



TECHNICAL BRIEF **FEBRUARY 2015**

ENABLING THE HEALTHY SPACING AND LIMITING OF PREGNANCIES: PROGRAMMATIC APPROACHES TO EXPAND POSTPARTUM IUD ACCESS



USAID
FROM THE AMERICAN PEOPLE

ACRONYMS

| | |
|---------------|--|
| ANC | ANTENATAL CARE |
| ASF | ASSOCIATION FOR FAMILY HEALTH |
| CHW | COMMUNITY HEALTH WORKER |
| DHS | DEMOGRAPHIC AND HEALTH SURVEY |
| DRC | DEMOCRATIC REPUBLIC OF CONGO |
| FP | FAMILY PLANNING |
| FP2020 | FAMILY PLANNING 2020 |
| IPPF | INTERNATIONAL PLANNED PARENTHOOD FEDERATION |
| IUD | INTRAUTERINE DEVICE |
| LAM | LACTATIONAL AMENORRHEA METHOD |
| LARC | LONG-ACTING REVERSIBLE CONTRACEPTION |
| MCHIP | MATERNAL AND CHILD HEALTH INTEGRATED PROGRAM |
| MCPR | MODERN CONTRACEPTIVE PREVALENCE RATE |
| MOH | MINISTRY OF HEALTH |
| MSI | MARIE STOPES INTERNATIONAL |
| PPFP | POSTPARTUM FAMILY PLANNING |
| PPIUD | POSTPARTUM IUD |
| PSI | POPULATION SERVICES INTERNATIONAL |
| SPIRES | STANFORD PROGRAM FOR INTERNATIONAL REPRODUCTIVE EDUCATION AND SERVICES |
| SFH | SOCIETY FOR FAMILY HEALTH |
| SRH | SEXUAL AND REPRODUCTIVE HEALTH |
| SIFPO | SUPPORT FOR INTERNATIONAL FAMILY PLANNING ORGANIZATIONS |
| USAID | UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT |
| WHO | WORLD HEALTH ORGANIZATION |

RATIONALE FOR POSTPARTUM FAMILY PLANNING (PPFP)

When a pregnancy comes less than 18 months after the birth of a sibling, mothers and children alike face significantly increased risks of adverse health outcomes, including maternal morbidity, low birth weight, small size for gestational age, pre-term delivery, and infant mortality.^{1,2} Very short intervals are particularly dangerous: infants conceived within 9 months of a sibling's birth are twice as likely to die as those conceived after an interval of at least 27 months.³ Experts estimate that if all couples in developing countries spaced their pregnancies by 24 months or more, maternal deaths around the world would decline by 32% and childhood deaths by nearly 10%.⁴

In developing countries, more than 220 million women—15% of all women of reproductive age—have an unmet need for contraception, meaning they want to prevent pregnancy, but are not using a modern contraceptive method.⁵ The level of unmet need is even higher among women in the postpartum period (up to 12 months following a birth). An analysis of Demographic and Health Survey (DHS) data from 27 countries showed that 65% of postpartum women had prospective⁶ unmet need for contraception. Only 5% of postpartum women wanted to have another child within two years. Nearly 40% of postpartum women expressed an intention to use a contraceptive method within the next year, but had not done so yet.⁷ Through the global Family Planning 2020 (FP2020) partnership, governments, donors, and partners aim to enable 120 million more women and girls to use modern contraception by 2020 if they so choose.⁸ Given the exceptionally high unmet need for contraception among postpartum women, scaling up access to PPFP could make a major contribution toward FP2020 goals and enable millions more women and couples to fulfill their reproductive intentions.

To address high levels of unmet need among postpartum women, a number of organizations provide technical assistance to public and private sector healthcare providers to integrate family planning (FP) counseling and services into maternal, infant, and child health services. This technical brief focuses on approaches taken by Population Services International (PSI), the Stanford Program for International Reproductive Education and Services (SPIRES), Jhpiego, Marie Stopes International (MSI), the International Planned Parenthood Federation (IPPF), EngenderHealth, and other organizations for increasing the accessibility and acceptability of the postpartum intrauterine device (PPIUD) within the context of informed choice.

CONTRACEPTIVE OPTIONS IN THE POSTPARTUM PERIOD

The range of modern methods that can be safely used in the immediate postpartum period is more restricted than those that can be used at other times. According to the current World Health Organization (WHO) Medical Eligibility Criteria as of 2014:⁹

- Immediately after a birth and for up to 6 months following it, the **lactational amenorrhea method (LAM)** can protect women who breastfeed exclusively and are amenorrheic.
- A **copper-bearing IUD** can be inserted immediately or up to 48 hours after birth, or any time after 4 weeks postpartum.
- **Female sterilization** can be performed immediately or up to 4 days after birth, or any time after 6 weeks postpartum.
- At any time, a woman's male partner can opt for a **vasectomy**.
- **Male or female condoms/spermicides** can be used at any time.
- Whether breastfeeding or not, women can use **emergency contraception** after 4 weeks following a birth and the **diaphragm or cervical cap** after 6 weeks.
- For *breastfeeding women*, all progestogen-only methods (**progestogen-only pills, injections, implants**) can be initiated at 6 weeks following birth.¹⁰ **Combined oral contraceptives** cannot be initiated until 6 months after birth.
- For non-breastfeeding women, **progestogen-only methods** can be initiated immediately following birth. **Combined oral contraceptives** can be initiated at 3 weeks after birth.¹¹

Women who are offered contraceptive methods, including LAM, in the immediate postpartum period are more likely to be using an FP method at 6 months postpartum, when LAM is no longer effective.¹² Studies have shown that rates of postpartum contraceptive use increase with each additional method offered.¹³ Offering a wide range of methods increases the likelihood that one will meet a woman's particular needs. PPIUD services afford women the option of a highly effective, long-acting reversible contraceptive before being discharged from a health facility following childbirth.

The convenient timing of PPIUD services is increasingly important in developing countries as more women are accessing both antenatal and childbirth care with a skilled provider.

