

FAMILY HEALTH RESEARCH

Kenya



A forum for putting knowledge into practice

INSIDE

- 2 | LAPMs contribute to family planning programs
- 4 | Lessons for revitalizing LAMP use
- 6 | The future of implants in Africa
- 7 | Encouraging greater use of vasectomy
- 8 | Revitalizing LAPMs



LONG-ACTING AND PERMANENT METHODS

In this issue we examine the unrealized potential of long-term contraception to help family planning programs meet the needs of their clients and improve public health.

Long-acting and permanent methods (LAPMs) of contraception include reversible contraceptive implants and intrauterine devices (also known as intrauterine contraceptive devices, or IUCDs), as well as the permanent methods of vasectomy and female sterilization.

LAPMs are the most effective modern methods for preventing unintended pregnancies. Because they are also cost-effective (see page 2), increases in their use can help sustain family planning programs. But in Kenya, as in most countries, the use of LAPMs is limited.

Challenges to LAMP use persist. However, experience from Kenya and other countries suggests that comprehensive efforts to improve service delivery and to educate potential clients can increase use (see page 4).

The Kenya Ministry of Health is committed to revitalizing LAPMs. The new APHIA II program (see page 8) offers an excellent opportunity to promote and provide LAPMs in Kenya and to once again attain a balanced method mix.

We hope that this issue of our newsletter will help you continue to support the revitalization of LAPMs in Kenya. We would also like to hear from you. Please send your comments on this issue to familyhealthresearch@fhi.org.



Maureen Kuyoh
Project Director
Kenya Office, FHI

KEYPOINTS

- Providing LAPMs expands contraceptive choice for clients.
- LAPMs can help countries reach national health goals.
- Persistent challenges to LAPM use need to be overcome.

LONG-ACTING AND PERMANENT METHODS

LAPMs contribute to family planning programs.

Long-acting and permanent methods (LAPMs) of contraception remain a relatively small — and sometimes missing — component of national family planning programs in sub-Saharan Africa. These methods can enhance family planning programs in meaningful ways if challenges to their availability, access, and acceptability can be overcome.

Responding to individual needs

The intrauterine device (IUD), implants, vasectomy, and female sterilization are appropriate choices for many people who want safe and effective protection against an unintended pregnancy. The long-term effectiveness and reversibility of the IUD and implants make these methods suitable for women and couples who want to space their

pregnancies, for young people who want to delay marriage and parenthood, and for women who discontinue other methods of family planning but still want to avoid pregnancy. Vasectomy and female sterilization are best suited for individuals and couples who are certain they do not want more children, although reversible LAPMs are also options for women who want to stop childbearing.

Providing a range of methods, including LAPMs, gives family planning clients more contraceptive choices. A woman who has more choices is more likely to start using a method, be satisfied with her choice, and continue using the method until she no longer wishes to prevent pregnancy.

Continuation rates appear to be substantially higher among women who use reversible LAPMs than they are among women who use short-acting methods such as oral contraceptives and injectables. This may be because of the high rates of contraceptive effectiveness and ease of use associated with LAPMs. In Africa, research suggests that about 80 percent of the women who choose the IUD — and even more women who choose implants — continue using the method for at least one year.¹ In contrast, data from surveys in some developing countries suggest that only 60 percent to 70 percent of women who choose oral contraceptives or injectables are still using them after one year.

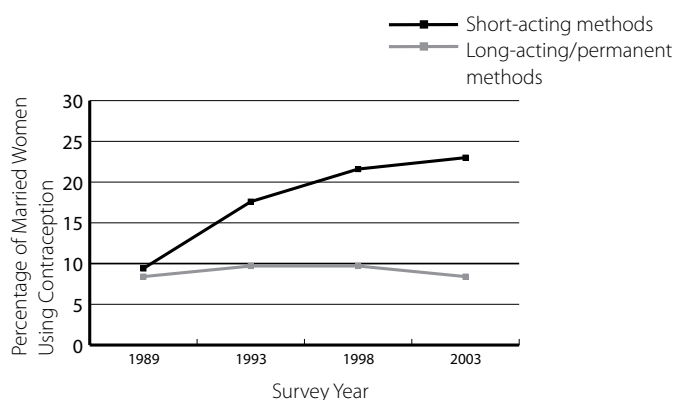
Sustaining programs

Over time, LAPMs are also cost-effective for programs. When compared with the use of other methods, the use of LAPMs results in fewer unintended pregnancies and fewer clinic visits. This eases the burden on overextended health systems and providers. If used for at least three years, the IUD and implants, along with vasectomy, are considered the three most cost-effective methods when all direct medical costs associated with the methods, their side effects, and unintended pregnancies are taken into account.

