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MCHIP and RESPOND Report of Postpartum IUD Technical Meeting



**Washington, D.C.
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Cover photo by Jhpiego.

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The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

Objectives and Rationale of the Technical Meeting

The immediate postpartum period is a valuable opportunity for women and couples to learn about and access family planning services. This is especially true today as more women are accessing the formal health care system during pregnancy and delivery through focused antenatal care (FANC) and emphasis on skilled birth attendants at delivery. **A review of Demographic and Health Surveys (DHS) from 27 countries reveals that the vast majority of women (64%) who want to avoid another pregnancy for at least two years are not using a method of family planning.**¹

The postpartum intrauterine device (PPIUD) is one of a number of family planning methods that can be offered as an option for postpartum family planning (PPFP). The PPIUD can be inserted immediately after expulsion of the placenta (postplacental) or through the initial 48-hour postpartum (immediate postpartum). Based on existing programs and lessons learned from Kenya, India, Rwanda and other countries, the success of a PPIUD program is directly related to:

- Strength of good communication and medical record documentation between antenatal care (ANC) and the maternity unit
- Good family planning counseling during ANC and immediate postpartum
- Confirmation of choice in the maternity unit for women who have chosen the PPIUD during antenatal care
- Counseling on PPIUD for women in early labor, if appropriate
- Skilled, trained providers available 24/7 in the maternity unit
- Supplies and instruments accessible 24/7 in the delivery room for postplacental insertion, and the maternity unit for immediate postpartum insertion
- Support staff who know that PPFP saves lives, and understand the PPIUD
- Women, couples and their families being well informed about the choices of family planning and benefits to their baby and the mother when they prevent another pregnancy for at least two years

During the immediate postpartum period, many women are motivated to prevent another pregnancy and studies show that women would like to receive family planning before they are discharged from the facility after delivery.

Lathrop E et al. 2010. Postpartum contraceptive needs in northern Haiti. *International Journal of Gynecology and Obstetrics*, doi:10.1016/j.ijgo.2010.09.012.

PPIUD services are not stand-alone services. They need to be introduced in ANC as part of PPFP choices available immediately after delivery. They are part of intrapartum care, provided for the women who have chosen them during ANC for insertion immediately after active management of the third stage of labor (AMTSL). They can also be provided to women who have chosen them during the immediate postpartum period and before going home.

Provision of the PPIUD is part of maternal health care services, part of PPFP, and one of the long-acting and permanent methods (LAPM). It is in this context that the Postpartum Family Planning Community of Practice and the Long-Acting and Permanent Methods Community of Practice are working together to address the resurging attention to the PPIUD as a safe and effective method that increases options for postpartum women (including breastfeeding women).

¹ Ross J and Winfrey W. 2001. Contraceptive use, intention to use and unmet need during the extended postpartum period. *International Family Planning Perspectives* 27(1): 20-27.

MCHIP and RESPOND hosted this PPIUD technical meeting on July 7, 2011. Twenty-eight experts, among whom were providers, researchers and programmers representing 10 organizations participated in the all-day meeting (see Appendix A).

Meeting Purposes

- Share current programmatic and technical experiences with the PPIUD; identify gaps in information, skills and service delivery; and identify ways to advance/ promote use of the PPIUD in the context of PFP.
- Explore issues and interest among collaborating agencies that might be addressed in a PPIUD working group (see Appendix B).

During the [immediate] postpartum time period, women are often highly motivated to initiate contraceptive use. Intrauterine device (IUD) insertion during this time period is an ideal method for some women, as it does not interfere with breastfeeding, is convenient for both women and their healthcare providers, is associated with less discomfort and fewer side effects than interval insertions and allows women to obtain safe, long-acting, highly effective contraception while already within the medical system.

Kapp N and Curtis KM. 2009. Intrauterine device insertion during the postpartum period: A systematic review. *Contraception* 80(4): 327-336.