ADVANTAGES OF IUDS

- Highly effective, low-cost FP method
 - » Less than 1 pregnancy per 100 women using an IUD during the first year
- High rate of user satisfaction and low rate of complications
- Long-acting, lasting up to 12 years if desired
- Reversible at any time with an immediate return to fertility
- Safe for women living with HIV
- Easy to maintain, requiring no routine action by the client

ADDITIONAL ADVANTAGES OF PPIUDS

- Doesn't interfere with breastfeeding; safe to use immediately postpartum
- Temporary IUD side effects may be less noticeable immediately postpartum:
 - » Cramps associated with insertion may be masked by cramps experienced as the uterus contracts to its pre-pregnancy size
 - » Post-partum amenorrhea, especially among breastfeeding women, means that women may not experience the longer, heavier menstrual bleeding associated with the first few months of using the copper IUD
- Convenient, cost-effective timing for client and provider; can be inserted during same visit to facility for childbirth; insertion involves fewer instruments and less staff time than for interval insertions¹⁴
- No risk of inserting IUD with client who may be pregnant

LIMITATIONS AND RISKS OF IUDS

- For all users: Client cannot discontinue IUD use on her own; the IUD must be removed by a trained provider
- Common: menstrual changes such as heavier bleeding, especially in first 3 to 6 months
 - » May be less noticeable to women immediately postpartum
- Rare: If chlamydia or gonorrhea is present at the time of insertion, pelvic inflammatory disease may occur
- Rare: Perforation of the wall of the uterus during insertion, which usually heals without treatment
 - » PPIUD insertion appears to have a lower rate of uterine perforation¹⁵



OPTIONS FOR TIMING OF COPPER IUD INSERTION¹⁶

| TIME OF IUD INSERTION | DEFINITION | OBSERVATIONS |
|---|---|-----------------|
| Intracesarean | During a cesarean section just prior to closing uterus | Safe |
| Postplacental/Delivery Room | After placental expulsion and before patient leaves delivery room | Safe |
| Immediate Postpartum/Morning After Delivery | After patient leaves delivery room, but before leaving facility (within 48 hours) | Safe |
| Late Postpartum | Between 48 hours and 4 weeks following delivery | NOT RECOMMENDED |
| Interval (not considered PPIUD) | Any time other than within 4 weeks following delivery | Safe |

NEW DEDICATED PPIUD INSERTER

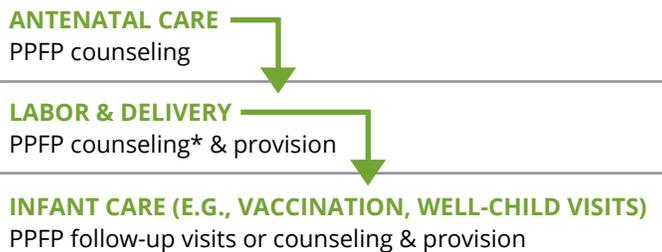
Although PPIUD insertion offers more benefits to clients and providers than interval insertion, it also comes with certain challenges due to the shape and size of the uterus postpartum:

- Conventional IUD inserters are not long enough to reach the postpartum uterine fundus. Currently, providers use forceps, which requires removing the IUD from the inserter sleeve, placing it at the tip of the forceps, and then inserting into the uterus.
- The string in conventional copper IUDs is too short to be visible after PPIUD insertion (visibility ensures that the IUD is in place).

PSI partnered with SPIRES and Pregna International Ltd., to create a low-cost inserter designed specifically for PPIUD insertion. The dedicated PPIUD inserter addresses the particular insertion challenges during the immediate postpartum period, including:

- Eliminates the need to use forceps for insertion, making the PPIUD insertion technique easier and similar to interval insertion.
- Has a firm consistency, but bends to accommodate the shape of the postpartum uterus.
- Has a longer string that is visible after PPIUD insertion
- Could improve provider acceptance of offering PPIUD services.¹⁷

CRITICAL INTEGRATION POINTS FOR PPFPP SERVICES



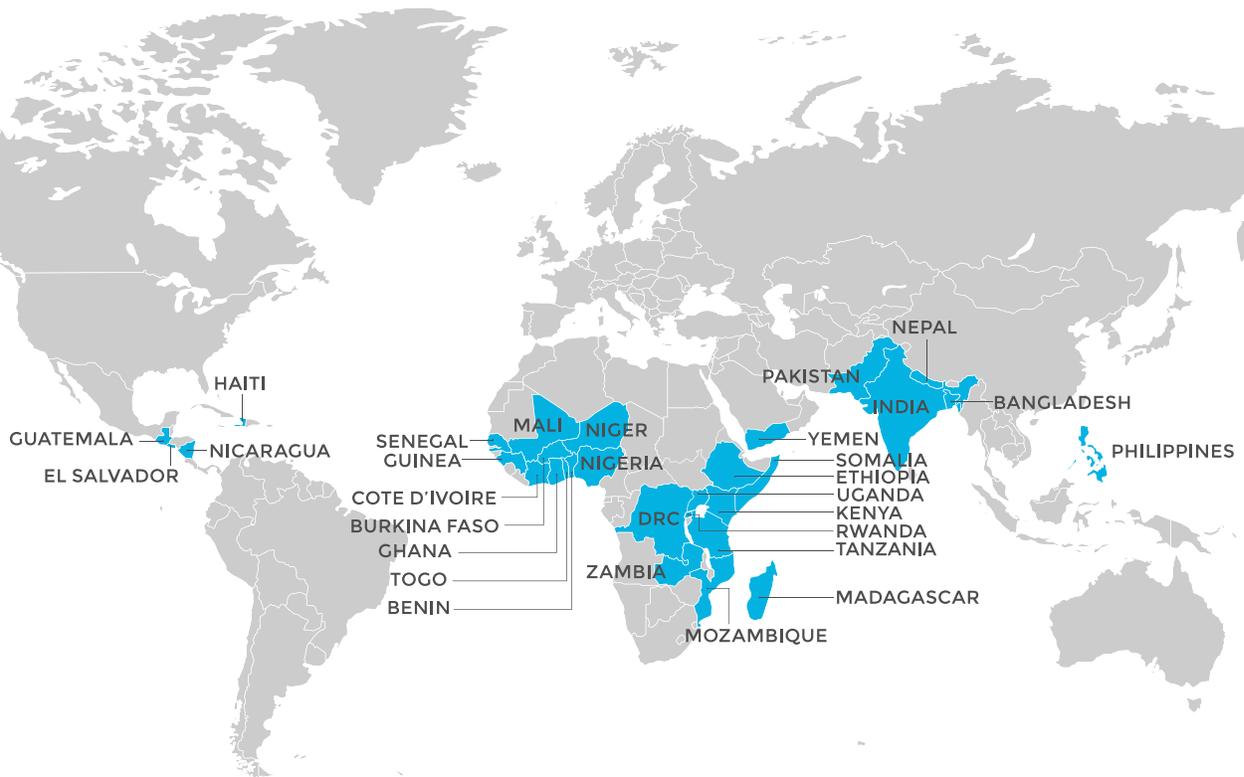
* PPFPP counseling takes place during ANC, in early labor if the client is in a facility and within 48 hours following childbirth, but NEVER during active labor. Whatever the timing, the client must be able to make an informed and voluntary choice.



