Repositioning of the intrauterine device continues

Healthcare providers play an integral part

Countless research studies have helped establish the intrauterine device (IUD) as a safe and effective contraceptive for most women, regardless of their health or HIV/AIDS status. The IUD is attractive for several reasons: It is reversible; it does not require daily or monthly action; and its total service delivery costs are very low, making it cost-effective with continued use. Also, despite common side-effects associated with the IUD, such as intermenstrual bleeding and spotting, continuation rates (approximately 80% after 1 year of use) are much higher for the IUD than for most other contraceptive methods.

Despite the IUD's numerous advantages, rates of use remain low in many areas of the world and have even declined recently in some developing countries. Significant factors that adversely affect use are poor access to quality services and pervasive myths and misperceptions among healthcare providers, clients, and communities. However, efforts have been undertaken to increase awareness and facilitate access to the IUD as part of a more balanced method mix, especially in sub-Saharan Africa, where most women use short-acting methods such as pills or injectables.

Increasing uptake in Kenya

In 2003, the Kenya Ministry of Health (MOH) launched an initiative in partnership with the AMKENI Project to increase IUD uptake. ('Amkeni' is the Swahili word for 'awakening.' The AMKENI Project was conducted by a group of partners led by the international reproductive health organization EngenderHealth.) During the subsequent 2 years, the number of new IUD acceptors at 97 AMKENI-supported facilities more than doubled, rising to approximately 2800 women.[1]

Adding to this work, in 2005 EngenderHealth's ACQUIRE Project joined the Kenya MOH to encourage women in Kisii District to choose the IUD as their contraceptive method. This effort included a multimedia campaign to dispel myths and misconceptions about the device. Within 1 year, IUD uptake tripled. Moreover, recent data show that the increase in the number of IUD insertions – to more than 1100 per year – has been sustained in Kisii since the project ended more than 2 years ago.[2]

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The success of the two initiatives in Kenya spurred efforts to reposition the IUD elsewhere in Africa.

A successful intervention in Guinea

One note-worthy example is Guinea. Between 1997 and 2006, Save the Children worked with the Guinea MOH to improve maternal and child survival in the district of Mandiana. Over time, the programme grew to include family planning services for women, but only two urban sites in Mandiana were offering the IUD. Even at those sites few women were accessing the method. So, in collaboration with several partners, Save the Children began an 8-month pilot programme in November 2004 to reposition the IUD and expand services to more rural sites in Mandiana.[3]

Before the intervention began, Save the Children identified and recruited stakeholders: community leaders, religious leaders, and members of the Guinea MOH

A couple waits with their young daughter outside a family planning clinic in rural Guinea. The IUD could be an appropriate method for them if they wish to delay, space, or limit their pregnancies.

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and local non-governmental organisations. Project organisers built ongoing stakeholder involvement into the intervention by devoting certain days to advocacy. They used this time to inform stakeholders about IUD services and garner their support for family planning services.

During the intervention, nine public awareness campaigns delivered messages about the benefits of family planning and IUDs to villages, and community members included the messages in organised theatre and folklore ceremonies. To reach a wider audience, local radio stations broadcast a variety of programmes focused on the IUD. Also, the partners trained community agents to sensitise community members about the IUD and refer interested women to the nearest health centre that offered IUD services.

Healthcare providers were another integral part of the project. EngenderHealth trained providers from four participating health facilities, supervisors from Mandiana's health department, and staff of Save the Children in infection prevention, family planning, contraceptive counselling, and IUD insertion and removal. Save the Children simultaneously strengthened services at the two existing urban sites (a maternity hospital and a health centre) where women could obtain IUD services. They also expanded services for IUD provision at two rural health centres and added services for IUD counselling and referral at nine others.

As a result of the intervention, IUD insertions increased five-fold in the four participating health facilities, from 13 in the 6 months preceding the intervention to 73 during the active phase of the project. Women in more than 100 villages enjoyed access to IUD services. Importantly, more than a year after the intervention, the rate of use remained as high as it was during the peak period of the project.

Later, Save the Children obtained approval from regional health authorities to introduce the IUD to the district of Kouroussa. Today, one additional health centre in Mandiana and two new rural health centres in Kouroussa also offer IUD services.

'It has been 4 months and I am feeling well… no pregnancy,' says one 23-year-old IUD user from Mandiana.'Otherwise each time my child was a year and a half, I would become pregnant, but now my last one is nearly 2 and I hope not to become pregnant again thanks to the device.'

The IUD catches hold elsewhere

Similar efforts have improved access to IUD services in several other places. For example, before the ACQUIRE Project ended in 2008, it led successful campaigns to revitalise IUD use in Guinea's Siguiri District and in parts of Uganda and Ethiopia.[4]

In each country, EngenderHealth worked with MOHs and other local and international partners to implement its Supply-Demand-Advocacy (SDA) model for delivering family planning and reproductive health services. The SDA model calls for partners to coordinate and synchronise activities to increase the supply of IUDs, encourage demand for IUD services, and spark advocacy of them.

How healthcare providers can help

- Offer the IUD alongside other family planning methods.
- Promote the IUD as both a spacing method and a limiting method.
- Participate in tailored IUD training.
- Promote the availability of IUD services.
- Offer the method as an option for women with HIV.
- Screen both parous and nulliparous women for eligibility.
- Do not use unnecessary antibiotics at the time of IUD insertion.
- Require only one follow-up visit 4 to 6 weeks after initiation of an IUD.
- Discuss normal side-effects and how to best manage them with your patients.

For more detailed information about how to support IUD use, see http://tinyurl.com/ydkk5r4.

In general, these interventions made IUD services stronger. The interventions also increased women's awareness of the services, knowledge about them, and demand for them. By also confronting and changing negative attitudes about the method, SDA interventions improved IUD uptake.

'The [SDA] model aims to foster an enabling environment for access to the IUD, through addressing health systems issues as well as awareness and misperceptions among providers, clients, and communities,' says Erin McGinn, a senior technical advisor of family planning at EngenderHealth. 'The best way to do this is to focus on care and gender issues, engage stakeholders, and take an evidence-based approach to the interventions,' she says.

According to McGinn, change takes time, and any initial success that increases IUD use at a national level might be quite modest. 'The reasons IUD use is low in Africa are complex, so interventions to revitalise the method must take a holistic and long-term approach. At the core, we must have supported and trained healthcare providers, and communities must have knowledge of and access to quality IUD services,' she says.

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