Reaching national health goals

LAPMs can contribute to healthy timing and spacing of pregnancies, which improve the outcomes of pregnancy and childbirth for

Short-Acting versus Long-Acting and Permanent Contraceptive Methods in Kenya



Source: ORC Macro. *Measure DHS STATcompiler*. Available: <http://www.measuredhs.com>.

Note: The trends in this figure are based on data from demographic and health surveys of married women ages 15 to 49 years. Long-acting and permanent methods include implants, the intrauterine device, female sterilization, and vasectomy. Short-acting methods include all other modern contraceptive methods.

mothers and their children. The risk that a woman will die as a result of pregnancy, childbirth, or unsafe abortion is about one in 16 in sub-Saharan Africa.² Harmful outcomes like these can be avoided if a woman waits at least two years after the birth of a child to become pregnant again.

The use of LAPMs is also part of an important but often overlooked strategy for preventing mother-to-child transmission of HIV. Meeting an unmet need for family planning among HIV-infected women who do not wish to become pregnant is at least as cost-effective as the traditional strategy of providing HIV counseling, testing, and treatment with antiretroviral drugs such as nevirapine.³ The use of family planning to avoid unintended pregnancy is already preventing the birth of an estimated 173,000 HIV-infected infants each year in sub-Saharan Africa.

Overcoming challenges

Providing women and couples access to a range of contraceptive choices, including LAPMs, protects their human rights and benefits public health. Yet several strong barriers to LAPM use persist in sub-Saharan Africa.

Policy-makers and program managers are sometimes reluctant to make LAPMs part of the mix of contraceptive methods because of perceived cost barriers. As a result, commodities, equipment and supplies, and opportunities to train providers are not always available. Even when programs provide LAPMs, stockouts of the necessary commodities or equipment can be problematic.

Limited access to LAPMs is a problem. Short-acting methods are becoming increasingly available through commercial outlets and community-based distribution, especially in rural areas, where most people live. However, the provision of LAPMs is often confined to urban facilities. Distance to clinics and fees for services can make it difficult to obtain services.

Even when trained providers are available, medical barriers inhibit access. Providers may not provide LAPMs to their clients because of unnecessary restrictions, such as age or the number of children a woman

already has. They may not be familiar with the latest evidence, and so may unintentionally deny a client an LAPM for inappropriate medical reasons. Or, they may not offer comprehensive information about all methods, thus limiting the ability of clients to make informed contraceptive choices.

Many potential clients lack information about LAPMs or have misconceptions about the methods. Even in countries where most people know about family planning, fewer people know of the IUD and vasectomy than know of other methods. Myths and misconceptions are also widespread for these methods.

Experience suggests that some of these obstacles to LAPM use can be overcome. To do so, policy-makers and program managers must promote an enabling environment through evidence-based policies and guidelines, improved provision of services, and the education of health providers, communities, and individuals.

LAPMs AND HIV

LAPMs are suitable options for most women and couples who want to prevent unintended pregnancies. Women living with HIV may rely on an IUD, implant, or female sterilization for contraception, with only two exceptions. If a woman has an AIDS-related illness, she should postpone surgical sterilization until after her condition improves. And IUD insertion is not usually recommended as a first choice for a woman who has developed AIDS if she is not on antiretroviral therapy or is not responding to treatment. This is because her suppressed immune system could increase the risk of infection during



A health care worker performs a female sterilization procedure in rural Uganda. Sterilization and other LAPMs can be appropriate contraceptive options for most people living with HIV.

insertion. However, HIV-infected IUD users who develop AIDS generally may continue using the device. Vasectomy can be used by any man, regardless of his HIV status.

References

- 1 Rivera R, Chen-Mok M, McMullen S. Analysis of client characteristics that may affect early discontinuation of the TCu-389A IUD. *Contraception* 1999;60(3):155–60.
- 2 AbouZahr C, Wardlaw T. *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF, UNFPA*. Geneva: World Health Organization, 2004.
- 3 Reynolds HW, Janowitz B, Homan R, et al. The value of contraception to prevent perinatal HIV transmission. *Sex Transm Dis* 2006;33(6):350–56.

LAPM INTERVENTIONS IN KENYA

KEYPOINTS

- Comprehensive interventions increased the use of LAPMs.
- After the interventions ended, the use of LAPMs declined.
- Long-term strategies are needed to sustain higher levels of LAPM use.