EXPANDING PPIUD ACCESS

Many postpartum women lack accurate information and access to PPF methods, including the PPIUD. Although the PPIUD is widely used in countries as populous and diverse as China, Mexico, and Egypt,¹⁸ only a small fraction (2.9%) of women in Sub-Saharan Africa use the IUD, whether or not it is inserted postpartum.¹⁹ Seven organizations—PSI, SPIRES, Jhpiego, MSI, IPPF, EngenderHealth, and Save the Children—have built capacity for PPIUD services. Services are currently available in 30 low- and middle-income countries in Africa, Asia, and Latin America, expanding the range of options available to postpartum women. The map below shows which countries received technical assistance from these organizations to introduce the PPIUD as of 2014.

30 COUNTRIES WITH PPIUD SERVICES



COMPONENTS OF SUCCESSFUL INITIATIVES TO ADD PPIUD TO THE RANGE OF PFPF OPTIONS

Through programmatic experience, PSI, SPIRES, Jhpiego, and other organizations have identified the following program components as critical to the success of PFPF programs that include PPIUD. *PPIUD should always be offered in the context of informed choice alongside other PFPF options.*

| PROGRAM COMPONENT | DESCRIPTION |
|---|--|
| Engaging Stakeholders & Conducting Advocacy | <p>As a first step, create an enabling environment for PPIUD services within a PFPF program that includes a variety of methods:</p> <ul style="list-style-type: none"> • Identify and engage stakeholders and champions from the national to the community level • Integrate PPIUD into the agenda of existing maternal health and FP stakeholders, technical working groups, and donor strategies • Generate and share data on program success to garner support from influential partners <ul style="list-style-type: none"> » Where local data on PPIUDs is not yet available, use international data from the same region to demonstrate the safety, feasibility, and acceptability of PPIUD services |
| Strategic Site Selection for Pilot and Scale-Up | <p>To demonstrate feasibility and improve programs, pilot PPIUD services in health facilities with:</p> <ul style="list-style-type: none"> • A high volume of deliveries that enables a sufficient client flow for providers to maintain their skills • Adequate infrastructure: sufficient staff, equipment, supplies, and commodities • Leadership (site administrators) supportive of and receptive to PPIUD programming <p>Once the pilot demonstrates success, introduce PPIUD services at other facilities that meet the site selection criteria.</p> |
| Training, Motivating, and Supervising Providers | <p>Training model:</p> <ul style="list-style-type: none"> • Builds providers' competency in counseling and informed choice as well as in PPIUD insertion and removal • Depending on client flow, not all trainees may be able to achieve and demonstrate competency by the end of one group training. Trainers should give preference to a subset of trainees who can coach their peers on the job post-training, until those peers achieve certification. <p>Trainee selection:</p> <ul style="list-style-type: none"> • Seek trainees who will have the opportunity to use their PPIUD skills immediately and repeatedly after the training (e.g., dedicated LARC providers or those who work in the labor & delivery unit) • Seek trainees with strong interpersonal skills, FP experience, and commitment to offering long-acting reversible contraception <p>Address provider attitudes:</p> <ul style="list-style-type: none"> • Trainers and supervisors identify provider biases and tailor messages accordingly <p>Conduct ongoing post-training follow-up, including routine supportive supervision and hands-on mentorship in the field to emphasize quality assurance:</p> <ul style="list-style-type: none"> • When PPIUD services are introduced, follow up with providers within two weeks of training and again at 6 weeks • Incorporate the country's Ministry of Health (MoH) to build their capacity to continue supervision visits |

Whole Site Orientation

At each site, conduct an orientation to PFP, including PPIUD services, for all site staff, including administrators, providers in the FP, ANC, and labor & delivery units, and all support staff (e.g., receptionist, security guards, cleaning staff, etc.). The orientation should:

- Be offered at **multiple times** to reach staff working various shifts
- Be offered in partnership with **site leadership** to demonstrate their support
- Be **tailored** to different cadres of workers in the facilities
- Provide **orientation details** for non-technical staff on: (1) What is the PPIUD?, (2) What are the advantages and disadvantages?, (3) When can it be inserted?, (4) Who will provide the service?, and (5) Where will information be available?
- Provide **advanced information and clinical skills** for service providers who work in the labor and delivery unit or the dedicated long-acting reversible contraception (LARC) providers
- Address staff members' **questions and concerns**, dispelling misconceptions about the PPIUD

Client Counseling & Communication

At health facilities, **integrate PFP counseling** into the antenatal, labor, and postnatal wards. In the community, raise awareness of PFP services, including the PPIUD, through **personalized, interactive communication channels**, such as interpersonal communication by outreach workers to:

- Address the **low perceived need** for PFP
- Provide advice on **health benefits** to mother and infant when pregnancy is prevented for at least 2 years
- Constructively engage **male partners** in ANC, PFP, and FP more broadly
- Present the range of available PFP options and emphasize **voluntary and informed choice**
- Address **common misconceptions** and **share the benefits** of PPIUDs and other PFP options
- Include discussions with **satisfied PPIUD clients**
- Offer **clear instructions on how/where/when** to access PPIUDs and other PFP options
- Use **language that resonates** with clients

For clients who desire a permanent method of contraception (female or male sterilization) to limit future births, make **referrals** to facilities where these are available. In some cases, providers who offer the PPIUD also offer permanent methods following childbirth.

