Aiming for 56% by 2015: Is Kenya’s contraceptive target a realistic goal?

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2011 International Conference on Family Planning, Dakar, Senegal, November 29 – December 2, 2011
Panel Objectives

• Review the evidence of the increase in CPR

• Factors that may have contributed to the rise

• Innovative strategies for reducing unmet need

• Define FP program components that could accelerate CPR from 46% to 56% by 2015
Increase in CPR

- Kenya: 2003-2008 rise in CPR from 39% to 46%

- Rise in CPR associated with
  - Demographics
  - Regions
  - Socio-economic characteristics
Increase in CPR

- CPR - Currently Married Women using any method
- Target

Graph showing the increase in CPR from 1985 to 2020.
Contributing factors

- High-level policy commitment in Government
- Donor support
- Improvements in health systems
- Demand creation
- Innovative service delivery models
To reach 56% by 2015

Considerations by the four panel presentations

• Focusing on critical populations to raise CPR
• Tailoring service delivery approaches
• Contraceptive commodity security
• Health systems strengthening
Connecting the dots: Health systems strengthening to improve family planning uptake in Kenya

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2011 International Conference on Family Planning, Dakar, Senegal, November 29 – December 2, 2011
Components of health systems strengthening

- Leadership/governance
- Funding for family planning
- Human resources
- Commodity supply
- Service delivery
- Information systems
Leadership/governance

- Govt initiated a multi-pronged approach to improve uptake
  - Repositioning of family planning after a decade of focus on HIV/AIDS
  - Implementation of a national program (APHIA II) with donor support
  - Formulation of family planning guidelines for service providers
**Funding for family planning**

- Increased health sector funding for family planning over time

![Graph showing increased funding for family planning over time](image)

**Govt allocation for family planning (USD)**

- Allocation (millions)
- Years: 2005/06 to 2008/09

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**Logos:**
- USAID
- Population Council
Human resources

- Training and capacity building for providers
  - Conducting contraceptive technology updates (CTUs)
  - Training providers on offering integrated services
  - Dissemination of family planning guidelines
  - Distribution of job-aids
  - Providing support supervision

- Use of community health workers
  - Commodity distribution
  - Referral
Commodity supply

- Steps to ensure commodity security
  - Streamlining of procurement and distribution of commodities under KEMSA
  - Establishment of Health Sector Services Fund
Service delivery

- Several approaches
  - Mobile outreaches
  - In-reach services/choice camps in facilities
  - Community-based distribution services

- Offering integrated services
  - FP/HIV services
  - FP/postnatal care services
Information systems

- Improvement in tools for capturing data
  - Commodity supplies
  - Consumption
  - Support supervision
Implications

- Dramatic rise in CPR after a period of stall
- Health systems strengthening partly contributed
  - involved several components (dots)
Future considerations to increase CPR to 56%

- Leadership/governance
  - Role of central and county govts

- Funding
  - Increase Govt allocation as demand increases

- Human resources
  - Shift tasks to CHWs
  - Strengthen community strategy
Future considerations (contd)

- Commodity supply
  - Ensure regular supplies- still a challenge

- Service delivery
  - Skills improvement for provision of LAPMs
  - Skills update for CHWs, private sector

- Information systems
  - Improve commodity reporting to enhance forecasting and quantification- still a challenge
Acknowledgements

- USAID/Kenya
- FHI360
- Population Council
- Jhpiego
- NCAPD
- Marie Stopes-Kenya
Experiences with the Post-Partum Intrauterine Contraceptive Device (PPIUCD) in Eastern Province, Kenya

Dr Kenneth Chebet¹, Dr Jahonga Ruth²

¹Chief of Party, APHIAPLUS KAMILI
²RH/FP Advisor, APHIAPLUS KAMILI

2011 International Conference on Family Planning, Dakar, Senegal, November 29 – December 2, 2011
Background

- Nearly half of mothers in Kenya access postpartum care by 6 weeks after delivery, yet only 32% of women in Eastern Province use modern contraception.
- The immediate postpartum period is a great opportunity to engage mothers on FP to meet the high unmet need in the Kenyan population.
Postnatal Consultation Timeline

Postpartum Family Planning Timeline

- **Ante Natal**
  - FP/Child Spacing intentions
  - LAM IUCD F.S.

