

# **Program Assessment of the Introduction of the Multiload 375 IUCD in the Family Welfare Program of the Government of India**

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## ACRONYMS AND ABBREVIATIONS

ANM	Auxiliary Nurse and Midwife
ASHA	Accredited Social Health Activists
CDMO	Chief District Medical Officer
CHC	Community Health Centre
CuT 380A	Copper T 380A Intrauterine Contraceptive Device
DH	District Hospital / First Referral Unit
FHW	Female Health Worker/Motivator
FPD	Family Planning Division
FWP	Family Welfare Program
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HLL	Hindustan Lifecare Ltd.
ICDS	Integrated Child Development Services
IUCD	Intrauterine Contraceptive Device
LHV	Lady Health Visitor
ML 375	Multiload 375 Intrauterine Contraceptive Device
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
NRHM	National Rural Health Mission
OB/GYN	Obstetrician/Gynecologist
OCP	Oral Contraceptive Pill
PHC	Primary Health Centre
PO	Program Officer
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
ZOE	ZOE® Pelvic Examination Trainer Model



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## EXECUTIVE SUMMARY

The intrauterine contraceptive device (IUCD) is the most widely used reversible method of contraception worldwide and was introduced as a family planning method in India in 1965. IUCDs come in two types, either copper bearing or hormonal levonorgestrel-releasing, and provide a safe and highly effective method of contraception, with a long duration of efficacy. The CuT-380A can be used up to ten years and the Multiload-375 and the hormonal levonorgestrel-releasing IUCD for up to five years. IUCDs unlike sterilization are quickly reversible, and hence can meet the needs of both women who want to postpone their next pregnancy and those who want to end childbearing altogether. IUCD use among married women of reproductive age in India remains below 2 percent. This low use is attributed to various factors, which include the lack of trained providers, poor quality of IUCD services, provider bias against IUCDs, and lack of awareness and misconceptions about the method among both clients and health care providers.

Beginning in 2006, the Ministry of Health and Family Welfare (MOHFW) started taking steps to revive and reposition the IUCD in the country, particularly in states with low contraceptive prevalence rates. In line with this, the MOHFW decided to include another type of IUCD, the Multiload 375 (ML 375), in the Family Welfare Program. The ML 375 IUCD is currently available in the private sector and is popular and well-regarded among providers and clients. The ML 375 comes packaged pre-loaded on its inserter. With this advantage, and to capitalize on the ML 375's popularity in the private sector, the MOHFW is seeking to include the ML 375 IUCD in the public sector's contraceptive method mix.

The Family Planning Division of the Ministry of Health and Family Welfare approached USAID India which in turn identified FHI to facilitate an assessment of the feasibility of introducing the ML 375 IUCD into the Family Welfare Program in six districts across India. The results of the assessment will be utilized by the MOHFW to facilitate the introduction of the ML 375 in the Family Welfare Program.

## OBJECTIVES

The assessment had the following objectives:

- Identify operational issues associated with the introduction of the ML 375 into facilities already offering the CuT-380 A under the Family Welfare Program.
- Identify barriers to access, uptake and use of the ML 375 and suggest measures to facilitate uptake.
- Identify appropriate community and facility-based services that will be required for the uptake of the ML 375.

The program assessment consists of three phases: **pre-intervention**, **intervention**, and **post-intervention**. The project was implemented across 6 sites in India;

- **Gandhinagar**
- **Hazaribagh**
- **Kamrup**
- **Mysore**
- **Nadia**
- **Varanasi**

At each of the study sites (districts) the DH/FRU and one PHC were selected for the study to achieve a total sample of twelve health facilities. The DH/FRU and one PHC in each district was selected using the following selection criteria: presence of staff trained in CuT-380A IUCD insertion; availability of trained personnel at the sites; provision of CuT-380A services as a routine FP method in the sites.

The post-intervention assessment included qualitative key informant interviews and service statistics collation. Key informant interviews were conducted with the healthcare providers eligible to provide family planning information and services at each of the sites. At the DH/FRU level the providers included: the medical superintendent, general physicians, surgeons, obstetricians, gynecologists, special nurses, ANMs, traditional birth attendants, and

female health worker / motivators. At the PHC level, key informant interviews were conducted with: Medical Officers, ANMs, ASHAs, community health workers, and female health workers/motivators. Five key informants were selected in each facility (DH/FRU and PHC) in each district for a total of 60 interviews.

## KEY FINDINGS

The key findings during the post-intervention assessment highlight various operational issues for the MOHFW to consider for scaling up the introduction of the ML 375 into additional public sector health facilities.

- The operational issues examined through this qualitative assessment include various service delivery aspects like ML 375 counseling, ML 375 service provision, following up of clients, training on the ML 375, intervention communication materials, barriers, and necessary facility- and community-based services.
- The overall feedback from providers, both those that inserted ML 375s and the community motivators, was positive and encouraging for further introduction.
- However, the assessment also exposed weaknesses not only in the ML 375 introduction, but in overall IUCD provision in the 12 facilities.
- Provider feedback, service statistics from the IUCD card, and observations from the study found that after one day of ML 375 training, providers with existing experience in inserting CuT 380A IUCDs are able to successfully counsel on and insert ML 375s with limited reports of clinical complications or other problems.
- Providers did recommend a longer training, particularly the ANM, which would include supervised ML 375 insertion on clients.
- A longer training could also accommodate more time on dispelling providers' misconceptions of all IUCDs, particularly eligibility criteria, and improving balanced and informed choice family planning counseling.
- Aside from some providers' misconceptions and insufficient counseling skills, most barriers hampering ML 375 provision and uptake result from facility- and community-level challenges that are relevant to all IUCD provision.
- Facility constraints like sharing space with services that take greater priority, limited privacy, insufficient equipment, and likely supply chain issues all limit women from receiving IUCDs. In the community, IUCDs lack visibility, especially the ML 375, and what are known by women, their husbands, and their mothers-in-law, is often incorrect.

## RECOMMENDATIONS

Based on these findings, the following recommendations are made to ensure a smooth and successful introduction of the Multiload 375 across India under the Family Welfare Program.

### 1. IEC strategy: Use mass media, mid-level media and interpersonal communication

- To counter the myths and misconceptions, and increase women's familiarity with the ML 375, demand generation activities need to engage the **mass and mid-level media**, and improve **interpersonal communication** and materials.
- Increasing overall IUCD visibility and understanding through working with the local leaders, **including Panchayat and religious leaders, and local NGOs and women's groups**, along with male family members and mothers-in-law.

### 2. Comprehensive training of all levels of health care providers

- Future scale-up efforts should adopt the **intervention's training materials, strengthening sections on client eligibility and counseling, and building in time for supervised insertions**, to provide comprehensive training for all levels of health care providers in ML 375 provision.
- **There should be six days of training on the CuT 380A and ML 375** for new and untrained service providers; **a one day**, eight hour training on ML 375 provision for service providers trained on the CuT 380A;

- Ensure thorough practice of insertions on ZOE models by all participants;
- Ensure training on how to use and complete the IUCD cards.
- Emphasis on developing skills on client eligibility for all IUCDs and counseling for side effects.

### 3. Different colored strings for different IUCDs would be useful

- Having different IUCD types with **different colored strings, to differentiate between the two types of IUCD**. The colors, uniform to each type, would serve as a reference for providers to identify IUCD type.