Linking Services

- For PPIUD services to work, communication and collaboration between the ANC, labor & delivery, and FP teams is critical. To facilitate this communication, use **mechanisms for PPIUD referrals**, such as a sticker or stamp on client ANC cards that indicate which PFP method the client selected.
- Ensure that **follow-up visits** are convenient for women. For example, integrating into other maternal and child health visits (e.g., postnatal and immunization visits, etc.).

Recordkeeping for Monitoring & Evaluation

To effectively monitor programs, disaggregate data on PPIUD use from its broader data on IUD use. Doing this requires:

- Establishing **simple mechanisms to enter and track data**
- Collecting **qualitative and quantitative data** on PPIUD service delivery
- **Training facility staff** on data collection and **emphasizing the importance of high-quality data** with disaggregation of PPIUD and interval IUD insertions, time of counseling, type of PPIUD, and any complications inclusive of request for early removal

PROGRAMMATIC APPROACHES TO SCALE UP OF PPIUD ACCESS

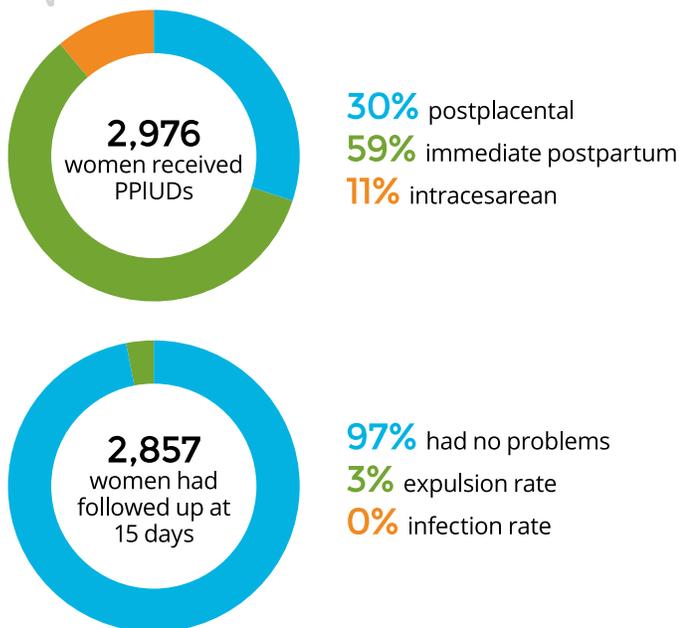
The country examples below illustrate approaches to PPIUD scale up that deliver PPIUDs through different types of healthcare providers:

1. Public sector providers
2. Dedicated LARC providers seconded to the public sector
3. Private sector providers

Case Study: Public Sector PPIUD Providers in the Democratic Republic of Congo (DRC)

In the DRC, 26% of births take place less than 24 months after a preceding birth, even though only 8% of women in the first year postpartum desire another birth within two years. During 6 to 12 months after a birth when LAM is no longer effective, when most postpartum Congolese women have returned to sexual activity, only 1 in 10 uses a modern method of FP. In the first year postpartum, two thirds of Congolese women have an unmet need for contraception. The great majority with an unmet need would like to space, rather than limit births, signaling the need for better access to reversible PPF methods like the PPIUD.²⁰ As part of the global partnership FP2020, the Government of the DRC aims to enable 1.4 million more women and girls in the DRC to use modern contraception if they choose, which would increase the modern contraceptive prevalence rate (MCPR) among those who are married or in union from 5.4% in 2010 to 19% by 2020.²¹

DRC PPIUD INSERTIONS AND FINDINGS
DECEMBER 2012 - MARCH 2014



To expand contraceptive choice, PSI's network member Association de Santé Familiale (ASF) introduced PPIUD services in five public sector clinics in Kinshasa beginning in December 2012. In partnership, the MoH and ASF selected pilot clinics that had:

- At least 100 deliveries per month
- Providers motivated to add PPIUD services
- An FP unit where clients could return for follow-up visits

ASF trained 10 trainers from the National Reproductive Health Program, the Congolese Ob/Gyn society, the Association of Delivery Nurses, ASF, and 15 public sector providers. A partner NGO led a separate training for other providers at the five pilot sites, helping to augment PPIUD service delivery during the pilot phase. In 2013, the National Reproductive Health Program integrated PPIUD approaches, including insertion techniques, into training modules for FP providers across the country. In 2014, ASF introduced PPIUD services in a second province.

In clinics and communities, trained CHWs now conduct information sessions on the range of available contraceptive options. During the third trimester of pregnancy, birth attendants provide balanced PPF counseling. Regular supportive supervision of PPIUD providers has helped reinforce their skills and positive attitudes about PPIUD. Another essential element of the program has been to ensure that labor and delivery wards are stocked and equipped at all times to offer PPIUD. At the participating clinics, PPIUDs are offered to clients for free or at subsidized prices.

ASF's experience in the DRC highlights the importance of gaining support for PPIUD from key influencers—from national-level decision-makers to all staff at health facilities to the male partners of postpartum women.

- National ownership of the program and buy-in from MoH technical staff were critical to institutionalizing PPIUD training for service providers. Before initiating PPIUD services, ASF invited MoH officials on a study tour to Zambia to learn about their PPIUD efforts (see below). The study tour demonstrated that PPIUD services could be replicated in similar settings.
- A remaining challenge is that the DRC's national health information system does not yet disaggregate PPIUD statistics from general IUD data. Doing so would help the MoH use data for decision-making about PPIUD service delivery.
- Education and balanced counseling during ANC and in the postpartum ward increased client demand for PPIUD services in the context of informed choice. Initially, mistrust of PPIUD among a subset of staff in pilot clinics impacted some women's opinions about PPIUD. ASF addressed this mistrust through whole site orientations and on-going sensitization of clinic staff.
- To facilitate continuity of care, ASF found that close collaboration was needed between providers inserting PPIUDs and those providing follow-up in FP units. Effective post

insertion counseling increased the likelihood that women would return for a 15-day follow-up visit. ASF only selected sites that could offer follow-up, including IUD removal, and trained providers in IUD removal techniques as well as in PPIUD insertion.

- Additional sensitization of male partners is needed to overcome issues such as spousal refusal, which prevents some women who chose a postpartum IUD from receiving one. ASF is working to reach men with messages about the benefits of FP services, including the IUD and PPIUD. Male CHWs hold informational discussions with men in locations where they typically gather, such as soccer stadiums and workplaces.

