



Emergency Contraception, Female Condoms and IUDs in Kenya's Public Sector:

Findings from a National Diagnostic Assessment





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EXECUTIVE SUMMARY

In May 2007, *ECafrique* conducted a diagnostic assessment of three underutilized family planning methods in Kenya's public sector: emergency contraception (EC), female condoms (FCs) and intrauterine contraceptive devices (IUDs). This assessment was requested by the Ministry of Health (MOH), Department of Reproductive Health (DRH), in order to inform future program strategies. The United Nations Population Fund (UNFPA) and the Hewlett Foundation provided support for this work.

Data was collected from 199 government health care facilities located in 8 districts in 5 provinces. Two primary sources were used in the analysis: a knowledge, attitudes and practices (KAP) survey administered among 524 health care providers; and a review of all EC, FC or IUD clients included in each facility's family planning (FP) register over an 18-month period.

Key findings include:

- Approximately half of all surveyed providers were trained on EC (56%) and FCs (47%); substantially more were trained on IUDs (71%). Less than a quarter of these providers received pre-service instruction on each method.
- Overall, trained providers demonstrated the technical capacity to provide EC, although many continued to harbor common biases against the method. As a result, EC appears to be provided most frequently to sexual assault survivors while adolescent access continues to be limited by provider concerns of increasing promiscuity.
- FCs are a relatively well-known method that is widely regarded by providers as appropriate and effective. Their acceptability, however, is undermined by the perception (reportedly shared by providers and clients alike) that the method is unappealing and difficult to use.
- While trained and experienced providers were most likely to offer IUDs, significant barriers to use remained. Providers most frequently cited public "misperceptions", including concerns that it did not work or would "migrate" to other parts of the body. They also identified a set of facility-level limitations, such as untrained staff, inability to maintain sterile environment, limited equipment and lighting.

Key recommendations:

- Further research is needed into client preferences and behaviors, especially for FCs and IUDs. This information is necessary to develop targeted, effective strategies for increasing institutional access and improving public perceptions of each method. Special emphasis should be placed on understanding the key barriers to adolescent access, which remains limited for each method.
- Expand both pre-service and in-service training on each method, while redressing the biases identified in this study.

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LIST OF ABBREVIATIONS

| | |
|------|-------------------------------------|
| ARH | Adolescent Reproductive Health |
| CTU | Contraceptive Technology Update |
| DRH | Division of Reproductive Health |
| EC | Emergency Contraception |
| FCs | Female condoms |
| FHI | Family Health International |
| FP | Family Planning |
| IUDs | Intrauterine contraceptive devices |
| KAP | Knowledge, attitudes and practices |
| KDHS | Kenya Demographic and Health Survey |
| MCH | Maternal and child health |
| MOH | Ministry of Health |
| NGOs | Non-governmental organizations |
| PRC | Post-rape care |
| PSI | Population Services International |
| STIs | Sexually Transmitted Infections |
| VCT | Voluntary Counseling and Testing |

ASSESSMENT BACKGROUND, RATIONALE AND OBJECTIVES

In 2005, the Kenya Ministry of Health (MOH), Department of Reproductive Health (DRH) began an initiative to strengthen the provision of emergency contraception (EC) in the public sector. As a first step, 700,000 units of the dedicated EC product Postinor 2 were procured by UNFPA for use in government facilities and select providers were trained on its administration. In 2006, the DRH requested assistance from *ECafrique*, the African Forum on Emergency Contraception, to expand access to the product.

This report documents the results of a diagnostic assessment conducted at the outset of this initiative. It examines provision and utilization of EC in the public sector in order to inform future program strategies. Upon request from the DRH and the United Nations Population Fund (UNFPA) this assessment also gathered data on two other “underutilized methods” of family planning: female condoms (FCs) and intrauterine contraceptive devices (IUDs).

Kenya’s current method mix

As indicated in Table 1 with data from the Kenya Demographic and Health Survey (KDHS), the three methods included in this study are among the least popular in Kenya’s current method mix. As an emergency method, EC use is expected to remain low, although current levels suggest that its access remains limited; FCs and IUDs also have an unrealized potential to serve a much wider population. As a new method, FCs have yet to establish themselves among clients, with only less than half of one percent of women ever having used the method. The popularity of IUDs, on the other hand, has steadily declined over the past decade, falling from 3% current use in 1993 to only less than 2% current use in the 2003 KDHS.¹ While implants also constitute an underutilized method, they are not included in this analysis.

Table 1: Ever use of modern methods, 2003 KDHS

| | Injectables | Pill | Male condom | IUD | Implants | EC | FC |
|---------------------------|-------------|------|-------------|-----|----------|----|-----|
| % of all women ever using | 25% | 25% | 10% | 6% | 2% | 1% | <1% |

Assessment objectives

To help improve access and utilization of these three methods, this assessment sought to identify the challenges and opportunities facing current programming efforts. It was guided by the following objectives:

- Assess current provider knowledge, attitudes and dispensing behaviors in regard to each method;
- Determine the effect of training efforts on providers’ knowledge, attitudes and dispensing practices;
- Develop a profile of clients who access the methods through public facilities;
- Estimate the availability and distribution patterns of commodities; and
- Identify areas for possible interventions and needs for further research.

¹ Central Bureau of Statistics (CBS) et al. 2004. Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS et al: 68.

METHODOLOGY AND SAMPLE CHARACTERISTICS

Fieldwork for this assessment was conducted between 7 and 21 May 2007. The sample consisted of 199 government health facilities in eight districts of five provinces (see Table 2). Within the districts, all levels of health facilities were sampled based on their distribution at the national level.

Table 2: Facilities sampled, by province and type

| Province | Districts | Facility type | | | Total |
|----------------|-----------------------------|-----------------------|---------------|------------|------------|
| | | Hospital ² | Health Center | Dispensary | |
| Coast | Mombasa Kilifi | 5 | 17 | 27 | 49 |
| Nyanza/Western | Vihiga Nyando Nyamira | 10 | 18 | 23 | 51 |
| Rift Valley | Nakuru Kajiado | 10 | 15 | 42 | 67 |
| Nairobi | Nairobi | 7 | 14 | 11 | 32 |
| Total | | 32 | 64 | 103 | 199 |

Provider KAP survey

At each facility, three types of data were collected. First, a knowledge, attitudes and practices (KAP) survey was administered to a total of 524 providers. Participants were recruited from all cadres likely to provide FP services, with participant selection approximating the distribution of providers at the national level (see Table 3).

Table 3: Providers interviewed, by province and cadre

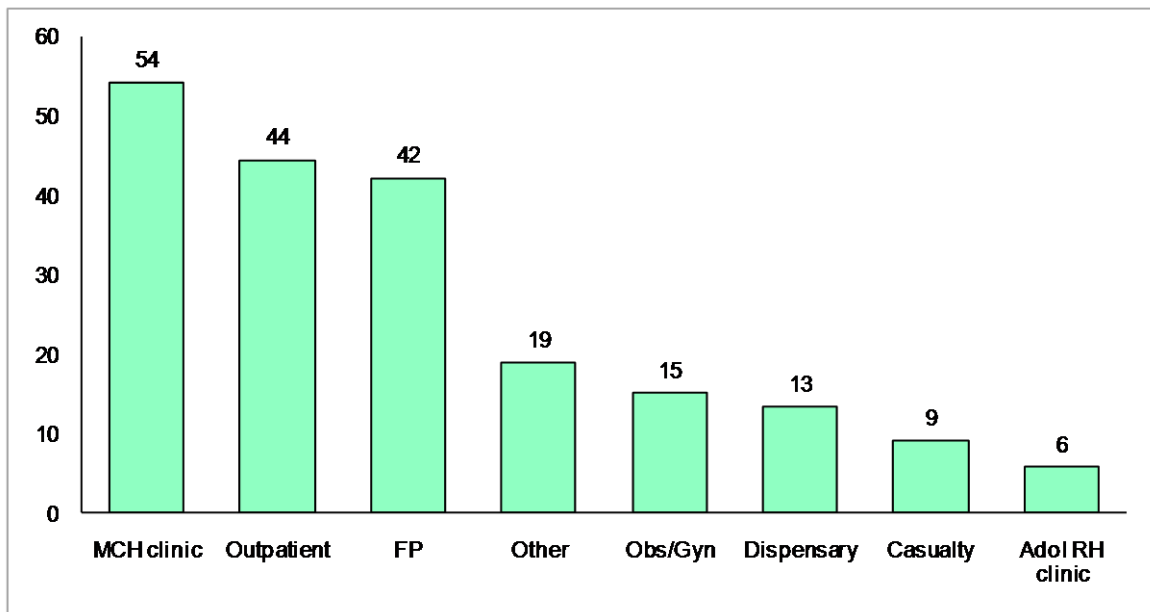
| Province | Cadre | | | | | Total |
|----------------|-----------|------------------|-----------|------------|-----------|------------|
| | Doctor | Clinical Officer | Midwife | Nurse | Other | |
| Coast | 1 | 11 | 17 | 63 | 24 | 116 |
| Nyanza/Western | - | 10 | 11 | 71 | 10 | 102 |
| Rift Valley | 7 | 33 | 16 | 123 | 38 | 217 |
| Nairobi | 2 | - | 17 | 65 | 5 | 89 |
| Total | 10 | 54 | 61 | 322 | 77 | 524 |

Providers were aged between 20 and 55, with a mean age of 37; over three-quarters (79%) were female. The majority of respondents were enrolled and registered nurses (62%), followed by midwives (12%), clinical officers (11%), or others (14%), such as VCT counselors and students (see Table 3).

As indicated in Figure 1, surveyed providers worked in a wide range of departments across the health facility. While most indicated serving in multiple departments, the vast majority identified the maternal and child health (MCH) clinic, outpatient department, or FP clinic as their current workplaces.

² Includes provincial, district and sub-district hospitals.

Figure 1: Distribution of surveyed providers, by department



As expected, the data suggest high turnover among providers, with approximately half having worked at their current facility less than two years. Slightly more than one-quarter, however, served in the same location for over four years, with a small proportion remaining for twenty years or more. Nurses were least likely to turnover rapidly, while 57% of doctors and 60% of clinical officers had been in their currently facility for less than one year.

Client record review

Second, in order to develop a client profile, FP registers were reviewed at each facility. All information on FC, IUD or EC distribution recorded in the register over an 18-month period (January 2006-May 2007) was abstracted for analysis. In total, 2,834 cases were reviewed, but only 2,394 included data on the method used.

Not all of these records, however, reflect individual client use. A total of 179 cases appear to be for large distributions of the methods which, when indicated, were for purposes such as “commercial sex workers” or “community use.” In the absence of clear specifications, the category “large distribution” was determined based on the number of units distributed above the amount typically provided to an individual client. This constituted more than 10 FCs, more than 2 IUDs (including one for demonstration or product wastage), and more than 2 units of EC. Most subsequent analysis in this report excludes “large distributions”.

According to all records, of the three methods included in this study, more individual clients sought IUDs and EC than FCs. However, more FCs were distributed than any of the other methods, most likely reflecting its one-time use status (see table 4).