### 4. Ensure constant supply of IUCDs

- To facilitate uptake of the ML 375, a constant supply needs to be ensured through **better forecasting and management of the supply chain**.

### 5. Infrastructure improvements

- Provision of **sufficient space for counseling** clients and inserting IUCDs.
- Postpartum units and labor rooms can be utilized for postpartum provision of ML 375s, but for women who have not recently given birth, **additional separate space would be ideal**.

### 6. IUCD cards

- **IUCD cards should be an integral part of IUCD services** and this will facilitate providers scheduling follow-up visits and care for women, by reminding them when to return to the facility or by ASHA going to their homes.

### 7. Following up IUCD insertions

- Post-assessment data pointed to a provider perception that if clients have complaints or problems with their ML 375, they will return to the facility to seek care.
- Providers generally make no efforts to follow-up on recent insertions, which is an opportunity **lost to identify and manage possible side-effects**.
- Additional client contact to gauge satisfaction could improve method continuation and work to improve the community-wide perceptions of the ML 375 and CuT 380A IUCDs. **Systematic follow-up of all IUCD insertions as per MOHFW policy**, is recommended.

## **I. BACKGROUND**

### **India and Family Planning**

In 1951 India was the first country in the developing world to initiate a state-sponsored family planning program with the goal of lowering fertility and slowing the population growth rate. The national government set method-specific targets and promoted sterilization vigorously, resulting in a narrow range of family planning options and limited client choice. Currently the government aims to offer high quality, client-centered, demand driven, and decentralized contraceptive services among eligible clients, with an emphasis on adequate spacing of births (1).

Overall, India's family welfare program has been successful in lowering fertility rates across the country. Countrywide, total fertility has decreased from 6.6 lifetime births per woman in the early 1970s to 2.7 lifetime births per woman in 2005-2006 (2). According to the most recent National Family Health Survey data, 37.3% of currently married women are sterilized (2). Condoms are the second most frequently used modern family planning method (5.2%), followed by oral contraceptive pills (3.1%), and the intrauterine contraceptive device (IUCD) (1.7%). This contraceptive method mix, skewed towards female sterilization, can be a concern when women want to delay their next pregnancy rather than cease childbearing altogether. Additionally, ensuring that women and their partners have access to a wide range of family planning methods increases their likelihood of choosing a method and results in higher contraceptive use (3, 4); increased use reduces unplanned pregnancies, unsafe abortions, and maternal morbidity and mortality (4, 5).

### **The IUCD**

The IUCD is the most widely used reversible method of contraception worldwide (5, 6). IUCDs come in two types, either copper bearing or hormonal levonorgestrel-releasing, and provide a safe and highly effective method of contraception with a long duration of efficacy. The copper bearing IUCDs, the Copper T 380A (CuT 380A) and Multiload 375 (ML 375), can be used for ten years and five years respectively; the hormonal levonorgestrel-releasing IUCD for up to five years. IUCDs, unlike sterilization, are quickly reversible, and hence can meet the needs of both women who want to postpone their next pregnancy and those who want to end childbearing altogether. Furthermore, because IUCDs can be used for several years, they are a very cost-effective method of contraception (7). In many countries the low use of IUCDs can be attributed to outdated safety concerns and misconceptions among providers and clients, added to infrastructure and resource challenges such as the need for supplies, equipment, and trained and motivated providers (7).

### **The IUCD in India**

With the approval of the Indian Council of Medical Research, the Lippes Loop was the first IUCD to be introduced into the Family Welfare Program (FWP) of India in 1965. This was followed by the introduction of the Copper T 200B in 1975, which was then replaced by the CuT 380A in 2002 (1). Despite its high degree of safety and effectiveness, the IUCD remains an underused method of contraception in India. Use among married women of reproductive age remains below 2% in the country (2). This low use is attributed to various factors, which include the lack of trained providers, poor quality of IUCD services, provider bias against IUCDs, and lack of awareness and misconceptions about the method among both clients and health care providers (1, 8-10). Moreover, use of public sector services for IUCDs is limited, and in the past decade there has been a major shift toward seeking IUCD services in the private sector.

Beginning in 2006, the Ministry of Health and Family Welfare (MOHFW) started taking steps to revive and reposition the IUCD in the country, particularly in states with low contraceptive prevalence rates (1). Key strategies for the repositioning include: enlisting policy support; ensuring the availability of skilled service providers; strengthening infrastructure and logistics for providing quality care; creating awareness and demand generation in the community; promoting public-private partnerships; developing a strong monitoring and evaluation system; and, exploring new opportunities for enhancing IUCD usage (1). In line with the final strategy, the MOHFW decided to include another type of IUCD, the ML 375, in the FWP. The ML 375

IUCD is currently available in the private sector and is popular and well-regarded among providers and clients. The ML 375 comes packaged pre-loaded on its inserter. With this advantage, and to capitalize on the ML 375's popularity in the private sector, the MOHFW is seeking to include the ML 375 IUCD in the public sector's contraceptive method mix.

## **II. RATIONALE FOR THE ASSESSMENT**

The Family Planning Division of the Ministry of Health and Family Welfare approached USAID India which in turn identified FHI to facilitate an assessment of the feasibility of introducing the ML 375 IUCD into the Family Welfare Program in six districts across India. The results of the assessment will be utilized by the MOHFW to facilitate the introduction of the ML 375 in the Family Welfare Program.

## **III. GOAL AND OBJECTIVES**

The goal of this assessment is to evaluate the feasibility of introducing the ML 375 IUCD into the Family Welfare Program.

The assessment had the following objectives:

- Identify operational issues associated with the introduction of the ML 375 into facilities already offering the CuT-380 A under the Family Welfare Program.
- Identify barriers to access, uptake and use of the ML 375 and suggest measures to facilitate uptake.
- Identify appropriate community and facility-based services that will be required for the uptake of the ML 375.

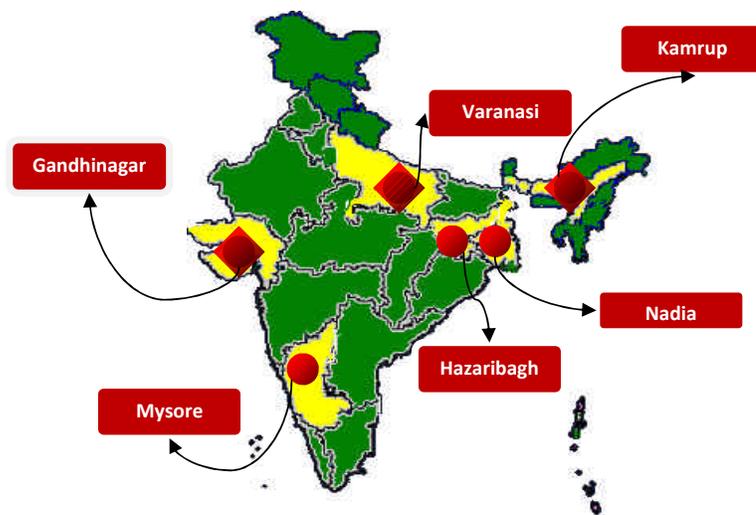
## **IV. STUDY DESIGN**

The ML 375 IUCD introduction assessment was a study designed to undertake and evaluate the introduction of the ML 375 IUCD in 12 public sector health facilities across India. The study included three phases: **pre-intervention, intervention, and post-intervention**. In the pre-intervention phase, health facility assessments and in-depth qualitative interviews with facility staff were undertaken to understand capacity and perceptions prior to the ML 375 introduction. During the intervention phase, providers underwent training to offer the ML 375 and the new IUCD was introduced into the selected study facilities. Finally, the post-intervention phase assessed the introduction intervention through in-depth interviews with facility staff. FHI had contracted research agencies and an intervention agency to conduct the whole assessment. FHI along with USAID provided technical assistance in all the phases in the assessment. (For specific scopes of work please refer to Appendix 1.)