Case Study: Public Sector PPIUD Providers in Guinea

In Guinea’s FP2020 commitment, the country set a goal of tripling the modern CPR among all women of reproductive age from 7% in 2013 to 22% in 2018.²² Among married women, modern CPR is even lower at just 4.6%, virtually unchanged since 1999. Only a quarter of all women have ever heard of the IUD and 0.2% of married women use it. One in four married women (24%) has an unmet need for FP—17% for spacing and 7% for limiting. For every 100,000 children born, 724 women die in pregnancy or childbirth. One in every 8 children born dies before his or her fifth birthday.²³

Through the Maternal and Child Health Integration Program (MCHIP), Jhpiego supported the MoH of Guinea to implement PPFPP programs inclusive of PPIUDs in the public sector. MCHIP trained 293 providers in PPFPP counseling, including providers working in ANC, maternity, child health, vaccination, and nutrition services. Among the 293, 85 providers working in 32 health

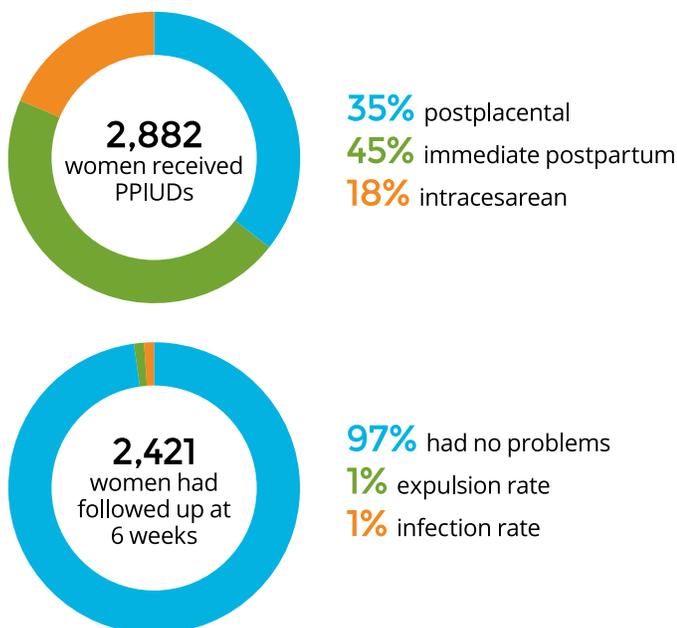
facilities also received clinical training in PPIUD insertion and removal. In addition to offering training, MCHIP provided PPIUD instruments and supplemental registers for monitoring service delivery. A wide variety of counselors, including CHWs, provided women with PPFPP messages. Since provider time is saved when an IUD is placed postpartum rather than at another time, the cost of the IUD was waived for women who received the method during a childbirth visit.

Initially, MCHIP trained and equipped providers from 6 health facilities in Conakry. Once PPIUD services were established at these sites, the program scaled up services to 3 of the 6 regions of the country, in addition to Conakry. From April 2011 to September 2013, 88% of women who gave birth at participating facilities were counseled on PPFPP and 4% (2,882 women) opted for and received the PPIUD.



Example of PPFPP stamp from Guinea.

GUINEA PPIUD INSERTIONS AND FINDINGS APRIL 2011 - SEPTEMBER 2013



MCHIP’s experience in Guinea demonstrates the importance of proactive steps to ensure continuity of care for PPIUD clients:

- Adding the PPIUD to the method mix required reorganizing services and establishing new communication mechanisms to link the ANC, labor & delivery, and FP units. For example, ANC providers need to communicate the client’s method choice to labor & delivery staff, who verify it with the client before placing a PPIUD. Furthermore, FP supplies need to be pre-positioned in labor and delivery. To enable this intra-facility coordination, the program:
 - » Identified a strong PPIUD champion in each facility to identify and address gaps and resistance by providers or staff
 - » Developed a PPFPP counseling stamp on the client card and held regular PPFPP coordination meetings to facilitate communication between units of care
 - » Trained staff from different shift rotations, including on-call night delivery staff
 - » Integrated standards for PPIUD service delivery into the existing Standards-Based Management and Recognition quality improvement program

» Conducted regular supportive supervision visits

- Providers called PPIUD clients who missed their six-week follow-up appointments. Following up with clients by phone serves two important purposes: it improves continuation rates by giving women an opportunity to discuss side effects and concerns with a provider; and it enhances the program's ability to track and address possible complications. In addition, during these calls, providers asked clients for permission to receive a call, whether the number belonged to a friend or relative, and if so, was the person aware of her method choice.

Case Study: Dedicated LARC Providers Seconded to Public Sector in Zambia

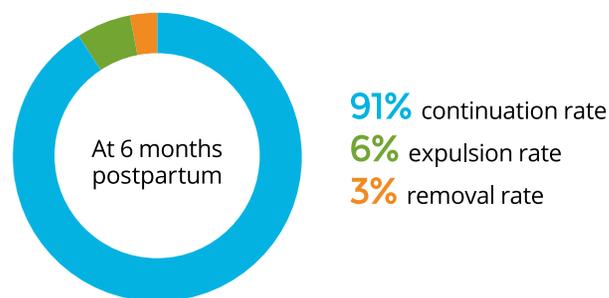
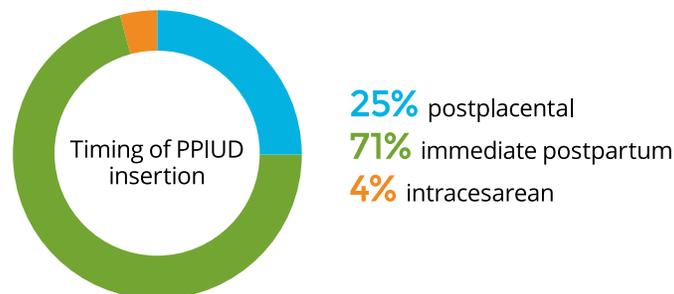
The Government of Zambia made an FP2020 pledge to increase the MCPR from 33% in 2007 to 58% by 2020. Reaching this goal would allow Zambia to avert 3.5 million unintended pregnancies, more than 100,000 child deaths, and nearly 10,000 maternal deaths.²⁴ Zambia has made great progress toward its FP2020 goal. By 2013-2014, the MCPR among married women had reached 45%—a five-fold increase over the MCPR of 9% in 1992.²⁵ As of 2007, more than a quarter of married women (27%) had an unmet need (17% for spacing, 9% for limiting). Use of the most effective methods (long-acting reversible contraception and permanent methods) had slightly declined from 1992 to 2007.²⁶ However, between the last two Demographic and Health Surveys, Zambia experienced an increase in IUD use of more than 10 times among married women, from 0.1% in 2007 to 1.2% in 2013-2014.²⁷

