A facility birth can be the time to start family planning: Postpartum intrauterine device experiences from six countries

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abstract

Initiation of family planning at the time of birth is opportune, since few women in low-resource settings who give birth in a facility return for further care. Postpartum family planning (PPFP) and postpartum intrauterine device (PPIUD) services were integrated into maternal care in six low- and middle-income countries, applying an insertion technique developed in Paraguay. Facilities with high delivery volume were selected to integrate PPFP/PPIUD services into routine care. Effective PPFP/PPIUD integration requires training and mentoring those providers assisting women at the time of birth. Ongoing monitoring generated data for advocacy. The percentages of PPIUD acceptors ranged from 2.3% of women counseled in Pakistan to 5.8% in the Philippines. Rates of complications among women returning for follow-up were low. Expulsion rates were 3.7% in Pakistan, 3.6% in Ethiopia, and 1.7% in Guinea and the Philippines. Infection rates did not exceed 1.3%, and three countries recorded no cases. Offering PPFP/PPIUD at birth improves access to contraception.

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1. Background

In 2012, an estimated 222 million women in low-resource countries wanted to avoid pregnancy but were not using modern contraception [1]. For many of these women, childbirth begins at an early age, intervals between pregnancies are too short, and lifetime fertility is high [2]. The resulting fertility patterns lead to excess mortality and morbidity for both mothers and offspring [3–5]. Although family planning services are intended to address desires to space and limit births, typically they are offered separately from maternity services. The providers who work in family planning units frequently are not the same individuals who care for women prenatally, at birth, and postnatally, so opportunities for integrating these services are limited. In many countries, institutional births are on the rise, and there is strong policy support for the use of skilled birth attendants. Thus, initiation of family planning during a facility stay at the time of birth is particularly opportune, especially since few women who give birth in a facility return for further postnatal care [6–8].

According to the World Health Organization (WHO), “postpartum family planning (PPFP) focuses on the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth” [9]. Operationalizing PPFP requires integration of family planning with maternal, newborn, and child health services (see Fig. 1). In the present paper, we define “immediate postpartum” as the first 48 hours after birth, “early postpartum” as the six weeks after a birth, and “extended postpartum” as the 12 months after a birth. The provision of a contraceptive method before discharge ensures that women are protected against pregnancy before they resume sexual activity or return to fecundity. Family planning programs with a wide range of contraceptive choices are associated with greater use and lower costs [10]. Yet, according to current WHO

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recommendations, contraceptive choices are more limited during the early postpartum period, in particular for hormonal methods, if a woman follows recommendations to exclusively or predominantly breastfeed her baby [11,12]. Some countries allow progestin-only hormonal methods in the immediate postpartum for lactating women, but many follow the WHO’s recommendation to delay initiation of these methods for at least six weeks. Exclusive breastfeeding for the first six months, without resumption of menses—the lactational amenorrhea method (LAM)—is a highly effective method of family planning in the short term [13]. Other immediate contraceptive options include the postpartum intrauterine device (PPIUD), which is an intrauterine device (IUD) inserted soon after delivery, as opposed to the interval IUD inserted later, or postpartum tubal ligation. PPFP includes any contraception used during the extended postpartum, regardless of timing of initiation, of which PPIUD is one option and is limited to the 48 hours after a birth. Quality programs always counsel women on all their PPFP options. Box 1 describes modalities for PPIUD insertion.

As a result of this convenient timing, PPF/PPIUD services can be organized to take advantage of prenatal care and labor and delivery as prime opportunities to address postpartum contraceptive needs. In many countries, PPF/PPIUD services also align with national efforts to promote facility-based births. However, early studies of PPIUDs that have examined different types and timings of insertion (up to seven days after birth) have found high expulsion rates, from 3.7% to over 30%, with mixed conclusions concerning post-placental or early postpartum insertion. These studies did not describe the PPIUD insertion technique used other than to indicate hand or instrumental insertion [14–17].