## Study Sites

The ML 375 introduction was implemented through the existing government structure of service providers under the National Rural Health Mission (NRHM) in six states across India (Figure 1): 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 purposively selected by the Family Planning Division (FPD) of the MOHFW to be geographically representative of the country. Originally, Burdwan district was selected for the state of West Bengal, but the District Hospital did not fall under the supervision of the District Health Administration, so Nadia district was added in replacement.

**Figure 1. Study sites for the ML 375 introduction**



In each district, the District Hospital/First Referral Unit (DH) and one Primary Health Centre (PHC) were selected for the introduction, for a total of 12 health facilities. Since the evaluation of the introduction was for descriptive purposes only, formal sample size calculations were not undertaken and facility selection was purposive. Facilities were included in the study if:

- Staff had received training in the CuT 380A IUCD in the past
- The trained personnel were still working at the facilities
- The CuT 380A IUCD was being inserted routinely on-site

If there was more than one DH in a district and they all met these criteria, the facility with the highest number of registered IUCD/family planning related cases in the past six months was chosen. The same procedure was followed for multiple PHCs meeting all the selection criteria in a district. The Chief District Medical Officer (CDMO) in each district was consulted before the facility selections were made final. After the pre-intervention phase, the PHC (Adalaj) of Gandhinagar in Gujarat was upgraded to a Community Health Centre (CHC) and no longer met study criteria. A new PHC, Daboda, was selected in discussion with the Department of Family Welfare in Gandhinagar.

## V. PRE-INTERVENTION PHASE

The pre-intervention phase included health facility assessments and in-depth qualitative interviews with facility staff to understand facility capacity and provider perceptions on family planning and IUCD services prior to the ML 375 introduction. Each of the 12 facilities was

assessed and five staff at each facility were interviewed, for a total of 60 interviews. Data collection activities took place in February 2010.

To ensure confidentiality, all of the participants were assigned ID numbers which were used on the audiotapes, notes pages, and transcripts, and all audiotapes were destroyed at the completion of data analysis. The study team was also instructed to respect the confidentiality of the interviews by not discussing the responses of particular individuals with anyone in the community or health care facilities. TNS transcribed, translated, and entered the data, with FHI conducting analysis. All analyses are descriptive and conceptually representative of the types of providers interviewed in the 12 facilities, and can be transferred to similar contexts.

A health facility assessment was conducted at each of the chosen 12 health facilities to understand the infrastructure and resources available for the introduction, and to document existing family planning services.

## **VI. INTERVENTION PHASE**

The intervention phase of the study began with development of ML 375 training and communication materials. Health service providers were trained on the provision of the ML 375 and community motivators and counselors received training on demand generation. ML 375s became available in the 12 facilities in June 2010 and service provision was monitored through the end of September 2010 for the intervention phase.

### **A. Development of Training and Communication Materials**

The development of the ML 375 IUCD introduction materials was based on MOHFW IUCD guidelines. All intervention materials were translated into Hindi and four other regional languages and pretested before final printing and distribution to facilities and staff.

The intervention training materials included two manuals:

*Trainer's Manual on IUCD:* This manual was developed for HLPPT's Lead Trainers to train Trainers from each study district. The manual introduces the ML 375 study and reviewed general family planning communication and counseling skills, record keeping, and data management. Technical information equally covers the ML 375 and CuT 380A IUCDs, including client selection and screening, insertion and removal, infection prevention, possible side-effects and management, and client follow-up. All material is based on MOHFW guidelines for IUCD provision.

*Handbook for Service Providers on IUCD:* This handbook was developed for the service providers eligible to insert IUCDs and trained to insert the ML 375 during the intervention (Figure 2). The handbook is a concise technical manual on overall IUCD provision and provides equally detailed information on both the ML 375 and CuT 380A IUCDs. Topics include design of each IUCD, mechanism of action, medical eligibility criteria, steps of insertion and removal for both types, infection prevention, possible side effects and management, and client follow-up.

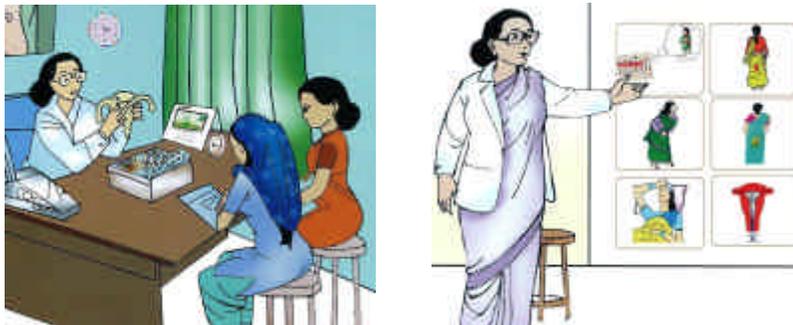
**Figure 2. Handbook for Service Providers on IUCD**



Intervention communication materials consisted of:

*Flipbook for Counselors on IUCD:* This flipbook was developed for use by the community motivators and counselors associated with the 12 study facilities and surrounding communities. These motivators and counselors are not qualified to insert IUCDs, but were used by the intervention to introduce IUCDs and the ML 375 to community women and to provide referrals for interested women. The flipbook is pictorial and helps to generally introduce IUCDs through the story of two women who visit a facility and are counseled by a provider about the IUCD (Figure 3).

**Figure 3. Images from the Flipbook for Counselors on IUCD**



*Leaflet for Users:* This leaflet was designed to be given away in the communities surrounding the 12 facilities (Figure 4). The leaflet briefly introduces both the ML 375 and CuT 380A IUCDs, and then goes on to provide general IUCD information on how it is used, the benefits and precautions of use, continuation, follow-up, and places where an IUCD can be obtained.

**Figure 4. Front page of Leaflet for Users**



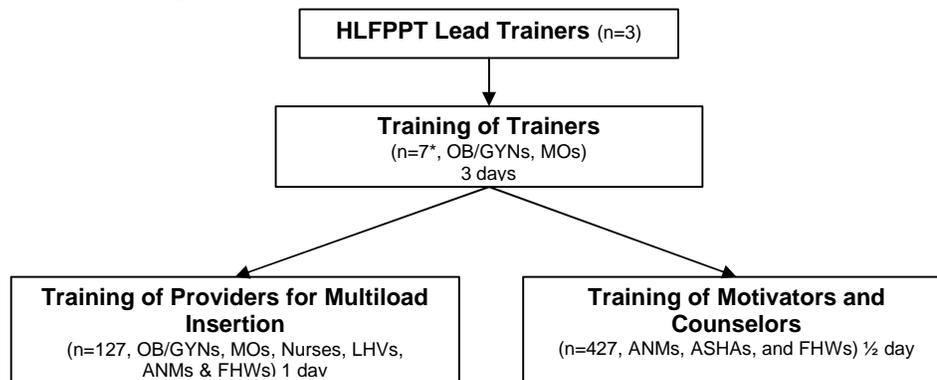
#### **B. Orientation to the Introduction intervention**

A series of orientation meetings in each of the 12 facilities were organized before the intervention began, where not only facility family planning staff attended, but also District MOs and other key stakeholders in each district and community. During the meetings, participants were introduced to the ML 375 study, its goals and objectives, the expected roles and responsibilities of facility staff, and intervention assessment strategies. The ML 375 itself was also discussed, along with its similarities and differences from the CuT 380A, which was already being offered in each facility.