Highlights and Key Themes from the Meeting

This document shares highlights from the technical meeting, focusing on themes that emerged throughout the day, and identified areas of new learning that will serve as the basis for the way forward for PPIUD.

Trish MacDonald, U.S. Agency for International Development (USAID) Senior Technical Advisor to MCHIP and RESPOND, welcomed the participants and spoke about the marriage of technical areas covered by PPIUD and maternal health providers. She acknowledged the experience of the ACCESS-FP Program in revitalization of PFP. She posed several questions for consideration: 1) How do we build on and scale up ACCESS-FP's experience in revitalizing PPIUD? 2) What is needed to scale up this technical intervention and at the same time maintain quality? 3) How can we plan and implement holistic programs that address the policy environment, create high-quality providers and services, and generate demand for facility-based births, PFP and PPIUD services among pregnant and postpartum women?

Setting the Stage: PPIUD in the Context of Unmet Need for PFP

PPIUDs: At the intersection of FP and Maternal Health: Dr. Jeffrey Smith, MCHIP Maternal Health Team Leader

Jeffrey Smith opened his presentation with four simple thoughts:

- Women are at risk of unplanned pregnancy during the first year postpartum.
- Provision of PFP/PPIUD should be by maternal health providers.
- IUDs are one of the safest methods of PFP.
- In order to support PPIUDs, providers need to modify their perspective of IUD use in the postpartum period.

Many health providers assume that when women are ready for family planning following the birth of a child, they will return to a facility for services. However, the reality is that women tend to think of their children and family first, especially when their children are young. Mothers often do not attend to their own needs, especially family planning. In many settings, breastfeeding women are traditionally not supposed to be sexually active. This means that women are often reluctant to ask openly about family planning, while providers may assume that postpartum women are not yet sexually active. Yet according to the DHS from India, 40%

of women are sexually active by three months postpartum.² Maternal health workers (e.g., ANC, labor and delivery staff) may assume that pregnant and postpartum women are not interested in family planning and also assume that other health staff will speak with them during their six-week postpartum check. In reality, many women do not return for their six-week visit. During the last decade, an emphasis on delivery with a skilled birth attendant, healthy timing and spacing of pregnancy, PFP and improved safety of IUDs, have re-opened the door for PPIUDs.

PFP is not merely family planning, but a maternal health intervention. As such, maternal health providers should be trained to offer PFP and PPIUD services. For this effort to be successful, the perspectives, attitudes and skills of maternal health providers will need to be updated. The focus should be on the client before, during *and after* the birth of a child. PPIUDs are a highly effective, long-acting, reversible method that does not interfere with breastfeeding and that can be provided before the woman leaves the health facility where she gave birth.

Synthesis of Findings from a PPIUD Literature Review

Holly Blanchard, MCHIP Family Planning Senior Technical Advisor

Holly Blanchard presented a literature review of key studies from 2000 to 2011 based on a Medline search of abstracts using the search words postpartum IUD. The review focused on the 380 A Copper T. Some of the key literature presented was from the Cochrane database review, updated in 2010, and the World Health Organization (WHO) review (2009). The literature demonstrated the following: PPIUDs are safe and effective; there is high motivation among mothers (for PFP); PPIUDs are convenient; there are few contraindications; expulsion rates are higher than with interval insertion³ (in the WHO systematic review, the overall expulsion rate was 9.5% for postplacental insertion);⁴ PPIUD insertion is popular in diverse countries, such as China, Mexico and Egypt; infections occur in less than 1% of clients; and early follow-up is important in identifying spontaneous IUD expulsions.⁵ Another key issue presented in several studies is that women are interested in having an IUD immediately after an obstetrical event.⁶ Those who had an IUD inserted were much more likely to be using an IUD six months later, compared to women who reported that they would get an IUD later.⁷