In the present article, we present program experiences from six countries where Jhpiego or the Jhpiego-led and USAID-supported Maternal and Child Health Integrated Program (MCHIP) integrated PPFP into maternal care, with PPIUD services offered. We describe the rollout and implementation of the programs, present service data on uptake and follow-up, and discuss operational challenges and solutions to support the scale-up and replication of PPIUD services in other countries. All six of the country programs used the Copper T 380A IUD. The Copper T is reversible and effective for 12 years, requires very little routine follow-up, and can be inserted within 10 minutes of placental expulsion, during cesarean deliveries, or within 48 hours after childbirth [18].

2. Methods and context

The authors reviewed program documentation, country-level monitoring and evaluation databases, and monthly summary reports from participating health facilities to assess commonalities and differences in program implementation. In Pakistan, Jhpiego staff obtained data compiled by facilities from the district or regional headquarters, while in Ethiopia, India, and the Philippines, data were obtained from monthly facility reports to program staff. In Guinea, monthly reports were sent to program staff at the same time as to the ministry of health (MOH). The
MOH of Rwanda provided the Rwanda data. The timing of interventions varied across countries, as did the availability of program data. Where country programs collected data with a lesser level of detail, we have indicated in our results that data are missing.

Secondary analysis of Demographic and Health Survey (DHS) data for prospective unmet need among women in the first year postpartum in the six countries shows high unmet need for family planning during the first year postpartum (Table 1) [19]. “Prospective unmet need” is based on DHS questions about desires for another child within the next two years (asked of postpartum women as of other nonpregnant women), whereas the standard unmet need definition is based on questions about whether a current or recent pregnancy was intended, for those women who are either pregnant or had a birth within the past two years. Total prospective unmet need for spacing and limiting births during the first 12 months after delivery ranged from 60.5% in the Philippines to 81.2% in Ethiopia. Overall, the use of IUDs ranged from a fraction of a percent of married women in Ethiopia, Guinea, and Rwanda to 3.7% of married Filipino women currently using a contraceptive [19]. Currently-married women in Pakistan and India reported IUD use of 1.7% and 2.3%, respectively.

3. PPIUD program elements: Process and variations

Table 2 shows the locations of PPF/PPIUD services in the six countries and the numbers and cadres of providers trained by Jhpiego and MCHIP from 2010–2013. India and the Philippines trained more physicians than nurses and midwives, whereas the other country programs did the opposite. From our experiences in these countries, we have synthesized common steps in the introduction of PPIUDs as part of a PPF program.

### Table 1

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage (%) of women with unmet need for spacing</th>
<th>Percentage (%) of women with unmet need for limiting</th>
<th>Total percentage (%) of women with unmet need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia (2011)</td>
<td>50</td>
<td>31</td>
<td>81</td>
</tr>
<tr>
<td>Guinea (2005)</td>
<td>58</td>
<td>17</td>
<td>74</td>
</tr>
<tr>
<td>India (2005–2006)</td>
<td>33</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>Pakistan (2006–2007)</td>
<td>35</td>
<td>30</td>
<td>65</td>
</tr>
<tr>
<td>Philippines (2008)</td>
<td>24</td>
<td>36</td>
<td>61</td>
</tr>
<tr>
<td>Rwanda (2010)</td>
<td>33</td>
<td>29</td>
<td>62</td>
</tr>
</tbody>
</table>

Abbreviation: DHS, Demographic and Health Survey.

### 3.1. PPIUD service delivery models

Ideally, women would receive PPFP counseling during prenatal care and decide which family planning method to use—a choice that would then be recorded in the prenatal care record and communicated to her provider when she arrives at the facility in early labor. However, if a client has not been counseled before birth, she can still be counseled during latent labor (if she is receptive) or in the immediate postpartum period. Active labor is not considered an appropriate time to provide PPFP counseling. PPIUDs are provided to clients who want them and who do not have exclusion factors, i.e. unresolved postpartum hemorrhage or chorioamnionitis. Every woman’s request for a PPIUD is confirmed immediately prior to insertion.

All six countries have adopted and trained providers on the insertion technique pioneered by Dr Vicente Battaglia Araujo, which focuses on achieving high fundal placement of the IUD. This is accomplished by elongating the cervical-uterine angle, elevating the uterus and the use of a long placental, or “Kelly,” forceps (Fig. 2) [20]. Placement of the IUD high in the fundus minimizes the risk of expulsion [21,22]. Jhpiego has also worked with an anatomic model manufacturer to devise a new uterine model, the “Mama-U,” that simulates the problem of the cervical-uterine angle to practice PPIUD insertion competencies.