#### **C. ML 375 Introduction training**

The trainings for the ML 375 introduction involved two different groups of service providers: those providers qualified to insert IUCDs and community motivators and counselors. Trainings for both types of staff followed a cascade approach, beginning with HLPPT identifying and orienting three of their own Lead Trainers who had training and CuT 380A insertion experience (Figure 5). These three individuals trained seven Trainers, approximately one from each study district selected by State government officials, who were OB/GYNs or MOs and had been trained in the past to provide CuT 380A IUCDs. The training of the Trainers took place over three days in the HLPPT office in Noida, and content covered the Master Trainer's Manual on the IUCD and hands-on practical experience inserting the ML 375 using ZOE® Pelvic Examination Trainer models (ZOE).

**Figure 5. Training approach for the Multiload Introduction**



\*At the request of the Additional Director (Health and Family Welfare) of Kamrup, two Master Trainers participated in the training: one for the Kamrup Metro area which covers the DH, and one for the Kamrup Rural area which covers the PHC. Additionally, the Master Trainer from Mysore could not join the main training in Noida and underwent a shortened training three weeks later.

The Trainers then returned to their respective districts and were responsible for training both providers at the DH and PHC on ML 375 insertions and the community motivators and counselors on IUCD counseling and demand generation. Participants for each type of training were selected by service managers at their facilities and all insertion providers were required to have previous CuT 380A IUCD insertion training.

Insertion providers were trained for one day on: screening clients using the adapted intervention materials; counseling on both the ML 375 and CuT 380A IUCDs; counteracting IUCD myths and misconceptions; insertion and removal of the ML 375, including infection prevention; managing side effects and complications; conducting follow-up with clients; and management and reporting of client data. The Handbook for Service Providers on IUCD were distributed during the training and used as a reference. A total of **127 insertion providers were trained**. The motivators and counselors associated with the 12 study facilities and surrounding communities went through a half-day training on introducing IUCDs and the ML 375 to community women, counteracting myths and misconceptions, managing side effects, and how to provide referrals for interested women. A total of **427 motivators and counselors were trained**.

#### **D. Provision of Multiload 375 IUCD services to women**

ML 375 IUCDs became available in the 12 facilities in June 2010 and service provision was monitored through the end of September 2010. Family planning clients attending the 12 facilities were counseled on both the ML 375 and CuT 380A IUCDs, with mention of their effectiveness, benefits, and side effects. Per current MOHFW recommendations, new IUCD clients also received appropriate counseling during scheduled and unscheduled follow-up visits. Several of the facilities also utilized other on-site trained counselors—Family Counselors, HIV testing center counselors—to strengthen counseling of clients seeking FP services.

#### **E. IUCD demand generation in the community**

ANMs, ASHAs, and other community-level health staff who were trained on the ML 375 IUCD introduction provided information and counseling during the intervention period to women living in the communities surrounding the 12 health facilities. Counseling covered available family planning options, including the two IUCDs, through one-to-one meetings with the women along with group education and information sessions at community Integrated Child Development Services (ICDS) centers and immunization or other health camps. MOs based at the facilities also were involved in the community processes to facilitate efforts at the health camps and other relevant group gatherings.

In the public sector, the FWP provides Rs 20 to the facility per CuT 380A inserted for facility improvements. However, the use of the funds is at the discretion of each individual facility. In Nadia and Kamrup, Rs 10 was provided each to ML 375 service providers and clients during the intervention, matching what is offered for CuT 380A.

**F. IUCD card**

A standard IUCD card was developed and introduced to monitor IUCD uptake during the intervention, for use in the 12 facilities (Figure 6). Up until this point, a standardized system for monitoring and tracking IUCD insertions within and across facilities had not been used. The study's card was developed per current MOHFW recommendations on medical record-keeping and printed in the five languages of the study area. Information collected on the card included age of the client, parity, type of IUCD inserted, type of service provider inserting the IUCD, follow up dates, reasons for follow up, and patient education on follow up and side-effects. The cards also have a perforated counterfoil that can be torn off and given to the client after receiving her IUCD. Aside from being a take-home record of the client's patient ID number, IUCD type and insertion date, the counterfoil includes six pictures reminding the women of problems or complications that could result from their IUCD use that require medical attention.

**Figure 6. IUCD card**

The IUCD card is divided into several sections:

- Header:** आई.यू.सी.डी. (IUCD) कार्ड
- स्वास्थ्य केन्द्र कोड पर गोला लगाएँ (Mark the health center code):** A grid of 12 facilities:
  1. सोनच DHFRU
  2. सोनच PHC
  3. सोनच DHFRU
  4. हजारीबाग PHC
  5. हजारीबाग DHFRU
  6. हजारीबाग PHC
  7. बालासुत DHFRU
  8. बालासुत PHC
  9. वैशुपु DHFRU
  10. वैशुपु PHC
  11. बालासो DHFRU
  12. बालासो PHC
- कमपाउंट की जानकारी (Client Information):**
  - कमपाउंट का प्रकार (IUCD): \_\_\_\_\_
  - कमपाउंट की उम्र: \_\_\_\_\_
  - कमपाउंट की संख्या: \_\_\_\_\_
  - सर्वोपयोगी चिकित्सक (Gynaecologist): \_\_\_\_\_
  - सर्वोपयोगी चिकित्सक (LMP): \_\_\_\_\_
- प्रवेशन और पुनः जाँच विवरण (Insertion and Follow-up Details):**

IUCD प्रवेशन की तिथि (दिनांक/घंटा)				
IUCD का प्रकार (C = कोपर टी (CuT)-380A, M = एम केएस-375)				
सेवा प्रदाता का नाम (दिनांक/घंटा)				
	पुनः जाँच का तिथि*	सिद्ध (आई) दिनांक (आई) दिनांक (आई) दिनांक (आई)	कमपाउंट	दिनांक गया उपचार
पहली पुनः जाँच				
दूसरी पुनः जाँच				
तीसरी पुनः जाँच				
चौथी पुनः जाँच				
पाँचवीं पुनः जाँच				
- Counterfoil (Right side):**
  - कमपाउंट का प्रकार (IUCD): \_\_\_\_\_
  - उम्र: \_\_\_\_\_
  - पारि: \_\_\_\_\_
  - प्रदाता का नाम: \_\_\_\_\_
  - प्रवेशन तिथि: \_\_\_\_\_
  - प्रकार: \_\_\_\_\_
  - IUCD प्रवेशन तिथि: \_\_\_\_\_

पुनः जाँच	तिथि
पहली पुनः जाँच	
दूसरी पुनः जाँच	
तीसरी पुनः जाँच	
चौथी पुनः जाँच	
पाँचवीं पुनः जाँच	

Six illustrations of complications: 1. Pain (दर्द), 2. Bleeding (रक्तस्राव), 3. Infection (संक्रमण), 4. Discharge (निर्गमन), 5. Pregnancy (संभव गर्भ), 6. IUCD string (IUCD डोरी).

