdown of respondents of 50 percent female and 50 percent male.^{xi} These respondents were sampled to represent the general population of Kisii District, not just FP users.

In the six months prior, 45 percent of these respondents reported hearing or seeing IUCD advertising. The majority of respondents cited radio, posters, and providers as sources of exposure. Mass media was the most mentioned. Overall, almost one-quarter of both men and women cited the radio program (phone-ins/expert interviews) as the best source for information. Nearly one in five respondents had attended a community session focused on the IUCD. Following those sessions, respondents were likely to take some action about FP, such as talking to a partner or family/friend. ACQUIRE project staff members concluded that while advertising encourages method awareness and consideration, community sessions are integral to driving people to action.

Stakeholders also expressed satisfaction with the ACQUIRE campaign and the materials. A provider noted that the radio messages helped clients to have a certain level of knowledge when they came to the facilities. As a result, clients were more educated about FP and the IUCD, thus making the job easier for the provider. Providers used the brochures to show the female anatomy while counseling FP clients. Providers also noted that they used the posters to show clients how women can work when using the IUCD, and explained that the IUCD will not have a negative impact on sexual relations with their partners.

The ACQUIRE campaign materials and radio advertising were also heard beyond Kisii District. Approximately 30 percent of the clients interviewed at the AMKENI and AMUA sites had also heard the IUCD advertisements on a nationwide radio station (Radio Citizen). A majority of FP clients at AMKENI facilities and about one-third of AMUA clients said that they had heard about FP outside of the clinic in the past six months (AMKENI 70%, AMUA 29%). Half of AMKENI clients and one-third of AMUA clients reported they had heard something about the IUCD in the past six months (50%, 32%). FP clients were most likely to have seen something about the IUCD in a brochure or on a poster, but several also mentioned hearing radio advertisements and call-in shows.

^{xi} The socio-economic status (SES) of the survey sample was representative according to population (7 out socio-economic class.

AMUA’s demand creation activities included branded marketing of franchises and media campaigns. Facilities received distinctive paint schemes, street signs, and IEC materials (Figure 7). One 37-year-old mother of four noted that she chose an AMUA clinic for her IUCD insertion because it was “branded as a family planning clinic called ‘AMUA’... It is clear when I come here I am handled with respect.” AMUA also ran radio spots in local languages advertising the AMUA network.

Figure 7: Sample of AMUA branded clinic, Nakuru



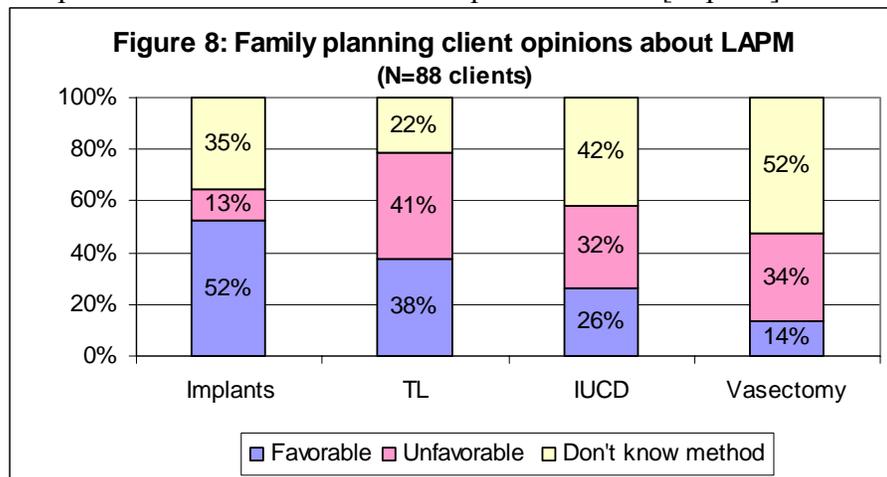
Client post-intervention knowledge and attitudes

The ACQUIRE household survey (described above) showed awareness of the IUCD was high in Kisii District; 89 percent were aware of the IUCD (spontaneous and aided awareness). Compared to the 2003 Kenya DHS where only two-thirds of all Kenyan women surveyed (67%) had knowledge of the IUCD, the ACQUIRE campaign appears to have had a positive impact on awareness.⁽³⁾ Respondents also had a generally positive impression of the IUCD. Half of the male respondents and three out of five women agreed that the IUCD was a “trusted method of family planning.”

Despite community outreach and mass media campaign efforts, relatively large proportions of respondents reported that their knowledge about a method was insufficient to make a judgment about it (Figure 8). This may indicate that provider counseling is not addressing clients’ needs for information. TL is the best-known method among these FP clients, but the most favorable opinions are about implants. As one facility in-charge noted, both clients and providers find reasons to like implants: “When [implant] services are available, the uptake is high.