Table 4: Number of individual cases and units distributed based on family planning registers, by method type

| Distribution type | Female Condom | | IUD | | EC | | Total number of cases |
|--------------------|---------------|-------------|-------------|-------------|------------|-------------|-----------------------|
| | Cases | Units | Cases | Units | Cases | Units | |
| Client use | 231 | 1365 | 1546 | 1143 | 438 | 605 | 2215 |
| Large distribution | 145 | 8233 | 4 | 14 | 30 | 2875 | 179 |
| Total | 376 | 9588 | 1550 | 1157 | 468 | 3480 | 2394 |

Due to inconsistencies in record-keeping, these data are only marginally useful in developing a client profile. Looking just at the data for client use, only one-quarter (26%) of all records included basic information such as age or sex, undermining in-depth analysis of client characteristics. For those records that did have sufficient data, however, it was found that 100 percent of the sample was female (n=1231), mean age was 25 (n=607), 54% were “revisit” clients (n=1076), and the largest proportion, 46%, sought care from a health center (n=1064).

Facility-level stock records

Stock records were examined to provide insight into availability at the facility level. Data collectors examined quarterly records at each sampled facility during the 15-month period between January 2006 (Quarter 1) and March 2007 (Quarter 1), and inventoried stocks on hand to approximate levels for Quarter 2 2007.

As with the client records, data quality was seriously compromised by record-keeping inconsistencies. These problems were found to be so endemic that the data were ultimately unusable. As Table 5 demonstrates, stock data were available for only a handful of the 199 facilities and complete data was found for even less. For this reason, the data has not been included in this analysis.

Table 5: Number of facilities with adequate stock records on surveyed methods

| | Number of facilities with some stock data on method n=199 | Number with data from all 6 quarters |
|-----------------------------------|--|--------------------------------------|
| Emergency Contraception | 27 | 14 |
| Female Condom | 43 | 4 |
| Intrauterine Contraceptive Device | 56 | 18 |

RESULTS: EMERGENCY CONTRACEPTION

As indicated in Table 1 above, less than one percent of Kenyan women had ever used EC in 2003. Facility records indicate that at least 438 clients sought EC from the 199 facilities surveyed over an 18-month period, i.e., approximately two clients per facility. As a method reserved for emergencies, such limited use is not necessarily a problem, and could even indicate the success of FP efforts on a larger scale.

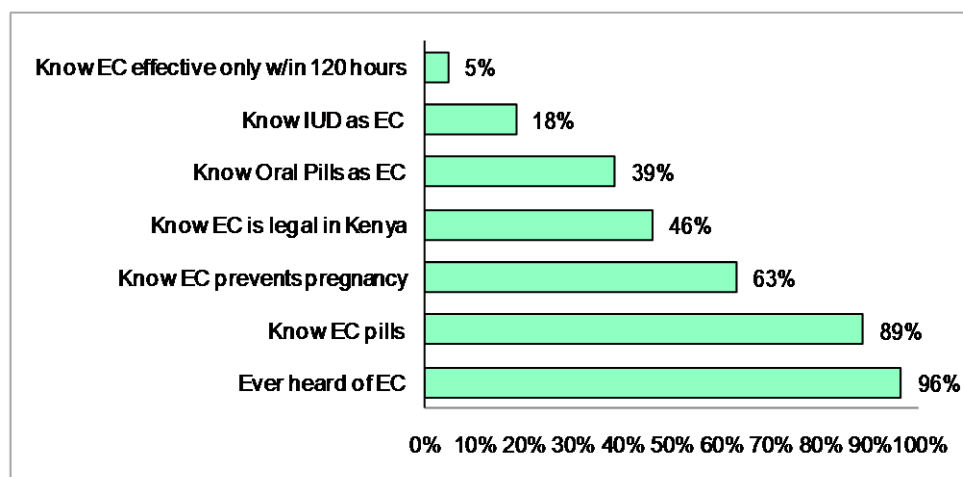
The data presented below, however, suggest that the low utilization of EC may be attributed to restricted access in public sector outlets. Recent research from Population Services International (PSI) Kenya demonstrates that the overwhelming proportion of EC users (95%) obtain the method from private sector pharmacies³. Serving largely middle and upper class clients, these outlets do not reach the vast segments of Kenyan society traditionally catered to by the public sector. The barriers to quality or consistent EC services in the public sector outlined below may account for such a bias toward the private sector.

Overall awareness of EC high, although specific knowledge low

Attesting to the increased attention and awareness of EC across Kenya, an overwhelming proportion of all public sector providers (96%) surveyed indicated that they had ever heard of EC. Nearly as many (89%) were familiar with EC pills such as Postinor 2, although far fewer indicated knowledge of other methods of EC (oral contraceptive pills and IUDs).

Despite nearly universal knowledge of EC, only 63% knew what it was used for (pregnancy prevention) and 5% knew when it should be taken (120 hours after unprotected sex)⁴. Interestingly, less than half of providers believed that EC was legal in Kenya, even though many of them had provided the method (see Figure 2).

Figure 2: Knowledge and awareness of EC, all providers



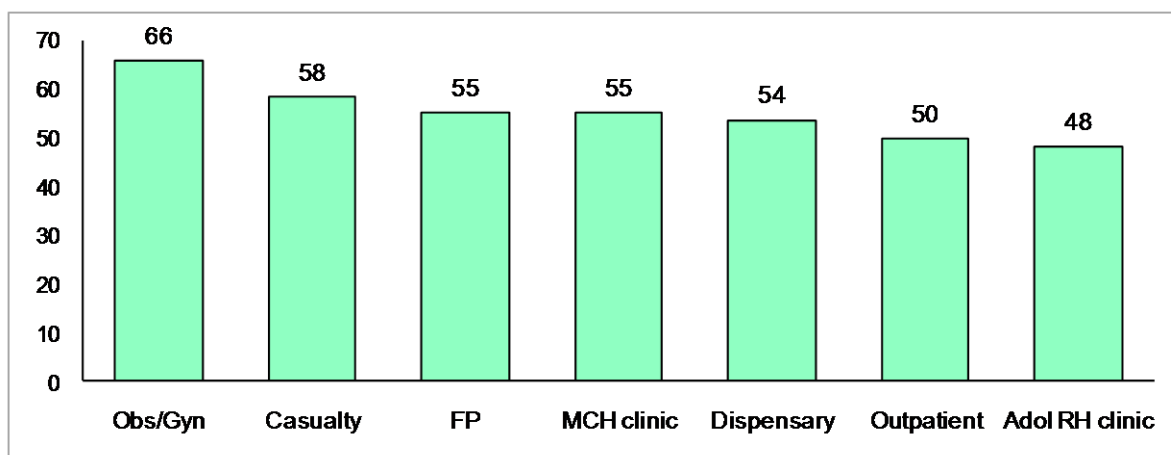
³ Morgan, Gwendolyn. "Private Sector EC Use: A Profile of EC Users." Presentation delivered to Kenya MOH DRH EC Data Interpretation Workshop, 28 August 2007. Population Services International: Nairobi, Kenya.

⁴ While 63% of providers knew that EC was to be taken within 72 hours of unprotected sex, current MOH FP guidelines (March 2005) clearly stipulate that the time limit extends to 120 hours.

Slightly more than half of all providers had been trained on EC, most on Postinor 2

Among the general population of providers, 56% had been trained to deliver EC. While few differences existed among cadre or facility type, interesting variations did exist at the departmental level. Nearly 66% of all trained providers were stationed in the obstetrics/gynecology wards, and the smallest percentage (48%) was found in the adolescent reproductive health (ARH) clinic (see Figure 3). This suggests a potential bias in EC service delivery toward clinical cases (such as sexual violence), and away from the needs of adolescents.

Figure 3: Proportion of providers trained on EC, by department



Of all trained providers, the overwhelming majority (92%) reported that they received instruction on dispensing only the dedicated product, Postinor 2. While this product is currently central to the country’s FP program, such heavy reliance on one brand could become problematic in the face of stock-outs or brand changes.

As Table 6 demonstrates, familiarity with the other methods of EC is highly limited. Slightly over one half of providers were trained on the Yuzpe method in which high doses of combined oral contraceptive pills are provided to clients. While 16% of respondents indicated that they were trained to provide IUDs as EC, that proportion could actually be higher. As Table 9 indicates, when the question was posed differently, as many as 27% of those trained to provide IUDs indicated that they were aware the method could prevent pregnancy after sex.

Table 6: Providers trained to deliver different types of EC

| Type of EC | % trained to provide |
|--------------|----------------------|
| Postinor 2 | 92% |
| Yuzpe method | 51% |
| IUD | 16% |

Most providers (43%) were trained by the Ministry of Health, followed by nongovernmental organizations (NGOs) (22%) such as JHPIEGO, IntraHealth, FHI and EngenderHealth. Despite inclusion in the FP program over a decade ago, only 20% indicated having received pre-service training on EC. Nearly half of all providers (49%) received this instruction two or more years ago.

Training has limited impact on knowledge and attitudes

Training did not appear to substantially improve provider knowledge and attitudes toward EC. In fact, it seemed to entrench or reinforce many common misconceptions about the method. While knowledge levels are generally higher among trained providers, they were only significantly higher for two indicators – the time limit for EC use and the side effect of nausea. Most importantly, training did nothing to change the proportion of providers who incorrectly believed that infertility was a common side effect of EC; nor did it dispel erroneous notions that EC induces abortion. Although the relationship is not statistically significant, it is notable that trained providers were 2.4% more likely to hold incorrect beliefs on abortion following instruction.