PPIUD services were not available in Zambia until 2009, when PSI's network member, Society for Family Health (SFH), and the Zambian MoH introduced the PPIUD into the range of contraceptives offered in the public sector. SFH developed partnerships in 26 high-volume clinics (at least 10 deliveries per day) in Copperbelt, Eastern, and Lusaka provinces. SFH sensitized clients and staff in antenatal and labor and delivery units on the PPIUD and other FP methods. In the public sector, all FP methods are offered at no cost to clients.

SFH uses a dedicated provider model to make PPIUD services available in Zambia. In addition to offering FP counseling and services, maternal health providers have a wide range of responsibilities, including deliveries and treatment of HIV/AIDS. In a country where 14% of adults have HIV,²⁸ providers are often too busy to offer a full range of contraceptive methods, especially LARC methods, which take more time than short-acting methods. To fill this gap, SFH identified, trained, supervised, and employed nurse-midwives who demonstrated enthusiasm and commitment to offering LARC methods, including the PPIUD, interval IUD, and implants as part of a full range of methods. SFH seconded these dedicated providers to public sector facilities to expand the range of contraceptive methods and hours of service availability. SFH conducts supportive supervision visits to ensure competency and

ZAMBIA PPIUD INSERTIONS FEBRUARY 2009 - MAY 2014
5,207 women received PPIUDs

ZAMBIA ASSESSMENT OF PPIUD SAFETY AND ACCEPTABILITY, 2009-2010
n = 305 PPIUD clients



94% were satisfied with PPIUD
98% were satisfied with counseling

confidence among the dedicated LARC providers. Lessons from Zambia include:

- ANC visits are an opportune time to begin PPF counseling. In a study of 305 PPIUD clients, SFH found that 66% first received counseling that included the PPIUD during ANC. An additional 26% first received counseling during the beginning of labor or in the immediate postpartum period, in part because some women do not come in for ANC or receive it at a small clinic closer to home. The need for accurate information on PPIUD side effects and benefits may be particularly high in countries like Zambia that have very low rates of interval IUD use.
- Providers new to PPIUD services require intensive training, mentoring, coaching, and supervision over an extended period. To increase opportunities for supervised practice with clients, it helps to send small groups of trainees with trainers to multiple practical sites near the training site. SFH started by training 9 nurse-midwives to demonstrate the feasibility of PPIUD services and to establish practical sites before conducting a training of trainers. The dedicated provider model allowed SFH to focus attention on supporting highly motivated providers to become experts in PPIUD insertion and, in turn, to help mentor their colleagues.
- When piloting PPIUD services, it is important to select sites with a sufficiently high volume of PPIUD clients for providers

to maintain their skills. When possible, it is best to select pilot facilities that have a high volume of uncomplicated deliveries and that serve the same women for antenatal, delivery, and postnatal/child health services.

Case Study: Private Sector PPIUD Providers in Pakistan

In Pakistan, MCPR among married women rose from 9% in 1990-1991 to 26% in 2012-2013. However, one in five married women still lacks access to the FP services she desires, and 9% report unmet need for birth spacing and 11% for birth limiting.²⁹ The Government of Pakistan made an FP2020 commitment to achieve universal access to reproductive health services and raise the MCPR to 55% by 2020.³⁰ Use of ANC and delivery services has increased rapidly since 2006-2007, providing an opportunity for PPFP services to meet Pakistani women's unmet need for FP. The percentage of deliveries that take place at a health facility grew from 34% in 2006-2007 to 48% in 2012-2013, with 71% of facility-based deliveries taking place in the private sector.³¹

Greenstar Social Marketing, PSI's network member in Pakistan, recognized the tremendous potential of the private health sector to address unmet need among postpartum women. In 2011, Greenstar launched a program to introduce the PPIUD to the range of PPFP methods offered at private maternities. Working with the Society of Gynecologists and Obstetricians of Pakistan, Greenstar trained 221 Ob/Gyns and Lady Health Visitors (female health professionals) to offer the PPIUD. These providers work in 206 private sector maternity homes. By December 2013, the Greenstar-trained providers had already provided PPIUDs to 15,935 women who chose it.

Greenstar encountered and overcame significant initial challenges related to both provider and client fears and misconceptions about the method. PPIUD services gained traction as a method of choice for many postpartum women only during the last quarter of 2012, more than a year and a half after Greenstar first trained providers. At first, providers and clients feared that the PPIUD would cause infections, bleeding, or worse. Providers and clients alike did not see a need for contraception so soon after delivery, assuming that postpartum women could not become pregnant until their menses returned. To address these challenges, Greenstar undertook a strategy of provider behavior change communication, advocacy, and technical capacity building in partnership with the Society of Gynecologists and Obstetricians of Pakistan. The strategy included:

- Recognizing the influence of opinion leaders in the medical field, Greenstar arranged seminars in which leading Ob/Gyns deliver PPIUD presentations to providers. The presentations emphasized the importance of addressing unmet need in Pakistan, the benefits of birth spacing, and the importance of integrating PPFP counseling with antenatal services.
- Greenstar published a quarterly newsletter, PPIUCD Alert, to provide technical updates, highlight success stories from

satisfied clients, and deliver encouraging messages from key opinion leaders.

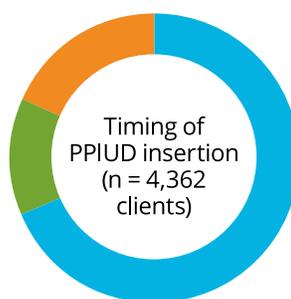
- Greenstar designed educational materials for providers and clients to address common myths and misconceptions about the PPIUD and to promote accurate information on the method as one of a wide range of contraceptive options
- To further address provider and client concerns, Greenstar hired PPFP counselors to rotate between clinics every week and to counsel ANC clients on their PPFP options, including the PPIUD as part of a range of contraceptive choices. The trained educators are well-prepared to answer client questions.