Assessment provides guidance for the future.

Interventions to expand contraceptive choice by improving access to long-acting and permanent methods (LAPMs) can be effective, but long-term strategies are needed to sustain the results of these efforts.

This was one of the lessons drawn from a recent assessment of interventions to increase the use of LAPMs in Kenya. The findings of the assessment will help guide the design of future efforts to revitalize LAPM use.

Rationale

Since the 1980s, the proportion of Kenyan women using LAPMs has declined, while the proportion using oral contraceptives and injectables has increased. The result is a trend in use that is skewed toward short-acting methods. For example, according to the Kenya Demographic and Health Survey

from 2003, fewer than 3 percent of married contraceptive users were using the intrauterine device (IUD). More than 14 percent were using injectables.

The current mix of contraceptive methods in Kenya is not considered cost-effective or sustainable. As a greater number of donors expect governments to provide their own contraceptive commodities, countries such as Kenya need to ensure a more balanced method mix that includes LAPMs.

Under the Ministry of Health's leadership, several interventions have been launched in Kenya since 2000 to increase the use of LAPMs. The Ministry of Health decided to assess three of them: the AMKENI Project, the ACQUIRE Project, and the AMUA network.

These three interventions were chosen because they all used a comprehensive approach that included advocacy, creation of demand for LAPMs, and improvement in the delivery of LAPM services. The multi-organizational AMKENI Project sought to improve the overall provision of reproductive health services, including LAPMs. The ACQUIRE Project, managed by EngenderHealth, worked to increase uptake of IUDs in the Kisii District. The AMUA network of "social franchises," managed by Marie Stopes Kenya, worked to improve access to clinical methods of family planning among rural couples. (A social franchise is a partnership among private-sector organizations that tries to help a public-sector organization reach a social goal they all share.)

Results

All three interventions resulted in large increases in the use of LAPMs. For instance, the number of female sterilizations performed at 96 AMKENI-supported facilities increased from 750 in 2001 to 3,318 in 2005. The number of IUDs inserted at the same facilities increased from 510 in 2001 to 1,169 in 2005. The provision of contraceptive implants also increased, but implant use varied from year to year depending on availability.

MORE EXPERIENCES

Ghana

From 1994 to 2004, EngenderHealth trained more than 300 medical teams to perform female sterilizations. The number of facilities providing female sterilizations nearly tripled, and more than 27,000 women chose the procedure.

Mali

Mali was among the first African countries to obtain regulatory approval for Norplant. The number of women using implants increased from fewer than 3,000 in 1987 to more than 10,000 in 2001.

Nepal

Through Population Services International/Nepal's Sun Quality Health Network of more than 200 private health clinics, providers inserted nearly 2,000 IUDs and performed 6,000 vasectomies and female sterilizations at both stationary and mobile clinics from 2003 to 2006.

Tanzania

Through the CHOICE Initiative, Marie Stopes International operates mobile teams of providers who offer free LAPM services at Ministry of Health posts in rural areas. In 2006, more than 30,000 implants and 47,000 female sterilizations were provided.

Despite large increases in LAPM use, direct comparisons of the interventions were difficult because they were conducted at different sites and targeted different methods. To facilitate comparisons, a small number of sites that were providing IUDs were selected to represent each of the three interventions. During the AMKENI intervention, the number of IUDs that were provided at the eight sites included in the assessment rose from one per month to a peak of six per month; a year later, that number had fallen to four per month. The AMUA project is still under way, but results from the ACQUIRE intervention were similar, with IUD use dropping after the initial intervention.

At its midterm evaluation, the AMUA network found that its costs were much higher than planned. The AMKENI and ACQUIRE interventions did not track their costs. However, given the large number of activities they involved and the modest increases in IUD provision observed, these interventions were also likely expensive relative to their achievements.

Lessons learned

A task force is using the lessons learned from these interventions to develop a comprehensive strategy for revitalizing LAPM use in Kenya. Some of the lessons identified by the assessment include the following:

- Sustaining a trained work force is important for reducing provider bias against LAPMs. Continued training is needed because providers are often transferred to different facilities after an intervention.
- Assuring consistent supplies of commodities and equipment is crucial. Supplies quickly decline after an intervention ends, and stockouts can force clients to choose methods they do not prefer.
- Community-based volunteers can effectively promote and refer clients for LAPM services. If funds are available, it may be cost-effective to maintain a core group of highly motivated community-based volunteers by providing them with regular incentives rather than constantly training new volunteers.
- Method-specific marketing efforts that use the mass media seem to reach potential clients more effectively than broader information campaigns about LAPMs.