Figure 4: Provider knowledge of EC, trained v. untrained

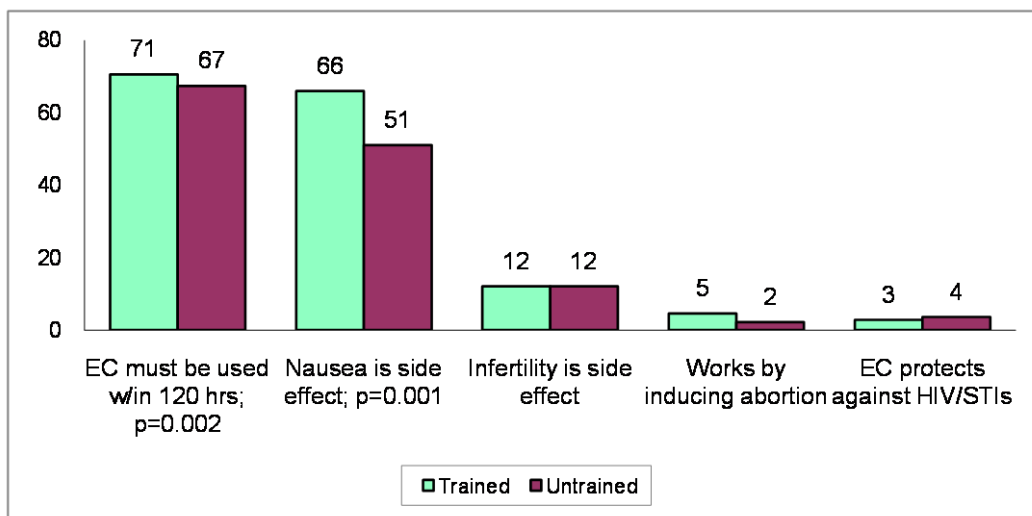
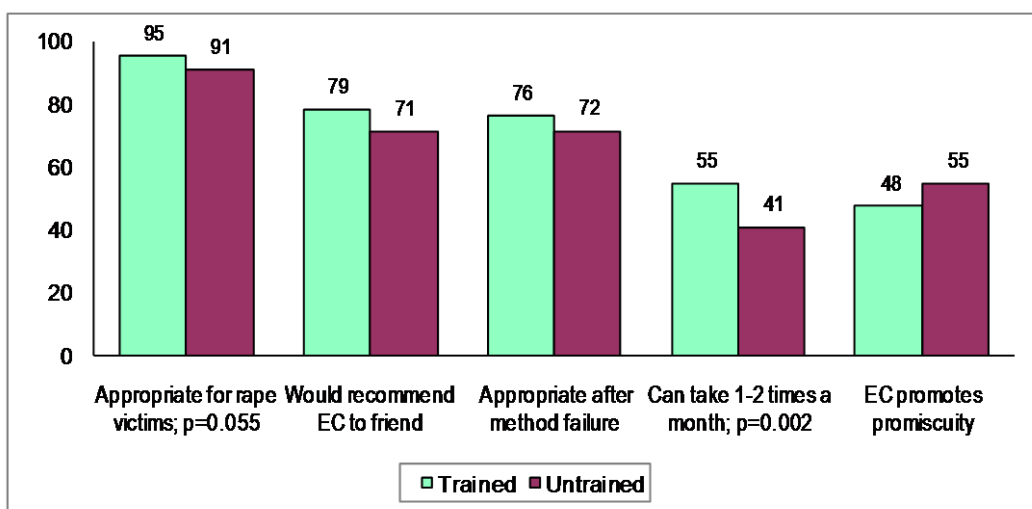


Figure 5 presents a similar picture of provider attitudes. Overall, trained providers had more favorable attitudes toward EC. They were less likely to believe that it promotes promiscuity among young women and more likely to recommend its use to a friend. Only two of these indicators were statistically significant, however, suggesting that training was most successful in communicating the message that EC is appropriate for rape survivors and should not be taken regularly.

Figure 5: Provider attitudes toward EC, trained v. untrained



Notably, 92% of providers (both trained and untrained) responded that EC was appropriate for survivors of sexual assault. The next most commonly identified indication for use, method failure, was listed by only 74% of providers. This finding clearly highlights that providers view EC as primarily intended for sexual assault survivors, a bias that is reinforced in training.

Unlike clients, providers are properly informed on side effects of EC

Despite the limited impact of training on provider perceptions, overall, providers did demonstrate a higher knowledge of EC's side effects, an issue that dominates public concerns over the method.

Recent studies conducted by PSI Kenya demonstrate that side effects are a key concern for users. Among women in the general public who knew of EC, 72% believed that it could cause deformed children and 61% noted that it could cause infertility.⁵

Data clearly indicate that similar misconceptions are not shared by providers, whether trained or untrained, and do not serve as an important barrier to provision. As Figure 4 highlights, only 12% of providers believe that EC causes infertility and only a negligible amount (6%) cited child deformity. When asked why they would recommend Postinor 2 to a friend, the largest proportion of providers (34%) indicated that it was due to its limited side effects.

The bulk of providers correctly identified nausea (see Figure 4), vomiting and dizziness as common side effects, but only about 10% stated that those conditions were severe enough to discourage them from prescribing Postinor 2.

Trained providers more likely to counsel on and dispense EC

While provider knowledge and attitudes were not substantially affected by training, instruction did positively influence behavior.

Training significantly increased the likelihood that a provider would discuss EC with clients on a routine basis. Nonetheless, even among trained providers, 40% rarely or never discussed the method (see Table 7). This ambivalence to discussing the method with all potential clients undermines its potential to serve as a back-up method for other contraceptives.

⁵ Morgan, Gwendolyn. "Private Sector EC Use: A Profile of EC Users." Presentation delivered to Kenya MOH DRH EC Data Interpretation Workshop, 28 August 2007. Population Services International: Nairobi, Kenya.

Table 7: EC Counseling and provision, trained v. untrained (p=0.000)

| | Trained | Untrained | All providers |
|--|---------|-----------|---------------|
| Counseling | | | |
| Discuss with every eligible client/ always discuss | 60% | 41% | 51% |
| Discuss only upon client request | 33% | 34% | 34% |
| Never discuss | 7% | 25% | 15% |
| Provision | | | |
| Ever provided EC | 78% | 44% | 63% |
| Provided EC/ Postinor 2 | 91% | 89% | 91% |
| Provided EC/ Yuzpe | 42% | 26% | 37% |
| Provided EC/ IUD | 6% | 3% | 5% |

Of all providers surveyed, 63% had ever dispensed any type of EC to a client. Again, trained providers were significantly more likely to do so than their untrained colleagues. When EC was given, Postinor 2 was by far the most frequently dispensed type.

EC more frequently serves as “bridge” to FP and HIV services than to post-rape care

As an emergency method, EC presents a unique opportunity to serve as a “bridge” to other FP methods or services. For women experiencing contraceptive failure, this bridge may involve counseling and providing more reliable FP methods. For rape survivors, this entails referrals to other medical or legal services; and all women at risk of pregnancy from unprotected sex also require information, counseling and testing for sexually transmitted infections (STIs) such as HIV.

Table 8: Additional services provided to EC clients, trained vs. untrained

| | Trained | Untrained | All providers |
|--|---------|-----------|---------------|
| HIV/STI/VCT counseling or referral | 65% | 54% | 62% |
| <i>Bridge to FP</i> | | | |
| FP advice | 63% | 58% | 62% |
| Client accepted new FP method | 51% | 41% | 46% |
| <i>Bridge to post-rape care</i> | | | |
| Rape referral to police | 35% | 38% | 36% |
| Rape referral to another health facility | 25% | 21% | 23% |
| No other service provided | 2% | 2% | 2% |

As Table 8 indicates, the bulk of EC clients did receive additional services. Providers appeared to be most willing to offer FP and STI services, perhaps because they could deliver such services themselves. The majority of all providers (62%) offered both FP advice and HIV/STI counseling to their EC clients. Notably, nearly half of those counseled on FP accepted a new or different FP method, suggesting that in many cases, EC is being effectively used as a bridge to other contraceptive methods.

Although client records only recorded 18 cases of FP “bridging”, the methods most frequently given with EC were injectables (11) and male condoms (3). While no statistical

significance exists between trained and untrained providers, the data indicate that trained providers are slightly more likely to “bridge” clients to other services.

Providers were less likely to refer sexual assault survivors for other post-rape care (PRC) services. Only 36% would refer a survivor to the police and far fewer providers, 23%, would send the survivor to a higher level health facility.

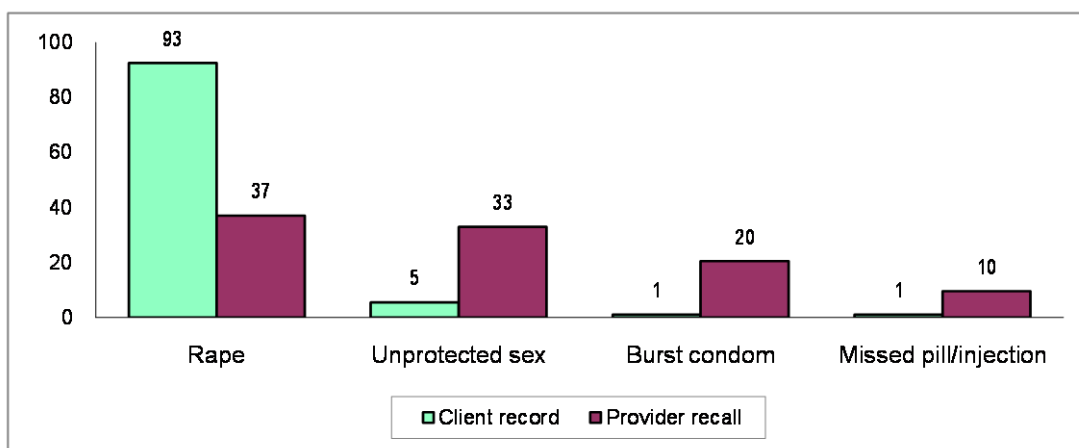
Bias toward meeting the EC needs of sexual assault survivors

As highlighted in Figure 5, nearly all providers (92%) identified rape as a key indication for EC provision, with training significantly increasing the likelihood of doing so. This bias toward serving sexual assault survivors also translates into service provision patterns.

According to FP registers, an overwhelming proportion of EC clients (93%) were rape survivors. These survivors were disproportionately young, with the bulk between the ages of 11-15 (34%) followed by 16-20 years olds (31%). Most presented to district or sub-district hospitals (53%), provincial hospitals (35%) or health centers (12%).

An interesting discrepancy emerges when these client records are compared with provider recall of client needs (see Figure 6). While the bulk of providers (37%) noted that rape survivors comprised the largest number of their clients, nearly as many (33%) cited unprotected sex as the reason for dispensing EC. Although this data is inconclusive, it could suggest that when entering EC use into FP registers, providers are more likely to record sexual violence cases, reflecting what they believe to be the proper use of the drug.

Figure 6: Reasons for providing EC, client records (n= 207) and provider recall



Further reflecting a bias toward providing EC in cases of sexual assault, hospital casualty departments (where most survivors present) top the list in counseling and provision of EC. Whereas approximately 60% of providers in other departments discuss EC with all likely clients, a full 71% of casualty staff does so. Even more of these providers (81%) have ever dispensed the method.

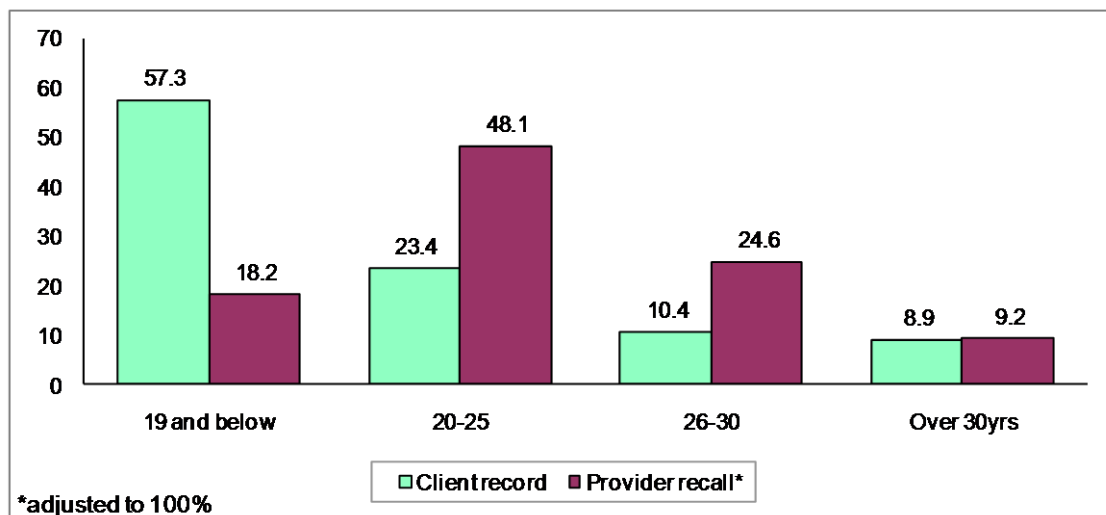
These findings clearly highlight the success of past efforts to promote EC as an important element of PRC. They also suggest the need to move beyond this initial emphasis on PRC to more effectively meet the needs of all potential clients.