- **Intra Partum**
  - LAM IUCD BTL Vasectomy
  - Condoms Progestin-only (if not BF)

- **48 hours**
  - LAM Vasectomy Condoms
  - Progestin-only if not BF
  - Plan for combined hormonal at 3 weeks if not BF

- **2 weeks**
  - LAM IUCD BTL Vasectomy
  - Hormonals, (prefer progestin-only if BF)
  - Condoms & other barriers
  - Natural FP methods (non BF) once menses pattern established

- **6 weeks**
  - LAM IUCD BTL Vasectomy
  - Hormonals Condoms & other barriers
  - Natural FP methods once menses pattern established

- **6 months**
  - LAM transition IUCD BTL Vasectomy
  - Hormonals Condoms & other barriers
  - Natural FP methods once menses pattern established

- **1 year +**
  - IUCD BTL Vasectomy
  - Hormonals Condoms & other barriers
  - Natural FP methods, once menses pattern established
Justification for PPIUCD

• Long term method and cheap compared with other long acting FP methods
• Post partum period presents a convenient opportunity for inserting a IUCD
• Cost effective
Methodology

- Advocacy with Embu PGH HMT and piloting
- Capacity-building for TOT
- Community mobilization for demand creation
- Integration of PPIUCD into other services
- 24 hour coverage for PPIUCD service provider
- Continuous on-the-Job Training (OJT)
- Exit interviews for clients and SP
Pilot results Embu PGH

- Client satisfaction 99%
- SPs recommended that PPIUCD counseling form part of focused antenatal care (FANC)
- PPIUCD attributes cites as: ease of insertion, cost effectiveness for clients, SPs, and the institution.
Scale up

- Scale-up in 25 facilities (3 DHs and 22 HCs)
- Revised FANC tools to incorporate PPFP into FANC
- Clients counselled on all FP methods
- Integration of FP and HIV services
- Five trained SPs became provincial and National PPIUCD champions who mentored facilities that newly offered PPIUCD services
Achievements: 1

- Established a team of 20 core trainers (18 from Embu and 2 from DRH)
- 75 service providers trained across the 25 facilities
- OJT conducted to 225 service providers including tutors from pre-service institutions
- PNC/PPFP orientation materials developed
- Performance standards developed
- Equipped sites with Infection Prevention tools
- Distributed copies of the PNC register to all sites
Achievements: 2

- During the period 2007-2010, a total of 936 PPIUCD insertions were done as follows:
  - Post-placental 615 (66%);
  - Immediate 224 (24%);
  - Transcesarean 94 (10%).
- Only one PPIUCD expulsion was noted.
Lessons Learned

- The integrated model of PNC/FP has potential and was appreciated by women and providers.
- For scale-up, mobilization providers from all levels of facilities and pre-service schools.
- Community mobilization is important for demand creation.
- Training can affect methods mix for postpartum women.
- An enthusiastic champion can make a program fly – and should be used in other parts of the program (recognition).
Conclusion

- The immediate postpartum period provides an opportunity to provide long-term contraception, such as PPIUCD
- The antenatal care period may also be a missed opportunity to create awareness around this method.
- Sensitization of key stakeholders, community mobilization, and ease of access to the method and to mentors are all useful in ensuring the uptake of the PPIUCD.
Acknowledgements

- Ministry of Public Health and Sanitation
- Ministry of Medical Services
- Communities in Eastern province
- Acess Uzima Project
- USAID
Strategies for increasing FP/RH services uptake among married adolescent girls in Nyanza Province

International Conference on Family Planning
November 29-December 2, 2011
Dakar, Senegal

Chi-Chi Undie, Francis Obare, Wilson Liambila, Ben Ochieng’, Harriet Birungi
Population Council

Rob Burnet, Bridget Deacon
Well Told Story

Gerald Akeche, Robert Omollo, Hezron Oluoch, John Odhuno
Ministry of Public Health & Sanitation, Kenya
Married adolescent girls (MAG): What’s the big deal?

- More susceptible to STIs than mature women
- In SSA, HIV incidence is growing fastest among young married women
- Pregnancy-related deaths: leading cause of mortality for all 15-19 year old girls worldwide
- High rates of fistula associated with marriage and childbearing in the 10-15 year-old age range
- Infant mortality among the children of MAG is higher than among those of older peers.
What we know about MAG in Nyanza

- Most are married to youth
  47% married to partners 15-24 years old

- FP use is low (38%)

- Most want to delay next birth for 3 or more yrs, but use short-term FP method
What we know about MAG in Nyanza

- Many have not received basic education
  52% had not completed primary school

- Many are hard to reach …
Reaching married adolescent girls in Nyanza
Reaching married adolescent girls in Nyanza
So, how do we reach them effectively?

