

Introduction of the Intrauterine Contraceptive Device 375 in India: Positive Assessment Findings Help Guide National Scale Up

Objective

To evaluate the feasibility of introducing the intrauterine contraceptive device 375 (IUCD 375) into the Ministry of Health and Family Welfare's (MOHFW's) Family Welfare Programme in India.

Methods

Under the guidance of the MOHFW, FHI 360 introduced the IUCD 375 into 12 health facilities in six states and assessed the feasibility of introducing it on a national level. Training and communication materials were developed and used to train 127 health service providers on IUCD 375 provision. In addition, 427 motivators were trained to generate demand for IUCDs in communities. A standard IUCD card was created and used to monitor IUCD 375 uptake. The intervention occurred from June 2010 through February 2011. An assessment of provider perceptions and experiences took place through two rounds of in-depth interviews (60 in the first round and 46 in the second), conducted in October 2010 and in September/October 2011.

Findings

- Providers with experience inserting Copper T (CuT) 380A IUCDs successfully counseled women on the IUCD 375 and inserted the device with limited reports of clinical complications or other problems.
- Providers liked the IUCD 375 because it came preloaded on its inserter, allowing for no-touch insertions. Providers also found it easier and less time-consuming to insert than the CuT 380A.
- Providers recommended lengthening the pre-intervention training and including supervised practice insertions on real clients.
- Providers liked the IUCD card for ease of recording the date of insertion and for the counterfoil allowing a section to be torn off easily and given to a client to highlight information such as potential problems or complications of IUCD use that would require medical attention.
- Despite being trained on the MOHFW's policy of three follow-up visits in the first year after insertion, follow-up schedules varied across the six districts. Large workloads kept providers from prioritizing follow-up, and providers felt that women would revisit the facilities on their own if they experienced problems with the IUCD 375.

- Most barriers to IUCD 375 provision and uptake were the result of facility-level or community-level challenges such as power failures and limited sets of instruments. Providers also reported that some facilities were in need of private rooms for family planning counseling and IUCD provision.

Conclusion

The assessment found that providers liked the IUCD 375 because it came preloaded on its inserter, allowing for no-touch insertions. Recommendations from the assessment addressed issues related to scaling up provision of the IUCD 375 in the public sector. The government of India approved a national introduction of the IUCD 375 and in December 2011 began a process of training of providers. An expert committee from the MOHFW has reviewed the study findings and is considering incorporating many of the recommendations into the national rollout. For example, the MOHFW has decided to adapt the IUCD card from the intervention to include information on the CuT 380A in the national campaign. The national rollout efforts have the potential to make a meaningful contribution to the contraceptive method mix in India's public sector.

Background

In 1951, India was the first country in the developing world to initiate a state-sponsored family planning program to lower fertility and slow population growth. Today, in response to local contraceptive demand, the government strives to offer high-quality, client-centered, and decentralized contraceptive services with an emphasis on birth spacing to all eligible clients.¹

According to data from the most recent National Family Health Survey, 37% of married women in India are sterilized, followed by the use of condoms (5%), oral contraceptive pills (3%), and the IUCD (2%).² Despite its safety and effectiveness, the IUCD remains an underused method of contraception in India. Various factors account for the low rate of use, including lack of trained providers, poor-quality IUCD services, provider bias, and lack of awareness and misconceptions among both clients and providers.^{1,3-5}

Beginning in 2006, the Ministry of Health and Family Welfare (MOHFW) started taking steps to revive and reposition the IUCD in India, particularly in states with low contraceptive prevalence.

Two copper-bearing IUCDs are available—the Copper T 380A (CuT 380A) and the IUCD 375—which are effective for up to ten years and five years, respectively.

Beginning in 2006, the Ministry of Health and Family Welfare (MOHFW) started taking steps to revive and reposition the IUCD in India, particularly in states with low contraceptive prevalence.¹ Key strategies included enlisting policy support, ensuring the availability of skilled service providers, strengthening infrastructure and logistics for high-quality provision, and creating awareness and demand in the community. Promoting public-private partnerships, developing a strong monitoring and evaluation system, and exploring new opportunities for enhancing IUCD use were also priorities.¹

In line with its strategies for repositioning the IUCD, the MOHFW became interested in adding the IUCD 375 to its Family Welfare Programme. The IUCD 375 was already available in the private sector, where it was popular and well regarded among

both clients and providers, and it had the advantage over the CuT 380A of being packaged preloaded on its inserter. Through a recommendation by USAID/India, the Family Planning Division of the MOHFW identified FHI 360 to facilitate an assessment of the feasibility of introducing the IUCD 375 into the Family Welfare Programme in six districts, each in a different India state.