Limited adolescent use of EC

Despite generally positive perceptions of the method, providers appear to remain uncomfortable with the idea of providing it to adolescents. As was indicated in Figure 5 above, 51% of all providers believe that access to EC pills encourages promiscuity among young women. Similarly, when asked why they would not provide the method to a friend, the largest proportion of respondents (23%) indicated fears of “misuse” especially among the youth. While such bias is somewhat lower among trained providers, ARH clinic staff were the least likely to have received training on EC (see Figure 3 above).

As with sexual assault, provider recall on the ages of EC clients differed substantially from client records. Providers are more likely to remember their last EC clients as between the ages of 20 and 25, whereas the FP registers indicate they were 19 and below (see Figure 7). While much of the disjuncture in client records can be attributed to the disproportionate number of rape survivors recorded (who tend to be younger), providers’ likelihood to report older clients could also be a function of their discomfort with serving younger women.

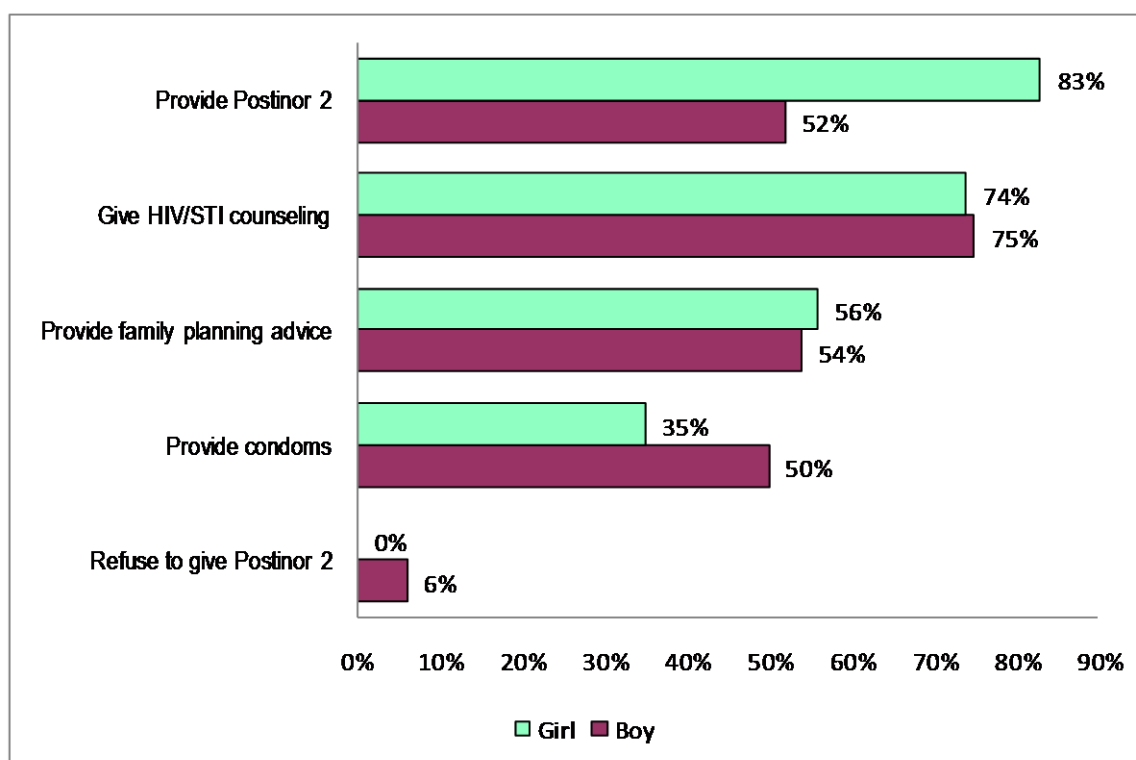
Figure 7: Age distribution of EC clients, client records (n=192) vs. provider recall



Providers were also likely to demonstrate a gender bias in providing EC services to adolescents. Figure 8 highlights responses to two hypothetical situations. In the first, an unmarried adolescent girl who recently engaged in unprotected sex turns to the provider for help in preventing pregnancy; in the second, the client is an adolescent boy seeking EC for his girlfriend.

Interestingly, in these scenarios, boys were 30% less likely to receive EC than girls and 25% more likely to be given condoms. This suggests that men are not seen as appropriate EC clients, even though providers noted that 5% of their most recent EC clients were men presenting alone and 20% were females accompanied by males.

Figure 8: Responses to hypothetical situation on adolescent EC provision, boy vs. girl



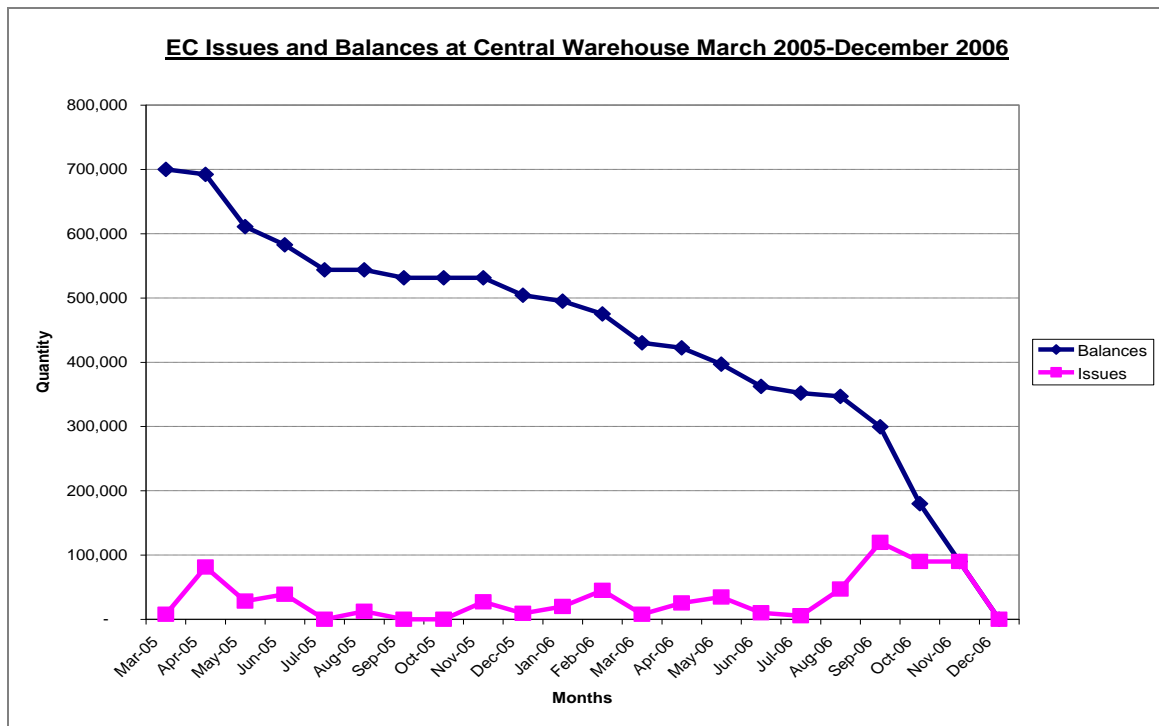
Counseling provided to adolescents in the hypothetical situation also differed from that provided to the general population. As Table 8 above demonstrates, approximately 62 percent of providers indicated that they counseled all EC clients in FP and HIV/STIs. For adolescents, providers were nearly 13 percent more likely to use EC as a “bridge” to HIV/STI services, but seven percent less likely to deliver FP advice. Again, this appears to highlight providers’ overall reluctance to give adolescents FP tools and knowledge.

EC currently out of stock in central stores

According to the official stocking data in Figure 9, the 700,000 units of EC procured in March 2005 were fully issued to district stores by December 2006. Although incomplete, data gathered as part of this assessment indicates that substantial stocks remain at district stores and that the facilities that dispense the most EC (district hospitals) are least likely to maintain sufficient stocks. These findings all suggest the need for improved logistical management of the commodity.

Demonstrating their commitment to providing continued EC services in the public sector, in mid- 2007 the MOH issued a tender for an additional 240,000 units of EC. EC has also been integrated into family planning commodity security plans for the remainder of the decade.

Figure 9: EC issues and balances at Central Warehouse March 2005-December 2006



Source: Kenya Ministry of Health, Department of Reproductive Health

RESULTS: FEMALE CONDOMS

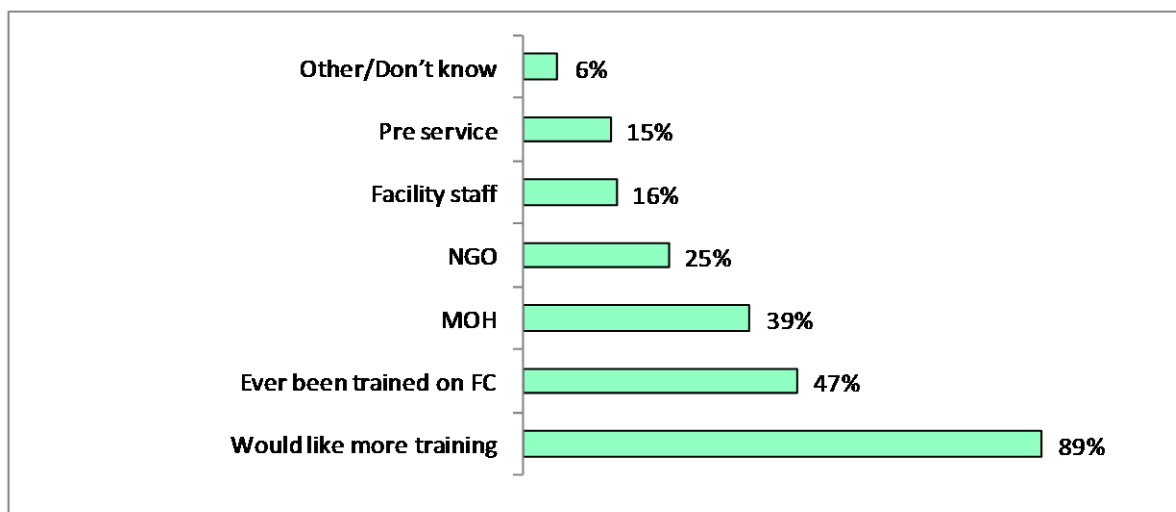
Of the three methods examined in this study, FCs had the largest number distributed, with at least 9,588 units being provided by the 199 facilities sampled in the 18-month period (see Table 4 above). When looking at distribution solely to clients, however, a much different picture emerges. FCs actually appear to be the least popular method among clients who visit the facility, with only 1,365 units distributed to 231 clients during the study period. Because FCs are a coital-dependent method, and should be used during every act of sex, this number does not seem to indicate regular use of FCs. Nor does it indicate high uptake in comparison to another underutilized method, the IUD, which saw 1,143 insertions during the same time period.

