

Highlights of Program Learning for Postpartum Intrauterine Contraceptive Device (PPIUCD) Integration with Maternal Health Services



Programmatic Experience from Multiple Countries

MCHIP and others have successfully introduced postpartum family planning (PPFP), inclusive of postpartum intrauterine contraceptive devices (PPIUCDs) to more than 65,000 postpartum women around the world. PPIUCD provision and uptake are feasible for both providers and clients. Effective implementation involves service strengthening that includes champions of PPIUCDs, whole-site orientation to PPIUCD, and competency-based training to maternal healthcare providers.

RATIONALE FOR PPFP/PPIUCD SERVICES

The World Health Organization (WHO) encourages all pregnant women to seek the services of a skilled birth attendant during childbirth. This is an increased opportunity to reach couples and help them achieve healthy timing and spacing of pregnancy.¹ PPFP services are an ideal platform to reposition family planning and integrate family planning into maternity services. The vast majority of women want to avoid another pregnancy for at least two years after delivery.² An analysis of Demographic and Health Survey (DHS) data from 52 developing countries revealed that children conceived less than 24 months after the birth of the next oldest sibling had a one to two times (1.1–2.3) higher risk of dying within the first year of life than children conceived 36 to 47 months apart.³ The DHS analysis also demonstrated that the likelihood of a child becoming stunted or chronically undernourished increases substantially with decreasing birth intervals. Children conceived after an interval of only 12 to 17 months are 25% more likely to be stunted and underweight than those conceived after an interval of 36 to 47 months.⁴ PPIUCDs can reduce the proportion of unintended pregnancies/births and abortions because it is one of the most effective family planning methods.

When can women have PPIUCDs?

- Postplacental: insertion within 10 minutes after placental expulsion
- Intracesarean: insertion before closing the uterine incision
- Pre-discharge: insertion from 10 minutes up to 48 hours postpartum

When can women have interval IUCDs?

- Anytime four weeks or later after childbirth if she is not pregnant

PPIUCDs are the only PPFP method for couples requesting a highly effective and reversible, yet long-acting, family planning method that can be initiated during the immediate postpartum in lactating women. WHO medical eligibility criteria state that IUCDs within the first 48 hours postpartum is category one or safe. PPIUCDs are cost-effective and can be inserted by a mid-level skilled birth attendant. Policymakers are now accepting evidence that **family planning is a low-cost intervention that reduces maternal, infant, and under-five child mortality.**

Advantages of PPIUCDs include:

- Fewer instruments and staff are necessary for PPIUCDs than for interval IUCDs.
- PPIUCD insertion only takes a few minutes for women who have been counseled and confirmed their desire for a PPIUCD; these women present no contraindications during labor and delivery for PPIUCD.
- PPIUCDs are more convenient for providers and clients—using the opportunity of childbirth when both the mother and provider are at the facility, another FP visit is not necessary.
- PPIUCDs meet the reproductive needs of women who want to space future pregnancies as well as those who have completed their family size and wish to limit future pregnancies.

“Immediate postpartum insertion of IUCDs appeared safe and effective, though direct comparisons with other insertion times were limited. Expulsion rates appear to be higher than with interval insertion. Advantages of immediate postpartum insertion include high motivation, assurance that the woman is not pregnant, and convenience. The popularity of immediate postpartum IUCD insertion in countries as diverse as China, Mexico, and Egypt support the feasibility of this approach... PPIUCDs are inserted post-expulsion of the placenta up through the initial 48 hours for women who choose this method and without complications of PPH or sepsis.” – Grimes et al. 2010. *Cochrane Database Systematic Review, Issue 5: CD003036.*

Country Experience

India is scaling up PPIUCD services nationally, with these services already present in 19 of 28 states. **Rwanda** now has PPIUCD services in each of its five regions. **Kenya** is targeting several districts where both midwives and physicians are providing PPIUCD services. **Zambia** is using a dedicated provider model. **Guinea** recently documented that when providers gain confidence in PPIUCDs, they also increase the number of interval IUCDs. **Paraguay** reviewed retrospective case series of 8,499 women who received a PPIUCD at the National Hospital in Asunción.

Key themes from these country programs include:

- **Engage experts:** From the earliest stage of program development, engage respected experts in the field, such as professors of obstetrics and midwifery, and their professional organizations (e.g., International Federation of Gynecology and Obstetrics, International Confederation of Midwives, and their national affiliates). Include these experts in stakeholders’ meetings.
- **Advocate to policymakers:** Policymakers are looking at mechanisms to reinvigorate family planning, particularly long-acting methods such as the IUCD. In Guinea, India, and Rwanda, Ministries of Health are repositioning IUCDs immediately during the post-obstetrical event, including postpartum and postabortion.
- **Include informed and voluntary choice:** Providers need to inform women and receive their voluntary consent before active labor, ideally during antenatal care (ANC).
- **Reduce unmet family planning need:** The number of women who have an unmet need for modern contraception in 2012 is 222 million. This number declined slightly between 2008 and 2012 in the developing world overall, but increased in the 69 poorest countries.⁵ In 2012, approximately 53% of women (58 million) in sub-Saharan Africa who wanted to avoid a pregnancy were not using family planning or were using a traditional method. These women accounted for 91% of unintended pregnancies.⁶

Integrated Approach

The approach for PPIUCD service provision in several programs is based on an integrated model for ANC, intrapartum care (labor and delivery [L&D]), and postpartum care. During ANC, women are asked about their reproductive goals and encouraged to wait at least 24 months after delivery before attempting another pregnancy if they plan to have additional children. Women also receive counseling on different

PPFP methods during their ANC, including the lactational amenorrhea method (LAM), DMPA injections, condoms, implants, IUCDs, and permanent methods. To facilitate improved communication between ANC and L&D, **several country programs have effectively used a PPFP rubber stamp to indicate the completion of PPFP counseling and the client’s desired family planning method.** Women who do not receive ANC are screened on arrival to the labor unit. Those who express interest in PPIUCDs are screened for clinical conditions based on WHO medical eligibility criteria. PPFP counseling is provided in early labor, if appropriate, and again in the postpartum ward. If the pregnant woman selected the PPIUCD, her choice is re-confirmed before childbirth. Her medical history is reviewed for conditions that are contraindicated for a PPIUCD, as well.