Well …

- 90% listen to the radio regularly
- 74% have ever listened to radio programs with their partners
- 39% have a mobile phone of their own → internet access
So, how do we reach them? Through an interactive media campaign.

- MAG-centered, culturally-appropriate radio soap opera
- Texts and calls into program by listeners
- FaceBook page for discussions
- Expert interviews
- Prizes for best questions/comments
How else do we reach them?
Through CHWs.

- Training of MOPHS CHWs (~200) on MAG-specific issues
- Intensive home visits, referrals, health info provision by CHWs
- Record-keeping by CHWs and CHEWs
- Monthly supervision with involvement of DHMT
What happened over an 8-month period?

- **3,407** questions/comments submitted by text to *Chakruok*
- **406** *Chakruok* FaceBook fans
- **39,500** *Chakruok* health leaflets distributed
- **7,200** *Chakruok* health posters distributed to 50 health facilities
- Entire *Chakruok* series repeated twice on 3 different FM stations in Nyanza by popular demand

By July 2011, *Chakruok* won a ‘Radio for Peace-building Africa Award’ in the ‘Gender’ Category
Did the intervention have any effect on key desired outcomes?

<table>
<thead>
<tr>
<th>Key Outcome</th>
<th>Base</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current use of FP</td>
<td>38% (n=383)</td>
<td>45%* (n=387)</td>
</tr>
<tr>
<td>Made the 4 recommended ANC visits during last pregnancy</td>
<td>22% (n=334)</td>
<td>30%* (n=350)</td>
</tr>
<tr>
<td>Received skilled attendance during last delivery</td>
<td>52% (n=353)</td>
<td>58% (n=365)</td>
</tr>
</tbody>
</table>
Did the intervention have any effect on key desired outcomes?

<table>
<thead>
<tr>
<th>FP Use in particular</th>
<th>Base</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current use of FP</td>
<td>38% (n=383)</td>
<td>45%* (n=387)</td>
</tr>
<tr>
<td>Current use of implants</td>
<td>2% (n=146)</td>
<td>9%** (n=176)</td>
</tr>
<tr>
<td>Current use of condoms by partner</td>
<td>13% (n=146)</td>
<td>25%** (n=176)</td>
</tr>
</tbody>
</table>
Did the intervention have any effect on key desired outcomes?

<table>
<thead>
<tr>
<th>Self-efficacy:</th>
<th></th>
<th>Base (n=468)</th>
<th>End (n=485)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Even if he doesn’t agree at first …”</td>
<td></td>
<td>67%</td>
<td>72%</td>
</tr>
<tr>
<td>“… I could convince my spouse to use condoms to prevent pregnancy if I feel we should.”</td>
<td></td>
<td>69%</td>
<td>73%</td>
</tr>
<tr>
<td>“… I could convince my spouse to use condoms to prevent HIV if I feel we should.”</td>
<td></td>
<td>66%</td>
<td>72%</td>
</tr>
<tr>
<td>“… I could convince my spouse to use some other FP method if I feel we should.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-efficacy mean score (0-3)</td>
<td></td>
<td>2.02</td>
<td>2.17</td>
</tr>
</tbody>
</table>
Did the intervention have any effect on key desired outcomes?

<table>
<thead>
<tr>
<th>Spousal support (mean score)</th>
<th>Base</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spousal support for FP (0-4) (gave permission, provided transport, gave money for services, accompanied MAG)</td>
<td>1.28 (n=350)</td>
<td>1.54* (n=356)</td>
</tr>
<tr>
<td>Spousal support for ANC (0-1) (provided money/transport)</td>
<td>0.59 (n=300)</td>
<td>0.72** (n=315)</td>
</tr>
<tr>
<td>Spousal support for delivery (0-5) (gave permission, gave money for essentials/services, provided money/transport, accompanied MAG)</td>
<td>3.27 (n=312)</td>
<td>3.19 (n=331)</td>
</tr>
<tr>
<td>Spousal support (0-10) (overall mean score)</td>
<td>3.97 (n=414)</td>
<td>4.25 (n=431)</td>
</tr>
</tbody>
</table>
Lesson learned

- By the endline period of the study, 66% of married adolescent girls had either listened to *Chakruok*, or been visited by a CHW in the past one year

- **Lesson**: Even in less-than-perfect circumstances, combining CHW outreach efforts with interactive media has a positive effect on FP uptake among MAG in rural settings.
Offering Religiously Acceptable Natural Family Planning Methods: The Case of the Standard Days Method in North Eastern Province, Kenya