Study Design

The IUCD 375 was introduced through the existing government structure of service providers under the National Rural Health Mission (NRHM) in six states: Assam (Kamrup district), Gujarat (Gandhinagar district), Jharkhand (Hazaribagh district), Karnataka (Mysore district), Uttar Pradesh (Varanasi district), and West Bengal (Nadia district). The six states and districts were selected by the Family Planning Division of the MOHFW to be geographically representative of the country. Twelve health facilities (the district hospital or first referral unit, plus one primary health center from each district) were selected for the introduction. All facilities were selected because their staff had received training on the CuT 380A in the past, the trained personnel were still working at the facilities, and the CuT 380A was being inserted routinely on-site.

The intervention began with the development of IUCD 375 training and communication materials based on the MOHFW's IUCD guidelines. These consisted of a manual for training trainers, a handbook for service providers, a flipbook for counselors, and an educational pamphlet for community members. All materials were developed in English and then translated into Hindi and four other regional languages.

A series of orientation meetings were held in the 12 facilities to introduce the study and facilitate discussions on the expected roles and responsibilities of facility staff. Health service providers were then trained to provide the IUCD 375, and community motivators were trained to counsel on and generate demand for the method. All study staff were trained using a cascade approach, beginning with the training of seven trainers who had been trained in the past to provide the CuT 380A. These trainers then returned to their respective districts and trained selected health care providers and motivators at the participating facilities. In all, 127 service providers and 427 motivators were trained.

IUCD 375s were supplied by the implementing partner, Hindustan Latex Family Planning Promotion Trust. They became available in the 12 facilities in June 2010, and the intervention was conducted from June 2010 through February 2011. Family planning clients attending the 12 facilities were counseled on both the IUCD 375 and the CuT 380A, with mention of their effectiveness, benefits, and side effects. The community health workers trained as motivators for the IUCD 375 provided information and counseling during the intervention period to women living in the communities surrounding the 12 health facilities.

During the study period, the MOHFW's policy on IUCD follow-up recommended that a client return to the facility for three follow-up exams within the first year of insertion: after her first monthly bleeding or one month after insertion, three months after insertion, and one year after insertion. Follow-up was generally provided in the health facilities, but was also carried out by Auxiliary Nurse Midwives and other community health workers during general IUCD camps or in client homes.

A standard IUCD card was developed and introduced to monitor IUCD uptake during the intervention. Previously, a standardized system for monitoring and tracking the CuT 380A insertions within and across health facilities had not been used. The new card collected information on client age, parity, type of IUCD inserted, follow-up dates, reasons for follow up, patient education on follow-up, and reported side effects. Each card also had a perforated counterfoil that could be torn off and given to the client after she received her IUCD. The counterfoil included six pictures reminding the women about potential problems or complications of IUCD use that would require medical attention.

Data Collection

In-depth qualitative interviews were conducted with facility staff to assess their perceptions and experiences of the introduction. Five staff members at each facility were interviewed in October 2010, with a total of 60 interviews held across the 12 facilities. Providers interviewed were Auxiliary Nurse Midwives (n=15), obstetricians/gynecologists (n=13), Medical Officers (n=11), nurses (n=5), and other community health workers (n=16).

An additional 46 interviews were held in September and October 2011 to understand provider perspectives on follow-up for IUCD 375 users. Similar to the initial round of interviews, this second round of interviews was conducted with Auxiliary Nurse Midwives (n=14), Medical Officers (n=10), obstetricians/gynecologists (n=6), nurses (n=9), and other community health workers (n=7).