Review of State-of-the-Art PPIUD Teaching Video

Dr. Jeffrey Smith, MCHIP Maternal Health Team Leader

Participants reviewed the teaching video developed under ACCESS-FP. The video, which was field-tested in 19 states in India, Rwanda, Albania and Afghanistan, was also used in other countries such as Yemen to advocate for PPIUD. The video documents [postplacental and/or immediate] PPIUD insertion using Kelly obstetrical forceps and is based on work done by Dr. Vicente Bataglia in Paraguay. Dr. Bataglia has documented more than 5,000 PPIUD insertions at Hospital Nacional, Asunción, Paraguay. Key elements of PPIUD shown in this video include: thorough counseling, adherence to infection prevention practices and high fundal placement of the IUD. All steps of AMTSL are completed first, then PPIUD insertion is done. This 30-minute video has been successfully used in clinical skills training in India and Africa.

² Indian National Family Health Survey III 2005–06.

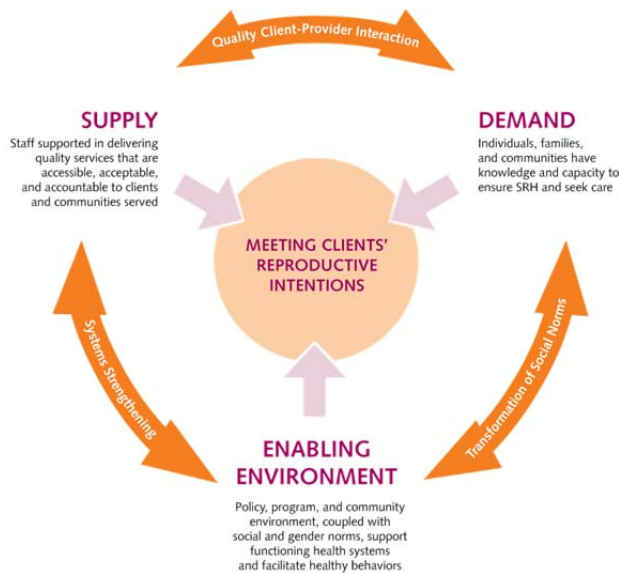
³ Grimes DA, Lopez LM, Schulz KF, Van Vliet HA and Stanwood NL. 2010. Immediate post-partum insertion of intrauterine devices. *Cochrane Database Systematic Review* May 12(5): CD003036.

⁴ Kapp N and Curtis KM. 2009. Intrauterine device insertion during the postpartum period: A systematic review. *Contraception* 80: 327–336. Epub 2009 Aug 29.

⁵ Ibid.

⁶ Glazer AB, Wolf A and Gorby N. 2011. Postpartum contraception: Needs vs. reality. *Contraception* 83(3): 238–241. Epub 2010 Aug 7.

⁷ Foxa MC, Oat-Judgea J, Seversona K, Jamshidia RM, Singhb RH, McDonald-Mosleya R and Burke AE. 2011. Immediate placement of intrauterine devices after first and second trimester pregnancy termination. *Contraception* 83: 34–40.



EngenderHealth. 2011. *The SEED Assessment Guide for Family Planning Programming*. New York.

Programmatic considerations include:

- Provider attitudes, knowledge and skills about IUDs and PPIUDs
- Service delivery—how to link and coordinate various parallel provision of services: ANC, labor and delivery, postpartum ward and postnatal care
- Policies, guidelines and service protocols
- Timely information and counseling about PPF and PPIUD
- Increasing demand
- Procurement/logistics and data gathering/ analysis
- Moving beyond champions to institutionalizing PPIUD



Photo by PSI 2011.

Current Country Experiences

Zambia: Jolly Chilambwe, PSI Senior Technical Advisor. In Zambia, the maternal mortality ratio is 591/100,000; the total fertility rate is 6.2 and HIV prevalence is 15% (Zambia DHS 2007). PPIUDs are a lifesaving choice for postpartum women. Population Service International (PSI) developed partnerships in high-volume clinics (10–15 deliveries/day), and sensitized clients and staff in antenatal clinics and postpartum wards on PPIUD and other family planning methods. They identified nurse midwives who demonstrated enthusiasm and commitment to the PPIUD. PSI provided competency-based training for staff in the delivery area, plus supportive supervision. These dedicated providers for PPIUD/IUD insertions at the facilities were employed by PSI.