Caroline Mackenzie, Marsden Solomon, Trinity Zan, Susan Igras, Abdullahi Mahat Daud, Fatuma Iman and David Adriance

2011 International Conference on Family Planning, Dakar, Senegal, November 29 – December 2, 2011
Background

- Kenya: national contraceptive prevalence rates (CPR): 46%
- CPR North Eastern Province (NEP): 4%
- Social and cultural barriers account for 40% of non-use
- NEP marginalised, few health facilities and health workers, Islamic religion
- Opportunity for Standard Days Method (SDM)
What is Standard Days Method?

- Modern, natural FP
- Based on woman’s awareness of fertile days
- Identifies days 8-19 of cycle as fertile
- For women with regular menstrual cycles of 26-32 days
The Process: Advocacy

- Situation analysis showed acceptability
- Buy-in by MOH & bilateral partner
- SDM part of FP method mix
- Education of religious leaders
- Mosque mentions by religious leaders
Training and Data Collection

- National training of trainers (Aug. 08)
- Provider training on SDM service provision (Dec. 08)
- Service provision and client interviews (Jan - June 2009)
- Informal interviews with seven service providers conducted (April 2009)
Goal and Objective

• **Goal of the pilot assessment**
  – Inform introduction of SDM into Kenya’s contraceptive method mix

• **Objective**
  – Document demographic characteristics and family planning history of acceptors of SDM in one district
  – Were they new users or switchers?
### Client Demographics of SDM Acceptors
(n=254 in 6 months)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>96%</td>
</tr>
<tr>
<td>Muslim</td>
<td>92%</td>
</tr>
<tr>
<td>Married</td>
<td>92%</td>
</tr>
<tr>
<td>Mean age in years (range)</td>
<td>27 (16 - 48)</td>
</tr>
<tr>
<td>Mean number of children alive (range)</td>
<td>4 (0 - 10)</td>
</tr>
</tbody>
</table>
**Contraceptive Use among Acceptors of the SDM**

<table>
<thead>
<tr>
<th>New users of FP (n=254)</th>
<th>92.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reasons for choosing the SDM (multiple responses)</strong></td>
<td></td>
</tr>
<tr>
<td>Do not affect health</td>
<td>42.3%</td>
</tr>
<tr>
<td>No side effects</td>
<td>37.8%</td>
</tr>
<tr>
<td>Religious reasons</td>
<td>32.5%</td>
</tr>
<tr>
<td>Easy to learn/use</td>
<td>31.3%</td>
</tr>
<tr>
<td>No need to come back to health facility</td>
<td>12.6%</td>
</tr>
<tr>
<td><strong>Reasons for switching (n=16)</strong></td>
<td></td>
</tr>
<tr>
<td>Former method had undesirable side effects</td>
<td>7</td>
</tr>
<tr>
<td>Former method against religion, affected health and others</td>
<td>7</td>
</tr>
<tr>
<td>Former method was difficult to use</td>
<td>2</td>
</tr>
</tbody>
</table>
Provider Opinions About Offering SDM

• Accepted, increased job satisfaction
• Positive attributes of SDM reported
  – Natural, non-hormonal, useful for clients contraindicated for hormonal methods
  – Culturally and religiously appropriate
  – Simple to use
  – Complements calendar method
  – Attractive color and packaging; appealing to wear around the neck
  – Similar to beads used during Muslim prayers (Kul)
• Knowledge gaps in service provision noted
Scale up and Use

- SDM institutionalized in national FP method mix
  - CycleBeads™ in national commodity procurement plan
  - MOH allocated procurement budget
  - SDM part of FP trainings and updates
  - SDM in revised FP service provider guidelines and client IEC materials
- Bilateral partner/donor procured commodity for rollout in other areas
Lessons Learned

- SDM attracted new users of FP
- SDM liked by women/couples who prefer natural methods
- Involvement of men and religious leaders possible
- Continuous training, updates, supervision and provider mentoring essential
- Sustainable partnerships with MOH, bilateral partners and donors ensure scale-up
Acknowledgements

- Service providers and respondents from region
- Ministry of Public Health and Sanitation / Division of Reproduction Health (Kenya)
- Provincial Director of Public Health and Sanitation (NEP)
- FHI 360 (Kenya and USA)
- Institute of Reproductive Health, Georgetown University (USA)
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Asante Sana