Less than half of all health care workers trained to provide FCs

Of all providers surveyed, less than half (47%) indicated that they were trained on FCs. No significant differences existed for cadre or department suggesting that, when delivered, training was given equally to all levels of providers.

The MOH trained the largest proportion of providers, 39%, while another 25% were trained by NGOs (see Figure 10). NGOs such as Pathfinder, FHI and the USAID-funded bilateral AMKENI Project were most commonly cited as providing training, although they were not identified frequently enough to allow for further analysis of each partner's efforts. Most of these trainings (60%) occurred more than one year prior to the survey, suggesting a need to revitalize instruction on FCs. Indicating an overwhelming desire to know more about the method, nearly 90% of all providers requested more training on female condoms in the future.

Figure 10: Provider training characteristics, FCs



Basic knowledge of FCs generally high, even without training

Overall, the providers surveyed had relatively high levels of knowledge and favorable attitudes toward FCs. As Table 9 indicates, among all providers, 91 percent believed that FCs are appropriate for all types of women, nearly 90 percent correctly identified its dual protection benefits, and 88 percent noted that it worked just as well as male condoms.

Table 9: Provider knowledge and attitudes toward FCs, trained v. untrained

| | Trained | Untrained | All providers |
|----------------------------------|---------|-----------|---------------|
| FC appropriate for any woman* | 94% | 88% | 91% |
| FCs prevent pregnancy and HIV** | 93% | 86% | 90% |
| FCs work as well as male condoms | 91% | 86% | 88% |

* p=0.036; ** p=0.021

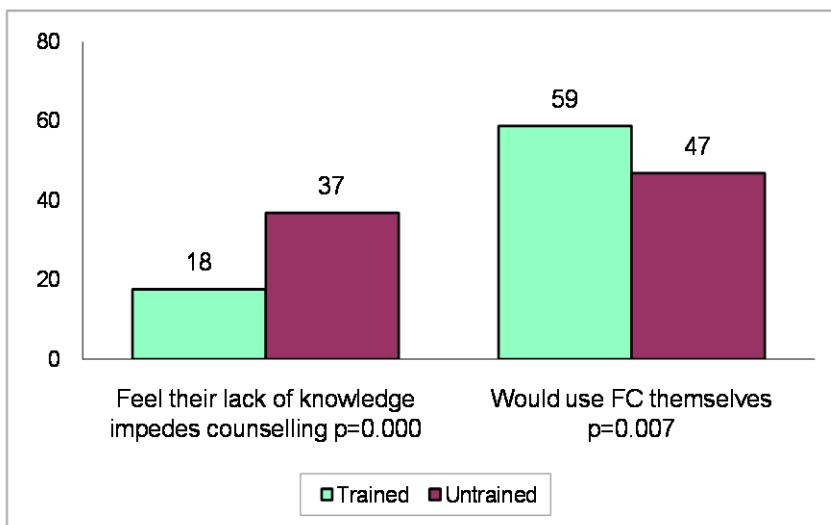
While training was found to significantly increase some indicators of knowledge and attitudes, the proportion of non-trained providers expressing the same favorable views suggests that the benefits of the method are widely understood among providers.

Trained providers more likely to counsel on and dispense FCs

While all providers appeared to have generally favorable knowledge and attitudes toward FCs, trained providers were more likely to actually deliver the method.

Those who were trained demonstrated greater levels of personal comfort with the method, which appears to translate into more favorable counseling and dispensing behaviors. As Figure 11 indicates, trained providers were less likely to identify a lack of personal knowledge as a barrier to counseling, and were more amenable to using it themselves.

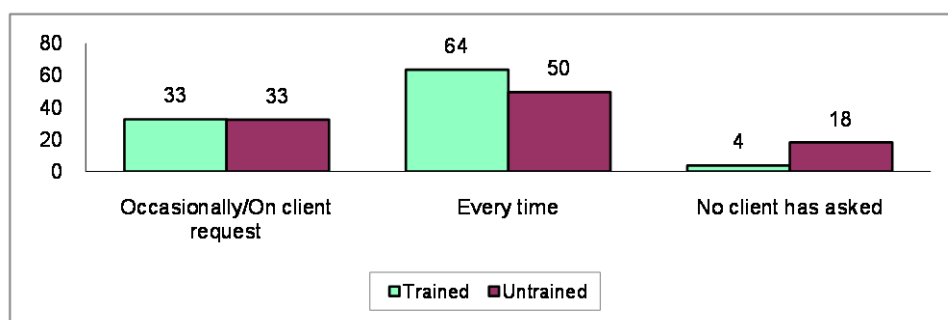
Figure 11: Provider personal perceptions of FCs, trained vs. untrained



Perhaps due to this increased sense of familiarity with FCs, more trained providers reported counseling clients on FCs during every visit (see Figure 12). When asked to identify common barriers to counseling, providers noted that the “majority don’t want to hear about FCs,” “we don’t have a dummy for instruction,” or that “no FCs available in our facility.”

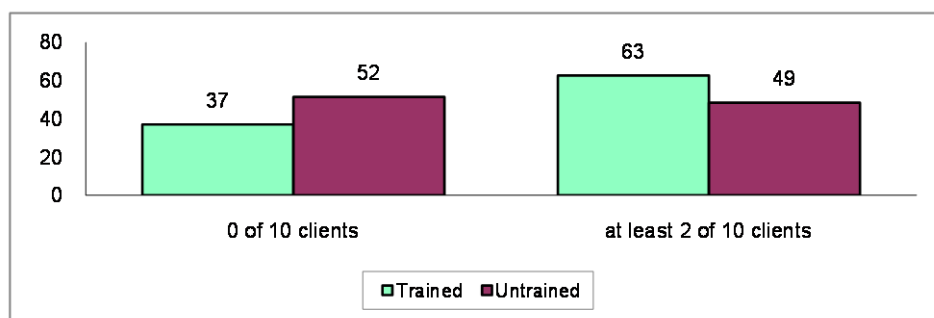
Interestingly, 18% of untrained providers noted that no client ever requested information on FCs from them, suggesting that they are either less likely to provide the opportunity to discuss FCs, do not recognize counseling opportunities when they arise, or reported less interest to compensate for their reluctance to counsel.

Figure 12: Frequency of counseling on FCs, trained v. untrained (p=0.000)



A similar pattern is found among those dispensing the method. When asked how many of the last 10 clients counseled on FCs accepted them, 63% of trained providers indicated that at least two of the clients took FCs home with them. Only 49% of untrained staff reported a similar acceptance rate, suggesting that those who were trained are more skilled at communicating the information needed to encourage uptake (see Figure 13).

Figure 13: Proportion of last 10 clients receiving FCs, trained vs. untrained (p=0.001)



FCs unappealing to both providers and clients

Despite a high level of technical competence on the method, even trained providers continue to harbor biases against it. Nearly 40 percent of trained providers noted that they would not use the method themselves; for untrained providers, that proportion was over 50 percent (see Figure 11 above). Overall, 47% of all providers state they would not use FCs.

When asked why they would not use FCs, the largest proportion of all providers (41%) noted that they were unappealing in some way – either that it was uncomfortable, difficult to use, un-enjoyable, messy, noisy or time-consuming. Importantly, providers not willing to use it themselves were 11% less likely to counsel clients on FCs and 19% less likely to have a client accept the method.

Providers also reported that they believed their clients were biased against the method. The majority (40%) noted that the largest hurdle to providing counseling on FCs was simply a lack of client interest. This disinterest, according to providers, was attributable to reasons such as partner dislike, difficulty of use, and a lack of familiarity with the method (see Table 10). Speculation on why clients did not accept the method echoed the comments offered by providers on their own reasons for disuse, including “size is scary,” “makes a lot of noise,” and “cumbersome to use.”

Table 10: Client reasons for non-use of FCs, according to providers

| | Percent | N= |
|-----------------------------|---------|-----|
| Partners do not like method | 51 | 265 |
| FC too difficult to use | 49 | 253 |
| Most do not know method | 40 | 208 |
| FC are expensive | 25 | 128 |
| Do not believe that FC work | 17 | 89 |
| Total | 100 | 522 |

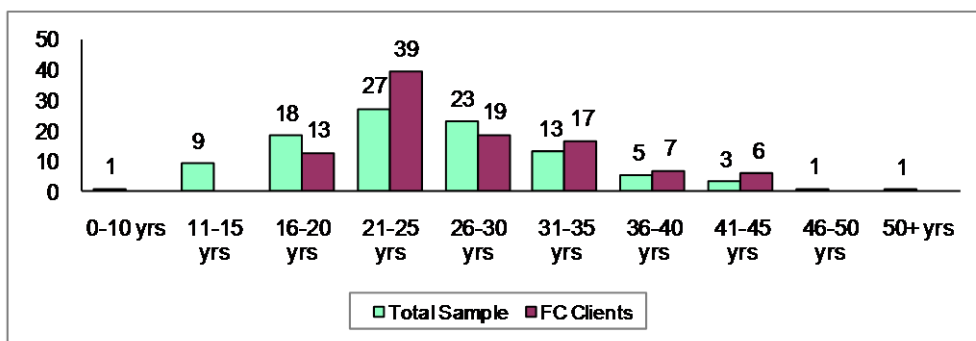
Using the current data, it is impossible to ascertain how closely client’s actual perceptions of the method correspond to the providers beliefs about them. It is likely, however, that provider bias has a notable impact on uptake levels.

Adolescents are least likely to receive FCs

Provider bias also appears to undermine adolescent access to FCs. While the majority of all providers (91%) noted that FCs were appropriate for “any type of woman”, they were divided on its utility for adolescents. Despite its potential to meet the unique needs of this group, only 65% believed FCs were a right choice for younger women. Training made no significant difference in this perception.

As Figure 14 indicates, a similar bias against adolescents was also found in client records. At the facility level, women under 20 were less likely to receive FCs than other methods, with most FCs being provided to women aged 21-25 years. While the data cannot show a direct link between provider attitudes and dispensing patterns, it does suggest that under-provision to young women can be attributed, in part, to provider reluctance in delivering the method to adolescents. It is also likely that, as with their adult counterparts, adolescents harbor similar biases against FCs.