**G. Monitoring implementation of the Multiload introduction**

When the Master Trainers returned back to their districts, the PO helped plan and implement the trainings for ML 375 insertion providers and motivators and counselors. The Master Trainers in each district supervised the technical aspects of the ML 375 introduction and IUCD provision.

## VII. FINDINGS (POST-INTERVENTION PHASE)

The post-intervention phase included in-depth qualitative interviews with facility staff to assess the introduction of the ML 375 through their perceptions and experiences. Five staff members at each facility were interviewed in October 2010, with a total of **60 interviews held across the 12 introduction facilities**. An attempt was made to interview the same respondents during the post-assessment as were interviewed during the pre-assessment; **36 of the 60 providers** were able to be interviewed at both time points. Service statistics collected from the intervention IUCD card were also reviewed.

### A. IUCD Service Statistics

During the three-month intervention period, IUCD providers filled out 597 IUCD Cards tracking insertions in the 12 participating facilities. Over this time, the cards showed 479 ML 375s were inserted (80%) and 118 CuT 380A IUCDs (20%). IUCD insertions tracked by the IUCD Card were not equally distributed across the six study sites (Table 6). The most ML 375 insertions were done in Kamrup (25%), and the fewest were undertaken in Mysore (6%). Different districts appeared to show preferences towards one type of IUCD or another (data not shown), with Multiload preferences seen in Gandhinagar (85% more), Hazaribagh (80%), and Kamrup (62%).

**Table 1. Distribution of IUCD insertions recorded on cards, by type**

	ML 375 (n=479)	CuT 380A (n=118)
	%	%
District		
Nadia	19	5
Gandhinagar	19	13
Hazaribagh	18	18
Kamrup	25	63
Mysore	6	0
Varanasi	13	1
Facility Type		
DH/FRU	39	39
PHC	61	61
IUCD Inserted by		
ANM	43	60
Doctor & Medical Officer	40	24
Nurses	9	10
FHW & LHV	8	6

Despite site differences in IUCD insertions, the facility type where insertions took place was consistent for the two IUCDs. Additionally, ANM were inserting the most IUCDs for both ML 375 and CuT 380A, although more so for the later.

In Varanasi, providers rarely used the IUCD cards to record their CuT 380A insertions, complaining that their reporting burden would be too great as a result of their high CuT 380A client load. Additionally, CuT 380A stock outs were noted during the intervention period in several of the facilities; in one facility the CuT 380A stock outs were acute. Stock outs of the ML 375 were not an issue during the introduction as they were supplied by HLPPT, independent of the public sector supply chain, and the POs monitored supplies carefully.

Between these two issues, having more ML 375 inserted during the intervention period should not be taken to represent a preference for one IUCD over the other.

Early on in the intervention, providers reported lacking clarity on whether the ML 375 insertions should be added to their monthly IUCD reporting. This issue was reviewed with State government officials and the facilities were subsequently granted permission to include the ML 375 insertions in their monthly IUCD reporting.

## **B. Key-Informant Interviews**

During the post-intervention key informant interviews, 60 providers were interviewed, 36 of who were also interviewed during the pre-intervention phase. Most providers were ANM (n=15), OB/GYNS (n=13), and MOs (n=11).

### *Provider Perceptions on the ML 375*

After three months of offering the ML 375 IUCD in their facilities, providers were asked their perceptions of the new IUCD. Most of the providers (n=43) had a positive opinion about the ML 375 as an IUCD and family planning method, citing general IUCD benefits like an extended effectiveness period (as compared to condoms or OCPs), that it is not permanent, and that few acceptors complain of side effects. From a service provision perspective, providers specifically liked the ML 375 because the IUCD comes preloaded on the inserter, resulting in no-touch insertions (n=19). Moreover, providers found the ML 375, as compared to the CuT 380A, easy and less time consuming to insert (n=37) and its soft and different shape reduced the possibility of complications (n=32).

### Voices from the field

*I feel it is easier to insert the Multiload. It is very convenient and effect. It is safe. It doesn't cause irritation and very much flexible. –MO, DH*

*At the time of insertion of Multiload 375, we felt it is easy and the material is made of plastic, so it is easy to insert. It is like ready made and so it does not take much time. We like to provide it. –ANM, PHC*

### *Multiload counseling*

Health care providers were asked to discuss their experiences on counseling clients about ML 375. Service providers generally found ML 375 counseling to be a challenge because of widespread myths and misconceptions surrounding IUCDs in general, along with low levels of knowledge about the different types of IUCDs and the low literacy among potential clients seeking services. Just over half of the service providers (n=36) reported that women were not aware of the ML 375 before coming to the facility, and thus most women were not familiar with its differences compared to the CuT 380A, particularly the difference in duration of pregnancy protection.

### Voices from the field:

*Here, the literacy level among patients is less. There are more myths prevailing regarding IUCD so, we have to clear their concerns during counseling. –OB/GYN, DH*

*They cannot say about Multiload from their own. They only tell that we are ready for the 5 years Cu T. Actually we do mention first regarding the Multiload. They don't say anything. –ANM, DH*

Providers in Varanasi reported different experiences in counseling clients. Here, many clients do know about the ML 375 before arriving at the facility, because the ML 375 has been socially marketed for the private sector. Client awareness about the ML 375 was high and providers reported that clients preferred it over the CuT380A as they perceived it to be a better IUCD.

Voices from the field:

*People are getting crazy about Multiload. Maybe because of its effect. They also ask for Multiload and we also tell them about all the options such as Multiload 375 and Cu-T 380A. In the advertisement they tell good things about Multiload. Cu-T is also good but people think Multiload is better. –MO, DH*

When it comes to recommending the ML 375 to clients, few providers considered it suitable for all types of women. Providers identified it as a good method for women with spacing needs, along with women who are unwilling to use other family planning methods. Additionally, women with one or two children were candidates for the ML 375, but providers felt that women with more than two children should be offered sterilization instead. Opinions on eligibility did vary considerably among providers, however perspectives were generally consistent with overall IUCD opinions expressed during the pre-intervention assessment.

#### *Multiload Insertion Process*

When questioned about the specific process of inserting the ML 375, nearly two-thirds of the service providers (n=37) reported that the insertion process is easier and less time consuming than the CuT 380A process. This was frequently attributed to the ML 375 being preloaded on the inserter inside the package, resulting in no additional time spent on preparing the IUCD for insertion. In addition, many providers saw this minimal handling as a benefit for potentially limiting infections. Half of the providers (n=30) noted that clients complained less frequently of pain and discomfort during and after the ML 375 insertions. Four providers did complain about the flexibility of the ML 375 insertion tube, saying that it could cause problems during the insertion process, requiring the providers to discard the IUCD and begin the insertion again with a new IUCD. Discarded or “wasted” IUCDs were tracked throughout the intervention, and there was little recorded wastage suggesting that while the flexibility of the insertion tube is a concern, it was not a widespread and common problem.