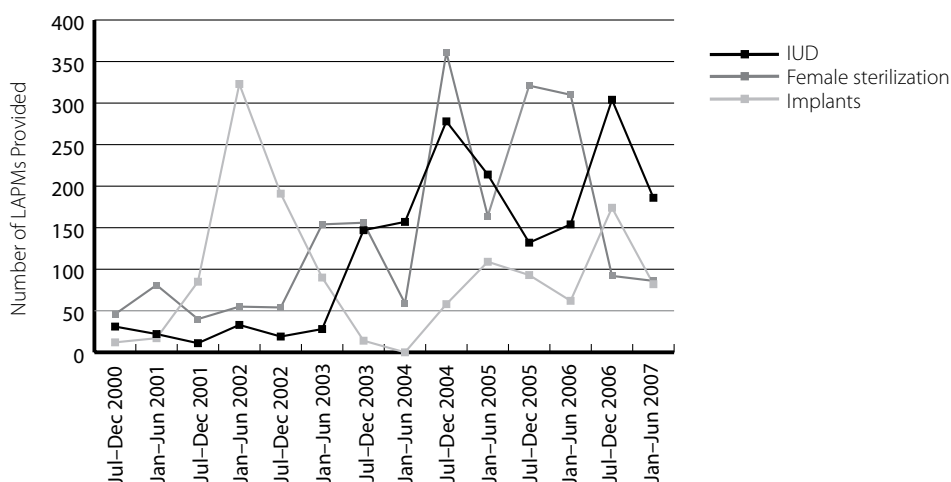
Resources

Long-Acting and Permanent Methods: Addressing an Unmet Need for Family Planning in Africa. This set of eight advocacy briefs examines the benefits of LAPMs and the rationale for introducing or revitalizing their use within national family planning programs. It also offers ideas about how to improve and expand LAPM provision. Four of the briefs are from the Global Health Technical Brief series produced by the INFO Project at the Johns Hopkins Bloomberg School of Public Health. Each brief provides the most current information about a specific LAPM. Available at: <http://www.fhi.org/en/RH/Pubs/servdelivery/LAPM/index.htm>.

The IUD Toolkit. The *IUD Toolkit* is a comprehensive source of up-to-date, evidence-based information about the IUD. This online resource for program managers, policy-makers, family planning providers, and potential clients was developed by the Maximizing Access and Quality Initiative of the U.S. Agency for International Development. It offers guidance on best practices, training materials, case studies, and tools to help increase access to high-quality IUD services. Available in English, French, and Spanish at: <http://www.maqweb.org/iudtoolkit/>.

Implants Toolkit. The types of resources provided by this online toolkit about contraceptive implants are similar to those found in the *IUD Toolkit*. Information is organized by topic and by the intended audiences: program managers, providers, policy-makers, logistics managers, communications professionals, trainers, researchers, and implant users. Available at: <http://www.implantstoolkit.org>.

LAPM Provision in Eight Former AMKENI Sites in Western Province, Kenya



Source: Kenya Ministry of Health. *Kenya Comparative Assessment of LAPM Activities: Final Report* (draft). Nairobi: Kenya Ministry of Health, Department of Reproductive Health, 2008.

IUD promotion and the availability of other methods both influence IUD use, as shown in this graph. IUD use dipped in 2005 when implants returned to the shelves after being out of stock for almost a year and dropped again after the AMKENI Project ended.

KEYPOINTS

- Demand for implants remains high in Kenya.
- Availability is expected to improve with simpler, cheaper implants.
- Greater use of implants could reduce unintended pregnancies.

THE FUTURE OF CONTRACEPTIVE IMPLANTS IN AFRICA

Greater availability could mean better public health.

An assessment of Kenya's experience with contraceptive implants — coupled with the availability of simpler, cheaper implants — suggests a brighter future in sub-Saharan Africa for this long-acting method of family planning.¹

FHI conducted the assessment to better understand the demand for implants and the capacity of providers to offer the method in Kenya. Much of this information was gathered through interviews with 35 policy-makers, donors, and family planning professionals. A modeling exercise was also performed to determine the possible impact that more implant use could have on the nation's public health.

A major finding was that the demand for implants has remained high since implants were first introduced in Kenya more than 20 years ago. Interviewers found that many providers have to keep lists of clients who are waiting for future shipments of implants.