Figure 14: Client age distribution in client records, FC (n=102) vs. total sample



Existing clients most likely to access FCs; most frequently obtained from health centers

According to facility FP registers, nearly 62% of all FC acceptors were returning clients. They were also most likely to obtain it from a health center (66%) followed by district hospitals (19%), with dispensaries constituting the least used outlet (4%). This suggests that FCs are most often delivered within the context of health center-based FP programs, and may not be routinely offered on the first visit.

RESULTS: INTRAUTERINE CONTRACEPTIVE DEVICE

IUDs were the most frequently used of the three underutilized methods examined in this study. As Table 4 indicates, 1,546 clients presented as “IUD clients” during an 18-month period and 1,143 IUDs were distributed. Taking into account potential product wastage or demonstration, it is estimated that 1,131 IUDs were inserted during this period. While this is the highest of the three methods, use of IUDs generally remains low and decreasing. Client knowledge and public perceptions of the method serve as the greatest barrier to provision.

Provider training on IUDs relatively widespread

In stark contrast to training on FCs, the majority of providers surveyed (71%, n=374) reported having been trained on IUDs. Of these, 98% had been trained on IUD counseling and 86% on insertion and removal. Nurses and midwives were significantly more likely to have been trained than other providers, most especially clinical officers.

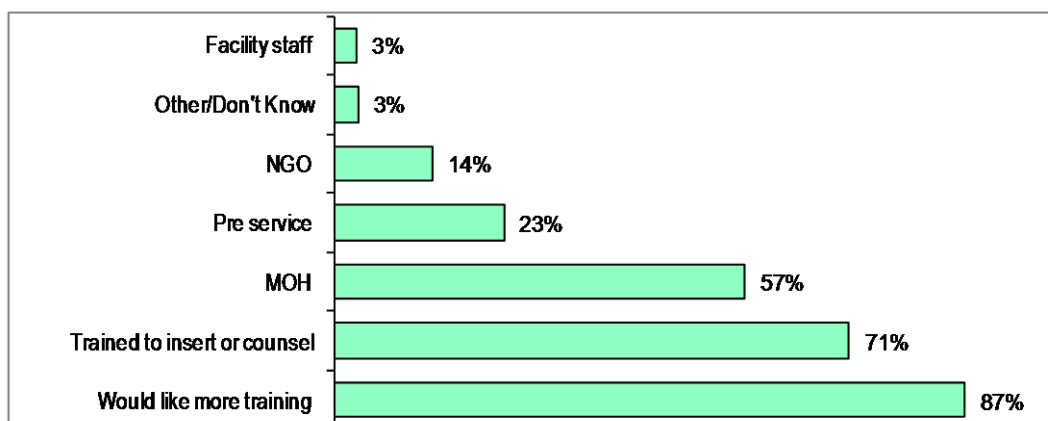
Every one of the 199 facilities surveyed had at least one provider trained to insert and remove IUDs, even if the service was not offered at that outlet. The proportion of trained staff across facilities was uniformly high, ranging from 76% in provincial hospitals to 66% in district hospitals.

Reflecting a rational distribution of trained staff, the highest proportion of trained staff were likely to be located in the obstetrics/ gynecology wards (84% of all providers), FP (79%), MCH (78%) and ARH (77%) departments.

Most IUD training was provided by the MOH (57%), followed by pre-service instruction (23%), highlighting the fact that most providers have been trained by public sector institutions (see Figure 15). Only 14% received training from NGOs, with groups such as AMKENI, Pathfinder, JHPIEGO and FHI most frequently identified. The bulk of this training (74%) occurred more than one year prior to the survey.

The content of these trainings appeared to differ little between institutions, as providers trained by the MOH, pre-service institutions or NGOs all demonstrated similar knowledge, attitudes and behaviors toward IUDs.

Figure 15: Provider training characteristics, IUDs

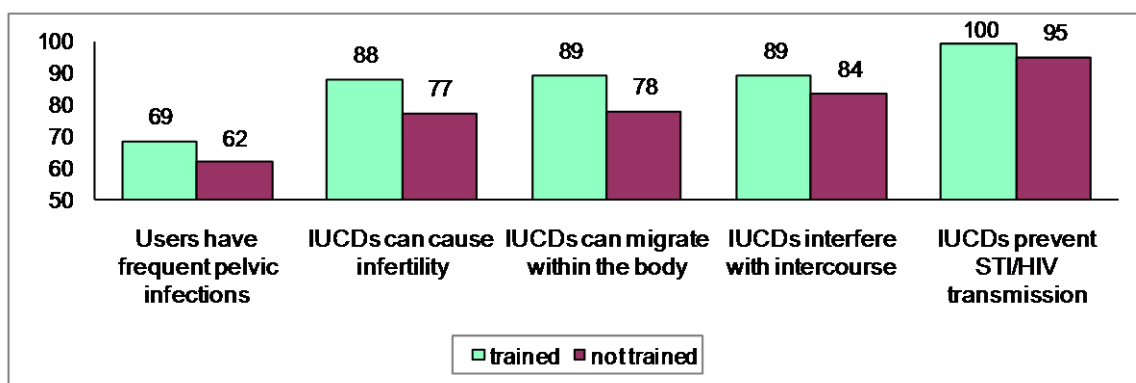


Despite such high levels of training, 87% indicated that they were interested in receiving more instruction. Of these, 62% expressed interest in learning more about inserting IUDs, 61% wanted more information on dealing with side effects, 44% on the removal of IUDs, and 40% on counseling.

Trained providers have higher knowledge and more favorable attitudes toward IUDs

Overall, basic understanding of IUDs was high among all providers, both trained and untrained, with 95% correctly identifying the mechanism of action. Less than one percent believed that it caused abortion. Trained providers, however, were less likely to share common misperceptions of IUD use. As Figure 16 demonstrates, trained providers were significantly more likely to not erroneously associate IUDs with side effects such as infertility and migration of the device within the body. Notably, over 30% of trained providers continued to believe that IUD users have frequent pelvic infections, suggesting that concern is not adequately addressed in current curricula.

Figure 16: Percent of providers who disagree with common misconceptions, trained vs. untrained (p=0.000)



Training also significantly improved providers' perceptions of the types of woman the method is most appropriate for, and increased their likelihood of using it themselves (see Table 11). Interestingly, training only marginally increased the percentage of providers who identified IUDs as a method of emergency contraception.

Table 11: For which women are IUCDs appropriate? (p<0.050)

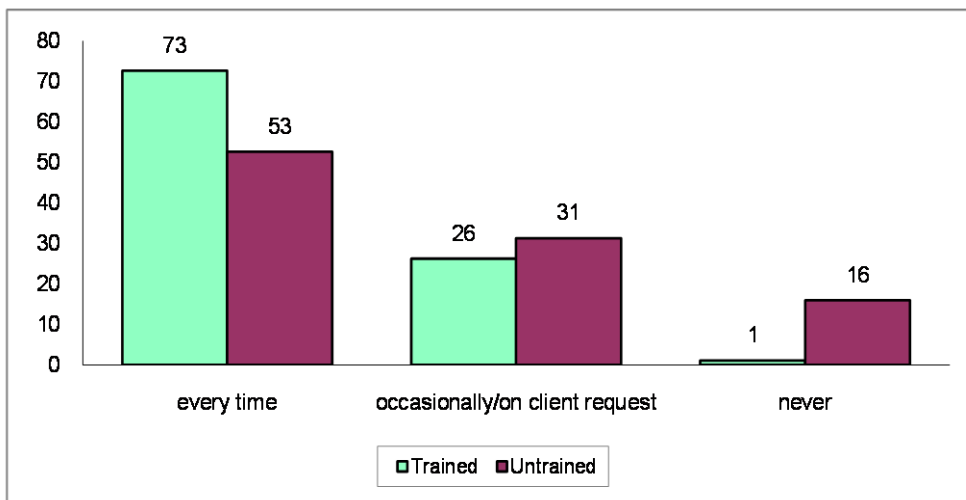
| | Trained | Untrained |
|--|---------|-----------|
| Type of women | | |
| Women who want long-term pregnancy protection | 95 | 88 |
| Women for whom other methods have failed | 84 | 66 |
| Women who've had unprotected sex and wish to prevent pregnancy | 27 | 26 |
| Women who are not menstruating | 22 | 20 |
| Women with fibroids | 12 | 9 |
| Commercial sex workers | 10 | 21 |
| Women with many sexual partners | 10 | 21 |
| Self/ friend | | |
| Would you/your partner use IUCD? (% Yes) | 84 | 69 |
| Would you recommend IUCD to a friend? (% Yes) | 90 | 81 |

Unlike FCs, a provider’s willingness to use the method herself has little impact on the frequency with which it is delivered suggesting that, for the IUD, negative provider attitudes are not an important barrier to provision.

Training dramatically increases counseling and provision of IUDs

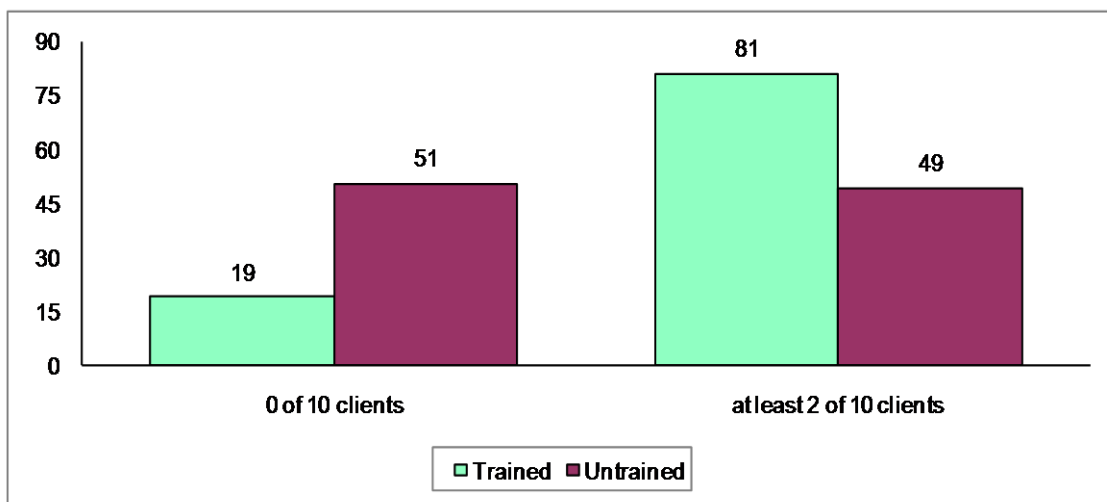
Training does appear to dramatically improve provision of the IUD. As Figure 17 highlights, over two-thirds of all providers counseled every client on IUDs, a proportion well above either of the two other methods examined in this study.

Figure 17: Frequency of counseling on IUDs, trained vs. untrained (p=0.000)



The impact of this counseling is seen in rates of utilization. Trained providers were 30 percent more likely to have at least two of their last 10 clients adopt the method (see Figure 18), suggesting that the confidence gained through formal training has an important impact on utilization.