Voices from the field:

*The process is very good, actually better than 380A. For Cu T the loading of the device takes much time and very critical to avoid touch, but for Multiload it is ready. Just open and insert. So, it takes less time than Cu T. –MO, PHC*

*We can insert it easily. There is no tension about inserting it. Earlier, I used to fear that it may be misplaced but, after the training, I have confidence. Complaints are very less, slight lower abdomen pain. –FHW, DH*

#### *Follow up of IUCD insertions*

The MOHFW policy on following up IUCD insertions recommends that a client returns to the facility for a follow-up exam after her first monthly bleeding or four to six weeks after the IUCD insertion. Subsequent visits should be made once a year. This follow-up policy was part of the ML 375 IUCD introduction and was included in the Handbook for Service Providers on IUCD. Qualitative data on IUCD follow-up, whether ML 375 or CuT 380A, was extremely limited; however, information collected during the study suggests providers lack a clear and well-defined strategy for routinely following up IUCD insertions, despite the MOHFW policy. In general, providers perceive that if clients have complaints or problems with their ML 375, they will return to the facility to seek care. Otherwise, there is no need to follow up with them. During the intervention period, as very few acceptors of the ML 375 returned to the facility during the intervention period, providers reported assuming that few ML 375 clients had complaints or complications.

Voices from the field:

*Yes, they come for follow-up. But there are some women they did not come yet. They will also come as per their requirement or convenience. The reason behind this is that if they are feeling no problem then they will not come for check-up as they come from interiors and it involves cost. –ANM, PHC*

The IUCD card did track how many IUCD acceptors returned back to the facility where they had their IUCD inserted; those returning to alternate facilities or visited in their home or other community location would not be tracked by the card. Overall, follow-up visits were only recorded among ML 375 acceptors, and just 8% of these acceptors (n=31) returned to the facility for a first visit; there were no repeat visits. These few women returned on average one month (32.2 days) after their ML 375 was inserted, although visits ranged from 7 to 71 days afterward. Of the 31 ML 375 users who made a follow-up visit, most complained of bleeding (61%) and pain (42%). Only one woman of the 597 tracked by the IUCD card was documented to have her IUCD, a ML 375, removed during the intervention period.

#### *ML 375 Introduction training*

Of the 60 providers interviewed, 47 (78%) had participated in one of the ML 375 trainings; participation was not an eligibility requirement for the interviews. The majority of the 47 had attended the Training of Providers for Multiload Insertion (n=41), while the remaining attended the Training of Motivators and Counselors (n=4) or were ML 375 Master Trainers (n=2).

Providers and motivators who were part of the Multiload introduction trainings were asked about their experiences during the training and what new information they learned. Participants reported that the details of the ML 375, including shape, duration of effectiveness, and side effects were new to them. Insertion providers also discussed the aspects of insertions they learned like loading the ML 375 on the inserter is not required, an adaptor is unnecessary, along with technical details for general IUCD insertions like maintaining hygiene before and after insertions with hand washing, wearing gloves, and disinfection with 0.5% chlorine solution.

After the training, most of the participating providers and motivators felt confident about counseling clients on the ML 375, and for the insertion providers, comfortable with inserting and removing the IUCD. When asked about suggestions for improving the training, the providers reported that the training duration should be increased to include supervised practice insertions on patients, as opposed to only on ZOE models (n=17). Moreover, motivators and providers recommended incorporating audio visual materials into the trainings.

Voices from the field:

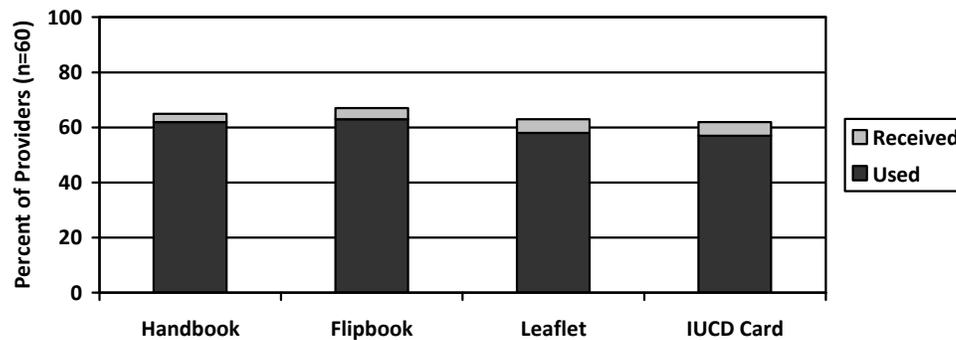
*The new information in the training was related to IUCD counseling. Specific counseling has to be given...we have to tell them about the side effects, the benefits of the product which we are inserting. –OB/GYN, DH*

*The training was very compact and I feel it could have been extended to two days for better perception . One day reserved for counseling and one day for the insertion part. Real life practice can be done for counseling and it is very difficult for real life insertion practice. Models can be provided for practice session for all participants. –MO, PHC*

#### *Intervention Materials*

During their interviews, all providers were asked if they had received and used the training and communication materials developed for the ML 375 introduction. About two-thirds had received all of them and slightly fewer used them in the three months of intervention (Figure 7).

**Figure 7. Intervention materials received and used by providers**



Of the four materials introduced, the IUCD card was used on a daily or near-daily basis by the providers inserting IUCDs, both ML 375 and CuT 380A. Overall, providers found the card a beneficial record of when and what type of IUCD a woman had inserted. During monitoring visits, some providers did raise concerns about the additional reporting burden these cards placed on them. In Varanasi, where high client loads were seen for CuT 380A IUCDs, the reporting burden was so great that providers would only use the cards to track ML 375 insertions; tracking CuT 380A insertions was too time-consuming.

Providers also highlighted the perforated counterfoil that could be given to the clients, considering it a useful and positive aspect. Providers would have liked a space to record the client's name on the IUCD card, which was not included during the study for ethical reasons, to facilitate client tracking and follow-up both within the facility and out in the community by ASHA.

Voices from the field:

*The card is prepared systematically, the follow up date is mentioned, so we can emphasize them to come for follow up, and the five warning signs have been demonstrated by pictures so the patient can make out that she needs to take advise in such condition. So, it is helpful. –OB/GYN, DH*

*It is quite good; all the required information could be recorded at the card as per the instruction given. It is good that we can give a record to the client also. It is also ready made and we need not to maintain a different copy as we used to do it for CuT earlier. – ANM, DH*

#### *Barriers for ML 375 Access, Uptake, and Use*

Health care providers were questioned about what they perceive to be major barriers limiting the access, uptake, and use of the ML 375. Within the facilities, providers identified barriers that were not solely confined to ML 375 provision, but provision of all IUCDs in the facility. Issues like power failures, poor infrastructure, and lack of necessary instruments were common. For example, in the Kamrup, Nadia, and Mysore facilities, there was an acute lack of space and limited sets of instruments that hampered the number of insertions that could be undertaken, leading to long waiting times. The inability to handle high client load for family planning services also impacted the acceptance of IUCDs, including ML 375.