Paraguay developed this integrated approach in 2000, which has since been used as the model in several countries where MCHIP is supporting PPIUCD programs. At the National Hospital in Asunción, Paraguay, expectant mothers are counseled during ANC on PPFP. If these women are in the early stages of labor and can make an informed contraceptive choice, they are counseled and offered PPFP, including the PPIUCD. If it appears that active labor or other conditions would preclude an informed choice, the counseling is deferred until the first day postpartum.

Protocols and Standards

Standardizing the provision of PPFP care with national guidelines is helpful to ensure that all women receive high-quality PPFP services. In India, the inclusion of PPFP in the national guidelines supported scale-up efforts, as all institutions have the same process to follow. Standards and guidelines are the foundation for quality of care. They provide the template for training/capacity-building of providers and for supervisors to assist staff to achieve high-quality services. Establishing a facility-based quality assurance program assesses performance at the facility, identifies gaps, and implements interventions to achieve desired performance. PPIUCDs are always provided within the context of volunteerism and informed choice.

Monitoring and Evaluation

Indicators for monitoring and evaluating PPIUCD programs may include:

- Number of antenatal clients/women in early labor and postpartum women counseled on PPFP
- Percentage of women delivered at the facility who received PPIUCD
- Percentage of PPIUCD insertions that are postplacental, intracesarean, and immediate or pre-discharge postpartum (e.g. **Figure 1**)
- Percentage of PPIUCD users who return for a follow-up visit within six weeks postpartum
- Percentage of PPIUCD users who reported complications such as spontaneous expulsion, infection, pregnancy, or request for removal within first six months due to side effects of PPIUCD (e.g. **Figure 2**)
- Percentage of facilities that provide PPIUCD services
- Percentage of facilities that have PPIUCD services and have achieved 80% of the national PPIUCD quality performance standards

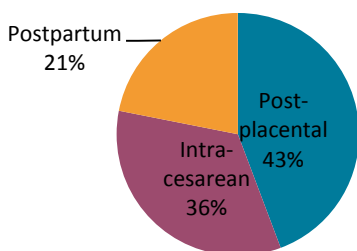
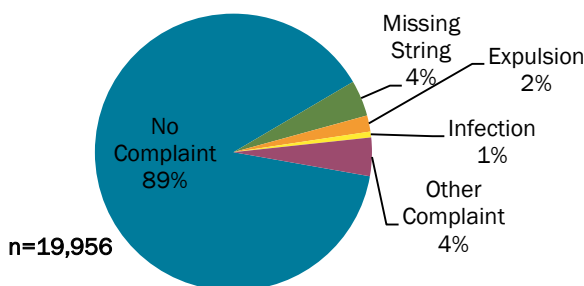


Figure 2. PPIUCD follow-up visit results at six weeks, India





RAISING AWARENESS AND PROVIDING INFORMATION

Behavior change communication, social marketing, and community mobilization (both at the facility and community levels) can help generate demand for and increase acceptability of PPIUCD services.

Key messages for providers and community workers include:

- For the health of the mother and baby, wait at least two years after a birth before attempting another pregnancy.
- Fertility can return before the menses resumes.
- PPIUCDs are an effective reversible family planning method that has no impact on breastfeeding and can be inserted while at the hospital/maternity unit prior to discharge.
- Side effects can include an increase in menstruation, spotting, and cramps in the lower abdomen. These side effects usually go away over time. Rarely, the PPIUCD expels on its own.
- The mother should return to the health facility in six weeks post-delivery or at any time if she has a question or problem.

FOR FURTHER INFORMATION

For further information on PPIUCD implementation, particularly service strengthening and training/capacity building, please consult the full brief, “Program Learning for Postpartum Intrauterine Contraceptive Device (PPIUCD) Integration with Maternal Health Services,” available at <http://www.mchip.net/node/1418>.

¹ Davanzo J et al. 2008. The effects of pregnancy spacing on infant and child mortality in Matlab, Bangladesh: How they vary by the type of pregnancy outcome that began the interval. *Population Studies* 62(2): 131–154;

Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. 2006. Birth spacing and risk of adverse perinatal outcomes: A meta-analysis. *JAMA* 295(15): 1809–1823.

² Ross JA and Winfrey WL. 2001. Contraceptive use, intention to use and unmet needs during the extended postpartum period. *International Family Planning Perspectives* 27: 20–27.

³ Rutstein SO. 2008. Further evidence of the effects of preceding birth intervals on neonatal, infant, and under-five-years mortality and nutritional status in developing countries: Evidence from the Demographic and Health Surveys. *DHS Working Papers, Demographic and Health Research* (41).

⁴ Ibid.

⁵ Singh S and Darroch JE. 2012. *Adding It Up: Costs and Benefits of Contraceptive Services. Estimates for 2012*. Guttmacher Institute.

⁶ Ibid.