Figure 18: Proportion of last 10 clients receiving IUDs, trained vs. untrained (p=0.000)

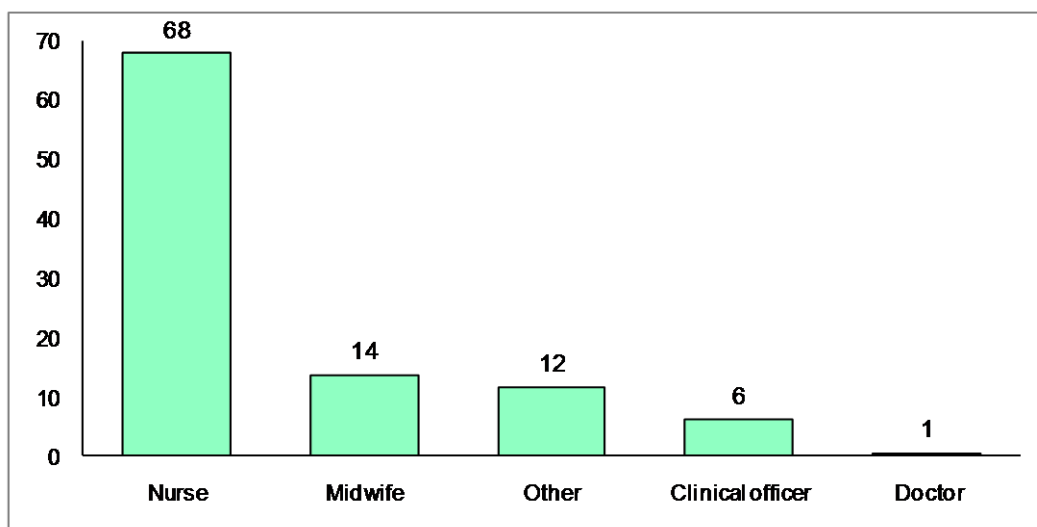


Experienced providers more likely to deliver IUD services

While training increases a provider's ability to deliver the method, actual experience has an even more important impact.

Overall, 36% (n=182) of sampled providers had inserted an IUD in the past year of which, as demonstrated in Figure 19, the vast majority were nurses (68%), followed distantly by midwives (14%). Of the ten interviewed doctors, only one had performed an IUD insertion in the past year.

Figure 19: Who inserts IUDs?



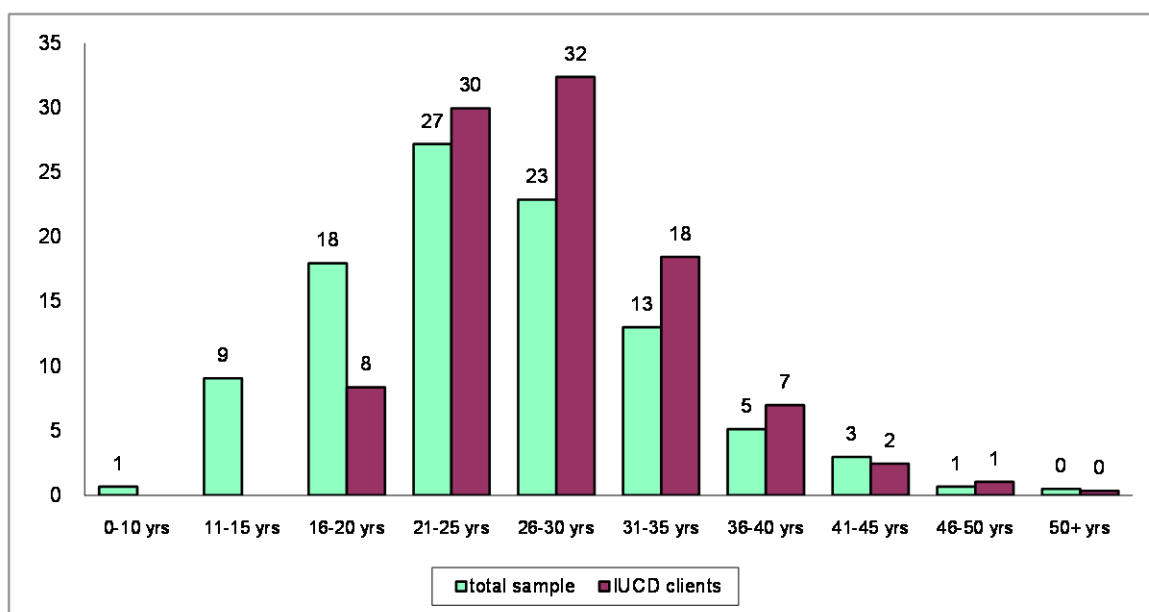
Of these experienced IUD providers, 81% counseled every client on IUD, and 94% had at least 2 of their last 10 clients opt for an insertion. Again, this demonstrates that the provider's confidence with the method positively influences their ability to deliver the service.

IUD clients are older, most often revisiting a facility

Experience with the health facility also appears to make a difference among clients. According to facility records, the majority of IUD clients (59%) were revisits. Unfortunately, record-keeping inconsistencies make it impossible to determine what type of IUD services these clients received during their visit (counseling, insertion, removal or follow-up care). Based on the mean age of clients (25 years old), it is likely that many IUD users have sought some other type of family planning on prior visits.

As with FCs, adolescents were least likely to receive IUDs, while women between 26 and 30 comprised the largest proportion of clients (see Figure 20). This suggests that IUDs are seen as a method most appropriate for older, married women who are likely to have at least one child.

Figure 20: Client age distribution in client records, IUD (n=287) v. total sample



Client misconceptions are the greatest barrier to provision, according to providers

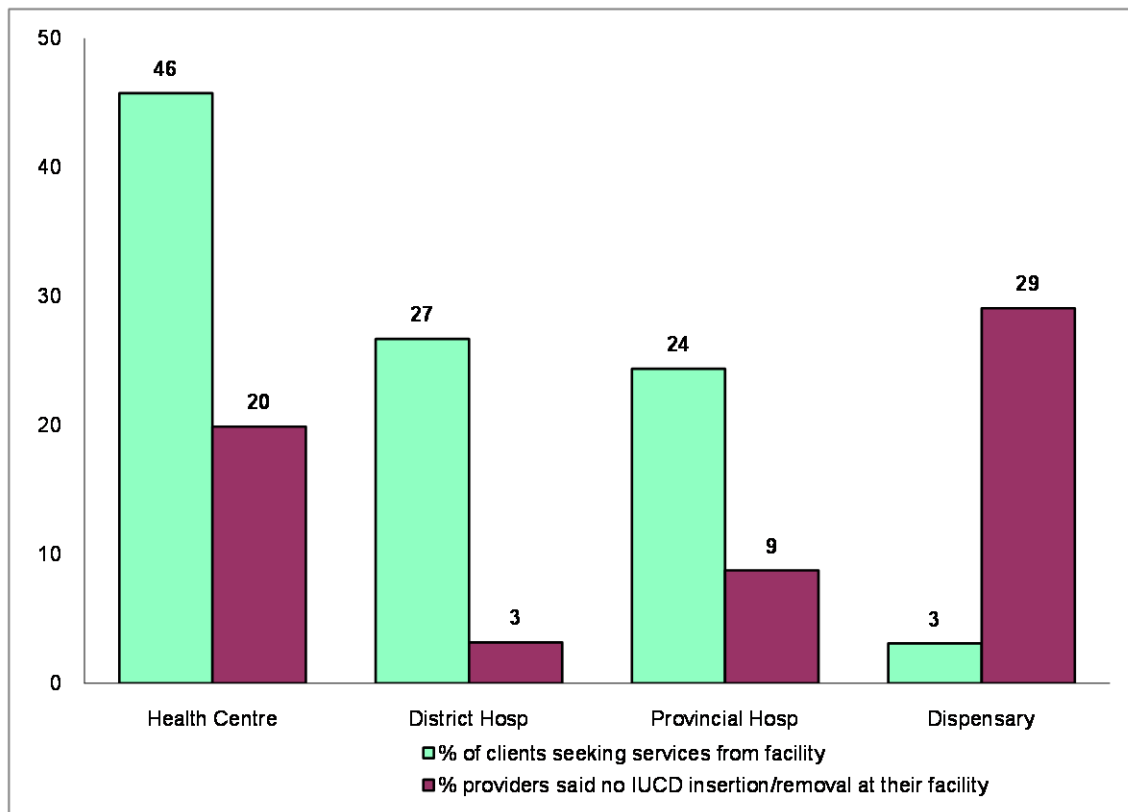
While providers tended to have generally positive attitudes toward the method, they believed that clients did not. When asked to recount the challenges encountered in counseling on the method, the largest proportion of providers (26%) noted that clients were simply not interested.

“Myths and misconceptions” among clients and communities were the most commonly cited reasons for such disinterest. Specific concerns included “fear that it does not work,” “discomfort,” “painful inserting,” “it goes to the brain,” and “it corrodes the vagina.” The apparent prevalence of these myths highlights the need for greater public knowledge on IUDs.

Demand for services not in step with facility capacities

According to client records, nearly 50 percent of those who sought IUD services received them from a health center. As indicated in Figure 21, however, nearly 20 percent of providers based at health centers indicated that their facility had no staff trained to insert or remove IUDs. This finding suggests that while client demand is highest at the health center, these facilities are not uniformly able to meet those needs.

Figure 21: Clients receiving IUDs vs. trained providers, by facility



Within facilities, providers also noted that physical constraints hampered provision. “Lack of space,” “sterility can’t be maintained,” “no equipment,” and “no supply” were identified barriers encountered at the facilities.

Reflecting these concerns, both providers and clients identified infection and other difficult-to-manage side effects as the most notable drawbacks of IUDs. When asked for their greatest worries when inserting an IUD, the largest proportion of providers (42%) noted infection and side effects. As indicated in Figure 16, even trained providers expressed the belief that IUD users are subject to frequent pelvic infections, though there is no data available to verify this contention. In the 2003 KDHS, the largest proportion of clients (32%) also identified “side effects” as the most common reason for IUD discontinuation.⁶

⁶ Central Bureau of Statistics (CBS) et al. 2004. Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS et al: 79.

CONCLUSIONS AND RECOMMENDATIONS

Table 12 highlights the key similarities and differences between the three methods. It demonstrates that, overall, providers are more prepared for providing the IUD and least qualified to provide FCs.