### 3.2. Demand creation

Approaches to creating demand for PPIUDs have evolved over time. Initially, demand creation materials, such as counseling pamphlets and posters, were developed for use in both individual and group counseling settings to recruit patients attending prenatal care at facilities where PPIUD services were available. Women who were missed in prenatal care were counseled in early labor or postpartum. In all programs, this facility-based approach alone was enough to maintain a steady level of PPIUD acceptors. The workload associated with PPFP counseling led the India program to develop and hire a new cadre of dedicated counselors for this purpose: social workers assigned to facilities providing PPIUDs. In 2011 and 2012, providers and obstetrics and gynecology faculty successfully advocated to the Government of India to hire these counselors as facility staff. As a result, in 2012, more than 1300 new positions were created for dedicated counselors at high-volume facilities across the country through the National Rural Health Mission. The dedicated counselors are typically stationed adjacent to the prenatal care ward in facilities, and all women who access prenatal care are routed through the counselor. The counselor also performs rounds in the maternity and postnatal wards to counsel women on PPFP.
Over time, strategies to extend demand generation beyond the facility have emerged. Guinea relies on community health workers to spread the word about PPFP services, while Pakistan supplies PPFP leaflets and counseling cards to lady health workers operating at the community level. Indian states now involve community-based, accredited social health activists (ASHAs) in demand generation. Future efforts might involve mass media.

### 3.3. Policy and advocacy

A policy to introduce PPIUDs was common across the six countries, as governments and ministries of health aimed to address unmet need for contraception and reduce the proportion of short birth intervals. In India, the Ministry of Health and Family Welfare launched a national strategy in 2009 to reinvigorate PPIUD use as part of a maternal, newborn, and child health initiative. These revitalization efforts dovetailed with the government-initiated Janani Suraksha Yojna (safe motherhood) scheme, which encouraged childbirth with a skilled birth attendant and has resulted in a more than 15-fold increase in institutional deliveries since 2005 [23]. In Guinea, the Philippines, and Rwanda, national strategies to revitalize family planning emphasized long-acting methods, including PPIUDs. In the Philippines, the Department of Health approved in late 2013 a separate guideline for PPIUD, which includes the PPIUD [24]. Similarly, the Federal Ministry of Health (FMOH) of Ethiopia supported expanding access to services by incorporating Jhpiego’s PPIUD training package into the national training package for family planning. In Pakistan, Jhpiego collaborated with the health and population departments at the subnational level to establish PPFP services at public health facilities.

The decision to initiate a PPFP program that includes PPIUDs involves engagement of international and national experts with relevant ministry officials. The favorable change in WHO medical eligibility criteria for IUDs in the immediate postpartum to category 1 has influenced this decision in many countries [11]. In India, leading voices from reputable universities were instrumental in reviewing the literature on PPIUDs and addressing concerns about expulsion rates. The program strategically introduced PPIUD services in one medical college and expanded them to other states after carefully documenting that the expulsion rate remained low. Experts in Rwanda conducted an operations research study to assess feasibility, and the results were used to inform guidelines for PPIUD insertion. In both Pakistan and Ethiopia, intensive policy engagement focused first on the provincial and regional levels before moving to national scale. In Pakistan, a technical working group with members from the public and private sectors and nongovernmental organizations developed a PPFP strategy and implementation plan. The group held several advocacy meetings and presented the plan at meetings and seminars organized by professional obstetrics and gynecology bodies and a medical university. In Ethiopia, early engagement and advocacy to support initiating PPFP/PPIUD service delivery in select facilities focused on regional health bureaus as gatekeepers for the individual facilities. The FMOH focal person was aware of the proposed PPIUD introduction at the regional level but not the details of the program. At a national family planning symposium in November 2012, an update on the program’s progress attracted national attention and resulted in significant policy support at the federal level. In all countries, the PPFP/PPIUD programs would not have been possible without ministry leadership and ownership.