Results: among the 305 women who requested and received a PPIUD, 71% had their IUD inserted between 15 minutes and 48 hours postpartum. **Findings showed a 6% expulsion rate at six months**, and **75%** were aware that their IUDs were expelled. **Three percent**

⁸ DHS of 36 countries from the past five years, StatCompiler Macro '08.

Programmatic and Systematic Needs

Dr. Carmela Cordero, RESPOND, EngenderHealth, Senior Clinical Advisor, Clinical Support

Dr. Cordero invited the participants to analyze programmatic issues before starting a PPIUD service. With 81% of women now receiving antenatal care and 54% of deliveries occurring in health facilities, there is an opportunity to increase services for postpartum IUDs.⁸

The SEED model applies a holistic programming perspective to address the *supply* of PPIUD service and system needs, the *enabling environment* to support PPIUD services, the *social norms* surrounding delivery and PPF, and the potential *demand* for PPIUD services.

requested removal. Reason for their success: a PSI provider is available for PPIUD insertions in the labor and delivery unit. The maternal health staff is frequently too busy in a high-volume delivery suite and coping with the high incidence of HIV to take on new tasks. Experienced PSI PPIUD providers conducted supportive supervision visits to ensure competency and confidence among the newly trained in PPIUD PSI staff at facilities.

India: Ricky Lu, Jhpiego, FP/RH Director. Forty-six percent of married women are not using any method of contraception. Among the 47% using modern contraception, only 12% are using reversible, modern methods, and the remaining 35% are sterilized.⁹ According to the 2006 India DHS, 65% of women have an unmet need for family planning during the first postpartum year.¹⁰ They do not want to have another pregnancy within two years after their last baby was born, yet only 26% are actively using family planning. Why the interest in PPIUDs? The Government of India is supporting IUDs as part of their national family planning strategy. They are also supporting facility births by giving women a financial incentive to deliver in a facility. This strategy has resulted in 83% of all deliveries now occurring in facilities in the state of Rajasthan. After ACCESS-FP demonstrated efficacy and uptake of PPIUD, other donors and projects—including MCHIP, NIPI (Norway India Partnership Initiative) and the Bill & Melinda Gates Foundation—have been supporting wide ranging scale-up of PPIUDs. Currently PPIUD services have been scaled up to 19 states in India. From 2009 in two district hospitals to June 2011 in 16 states, a total of 6,664 PPIUDs were inserted; 58% were postplacental, 29% intra-cesarean and 13% immediate (within 48 hours).



Photo by Jhpiego India 2010.

Approaches and tools for high-quality service include:

- Identifying and nurturing champions— for example, influential ob-gyns
- Service delivery—standard protocols for quality services, ANC counseling, logistics
- Training—training packages, anatomic models, training centers with adequate case loads, trainers
- Supplies—IUDs, instruments in the delivery room and maternity unit
- Monitoring—registers, databases where PPIUD services are in place—management staff adjust services according to data
- Client education and materials—for before, during and after PPIUD insertion
- Advocacy—targeted to all staff in facility, all providers in community and mothers-in law

Dominican Republic and Bangladesh: Barbara Jones, Senior Technical Advisor, Service Delivery Approaches, RESPOND Project. PPIUD programs were implemented in a number of countries in the 1980s and 1990s with varying degrees of success. Research findings from those earlier experiences may offer useful lessons as we again look at ways to revive and expand PPIUD services. Studies conducted in the early 1990s (1992–1994) found that:

- Clients were interested in getting a contraceptive method at the time of delivery because it was convenient.

⁹ Indian National Family Health Survey III 2005–06.

¹⁰ ACCESS-FP. 2009. Reanalysis of India DHS postpartum women.