According to data from the Demographic and Health Surveys, knowledge of the method has also increased. Even though the rate of implant use has never exceeded 1 percent in Kenya, more than half of Kenyan women say they know about the method. More than 1,000 health facilities are providing implants, and the current network of family planning providers appears ready to increase the volume of services offered.

Unfortunately, the facilities that offer implants in Kenya are often short of stock because donors have historically invested more heavily in short-acting methods, such as oral contraceptives, which are less expensive to purchase. However, studies have shown that implants are often more cost-effective than oral contraceptives over time.

The availability of implants is likely to improve. Their costs have been decreasing, and simpler implants are entering the market. Compared with Norplant (which is being phased out), these newer implants are easier for a trained provider to insert and remove. They also have fewer surgical complications.

The modeling exercise

- The modeling exercise used published material on the relationships between different methods of family planning and the rates of discontinuation and unintended pregnancies associated with their use.
- Information on the current population of reproductive-age women in Kenya was used to determine baseline levels of use for the different methods.
- The scientists then estimated the number of unintended pregnancies that could be prevented if some oral contraceptive users chose implants instead.

Potential benefits

- If just 100,000 oral contraceptive users in Kenya chose implants, roughly 26,000 unintended pregnancies could be prevented over the next five years.
- This decrease in unintended pregnancies would prevent about 260 maternal deaths.

Reference

1 Hubacher D, Kimani J, Steiner MJ, et al. Contraceptive implants in Kenya: current status and future prospects. *Contraception* 2007;75(6):463–73.



A doctor inserts Norplant capsules. Compared with Norplant, the implants just entering the market are easier to insert and remove.

AVAILABILITY

- Norplant: Six levonorgestrel-releasing capsules approved for five years of use. Although still available in Africa, Norplant is being phased out.
- Jadelle: Two levonorgestrel-releasing rods approved for five years of use. Jadelle is already cheaper than Norplant once was, and its public-sector price appears to be dropping.
- Sinoplant-2: Nearly identical to Jadelle, but currently available only in China and Indonesia. If Sinoplant-2 is registered in Africa, its public-sector price is expected to be much lower than that of Jadelle.
- Implanon: One etonogestrel-releasing rod approved for three years of use. Its public-sector price is similar to that of Jadelle.

VASECTOMY IN TANZANIA

Study examines acceptability among men and women.

Research by FHI, the ACQUIRE Project (managed by EngenderHealth), and the nongovernmental organization Healthscope in Tanzania's Kigoma Region identified a number of reasons why men and their partners might choose vasectomy. The findings also highlight barriers to the acceptance of vasectomy and suggest ways to increase the adoption of the method, both within and outside the region.

Rates of vasectomy use are slightly higher in Kigoma Region than they are in other parts of

Tanzania. But in general, less than 1 percent of the couples who use contraception in Tanzania or other sub-Saharan countries rely on vasectomy.

For this study, 10 vasectomy clients were interviewed during July and August 2004 about their decisions to have a vasectomy. An additional 28 clients and 22 of their wives, 29 potential clients, and 33 women who had undergone tubal sterilization were also involved in group discussions about contraceptive decision-making.

Read or download the full study, published in *International Family Planning Perspectives*, at: <http://www.guttmacherinstitute.org/pubs/journals/3301307.html>.

What men say:

"I had been expecting to be more educated about it, because I have no idea what is being done during the procedure. How do they start? I don't know. I need to get a whole picture about vasectomy before I decide to do it."

— Potential vasectomy client, Kigoma Region

RESULTS

- Economic hardship due to the expense of raising children was the most common reason participants gave for finding vasectomy acceptable.
- Wives played an important role in the decision to undergo a vasectomy. While most wives accepted the procedure, four potential vasectomy clients said their wives did not want them to be sterilized.
- Several men decided not to have a vasectomy for religious reasons, but an equal number of participants had been sterilized despite the disapproval of their churches.
- More than one-quarter of vasectomy clients said that they had to postpone the procedure because a provider was not available to perform it. Several mentioned that vasectomy clients often have no one to turn to if they experience problems after the procedure.
- Some men and women feared that they might want more children later or that their spouses would be unfaithful after the procedure.

- A general lack of knowledge was the most common reason why potential clients had not undergone the procedure. Both men and women cited specific rumors and misconceptions about vasectomy.