Engagement with government decision-makers, medical, or academic gatekeepers to advocate regarding the safety and benefits of PPFP/PPIUD services has been a key and ongoing component of the programs. In preparation for initiating PPIUD services, Rwandan stakeholders visited a demonstration program in Kenya [25], while project staff in Pakistan looked for opportunities at professional meetings to marshal interest in and overcome resistance to PPIUDs. All six countries needed continued advocacy after initiation of PPIUD services and have shared their progress along the way, including service data on expulsions and infections, to help address resistance. For example, in the Philippines, the program worked to incorporate PPIUD into new clinical practice guidelines for cesarean delivery and family planning. In India, whenever the program expands to new states, it begins with a state-level workshop for the heads of all district health teams.

*Fig. 2. Illustration of uterine extension during placement of postpartum intrauterine device. Adapted with permission from Jhpiego [20].*
3.4. Site selection and training

Site selection for PPIUD services has focused on facilities with: (1) a high volume of deliveries; (2) interested providers; and (3) adequate staff to integrate PPIUD service delivery into routine care, along with the ability to conduct supportive supervision. Through needs assessments, programs identified sites with high delivery caseloads and gaps in equipment and training. In the Philippines, the program specifically selected “centers of excellence” in 10 geographical areas to serve as model service delivery sites for training, with the intent of increasing sustainability. In Pakistan, the program conducted qualitative formative research with new mothers, husbands, and grandmothers (mothers-in-law) to help craft better counseling messages and educational materials. In Guinea, the program started in six high-volume facilities in the capital city, Conakry. The facilities served as clinical practice sites for medical and midwifery school students. The program then expanded to sites in the interior of the country. In all six programs, instrument kits—containing, in particular, long placental forceps such as Kelly forceps—were distributed when training was initiated. In some countries, such as Ethiopia and Pakistan, infection prevention materials were also provided. In both the Philippines and India, the government has taken over the procurement of instruments at the state level. In India, a country-approved manufacturer produces modified long placental forceps.

All six programs also developed a pool of national trainers who could support program expansion and sustainability. In Ethiopia, Guinea, Pakistan, and Rwanda, training of healthcare providers began with a training event on general PPFP counseling, which targeted providers from the prenatal care, labor and delivery, and postnatal wards and covers all contraceptive options, including LAM. The PPFP counseling event was followed by a course on PPIUD insertion (covering all types of insertion) for labor and delivery staff. During the time between training events (an interval that ranged from two weeks to several months across the programs), clients were counseled on PPFP, including PPIUDs, and PPFP counseling event was followed by a course on PPIUD insertion (covering all types of insertion) for labor and delivery staff. During the time between training events (an interval that ranged from two weeks to several months across the programs), clients were counseled on PPFP, including PPIUDs, and PPFP counseling and LAM use, as well as a separate register for recording PPIUD insertions. The Philippines approved a new version of a family planning form that includes PPIUD, but this form has yet to be widely disseminated. In Guinea, India, Pakistan, and the Philippines, facilities prepare monthly summary reports to share with relevant health authorities. Because only a subset of clients typically return for a postnatal visit, during which a PPIUD can be checked, three programs—India (selected facilities), and the Philippines—monitor use after discharge by having providers call women to ask about complications or expulsions.

Where PPIUD services were still a novelty, failure to communicate facilities staff about the introduction of the services sometimes resulted in instances of nontrained staff influencing clients to reverse their decision about PPIUD. As a result, whole-site orientations for all facility staff members, not just those who attended training, have been conducted in all programs. These orientations have even included cleaning and support staff so all staff would be informed about the service integration and respond accurately to client questions about the availability of PPIUD services.

The timing of the orientations varied across programs. In Guinea, for example, the orientation takes place immediately after training and before the start-up of services; in Pakistan and the Philippines it is held after training as part of onsite mentoring or supportive supervision visits by technical staff. In both Guinea and Ethiopia, participants in the training carry out this orientation as part of their post-training action plan, which is subsequently monitored by program staff in follow-up visits.