- Nearly all women expressed interest in receiving information about family planning options during prenatal care and/or while in the hospital, after delivery and before they were discharged.



Photo by EngenderHealth 2011.

Dominican Republic (AVSC 1990s).

During the first year of a PPIUD program undertaken in a large maternity hospital in Santo Domingo, 1,437 postpartum IUDs were provided, representing 6% of all women who delivered at the hospital. Fifty-five percent of the PPIUD clients had not used a method prior to the last pregnancy. Insertions were done within the first 24 hours after vaginal delivery, not immediately

postplacental, because of logistical and service organization obstacles in the delivery area. As an alternative, a nurse counseled newly delivered women about the PPIUD, and insertions were done in a separate area before women were discharged from the hospital. The program ended when the physician who championed the program left the hospital. This experience highlights the importance of policy and management support to institutionalize the PPIUD and the options for organizing services to ensure availability.

Bangladesh (ACQUIRE, RESPOND/Mayer Hashi). PPIUD services were introduced in three hospitals by the ACQUIRE project in 2007; 1,300 PPIUD insertions were done, over 70% of them intra-cesarean. RESPOND and the Mayer Hashi project are now expanding to 21 districts using the SEED holistic programming approach—supply, enabling environment and demand—to integrate FP with maternal and child health services and increase points of contact between clients and providers during the antenatal and extended postpartum periods.

- **Supply:** Mayer Hashi is training health personnel about FP, adding FP to ANC, immunization and other services to increase client contacts and the number of facilities where PPIUD and interval IUD services are available.
- **Enabling environment:** The program is working at the national policy level to make PPF available in both branches of the Ministry of Health that deal with maternal and child health and to obtain administrative authorization for nurses to be trained as IUD providers.
- **Demand:** Behavior change communication, which provides information on all methods, is being implemented at the community level for PPF.

Group Work

The group brainstormed on key issues relating to PPIUD services. What are the key elements around supply, demand and advocacy? The groups identified several successful PPIUD programs, such as Paraguay and India, among others, where PPIUD services have been institutionalized, mid-level providers and physicians are providing the services, successful programs and satisfied clients have helped to generate demand, and policies developed to encourage scale-up. The group identified many challenges, such as IUD myths generated by providers, the lack of systematic provision of PPF including PPIUDs, and the lack of awareness among many community members about the need for PPF (see Appendix C).

Next Steps

Based on the discussions during the PPIUD Technical Meeting, participants agreed that formation of a PPIUD working group would be useful to continue advocacy for the PPIUD and address knowledge and evidence gaps identified during the meeting. Some recurring themes that surfaced include: the need to institutionalize PPFIP inclusive of PPIUD in ANC, as well as in maternity care and postabortion care. The group wants to pursue a learning agenda that supports successful service delivery models through holistic programming, as well as working collectively to develop advocacy tools.

Participants at the meeting agreed that MCHIP will serve as the secretariat for the newly formed PPIUD working group. As an initial step, an online survey will be sent to participants and other likely partners to inquire about their interest in and level of commitment to the PPIUD working group, as well as to explore priority areas of technical and programmatic work. The first PPIUD working group meeting will take place in the fall. A list of core partners includes: MCHIP, PSI, FHI, RESPOND and USAID. The invitation to join the working group will be shared broadly among agencies.

APPENDIX A: MEETING AGENDA

Postpartum IUD Services and Programs: A Technical Meeting

Date and Time: July 7, 2011, 8:30 am–4:00 pm

Location: Association of Reproductive Health Professionals – Stewart Center,
1901 L Street, NW, Washington, D.C.

Context

The immediate postpartum period is a valuable opportunity for women and couples to learn about and access family planning services. This is especially true today as more women are accessing the formal health care system during pregnancy and delivery through focused antenatal care (FANC) and emphasis on skilled birth attendants at delivery. A review of Demographic and Health Surveys (DHS) from many countries reveals that the vast majority of women (64%) want to avoid another pregnancy for at least two years but are not using a method of family planning (Ross and Winfrey 2001). During the immediate postpartum period, many women are motivated to prevent another pregnancy and studies show that women would like to receive family planning before they are discharged from the facility after delivery (Lathrop E et al. 2010. Postpartum contraceptive needs in northern Haiti, *International Journal of Gynecology and Obstetrics*, doi:10.1016/j.ijgo.2010.09.012).