One reason is that it does not concern the client so much because it is inserted once, it is not tedious. Very few clients complain about the implant. Also, the providers say

that the implant is good.” The major advantage that clients associated with LAPMs was the long-acting effectiveness or permanence of the methods.



More clients said they did not know about vasectomy than reported any opinion about it at all. According to providers, many men still view vasectomy as castration. There are also women who are opposed to their husbands undergoing vasectomy. A national program manager, commenting on cultural issues, noted, “I think the problem is just the attitude of our society as far as vasectomy is concerned, because I hear of cases where the wife herself ... refuses her partner to be done vasectomy. I think there is something not known about the whole issue.” All of the three vasectomy users who were interviewed as part of the assessment were pleased with the method. Regarding negative public opinion, one vasectomy user, a 48-year-old father of four said, “After having gone for vasectomy, people initially started saying that they now learnt to make use of my wife because [I] am now castrated. But later...they started knowing the truth, and joined me.”

Male involvement

Many communities still view FP as a female issue, which does not involve men at all, but providers, clients, and stakeholders interviewed for this assessment agreed that involving more men in FP would help to increase uptake of FP in general, and LAPMs in particular. While most women say their partners are involved in FP decision-making (AMKENI 85%, AMUA 89%), FP clinics are themselves not seen as “male friendly,” as a respondent from FHI explains: “Vasectomy has remained low because providers offer services to the men as if they are ... just helping the men. The services are not male friendly, and it is even referred to as the MCH clinic, so ... it is basically for the mother and child welfare, automatically locking the man out. There are even no clinics that are specialized to deal with male problems like prostate cancer or infertility.”

Though there have been many advances in gender equity in Kenya, men are still the principal decision makers in all matters, including RH/FP. Many women still have difficulty accessing FP services without their husbands’ approval. One 39-year-old mother of six who received TL explained why she did not tell her husband about her intention to use the method before she had the procedure: “I never told him. He knew after I had already finished doing TL, because if I told him, he wouldn’t agree. And, you know, a man wants many children. He’s never satisfied with children. He wants many and yet he can’t take care of them.” The AMKENI project found that peer family discussion groups could be very effective means of enabling family members to discuss RH matters openly. In addition, open days, such as Mothers Days, Fathers Days or community barazas, encouraged discussion around the ambivalence and dilemmas which accompany the process of effecting behavioral change. As a result, the community dialogue approach could be very effective in increasing fathers’ involvement in RH decision making. One clinic in-charge said that they include FP messages in the health talks they give to outpatient clients who have come to the clinic for treatment. Many of these clients are men. Stakeholders in the ACQUIRE project reported that men became much more involved in FP in Kisii District than they had in the past. Peer educators reached an estimated 21,000 men. Many men listened and called into the Egesa radio program to obtain more information about family planning. One Kisii District provider noted that after she spoke about male engagement on the Egesa program, men came to the clinic to talk to her.

Pricing of commodities and client incentives

Interventions in the public sector generally provide contraceptives free to clients, however some facilities charge a consultation fee. The private sector does not have regulated prices. One of the elements of the AMUA social franchising network was to establish recommended prices for methods provided by the franchises. Tubal ligations are provided free of charge as part of the Marie Stopes Kenya mobile TL outreach. This is seen as particularly valuable to clients and providers, who report that having to pay for TL is a hardship. As a 24-year-old mother of five said, “I wanted to go to town [for TL], but there was no money. That’s when I heard from [the] doctor’s wife that there were doctors from Nairobi coming to give this service here. So God helped me to come here instead of town. For there was no money and the doctors wanted no money...so I came here.” Some AMUA facilities also ran “Free IUCD Weeks,” which providers said helped to build a buzz around the method and, at the same time, recruited clients to their clinics who would then come back for other services.

The AMKENI project provided transport compensation for clients seeking sterilization services. Although the uptake of the service increased under AMKENI, some stakeholders were critical because the MOPHS could not sustain such a practice. One respondent in Coast Province noted: “... we were giving [the clients] lunch and taking them back home, so the moment the funding for the project ended, [clients] did not come. So there is no way the Ministry of Health could have continued with that, because that is not how we operate. So, we need to change that. I think now if we need to re-do it ... we need to change the focus and try to make the population and the public understand and appreciate the service so that [the clients] can come out for the service.”