Table 12: Data summary, by method

| | EC | FC | IUD |
|--|-----|------------|-----------|
| Number of clients records in sample | 438 | 231 | 1546 |
| Trained on method | 56% | 47% | 71% |
| Trained by MOH | 43% | 39% | 57% |
| Trained by NGO | 22% | 25% | 14% |
| Trained pre-service | 20% | 15% | 23% |
| Attitude (all providers) | | | |
| Would use method yourself/ recommend to friend | 75% | 53% | 80% |
| Provision behaviors (all providers) | | | |
| Counsel with every eligible client/ always | 51% | 56% | 67% |
| Ever provided method | 63% | 55% | 36% |
| Client characteristics (client records) | | | |
| Clients 19 and below | 57% | 10% | 3% |
| Obtained from health center | 18% | 66% | 51% |

While individual conclusions and recommendations are provided for each method below, some key recommendations emerge across all three underutilized methods. These include:

- *Conduct further research into client preferences and behaviors.* This study focuses primarily on supply-side determinants of method use, including provider competence and facility-level capacity. For each of the three methods, however, data indicate that limited client demand is a key issue inhibiting use. To most effectively reach potential clients, detailed information is needed on their needs, biases and perceptions; unfortunately, little research of this kind has been conducted to date in Kenya. It is hoped that this study will serve as the springboard for such further research.
- *Increase accurate and positive public perceptions of each method.* Communication strategies are clearly needed to increase awareness and correct the misconceptions that contribute to underuse of each method. It is recommended that such strategies are informed by the rigorous research discussed above, and will be undertaken as part of the MOH's recently developed National Reproductive Health Communications Strategy.
- *Expand in-service training and strengthen pre-service instruction.* While nearly three-quarters of surveyed providers were trained to deliver IUDs, only about half have received instruction in either EC or FCs. To increase the quality and utilization of such services, substantially more training is necessary. Pre-service instruction is a highly cost-effective way to increase the number of trained providers, although less than a quarter identified it as a source of information. In light of the benefits of training outlined above, it is critical that the MOH promotes greater emphasis of each method in national training institutions. APHIA II partners are also encouraged to integrate these methods into their upcoming training and Contraceptive Technology Update (CTU) activities.

- *Expand access for adolescents to each method.* As Table 9 indicates, only EC has been consistently provided to adolescents, a development that is most likely attributable to the relative youthfulness of sexual assault survivors. Despite their potential appeal to adolescents, providers have been reluctant to offer any of these underutilized methods to young clients. As the MOH works to expand access to these methods, it is recommended that specific strategies, informed by rigorous research, are developed to meet the needs of this clientele.

Emergency Contraception

In a short period of time, the MOH has made great strides in mainstreaming EC into its FP and PRC services. Since introducing Postinor 2 in 2005, over half of all providers have been trained in the method and supplies have been distributed across the country. All indicators suggest that EC is well-integrated into PRC, with high provision levels most likely attributable to greater emphasis during training. Among both FP and PRC clients, EC provision has been positively associated with greater access to other FP methods and services.

Challenges, however, continue to exist in ensuring the broadest possible access to the method. While provider awareness of EC is high, and attitudes are generally favorable, many continue to lack the specific knowledge needed to prescribe the method properly. Among those who have been trained, current instruction appears to adequately address technical issues, such as the time limit for use, but does not effectively grapple with social concerns like adolescent promiscuity and abortion. Perhaps for this reason, provision to adolescents for routine contraceptive use has lagged behind that for sexual assault survivors. Integrating the new drug into existing commodity management systems also appears to be a challenge, although one the MOH has already demonstrated a commitment to overcoming.

Based on these findings, the following recommendations are made for strengthening EC provision in Kenya's public sector:

- *Improve the frequency and quality of in-service training.* While training was found to increase provider's likelihood of appropriately offering the method to clients, only 56% of sampled staff had received formal instruction on EC. Thus, greater emphasis needs to be given to broadening training efforts, most likely through the APHIA II partners. The CTU curricula and training strategies also need to be revisited to ensure that they effectively address the key EC knowledge and attitude issues outlined in this report. Specific attention should be given to providing instruction on all types of emergency contraception, especially the Yuzpe method and dedicated products apart from Postinor 2, and to using EC as a "bridge" to other methods and services.
- *Revitalize pre-service instruction.* Only 20% of all surveyed providers recalled receiving pre-service training on EC. While the method is a standard element in the curricula of all Kenyan medical training institutions, this finding suggests that it remains underemphasized. Efforts are needed to ensure that medical training staff are well-versed on EC and understand the importance of including it in instruction. Updates or workshops targeted specifically toward these instructors are one possible strategy for accomplishing this goal.
- *Produce EC-specific job aids and provider tools.* To ensure that the investments of training are not because of high provider turnover and competing demands, EC-specific materials are needed to ensure the quality and continuation of services. Experiences

from countries such as Bangladesh and Senegal demonstrate that job aids increase the likelihood that trained providers will consistently offer quality EC services (including “bridging”) and can improve knowledge-transfer to untrained providers, thereby ensuring programmatic sustainability.

- *Utilize the MOH National Reproductive Health Communications Strategy to increase awareness of public sector EC provision.* A large proportion of EC clients present to a facility for other services, namely PRC, and not specifically for EC. The strikingly low levels of EC utilization found in client records (only 438 clients in 199 facilities over 18 months), suggest that the public sector is not the preferred point for most EC services; according to a PSI study, 95% of EC users obtain their supplies from private pharmacies. It is necessary, therefore, to increase demand for EC in the public sector at the same time as improving provider competency. The communication strategy recently developed by the MOH/DRH provides an excellent opportunity to do so. Because PSI will launch a national-level mass media campaign on EC in late 2007, it is recommended that DRH communication efforts specifically target users at the community level.
- *Explore new strategies for employing EC as a “bridge” to other methods and services.* While data indicate that some providers already use EC as a “bridge,” most frequently to other FP services, this practice is by no means universal. EC provision in the public sector presents a unique opportunity to encourage better RH care for all clients, from sexual assault survivors to those experiencing method failures. This opportunity can be harnessed through greater awareness of the need for further services and the development of strategies designed specifically to encourage appropriate and effective referrals. One possible strategy includes providing FCs to EC clients in order to encourage dual protection among the primarily female EC clientele. Because of the innovative nature of such an undertaking, small-scale pilots or operations research studies will be useful in defining effective strategies.
- *Emphasize EC provision in ARH clinics.* The MOH is committed to ensuring broad access to EC, including adolescents as well as sexual assault survivors. Nonetheless, ARH staff are least likely to have been trained in EC provision. To ensure quality EC services are provided to young women and men, special emphasis should be placed on training ARH service providers. The current EC CTU should be reviewed in light of its appropriateness for this special population.
- *Ensure commodity supply and distribution continuity.* The DRH’s success in fully distributing the 2005 procurement of 700,000 units of EC demonstrates the public sector’s commitment to providing the method. At this juncture, it is critical that the DRH maintains this momentum by ensuring the adequacy and availability of future stocks. The 2007 procurement of 240,000 units is a key first step in this process. This order, however, constitutes roughly one-third of the 2005 amount, which lasted approximately 18 months. To ensure program sustainability, this new shipment must be constantly and accurately monitored to guard against stock-outs.

Female Condoms

The MOH and its partners have been successful in increasing provider competency on FCs through training. As with EC, even though levels of provider knowledge are generally high, instruction increased personal perceptions of FC acceptability, counseling and dispensing behaviors. Unfortunately, only 47% of all providers surveyed benefitted from this training.

Despite the success of this training, FC uptake remained low. The primary reason for such disuse appears to stem from general dislike of the method among both providers and clients alike. Nearly half of all providers noted they would not use FCs themselves, most often for reasons related to the product itself, including noise, partner dislike or difficulty to use. Providers noted that clients also expressed similar concerns, although it is unclear if these responses were a function of their own skewed recall. Similarly, provider bias may limit FC use among adolescents, many of whom are uniquely suited for the method due to their infrequent, unplanned sexual behaviors that necessitate dual protection.

Based on these findings, the following recommendations are made for strengthening FC provision in Kenya's public sector:

- *Position FCs as a dual HIV protection strategy rather than solely as a FP method.* Client records indicate that FCs are primarily provided as a FP method, distributed most often through health center-based clinics. In light of the significant biases against this method, this may not be the most appropriate service delivery strategy. FP clients are most often concerned with preventing pregnancy, something that is often better addressed by any number of short- or long-term methods. Because the distinguishing characteristic of FCs is that they are a female-controlled dual protection method, they may be most effectively targeted to those who require dual protection but are not able to negotiate male condom use. These clients are likely to be found in HIV-centered services, such as VCT and Comprehensive Care Clinics.
- *Increase frequency of training on FCs.* Regardless of who the method is targeted to, it is clear that investment in provider training increases service quality and uptake. As Table 9 indicates however, fewer providers were trained on FCs than on any other of the three methods examined in this study. This is especially necessary if FCs are to be positioned more broadly within the country's RH care system.
- *Conduct further research on client attitudes and utilization patterns.* While this research provided important insights into providers' attitudes and experiences with FCs, it raised even more questions about the dynamics of client use. We know, for example, that providers believe the method's unappealing nature accounts for its underuse; but is this really the case, or do provider biases actually restrict client choice? Other key questions include: What are the characteristics of clients who access the method from public sector FP facilities? Is it possible to target those clients specifically or promote similar characteristics in others? Would it be acceptable in other RH outlets? What are the barriers to adolescent use of FCs? Could EC possibly be used as a "bridge" to greater FC use? Once a woman tries a FC, what is her likelihood of continuation? In other words, how do we ensure that FCs are not seen as a novelty product?

These questions could best be answered through an initial series of client or user surveys, followed by operations research efforts designed to test promising FC delivery innovations.

Intrauterine Contraceptive Devices

Unlike the other methods, training on IUDs dramatically improved provider knowledge, attitudes and practices; and many more providers received instruction on the method. Overall, trained providers were significantly less likely to agree with common misconceptions about the method (such as migrating within the body), use it themselves and discuss IUDs regularly with clients. The only areas in which training did not have such an impact were the belief that IUD users had frequent pelvic infections and that IUDs were a

method of EC. While training is key to increasing provider competence, experience is an even more powerful predictor of likelihood to provide quality services.

Providers, however, note that client disinterest and facility limitations ultimately undermine the method's acceptability. Among clients, rumors and misconceptions, such as method migration to other parts of the body, are believed to dominate common conceptions of IUDs. More importantly, however, may be their concerns over infection and side effects. At health centers, where the bulk of IUD insertions occur, providers noted that they lack trained staff, the ability to guarantee sterile conditions and basic operational requirements such as electricity and running water.

Based on these findings, the following recommendations are made for strengthening IUD provision in Kenya's public sector:

- *Conduct rigorous research to identify the nature, extent and possible strategies for overcoming client misconceptions.* While client misconceptions are routinely identified as a key reason for the bias against IUDs, little reliable data exists on the full scope of those issues. Even the data presented here discusses client misconceptions from the provider's perspective. In order to develop effective, informed strategies for overcoming such public perceptions, a more nuanced and in-depth understanding of these issues is necessary.
- *Ensure that all facilities have the physical capacity to deliver IUDs.* A second key barrier to IUD provision, facility capacity, can be overcome by a greater focus on management and supervision.
- *Increase provider experience with IUD delivery.* Data indicate that a provider's experience, even more than training, improves the quality and frequency of IUD services. Unfortunately, only slightly more than one-third of all providers had inserted an IUD in the past year. To further improve the performance of trained providers, therefore, innovative strategies to increase regular post-training exposure to the procedure are recommended.

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