Provider Perceptions

Interviews showed that most of the providers had a positive opinion about the IUCD 375 as a family planning method, citing general benefits like extended effectiveness (as compared to condoms or oral contraceptive pills) and reversibility. Many providers also felt that IUCD 375 users had fewer complaints and side effects than CuT 380A users. In regard to service provision, providers specifically liked the IUCD 375 because it came preloaded on its inserter, resulting in no-touch insertions. Moreover, providers thought its soft and different shape reduced the possibility of complications.

Despite their overall positive perceptions, providers found counseling on the IUCD 375 to be challenging because of widespread myths and misconceptions surrounding IUCDs in general, low levels of knowledge about the different types of IUCDs, and low levels of literacy among potential clients. Some providers also felt a need to counsel not only clients but also husbands and mothers-in-law.

Providers identified the IUCD 375 as a good method to recommend for women with spacing needs or for women who are unwilling to use other family planning methods. Providers also thought women with one or two children were good candidates for the IUCD 375, but they felt that women with more than two children should be offered sterilization instead.

Training and Materials

About two-thirds of the providers reported that they had received all of the training and communication materials. Slightly less than two-thirds reported using them in the first three months of the intervention. Providers who inserted both the IUCD 375 and the CuT 380A reported using the IUCD card on a daily or near-daily basis. Overall, they found the card helpful for recording when IUCDs were inserted, for recording what types of IUCDs were inserted, and for

tracking follow-up visits and complaints. Providers also liked the perforated counterfoil that could be given to clients, mentioning its usefulness for highlighting side effects that need medical attention and for reminding clients when they should make follow-up visits. Some providers did raise concerns about the additional reporting burden these cards placed on them.

Most providers and motivators who participated in the training felt confident about counseling clients on the IUCD 375. The providers doing the insertions also felt comfortable with inserting and removing the IUCD. When asked about suggestions for improving the training, the providers reported that the training should be longer and include supervised practice insertions on real patients. Providers and motivators also recommended incorporating audio-visual materials into the trainings.

Insertion and Follow-up

Providers with existing experience in inserting the CuT 380A were able to successfully counsel women on the IUCD 375 and insert the device with limited reports of clinical complications or other problems. Half of the providers noted that clients complained less frequently of pain and discomfort during and after IUCD 375 insertions than during and after CuT 380A insertions.

Nearly two-thirds of the service providers reported that the insertion process was also easier and less time-consuming for the IUCD 375 than for the CuT 380A. This was frequently attributed to the IUCD 375 being preloaded on the inserter inside the package, resulting in no additional time needed to prepare the IUCD for insertion. Many providers also saw this minimal need for handling as a benefit that might limit infections. A majority of IUCDs were inserted by Auxiliary Nurse Midwives, not medical doctors, demonstrating an approach to task sharing for providing IUCDs in India.

Despite providers being trained on the MOHFW's follow-up policy, data from interviews and from the IUCD cards suggested that the providers were not consistently following the guidelines and that follow-up schedules varied across the six study districts. Providers would tell women when they should revisit the facility for follow-up care, but they still believed that women would seek care on their own if they had complaints or problems with the IUCD 375. In general, the providers felt that facility-



Front page of a leaflet used in communities

based follow-up visits were more convenient than home visits because they facilitated greater access to medical supplies and records. A few providers also believed that home visits could breach confidentiality.

Barriers to Provision, Uptake, and Use

Providers identified barriers to the provision, uptake, and use of the CuT 380A, as well as the IUCD 375, in their facilities. Power failures, poor infrastructure, and lack of necessary instruments were common. In some facilities, lack of space and limited sets of instruments hampered the number of insertions that could be performed, leading to long waiting times. The inability of providers to handle high client loads for family planning services also affected the acceptance of IUCDs.

Stock outs of the CuT 380A were noted in several facilities. Stock outs of the IUCD 375 were not an issue during the study, as the supply of this IUCD was independent of the public-sector supply chain and was carefully monitored by study staff; however, IUCD 375 stocks could face similar stock outs when their supply shifts to the public-sector system for the national introduction. Additionally, providers noted supplies and medicines for managing side effects like pain and bleeding were lacking.

Barriers to uptake of the IUCD 375 included myths, misconceptions, and low awareness of IUCDs among clients. According to the providers, women's decisions about adopting the IUCD 375 were guided by their preference for or aversion to IUCDs in general. Providers also reported that clients often assumed that all IUCDs have similar side effects and efficacy profiles. In addition, providers were faced with overcoming misconceptions that were

common among husbands and mothers-in-law, who must often approve a woman's use of family planning and can influence her method selection.