IMPLICATIONS FOR SERVICE DELIVERY

To improve access and service delivery:

- Establish vasectomy outreach services and referral systems.
- Improve counseling by providers.
- Ensure that clients understand the need to use alternative contraception for 12 weeks following the procedure.

To increase demand for vasectomy:

- Orient family planning services toward men.
- Design communication strategies to improve public knowledge about vasectomy.
- Target spouses as well as potential clients with promotional messages.

Vasectomy acceptability was linked to economic hardship in the study, particularly among men.



FAMILY HEALTH RESEARCH is a newsletter of the FHI Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) program, which is supported by the U.S. Agency for International Development (USAID) under the terms of Cooperative Agreement No. GPO-A-00-05-00022-00. The contents do not necessarily reflect the views of USAID.

Managing Editor:
Kathleen Henry Shears

Writers:
Kerry Wright Aradhya, Monica Wanjiru

Art and Production Editor:
Karen Dickerson

Photos:
Cover: Sven Torfin/Panos Pictures

Page 3: Emmanuel 'Dipo Otolorin/
courtesy of Photoshare

Page 6: John Stanback/FHI

Page 7: Jim Daniels

Page 8: Jennifer Wesson/FHI

Inclusion of persons in photos
should not be construed as
indicating their HIV status.



USAID
FROM THE AMERICAN PEOPLE



FHI Kenya
The Chancery, 2nd Floor,
Valley Road
PO Box 38835-00623
Nairobi, Kenya
Tel: 254.20.271.3913

FHI Headquarters
PO Box 13950
Research Triangle Park, NC 27709
USA
Tel: 1.919.544.7040

publication information:
familyhealthresearch@fhi.org

www.fhi.org

February 2008
Volume 2, Issue 1

COLLABORATIONS

APHIA II PROMOTES LAPM USE

Although long-acting and permanent methods (LAPMs) of contraception are safe, convenient, and cost-effective, their use has actually declined in Kenya in recent years.

The Ministry of Health (MOH) has been working with many partners to address this decline. These efforts include collaboration with the AIDS, Population, and Health Integrated Assistance (APHIA) II program to strengthen service provision and to stimulate demand for LAPMs.

The three-year APHIA II program, which is funded by the U.S. Agency for International Development, has been implemented across different regions in Kenya since 2006. FHI manages the APHIA II program in the Rift Valley and Coast provinces.

In those two provinces, APHIA II is training providers to improve the skills needed for insertion and removal of intrauterine devices and implants. Supervisors are trained to make supervisory visits opportunities for further skills building. At the same time, an active community education program raises awareness of the advantages of LAPMs.

To expand access to LAPM services, APHIA II collaborates with Marie Stopes Kenya to provide surgical sterilization through mobile services in Rift Valley Province. The program is also training doctor-nurse teams to perform bilateral tubal ligation in the Coast Province; so far, 11 teams from six district hospitals have been trained.

APHIA II is also training health workers in the logistical management of family planning commodities. Despite the continuing prevalence of misconceptions about these methods, "the interest in LAPMs has been steadily rising, and it is important that we ensure that clients are not frustrated by stockouts," said Dr. Frank Mwangemi, senior technical advisor for APHIA II in Coast Province.



George Wanzala, a district public health nurse in Kenya's Bungoma District, talks to community-based family planning workers about the IUD.

NEW LAPM STRATEGY EXPECTED

A task force has been established to develop a strategy for revitalizing the use of long-acting and permanent methods (LAPMs) of contraception in Kenya. This LAPM Revitalization Task Force was formed at the conclusion of a November 14, 2007 meeting in Nairobi, convened by the Division of Reproductive Health (DRH) of the Ministry of Health (MOH) and funded by the U.S. Agency for International Development.

The purpose of the meeting was to disseminate the findings of an FHI study of recent interventions to promote LAPMs (see page 4). The 56 participants represented the MOH and other organizations working in reproductive health.

The participants recommended that training on the whole range of LAPMs be included in the preservice training curriculum for medical staff. They also expressed concern that supplies of family planning commodities are still unreliable in some parts of the country, thus undermining sustained use of LAPMs.

The 11 members of the LAPM Revitalization Task Force were drawn from the MOH, agencies implementing reproductive health programs in Kenya, and medical training and regulatory institutions. The group is expected to complete the strategy by April 2008.

The strategy will then be discussed by the Family Planning Working Group, which is chaired by the DRH and composed of technical experts and decision-makers with an interest in family planning. If this group adopts the strategy, the MOH will begin to implement it with the assistance of its partners.