Promising directions for future LAPM interventions

Despite limitations, the interventions were successful in providing LAPM to some clients. In-depth interviews with some of those LAPM users helped understand why they made the choice to use LAPM, and how best to promote these methods in the future. For LAPM users, the long-acting effectiveness or permanence of the methods is important. Some users emphasized the convenience of not having to make repeated trips to the clinic. For example, one 22-year-old mother of two said, “If I compare with other methods I have used or heard about, I think this method [implant] is good because it’s unlike the injectable...which you’ve [got] to keep coming for re-supply. This one you stay for a long time without coming to [a] facility unless you’re experiencing side effects.” Other users said they prefer long-acting methods because they don’t have to remember to take pills every day, or remember to come back for re-injection.

Some users noted the lower costs associated with using a long-acting method. For example, a 44-year-old mother of four said, “This [TL] is a good method which is cheap — about one hundred shillings only, and then the hospital helped. This is done once and that is all, expenses [are] less and [it] is a sure method.” Interestingly, although these methods are perceived by some users as saving them money, some providers felt that providing LAPMs was expensive in terms of both time and resources expended. This is

despite the fact that frequent resupply visits by short-acting methods may in the end make those methods more time intensive for providers.

Clients reported that undertaking TL is based on whether she believes she already has enough children. Many IUCD and implant users said that once they had achieved their desired number of children, they would be happy to switch to TL and have worry-free protection from pregnancy. However, some women said they would never be ready to make such a permanent decision. As one 33-year-old mother of two expressed, “I cannot use [TL] because anything can happen. You know, these marriages are not permanent, and one can divorce and get re-married. Then, my husband can want another child with him, what will I do? You know you can get a man who looks after you ‘like an egg,’ and he says he can give you the world as long as you give him a child. What will you do? And you have done permanent FP, what will happen? You would have lost (laughs).”

Latent demand for TL

While overall use of TL has declined in Kenya, many providers interviewed noted that TL demand was strong and increasing in their facilities. The AMUA project reports that acceptance of TL is 30 percent higher than acceptance of IUCD. An AMUA in-charge said, “Back in the year 2004, I could not see anyone go for tubal ligation, but now I am able to send about 10 clients.” The ACQUIRE project observed a 20-percent increase of TL in the Kisii District, even though the focus of the intervention was on IUCD. The increase of TLs provided in the AMKENI project was twice as high as the increase in IUCDs. Current LAPM clients seemed to have a good impression of female sterilization overall, and many indicated that it would be their preferred method of contraception once they had “enough” children. Over one-third of general FP clients also expressed favorable opinions about TL, but another 20 percent said they didn’t know about the method.

Despite the demand for TL, interventions have faced challenges in increasing access to permanent methods of contraception. Among the facilities included in this assessment, only about half offer TL and/or vasectomy services, although some of those facilities do not have the surgical infrastructure to provide TL. The 2004 Kenya service provision assessment found that only 46 percent of hospitals in Kenya offer female sterilization. {#139} The AMUA project was unable to recruit medical doctors to its network who would be able to furnish clients with TL services, so it had to rely on mobile TL services. Mobile TL services have been successful in providing thousands of women with TL in the past few years. Although this model of service provision requires resources beyond those typically available in fixed clinical settings, it is unclear whether training providers in static services and maintaining their surgical facilities would be more cost-effective.

Conclusion

The interventions examined lasted from two to five years, and attempted to address significant issues with health systems and entrenched attitudes among providers and clients. A reversal of a decade-long trend of IUCD decline was not expected. Although

all three projects made progress, the magnitude of progress, in terms of the total number of clients served was relatively modest, compared to the total number of FP clients. Medium-term outcomes were mixed. In the case of AMKENI, cessation of project activities appears to have coincided with rapid returns to near-baseline levels of method provision. This failure to sustain progress could be due to staff transfers and to logistical problems with equipment, supplies, and commodities. On the other hand, the ACQUIRE project observed continuing increases in IUCD service provision several months after the project concluded. Still in progress, AMUA has increased and maintained its increase of LAPM provision. Regardless of how the intervention performed, they all had challenges with training, readiness of facilities in terms of equipment and commodities, and demand creation. One single element did not stand out as the most important determinant of increased LAPM uptake.

The assessment observed that staff transfers can have a dramatic impact on the effect of an intervention in its target sites. Program managers reported that staff members who were trained on LAPMs as part of an intervention were often transferred, leaving few or no trained providers in their facilities. Programs need to have a greater commitment to maintaining access to services through maintenance of a trained workforce. **Two approaches should be investigated:**

- Mechanisms for improved management of human resources should be instituted, including better oversight of transfers and identification of replacement staff that have LAPM skills and/or systems for continual training.
- The MOPHS should experiment with mobile services, investing training dollars into transportation and support of experienced providers who can extend services to various sites. A cost effectiveness comparison of these two approaches would provide better direction as to how the MOPHS can maintain a trained LAPM workforce.