Providers' own misconceptions, insufficient knowledge, and lack of skills for counseling women about informed choice can also be considered barriers to uptake of the IUCD 375 and of IUCDs in general. Although providers were not asked to comment on their own performance, interviews revealed that some providers lacked necessary skills for providing IUCD services. Both before and after the intervention, providers could not fully cite accurate IUCD eligibility criteria and exhibited bias when considering who was a possible candidate for an IUCD.

Providers also reported that women did not always return for their scheduled follow-up visits. Some women went to a different facility to have their IUCD removed, which made it difficult for providers to keep accurate records of insertions and removals. Another barrier to follow-up was a lack of educational materials that providers could use to counsel clients on the importance of returning for follow up care. When faced with commanding workloads and competing priorities, providers also mentioned that following up with clients was not a high priority. When asked about suggestions for improvement, providers most frequently requested that the intervention be changed to include incentives for IUCD 375 motivation, uptake, and provision.

Recommendations

The study findings led to the following recommendations to the MOHFW, to help ensure a successful introduction of the IUCD 375 across India:

- Use mass media, mid-level media, and interpersonal communication to increase demand for the IUCD 375 and acceptance of IUCDs in general. Media and communication can counter myths and misconceptions and can increase women's familiarity with the IUCD 375. Local village governments (called Panchayat), religious leaders, local nongovernmental organizations, women's groups, male family members, and mothers-in-law should all be involved in increasing the visibility and understanding of IUCDs.
- Adopt comprehensive IUCD training for all levels of health care providers. Future scale-up efforts should adopt the intervention's training materials, strengthen sections on client eligibility and counseling, use the IUCD tracking cards, and include time for supervised client insertions.

Training should include three days on the CuT 380A and IUCD 375 for new and untrained service providers. A one-day training on IUCD 375 provision should be used for service providers who are already trained on the CuT 380A.

- Manufacturers should use different colored strings for the different types of IUCDs. This will help providers determine which type of IUCD a woman has and when it needs to be replaced.
- Ensure a constant supply of IUCDs to facilities. To facilitate uptake of the IUCD 375 along with the CuT 380A, better forecasting and management of the supply chain is needed.
- Improve the infrastructure of facilities. Sufficient private space is needed for counseling clients and inserting IUCDs, particularly in facilities with high client loads. Postpartum units and labor rooms can be utilized for postpartum provision of IUCD 375s, but additional space is required for women who have not recently given birth.
- Introduce IUCD tracking cards as an integral part of all IUCD services. This will help providers schedule follow-up visits and care, by reminding them when women should return to the facility or when a community health worker should visit their homes. The cards also help facilities track all IUCD insertions and maintain a reliable supply.
- Ensure systematic follow-up of all IUCD insertions as recommended by the MOHFW policy. Additional client contact can help providers gauge client satisfaction, increase method continuation, and improve community-wide perceptions about IUCDs. Standardized procedures for follow-up should be developed and disseminated.

Next Steps

The government of India has approved a national introduction of the IUCD 375. In December 2011, the MOHFW organized a training workshop on insertion of the IUCD 375 for service providers from most Indian states. These providers are scheduled to return to their states and proceed with cascade training. FHI 360 has provided copies of the training and communication materials that were developed for the assessment to be available for these trainings. Also, the MOHFW has requested that FHI 360 print 200,000 copies of an updated IUCD card to be used during the national rollout, adapted to cover the CuT 380A as well as the IUCD 375. Based on the results of the study, the government has also begun to make broader improvements in public-sector IUCD provision in general.

Differentiating the two types of IUCDs is difficult for some service providers, and the MOHFW wants providers to link the IUCD 375 to its duration of protection rather than to a brand name (e.g., M-Care or Pregna). Therefore, discussions are ongoing between the MOHFW and the manufacturer HLL Lifecare Limited about making the strings of the two IUCDs different colors. An expert committee from the MOHFW has reviewed all of the study findings and is considering incorporating other recommendations into the rollout as well.

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