3.5. Post-training and ongoing monitoring

Ongoing supportive supervision visits and post-training follow-up visits to support the transfer of learning enable programs to reinforce provider performance, promote quality of services, and troubleshoot issues with service delivery or equipment. The visits enable newly trained providers to reorganize processes in a way that optimizes a consistent supply of instruments and contraceptives in the delivery rooms and initiate PPFP/PPIUD services with help from trainers. Post-training transfer-of-learning visits are conducted in all but the Philippines program. In the Philippines, structured supportive supervision visits, coordinated with government, begin immediately after training to reinforce provider performance, promote quality services, and troubleshoot. The programs in Ethiopia, Guinea, India, Pakistan, and Rwanda also conduct quarterly supportive supervision visits. In some cases, like Guinea, program staff conduct these visits, while elsewhere, like Pakistan, these are conducted jointly with government supervisors. Structured tools are used to support supervision in India, Pakistan, and the Philippines.

Because routine health management information systems (HMIS) are not yet adapted for tracking PPIUDs, as they are for interval IUD insertions and removals, programs have established a variety of supplementary records and data collection tools and systems, including modified or separate registers in prenatal and labor and delivery wards, client cards, or other similar files kept in facilities. The need to capture country-specific data and evidence of the feasibility and safety of PPFP/PPIUD services justified the request for supplemental data reporting. Guinea and the Philippines have included PPFP on their national HMIS forms. The Guinea National HMIS and National Safe Motherhood Program approved a modified labor and delivery register with a column added for PPFP counseling and LAM use, as well as a separate register for recording PPIUD insertions. The Philippines approved a new version of a family planning form that includes PPIUD, but this form has yet to be widely disseminated. In Guinea, India, Pakistan, and the Philippines, facilities prepare monthly summary reports to share with relevant health authorities. Because only a subset of clients typically return for a postnatal visit, during which a PPIUD can be checked, three programs—India (selected facilities), and the Philippines—monitor use after discharge by having providers call women to ask about complications or expulsions.

In Guinea, India, Pakistan, and Rwanda, programs use a special use after discharge by having providers call women to ask about complications or expulsions. In India, a country-approved manufacturer produces modified long placental forceps.

| Table 3 | presents the proportion of eligible women in the six programs who were counseled on PPFP and accepted a method. The Pakistan and Philippines programs counseled more women at prenatal care than at the time of birth. Ideally, all women delivering in facilities would have been counseled at prenatal care and made their choice at that time, but tracking counseling offered in facilities other than that of the birth facility poses a challenge. Percentages of PPIUD acceptors ranged from 2.3% of women counseled in Pakistan to 5.8% in the Philippines. When accounting for all facility births, India had the highest percentage of acceptors, with 6.9% of women who delivered in Jhpiego-assisted facilities electing to have a PPIUD. The India program was the most extensive, reaching more than 99 000 women over the course of about three years (February 2010 to April 2013). Timing of PPIUD insertion varied among countries (Fig. 3), with Pakistan achieving the highest proportion of postpartum IUD insertions (68%) and Rwanda the highest proportion of insertions during cesarean deliveries (43%). Ethiopia had the highest proportion of insertions during the immediate postpartum period (53%) and the lowest percentage during cesarean deliveries (3%). Only three countries systematically track alternative methods of immediate postpartum contraception. LAM uptake is higher than PPIUDs in Ethiopia (8% of facility births) and Guinea (29% of births), whereas documented LAM uptake is roughly equivalent to PPIUD acceptance in Pakistan.

Rates of complications noted during six-week postpartum follow-up visits were collected from facility registers in five of the six country programs (Table 4). Although the proportion of women who returned to the hospital or health center for follow-up varied greatly, data on
counseling for PPFP that includes PPIUDs is key to increasing consistent access. At the same time, emphasizing universal prenatal integration at multiple points and by multiple providers to ensure prenatal, at birth, or in the immediate postpartum period, means integration of counseling at every possible contact with a client, whether in maternity, is a basic minimum for continued service delivery. Integrating the percentage of PPIUD acceptors among women counseled on PPFP, or the proportion of prenatal care clients counseled, although it is difficult to determine individual prenatal care coverage given that clients are expected to have repeat prenatal care visits.