The postpartum intrauterine device (PPIUD) is one of a number of family planning methods that can be offered as an option for postpartum family planning (PPFP). The success of a PPIUD program is directly related to:

- Strength of good communication between ANC and the labor ward
- Good family planning counseling during antenatal care (ANC)
- Counseling in labor and delivery that confirms choice by those who have chosen the PPIUD
- Skilled, trained providers available 24/7 in the maternity unit
- Appropriate instruments that are correctly sterilized
- Supplies and equipment accessible 24/7 in the delivery unit
- Support staff who know that PPFP saves lives, and understand PPIUDs
- Women and couples being well informed about the choices of family planning and benefits to their baby when they prevent another pregnancy for at least two years

PPIUD programs are not stand-alone programs, but rather providers and programmers need to address ANC, intrapartum care, active management of the third stage of labor (AMTSL) and the immediate postpartum period. It is in this context that the Postpartum Family Planning Community of Practice and the Long-Acting and Permanent Methods Community of Practice, plan to work together to address the resurging attention to PPIUD as a safe and effective method that increases options for postpartum women (including breastfeeding women).

Meeting Purpose

- Share current programmatic and technical issues and experience with the PPIUD, identify gaps in information and service delivery, identify ways to advance/promote use of PPIUD in the context of postpartum family planning (PPFP).
- Explore issues and interest among collaborating agencies that might be addressed in a PPIUD working group.

Desired Meeting Outcome

By the end of this technical consultation, the group will have:

- Clarified current issues and experiences in PPIUD services and programs
- Identified gaps in knowledge and practice in PPIUD services and programs
- Developed a vision of how concerned organizations might begin to address these gaps
- Identified a path forward on an interagency working group on PPIUD

Agenda

- 8:30–9:00 am Sign-in coffee/continental breakfast/networking
- 9:00–9:15 am Welcome and Introductions, *Holly Blanchard introduction to Meeting Chair, Trish MacDonald, USAID*
- 9:15–9:30 am Setting the Stage: PPIUD in the context of unmet need for PFP, *Jeffrey Smith, Maternal Health Team Leader*
- 9:30–10:45 am Panel Session: Experience and Lessons—What Has Worked and What Has Not? Moderator, *Trish MacDonald, USAID*
- Synthesis of Findings from PPIUD Literature Review: *Holly Blanchard*
 - Review of State-of-the-Art PPIUD Teaching Video: *Jeffrey Smith*
 - Programmatic and System Needs: *Carmela Cordero*
- 10:45–11:00 am Break
- 11:00 am–12:30 pm Panel Session: Current Country Experiences. Moderator, *Jim Shelton, USAID*
- Zambia: *Jully Chilambwe, PSI*
 - India: *Ricky Lu, Jhpiego/MCHIP*
 - Bangladesh, Dominican Republic: *Barbara Jones, EngenderHealth/RESPOND*
- 12:30–1:15 pm Lunch
- 1:15–1:45 pm Brainstorm on Key Broad Areas: Supply, Demand and Advocacy: *Tsigué Pleah, Jhpiego*
- 1:45–2:30 pm Break-Out Groups: Three broad areas of supply, demand and advocacy. Based on the presentations, ideas generated from brainstorming and expertise among the group, each small group will address the following questions: *Tsigué Pleah, Jhpiego*
1. What are successful examples of programmatic/technical areas that address the issue in your group?
 2. What are the identified gaps in the area that your group is working?
 3. What is needed (strategies, activities, collective action, tools or other products, etc.) to address these gaps?
- 2:30–3:15 pm Presentations of each small group; limit to top two bullets to each question: *Maxine Eber, PSI*
- 3:15–4:00 pm Need for a PPIUD WG and How to Mobilize: *Holly Blanchard, MCHIP*
- 4:00 pm Summary and Closing: *Holly Blanchard, MCHIP*