Voices from the field:

*Only if we have our own set of equipments for insertion and all then we need not to depend on the OT instruments and the waiting time of the patient's decreases and the process become faster. – MO, DH*

Myths and misconceptions, along with low awareness of IUCDs in general, limit client uptake of the ML 375. According to the providers, women's decisions about adopting the ML 375 are guided by their overall preference or aversion to the IUCD in general, as few are aware that there are multiple IUCD options. With the CuT 380A already available in the public sector, many women's exposure to the IUCD is through hearing about it and its side effects, whether truth or myth. Providers report that clients often assume that all types of IUCDs have similar side effects and efficacy profiles, posing a challenge to providers who try to differentiate the ML 375 and discuss its benefits, let alone dispel myths like that the IUCD will move around in the body or cause infertility. Additionally, providers are faced with overcoming the misconceptions of the client's husband and mother-in-law, who often must approve of a woman's use of family planning and can influence her method-selection.

Providers' own misconceptions along with insufficient knowledge and informed choice counseling skills can also be considered a barrier to ML 375 and overall IUCD uptake. While providers were not asked to comment on their own performance, it became apparent through the interviews that some providers lacked these necessary skills. Both before and after the intervention, providers could not fully cite accurate IUCD eligibility criteria and exhibited bias in their consideration of who was suitable to receive an IUCD. When providers were asked to discuss their experiences on counseling clients about the ML 375, discussions on side effects could often be limited or incorrect, thus not fully preparing clients on what to expect, increasing the likelihood of discontinuation.

#### *Facility and community based services required*

The most frequently requested change in the ML 375 intervention was the provision of incentives for ML 375 motivation, uptake, and provision. In some areas, incentives were available in the private sector for the ML 375. Providers repeatedly emphasized that these IUCD incentives should be consistent across both the private and public sectors to prevent competition for IUCD services.

Some of the facilities need separate rooms for IUCD insertion, aside from operating theatres, postpartum units, and labor rooms, where IUCD insertions have less priority. Additionally, more private spacing for family planning counseling needs to be created. The lack of space and privacy created significant concerns during the intervention since they led to longer waiting time for clients and indicated an inability to handle larger volumes of service delivery if the program was rolled out as a routine service. Separate insertion and counseling space could alleviate this burden. Facility staffing needs to be shored up and some providers requested a more formal supervisory system to monitor and ensure service delivery. Moreover, there is a need for a structured referral system to manage serious complication or offer higher levels of care for all IUCD clients at PHCs.

In several of the districts, providers discussed the benefits of having ASHA and other community-level staff actively promoting the ML 375 out in the surrounding communities. These motivators were introducing the ML 375 to women in their homes and during village health days, leading interested women to then visit the facilities for more information and IUCD uptake. While it was often reported that the clients could not specifically name the ML 375, women could specify their interest in the "5-year IUCD". Including community-level promotion of the ML 375 with women, along with their husbands and mothers-in-law, should be required for ML 375 introduction.

Voices from the field:

*Yes, because our ANMs and fieldworkers counsel them on their home visit and motivate them before sending to this facility. They know that the new copper T for 5 years and the older one is for 10 years. They cannot take the name of Multiload or mention any number also. They know it from the ANMs that its safe. –Nurse, DH*

## **VIII. DISCUSSION ON CHALLENGES**

The post-intervention assessment highlights various operational issues for the MOHFW to consider for scaling up the introduction of the ML 375 into additional public sector health facilities. The operational issues examined through this qualitative assessment include various service delivery aspects like ML 375 counseling, ML 375 service provision, following up of clients, training on the ML 375, intervention communication materials, barriers, and necessary facility- and community-based services. The overall feedback from providers, both those that inserted ML 375s and the community motivators, was positive and encouraging for further introduction. However, the assessment also exposed weaknesses not only in the ML 375 introduction, but in overall IUCD provision in the 12 facilities.

Provider feedback, service statistics from the IUCD card, and observations from study monitoring visits found that after one day of ML 375 training, providers with existing experience in inserting CuT 380A IUCDs are able to successfully counsel on and insert ML 375s with limited reports of clinical complications or other problems. Providers did recommend a longer training, particularly the ANM, which would include supervised ML 375 insertion on clients. A longer training could also accommodate more time on dispelling providers' misconceptions of all IUCDs, particularly eligibility criteria, and improving balanced and informed choice family planning counseling. Aside from some providers' misconceptions and insufficient counseling skills, the majority of barriers hampering ML 375 provision and uptake has less to do with the providers and are more a result of facility- and community-level challenges that are relevant to all IUCD provision. Facility constraints like sharing space with services that take greater priority, limited privacy, insufficient equipment, and likely supply chain issues all limit women from receiving IUCDs.

If the ML 375 IUCD is to be considered a viable limiting option, the MOHFW, both at national, state, and district levels need to take steps to facilitate all IUCD provision. Moreover, the unequal incentive scheme for the different IUCD types in the public and private sectors is a problem. If clients can receive incentives for adopting the ML 375 in the private sector, women lack motivation to choose the ML 375 from the public sector.

In spite of these challenges, the ML 375 was well received in the 12 facilities and their surrounding communities. With improvements in the intervention and appropriate health system infrastructure and policy modifications, the ML 375 has the potential to be a meaningful contribution to the family planning method mix available under the MFPP.

## **IX. RECOMMENDATIONS**

The results of this study indicate that the ML 375 IUCD can be successfully introduced into DH and PHC facilities through training providers already qualified to offer the CuT 380A with minimal operational difficulties. When considering scale-up of the ML 375 introduction, seven recommendations can be taken from this study addressing:

- A. Improvements in the design of the introduction
- B. Suggestions for adding ML 375 in the public health system

## **A. Improvements in the design of the introduction**

**1. Use of mass media, mid-level media and interpersonal communication activities are required for increasing ML 375 demand and addressing overall IUCD myths and misconceptions.**

During the intervention, ANMs and ASHAs provided information on the ML 375 and all IUCDs to women living in communities surrounding the 12 facilities. Providers found this **community work beneficial**, but it was not considered sufficient alone for demand generation for the ML 375. Often times women had not heard of the ML 375 before arriving at the health facility. Additionally, what general information women did know about IUCDs was frequently incorrect, as IUCD myths and misconceptions are widespread. To counter the myths and misconceptions, and increase women's familiarity with the ML 375, demand generation activities need to engage the **mass and mid-level media**, and improve **interpersonal communication** and materials. During the pre-assessment in-depth interviews, providers suggested increasing overall IUCD visibility and understanding through working with the local leaders, **including Panchayat and religious leaders, and local NGOs and women's groups**, along with male family members and mothers-in-law. These IUCD recommendations can easily be tailored to encompass or focus solely on the ML 375, but on the whole, they need to aggressively address the myths and misconceptions surrounding IUCD use.