The country programs in India and the Philippines have sought to saturate facilities with trained PPIUD providers, whereas the other programs have struggled with staff turnover. In India, this saturation has enabled widespread institutionalization of the service. In the Philippines, capacitating providers as trainers has helped to ensure that more providers, including residents, are involved in service delivery, and that the program is prepared to expand from the 10 centers of excellence outward, including reaching out to private sector midwives. Post-training support to facilities, either through transfer-of-learning follow-up visits, supportive supervision visits, or other strategies for assistance has been crucial to address quality gaps in the medium term.

Ensuring that all staff in a given facility are aware of and understand the messages around the introduction of PPIUDs has been essential, particularly during expansion to new sites. This review did not detect any implications of the variation in timing in programs’ whole-site orientations, but failing to hold such orientations appears to contribute to low uptake of the service.

Record-keeping systems for monitoring PPIUD services help show where improvement is needed. Transparent sharing of monitoring results allows for continued advocacy for expansion to government

### Table 3

Postpartum family planning counseling and method acceptors by country.

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of facility births</th>
<th>Number of women counseled on PPFP by timing</th>
<th>Number of women accepting PPFP by method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Prenatal care Labor Postpartum Total a</td>
<td>LAM PPITL PPIUD PPIUD as percentage (%) of women counseled PPIUD as percentage (%) of facility births</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>61,164</td>
<td>20,349</td>
<td>18,139</td>
</tr>
<tr>
<td>Guinea</td>
<td>1,450,084</td>
<td>1,387</td>
<td>1,322</td>
</tr>
<tr>
<td>India</td>
<td>1,135,280</td>
<td>9888</td>
<td>9888</td>
</tr>
<tr>
<td>Kenya</td>
<td>1,000,000</td>
<td>926</td>
<td>926</td>
</tr>
<tr>
<td>Pakistan</td>
<td>24,618</td>
<td>19,578</td>
<td>19,578</td>
</tr>
<tr>
<td>Philippines</td>
<td>34,502</td>
<td>14,322</td>
<td>14,322</td>
</tr>
<tr>
<td>Rwanda</td>
<td>1,273,054</td>
<td>33,900</td>
<td>33,900</td>
</tr>
</tbody>
</table>

Abbreviations: LAM, lactational amenorrhea method; PPFP, postpartum family planning; PPIUD, postpartum intrauterine device; PPITL, postpartum tubal ligation.

a It is likely that some women were double-counted in the total number of women counseled on PPFP since women may have been counseled at multiple visits.

b For Guinea, the total number of women counseled is an estimate constructed as a sum of all LAM, PPTL, and PPIUD acceptors (all of whom received counseling). Women who were counseled but did not opt for one of these methods prior to discharge are thus not captured in this total, artificially inflating the percentage of PPIUD acceptors among women counseled on PPFP.
6. Conclusion and recommendations

Women around the world are at risk of unintended pregnancy in the postpartum period and need improved access to effective contraception methods before they resume sexual activity and their fertility returns. Equipping and motivating maternal health providers to offer PPFP/PPIUD counseling in prenatal care and at the time of birth improves access to contraception. For integration of PPFP/PPIUD services to be effective, the target of training and mentoring must be different than it is for traditional family planning programs: the focus must be on prenatal care and maternity staff, those assisting women at the time of birth. In most low-resource contexts, midwives and obstetric nurses are the cadres with the most contact with women during birth. To succeed, PPFP programs require effective counseling in the prenatal period, availability of trained and competent staff at the time of birth, and adequate follow-up of trained providers. IUDs, including PPIUDs, are among the safest and most effective methods of contraception. They offer the additional advantage of being "forgettable" contraception, in the sense that little or no follow-up is required, other than for removal of the device. But ensuring widespread access to this convenient and cost-effective method requires greater acceptance and uptake among maternal healthcare teams in clinical settings and the larger maternal health community. Data and evidence on acceptability, feasibility, and complication rates of PPIUDs can play a part in ongoing advocacy for expanding access to this underutilized PPIUD method.

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Conflict of interest

The authors have no conflicts of interest to declare.

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