APPENDIX B: PPIUD TECHNICAL MEETING PARTICIPANTS

| NAME | ORGANIZATION | TITLE | COUNTRY | EMAIL |
|-----------------------|--------------|-------------------------------|---------|--|
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APPENDIX C: TABLE OF SMALL GROUP WORK

| BRAINSTORMING | SUPPLY | DEMAND | ADVOCACY |
|---------------|--|--|---|
| | <ul style="list-style-type: none"> Hospitals do not have a supply of contraceptives and instruments; If they do have supply, they may not always be on site in L&D Providers authorized to perform PPIUD insertions are not physically available (HR) Supply of providers is inadequate (at the right time) Lack of a linkage between supply and demand—providers lose their skills Availability of services for 24 hours; service delivery model not worked out yet Training of maternal health providers on FP and the importance of PPF that includes PPIUD (who should be trained, which unit) Infrastructure for service provision; lack of financial resources Infection prevention supplies Rewards for MCH staff for FP → champions, incentives Client flow; tracking clients → counseling Communication between different units, e.g., L&D and ANC IEC materials need to be available in delivery room Logs/registers; facility training—all site training | <ul style="list-style-type: none"> Myths and misconceptions within the community and providers Education in ANC and other services Increasing women’s risk perceptions of when they can get pregnant again Critical mass of satisfied users to promote PPIUD Significant demand generation for clients → also supply for providers to practice Counseling and communication IEC materials; community involvement, specifically male involvement for IUD (religious leaders) Cultural context → identify our path and obstacles for provision of PPIUD services | <ul style="list-style-type: none"> Link between ANC and L&D staff Motivation for service providers—HR management (performance appraisals) For expanded method mix Policy, protocols for PPF Advocate for the method and leadership commitment to sharing the evidence Champions at a high policy level (MOH); including PPF with PPIUD in pre-service education, formalization of continuing education for health providers Professional association endorsements Appropriate planning for services → synchronize supply and demand Gender bias—HTSP for all PPF, promote IUDs for both spacing and limiting Reach out and advocate to other units within the government (MOH, finance, etc.) |

| BRAINSTORMING | SUPPLY | DEMAND | ADVOCACY |
|---------------------------------------|--|--|--|
| Examples of programs that work | <ul style="list-style-type: none"> Paraguay: Institutionalization of PFP/PPIUD at National Hospital Jabalpur, India, where midwives are responsible for PPIUCD service | <ul style="list-style-type: none"> Satisfied users in Kenya ACCESS-FP study Trusted MCH provider in Rwanda | <ul style="list-style-type: none"> Government of India support to PPIUD |
| Gap | <ul style="list-style-type: none"> Providers' bias against IUDs Management/coordination among clinics, supplies, providers Systematic PFP counseling Authorization for mid-levels to do PPIUD Identification of service delivery models that are feasible in various facilities | <ul style="list-style-type: none"> Changing perceptions among community and providers | <ul style="list-style-type: none"> Overarching task is to develop evidenced-based advocacy piece on PFP/PPIUD integrating into MCH services; this advocacy tool's audience is the policy/decision-makers |
| Addressing the gaps | <ul style="list-style-type: none"> Dissemination of evidenced-based practice Policy and job description Pre-service and in-service education | <ul style="list-style-type: none"> Change perception through competency-based training and use of champions (both provider and user of PPIUD) Education/counseling during ANC (IEC materials as job aids), pre-discharge, community and early labor Need to address return to fertility, how in open postpartum ward? | <ul style="list-style-type: none"> Include the need to strengthen the FP component of PAC, particularly IUDs Promote IUDs for both spacing and limiting Reach out to other policymakers such as ministries of finance |