To ensure continuity between ANC counseling and PPFP provision, the counselors stamped the files of ANC clients requesting a PPIUD. These stamps served as visual reminders for labor and delivery providers, who then reaffirmed the client's choice and provided the service at the time of delivery.

PAKISTAN PPIUD INSERTIONS MARCH 2011 - DECEMBER 2013

15,935 women received PPIUDs

PAKISTAN FINDINGS APRIL 2013 - DECEMBER 2013



2% expulsion rate (n = 7,133 clients)

Case Study: Regional Meetings in East and West Africa

PSI, through USAID's SIFPO project, and Jhpiego, through MCHIP, convened regional meetings in East and West Africa to advance the integration of PPFP and PPIUD services into maternal health services. A meeting for English speakers took place in Zambia in April 2013,³² and a meeting for French speakers took place in Burkina Faso in February 2014.³³ Meeting attendees included staff from MoHs, professional associations, health facilities, global agencies, international organizations, and donor agencies. A total of 107 participants from 21 countries engaged in country presentations, demonstration sessions, site visits, small-group knowledge exchanges, self-assessments of the state of PPIUD scale-up, and action planning. Following the meetings, participants took steps to scale up and improve PPIUD services in their countries, including meetings between international organizations and MoHs and through provider trainings.

LESSONS LEARNED

Postpartum women in developing countries have an exceptionally high unmet need for FP and face grave health risks if they become pregnant soon after delivery. Addressing their needs will be critical for the FP2020 to reach its goals and enable women and couples to fulfill their reproductive intentions. The PPIUD is one of only a few contraceptive methods that can be safely used immediately following a delivery, yet is unavailable in many parts of the world.

In Africa, Central America, and South Asia, numerous national and international organizations have worked with governments to introduce the PPIUD into the postpartum method mix. While approaches to PPIUD service delivery have varied based on challenges and opportunities unique to each setting, common lessons have emerged across countries. These lessons highlight how PPIUD service delivery differs from delivery of other FP services:

1. PPIUD services can be more complex than other contraceptive services because they require close collaboration between providers in ANC, labor and delivery, and FP units who see the client at different points in time. Communication between units can be improved by whole site trainings, stamps on client files, and dedicated providers or counselors.
2. The effective introduction of PPIUD services looks different from the introduction of other services for a number of reasons. Not all facilities offering FP perform deliveries and have a high enough volume of uncomplicated deliveries to allow PPIUD providers to maintain their skills. Furthermore, providers need more intensive coaching and supervision to offer the PPIUD than many other methods. Thus, whether for a pilot project or initial scale-up, it is important to select sites carefully to ensure that time and resources are well spent.
3. As a new service, PPIUD was initially met with skepticism by some government officials, providers, clients, and clients' partners based on outdated information about the method. It is important to understand and address provider misconceptions. With newer approaches that ensure reaching the fundus of the postpartum uterus, the reported expulsion rates are much lower than in earlier studies. Using country-specific data has increased acceptance. Programs have succeeded by leveraging the influence of champions, ranging from the MoH officials who participated in the study tour from DRC to Zambia and attended regional PPIUD meetings, to the leading ob/gyns who delivered PPIUD seminars in Pakistan, to the PPIUD clients in many countries who continue to share their positive experiences with peers, providers, and policy-makers.

Through FP2020, governments, organizations, donors, and the private sector will continue to change the landscape of contraceptive options for women and girls, including postpartum women. As they do so, sharing lessons will remain key to ensuring that their efforts are effective.