This comparative assessment has shown that while the availability of supplies can be improved through these interventions, once the project is ended, there appears to be a rapid decline in supply assurance for both commodities and equipment. **What innovative approaches can the MOPHS use to improve logistic systems for LAPMs?** Should the MOPHS revisit the idea of socially marketing IUCD or implant kits? Alternatively, would moving to a mobile system of LAPM services improve supply issues? The MOPHS should continue its efforts to build systems that ensure method choice in all facilities.

Despite the extensive informational and demand creation efforts, significant gaps in client knowledge about LAPMs remain. Beyond community-level communication efforts, clients consistently say that their choice of method is influenced by their provider. Accordingly, a concerted effort was made to educate providers about LAPMs, particularly the IUCD, but negative attitudes persist. Some providers, for example, still have inaccurate beliefs about whether the IUCD is appropriate for nulliparous or young women, and unnecessary concerns about pelvic infections. In addition, the few reports from clients and providers of the IUCD being ineffective for preventing pregnancy may point to both problems with the quality of insertions and persistent myths and misconceptions. Lack of belief in the effectiveness of IUCDs among providers is of

particular concern since we know that providers influence client selection of methods, and LAPM clients cite the effectiveness of these methods as one of their key advantages.

Several providers and program managers also reported that many men and women still oppose vasectomy because they equate it with castration. Although the exact reason is unknown, 34-percent of clients did report negative opinions about vasectomy. Erroneous beliefs about vasectomy, such as that it is similar to castration, need to change if the number of men choosing this highly effective method is ever to increase. Some of these biases against LAPMs may explain why, according to clients, providers counseled about IUCDs, TL and vasectomy in less than half of their client interactions.

While each of these interventions included some level of demand creation, the approach and intensity of demand creation activities differed significantly. In particular, the ACQUIRE project focused on method-specific marketing efforts and used mass media channels, while the AMKENI project and AMUA Network undertook more general FP BCC/IEC efforts. The cost and impact of these approaches differed and need to be examined to determine their potential cost-effectiveness and sustainability. The broader IEC messages appeared to be less effective than targeted messages, though political sensitivities did exist early on regarding method-specific promotions. A key question that remains is **what level of effort is needed with respect to marketing, and how often do media campaigns need to be repeated. Is there a “tipping point” in marketing when advertising can be said to be effective?**

CBD agents seemed to play a key role in education and referral to clinics, but retaining committed volunteers over time is challenging. Although donors and MOPHS personnel noted the importance of demand creation activities, and urged providers to do more community outreach regarding LAPM, many facility managers said that they lack the resources (staffing and monetary resources) to accomplish this. Community mobilization activities must address the volunteers' own needs, the most important being economic survival. It may be cost-effective to maintain a core of highly motivated, effective volunteers by providing them with regular incentives rather than constantly training new volunteers, but funding for volunteer incentives is rarely available. The AMUA project gives KSh.100 for every client a CBD refers to one of their network facilities. This practice may not be feasible outside the private sector, but needs to be explored further. According to conversations with staff members, AMKENI's experience suggests that incentives do not have to take the form of a regular salary, nor do they need to be costly. Items such as uniforms (i.e., t-shirts, caps), badges, opportunities to participate in workshops, certificates of attendance at training courses, and the opportunity to participate in income-generating activities are also highly motivating. **Strategies for how these CBD agents can be further leveraged while providing a mechanism for incentives to strengthen their commitment and retention could be investigated more widely.**

Implementing both supply-side and demand-side activities at the same time as conducting advocacy, which all three interventions did, appears to be a good model as long as supply is in place before demand is created. However, the medium-term results of the projects

were mixed. ACQUIRE, an intervention targeted at one method, seemed to yield more positive results, but the costs involved in such a project need to be examined. In fact, the costs associated with either targeted IUCD or broader LAPM/FP interventions have not been closely examined, thus information on cost per CYP, replicability, and sustainability is lacking. Filling this knowledge gap should be a priority, as it will be important information for policy makers when deciding where to invest their limited resources. It will also be important to follow the work of the AMUA project over time, as a social franchising network of private providers may be a promising direction for future public-private partnership efforts, especially if its costs decrease over time allowing for a greater potential for sustainability. Instead of primarily relying on donor funds, LAPM efforts should be mainstreamed into the MOPHS structure and funded through the annual operating plans (AOP). Finally, if they decide that LAPM efforts should continue to be prioritized, the MOPHS and donors need to take a long-term approach to promoting LAPM utilization so that progress achieved during interventions can be sustained over time.

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