**2. Comprehensive training of all levels of health care providers on IUCD counseling, insertion, and follow up, with special focus on supervised insertions.**

Through a cascade training approach, the introduction trained both health service providers on the provision of the ML 375 and community motivators and counselors on demand generation. In the post-intervention assessment, insertion providers repeatedly requested a longer training focusing on both theory and supervised insertions on clients, instead of models. This was particularly true for ANMs, who on the whole have less formal professional training than some of the other insertion providers who were OB/GYNs and MOs. While the post-intervention assessment did not detect reports of clinical complications or other problems, some providers did report feeling less than fully prepared to offer the ML 375s. Moreover, providers were found to have gaps in their skills on client eligibility for all IUCDs and counseling for side effects. Future scale-up efforts should adopt the **intervention's training materials, strengthening sections on client eligibility and counseling, and building in time for supervised insertions**, to provide comprehensive training for all levels of health care providers in ML 375 provision. Discussions with the MOHFW have outlined proposed components of training including: **three days of training on the CuT 380A and ML 375 for new and untrained service providers; a one day, eight hour training on ML 375 provision for service providers trained on the CuT 380A; possible reduction in number of participants per training session, to ensure thorough practice of insertions on ZOE models by all participants; and, instruction on how to use and complete the IUCD cards.**

**3. Different colored strings for different IUCDs**

Providers noted during the intervention that the perforated counterfoil of the IUCD card was a good take-home record of the type of IUCD a client had inserted. Yet, considering the long duration of IUCD efficacy, there is the likelihood that women may have difficulty retaining the counterfoil for five to ten years, or they may move from that area, no longer attending the facility where their IUCD was inserted. Having different IUCD types with different colored strings, to differentiate between the two models, could be one solution for situations like these. The colors, uniform to each model, would serve as a reference for providers not only of the IUCD type but when the client would need to have it replaced.

## **B. Suggestions for adding ML 375 in the public health system**

### **1. Ensure constant supply of IUCDs**

Stock outs of the ML 375 IUCD were not an issue during the introduction as they were supplied and monitored by the intervention agency. CuT 380A IUCD stock outs were, however, noted during the intervention period in several of the facilities. During scale-up of ML 375 provision, the IUCDs will be procured through the public sector supply chain like the CuT 380As, making the ML 375 just as susceptible to stock-outs. To facilitate uptake of the ML 375, a constant supply needs to be ensured through better forecasting and management of the supply chain.

### **2. Infrastructure improvements, including provision of adequate space for counseling and IUCD insertions, and additional instruments are required.**

Providers on the whole found their space sufficient for ML 375 IUCD provision; however, many in facilities with high family planning client loads noted a **need for sufficient space for counseling** clients and inserting IUCDs. In these locations, providers were often forced to compete with operating theatres, postpartum units, and labor rooms for space and equipment, limiting the number of ML 375 insertions they could complete and increasing the waiting time for clients. Postpartum units and labor rooms can be utilized for postpartum provision of ML 375s, but for women who have not recently given birth, **additional separate space would be ideal**. As facilities are selected to offer the ML 375, infrastructural improvements or reorganization should be encouraged to facilitate unhampered IUCD provision.

### **3. IUCD tracking cards provide a systematic record to manage clients and monitor facility insertions.**

Overall, providers found the IUCD card a beneficial record of when and what type of IUCD a woman had inserted, and asked that it be modified to include a client's name to make matching the card and woman easier. While there was insufficient time to assess how ML 375 follow-up was operating, the systematic record of IUCD insertion dates could facilitate providers scheduling follow-up visits with women, whether through reminding them when to return to the facility or by ASHA going to their homes. The cards did provide a way for each facility to singularly track all IUCD insertions taking place in the various services or units of the facility, which did not exist before the ML 375 introduction. Based on this study, IUCD cards should be an integral part of introducing the ML 375 into facilities and could even be considered for facilities only offering the CuT 380A.

### **4. Developing a practice of following up IUCD insertions**

The MOHFW policy on following up on IUCD insertions was part of the ML 375 introduction and was included in training and communication materials. Post-assessment data from interviews and the IUCD cards was extremely limited, however it pointed to a provider perception that if clients have complaints or problems with their ML 375, they will return to the facility to seek care.

Otherwise, providers generally make no efforts to follow-up on recent insertions, which is an opportunity **lost to identify and manage possible side-effects**, to assuage any possible concerns, and dispel any lingering misconceptions with the woman or her family. This additional client contact to gauge satisfaction could improve method continuation and work to improve the community-wide perceptions of the ML 375 and CuT 380A IUCDs. **FHI encourages systematic follow-up of all IUCD insertions as per MOHFW policy**, yet specific recommendations on making this policy a practice are forthcoming, once FHI's assessment of five additional months of ML 375 provision in the 12 facilities is complete.

## X. REFERENCES

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## APPENDIX 1

### **Responsibilities of various organizations:**

**USAID and FHI:** USAID and FHI provided technical assistance to throughout the assessment. FHI developed the concept note and protocol. Data collection forms were developed and finalized by FHI. The ethical clearances from Protection of Human Subjects Committee (PHSC) and local ethics committee (IEC Futures Group) were undertaken by FHI. FHI also took the lead in contracting research agencies and intervention agencies. During all these stages USAID had provided technical assistance to FHI and reviewed all research and contractual documents developed by FHI. FHI along with USAID closely monitored all the assessment activities.

**Research Agencies:** Pre-intervention data collection was undertaken by TNS/India, with instruments designed by FHI and technical inputs from USAID. The facility assessments were conducted using a combination of both direct observation aided by a checklist and interviews with a senior official based at the facility. All of the in-depth interviews were audio recorded to ensure an accurate recording and summarization of the interview information, and interviewers also took written notes. Post-intervention data collection was undertaken by Sigma Research and Consulting Pvt Ltd. The same procedures described under the pre-intervention phase for data collection and management, and ensuring confidentiality were also used during post-intervention.

**Intervention agency (HLFPPT):** The ML 375 Introduction intervention was carried out by Hindustan Latex Family Planning Promotion Trust (HLFPPT). HLFPPT recruited a Project Coordinator who was responsible for the day-to-day management of the intervention and coordination with Project Officers (PO) located at each of the 12 facilities. The POs were hired by HLFPPT on a contractual basis, to oversee and monitor intervention activities, along with maintaining a system for procurement, storage, and disbursement of the ML 375s. Hindustan Lifecare Ltd. (HLL), a subsidiary of HLFPPT who manufactures the ML 375s for the private sector, provided the ML 375s to the study. HLFPPT was responsible for the development of the ML 375 IUCD introduction materials consisting of Trainer's Manual on IUCD, Handbook for Service Providers on IUCD, Flipbook for Counselors on IUCD, Leaflet for Users based on MOHFW IUCD guidelines, with technical oversight and final approval by FHI. HLFPPT organized a series of orientation meetings in each of the 12 pilot facilities before the intervention began. The trainings for the ML 375 pilot introduction were designed and led by HLFPPT and involved two different groups of service providers in a cascading approach. Throughout the intervention, HLFPPT provided additional supervision and technical and counseling support to the ANMs and ASHAs.

To monitor IUCD uptake during the intervention, HLFPPT and FHI developed and introduced a standard IUCD card for use in the 12 pilot facilities with technical inputs from USAID. The POs were the main individuals responsible for monitoring the pilot introduction at each facility. Throughout the intervention, the PO managed communication between the providers, facilities, HLFPPT, and FHI, and promoted the visibility of the pilot introduction. They attended monthly meetings of ANMs at the PHC level to discuss and strengthen community-level strategies for introducing the ML 375 and IUCDs in general. Additionally, they submitted periodic activity reports, collected and reviewed financial documents, preempted problems in the facilities, and otherwise ensured the pilot introduction was operating as planned. Aside from the PO's responsibilities, the Master Trainers in each district supervised the technical aspects of the ML 375 introduction and IUCD provision. Additionally, HLFPPT staff conducted regular facility monitoring and FHI visited all project sites twice during the intervention period.