- 1 World Health Organization (WHO). 2006. Report of a WHO Technical Consultation on Birth Spacing. Geneva, Switzerland. Available at: http://www.who.int/maternal_child_adolescent/documents/birth_spacing.pdf?ua=1
- 2 Cleland, J., Conde-Agudelo, A., Peterson, H., Ross, J., Tsui, A. 2012. "Contraception and health," *Lancet*, 380: 149-56.
- 3 Fotso JC, Cleland J, Mberu C. 2012. Birth spacing and child mortality: an analysis of prospective data from the Nairobi Urban Health and Demographic Surveillance System. *J. Biosoc. Sci.*, 45, 779-798, 6, Cambridge University Press.
- 4 Cleland, J, Bernstein, S, Ezeh, A, Faundes, A, Glasier, A, Innis, J. 2006. "Family planning: the unfinished agenda," *Lancet*, 386(9549):1810-27.
- 5 Singh, S & Darroch, JE. 2012. Adding It Up: Costs and Benefits of Contraceptive Services: Estimates for 2012. Available at: <http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf>
- 6 Prospective unmet need is based on the desire of postpartum to have another birth within two years, rather than on whether their last birth was wanted.
- 7 Ross JA, Winfrey WL. "Contraceptive use, intention to use and unmet need during the extended postpartum period," *International Family Planning Perspectives*. 2001. 27(1):20-27.
- 8 Family Planning 2020. 2015. About FP2020: What is Family Planning 2020? Available at: <http://www.familyplanning2020.org/about-us/about-us>
- 9 World Health Organization. Medical eligibility criteria for contraceptive use. Fourth edition, 2009. Available at: http://www.who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html
- 10 This list is under review and may be revised soon to include earlier initiation of certain methods.
- 11 WHO, USAID, MCHIP. 2013. Programming Strategies for Postpartum Family Planning. Geneva: WHO. Available at: http://www.usaid.gov/sites/default/files/documents/1864/postpartum_family_planning.pdf
- 12 Foreit KG, Foreit JR, Lagos G, Guzman A. 1993. "Effectiveness and cost-effectiveness of postpartum IUD insertion in Lima," Peru. *International Family Planning Perspectives*. 19(1):19-24, 33.
- 13 Vernon R, Lopez-Canales JR, Carcamo JA, Galindo J. 1993. "The impact of a perinatal reproductive health program in Honduras," *International Family Planning Perspectives*. 19(1):103-109.
- 14 "Interval" insertions are those that occur any time other than within 4 weeks following delivery.
- 15 Jhpiego. ACCESS-FP. 2010. Postpartum Intrauterine Contraceptive Device (PPIUD) Services: A Reference Manual for Providers. Available at: <https://www.glowm.com/pdf/Global%20PPIUD%20Reference%20Manual.pdf>
- 16 Blanchard, H, McKaig, C, ACCESS-FP. 2006. The IUD: A Contraceptive Option for Postpartum and Postabortion Women. Available at: https://www.k4health.org/sites/default/files/postpartumabortion_English.pdf
- 17 Blumenthal, PD, Eber, M, Vajpayee, J. 2013. "Dedicated inserter facilitates immediate postpartum IUD insertion," *Global Health Science and Practice*, 1(3), 428-429. Available at: <http://www.ghspjournal.org/content/1/3/428.short?rss=1>
- 18 Grimes DA, Lopez LM, Schulz KF, Van Vliet HAAM, Stanwood NL. 2010. "Immediate post-partum insertion of intrauterine Devices (Review)," *Cochrane Database of Systematic Reviews*, Issue 5. Wiley. Available at: <http://www.thecochranelibrary.com/userfiles/ccoch/file/Intrauterine%20devices/CD003036.pdf>
- 19 Seiber, EE, Bertrand, JT, Sullivan, TM. 2007. "Changes in contraceptive method mix in developing countries," *International Family Planning Perspectives*, 33(3): 117-123. Available at: <http://www.guttmacher.org/pubs/journals/3311707.pdf>
- 20 ACCESS-FP. Family planning needs during the extended postpartum period in the Democratic Republic of Congo. Available at: http://www.accesstohealth.org/toolres/pdfs/Congo_Analysis.pdf
- 21 FP2020. 2015. Democratic Republic of Congo. Available at: <http://www.familyplanning2020.org/countries/all-countries/democratic-republic-of-the-congo>
- 22 FP2020. 2015. Guinea. Available at: <http://www.familyplanning2020.org/countries/all-countries/guinea#commitment>
- 23 Guinea National Institute of Statistics & MEASURE-DHS. 2013. Demographic and Health Survey-Multiple Indicator Cluster Survey 2012. Available in French only at: <http://dhsprogram.com/pubs/pdf/FR280/FR280.pdf>
- 24 FP2020 Partnership in Action: 2012-2013. Available at: http://advancefamilyplanning.org/sites/default/files/resources/FP2020_PartnershipInAction_2012-2013_lores.pdf
- 25 Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University Teaching Hospital-Virology Laboratory, University of Zambia, and the DHS Program. 2014. Zambia Demographic and Health Survey 2013-14. Calverton, Maryland, USA: ICF International Inc.
- 26 Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. Zambia Demographic and Health Survey 2007. Calverton, Maryland, USA: CSO and Macro International Inc.
- 27 Zambia Demographic and Health Survey, 2013-14.
- 28 Zambia Demographic and Health Survey, 2007.
- 29 National Institute of Population Studies (NIPS) [Pakistan] and ICF International. 2013. Pakistan Demographic and Health Survey 2012-13. Islamabad, Pakistan, and Calverton, Maryland, USA: NIPS and ICF International.
- 30 FP2020. 2015. Pakistan. Available at: <http://www.familyplanning2020.org/countries/all-countries/pakistan>
- 31 Pakistan DHS, 2012-2013.
- 32 MCHIP & PSI. 2013. MCHIP and PSI Report of PPIUD Services: Start-Up to Scale-Up Regional Meeting, Zambia. Available at: <https://www.k4health.org/toolkits/ppfp/mchip-report-ppiud-services-start-scale-regional-meeting-zambia>
- 33 MCHIP & PSI. 2014. MCHIP and PSI Report of PPIUD Services: Start-Up to Scale-Up Regional Meeting, Burkina Faso. Available at: <https://www.k4health.org/toolkits/ppfp/mchip-and-psi-report-ppiud-services-start-scale-regional-meeting-burkina-faso>

RECOMMENDED CITATION

Population Services International. 2015. Enabling the Healthy Spacing and Limiting of Pregnancies: Programmatic Approaches to Expand Postpartum IUD Access. Washington, DC: PSI.

Ordering Information

This publication is available for electronic download at: <http://www.psi.org/resources/publications>.

PSI shares its technical briefs with all interested individuals or organizations. Please note that the technical briefs are updated periodically based on the latest available epidemiological, demographic, intervention effectiveness and utilization data. As a result, numbers used in this document should be considered as illustrative only. They show how the intervention works, but they may have changed since the time of writing.

For more information about this technical brief and PPIUD services, contact:

Ashley Jackson or Maxine Eber
1120 19th St., NW, Suite 600
Washington, DC 20036
ajackson@psi.org or meber@psi.org

ACKNOWLEDGEMENTS

PSI gratefully acknowledges the United States Agency for International Development (USAID) and the Support for International Family Planning Organizations (SIFPO) project for supporting the development of this technical brief. Ashley Jackson, Technical Advisor for Reproductive Health for PSI, wrote the brief with review by Maxine Eber, Deputy Director of PSI's SIFPO Project, Dr. Paul D. Blumenthal, Director of SPIRES and Global Medical Director for PSI, Holly Blanchard, Senior Reproductive Health/Family Planning Advisor for Jhpiego, Elaine Menotti, Health Development Officer for USAID, and Kimberly Cole, Technical Advisor for USAID. Special thanks go to the PSI network members in DRC, Pakistan, and Zambia and Jhpiego/Guinea for providing information used in this report.

SIFPO is a five-year program funded by USAID aimed at improving PSI's capacity in family planning programming worldwide. Working in partnership with IntraHealth International and SPIRES, PSI's vision is to significantly scale up delivery of high quality FP products and services to address unmet need in an increasingly targeted and cost effective manner. PSI emphasizes increasing access, expanding contraceptive choice, and developing local leadership.

To access the capabilities of SIFPO, USAID missions and bureaus can buy into the cooperative agreement.

This case study is made possible by the support of the American people through USAID, under the terms of Cooperative Agreement No. AID-OAA-A-10-00030. The contents of this case study are the sole responsibility of PSI and do not necessarily reflect the views of USAID or the United States Government.

© Population Services International, 2015
POPULATION SERVICES INTERNATIONAL (PSI)
1120 19th Street, NW, Suite 600
Washington, DC 20036



© Sala Lewis



Population Services International
1120 19th Street, NW, Suite 600 | Washington, DC 20036
psi.org | psiimpact.com | twitter: @psiimpact