

FIGO (The International Federation of Gynecology and Obstetrics) – **Postpartum IUD** initiative



2013 - 2020



Background and Intro

Currently an estimated 214 million women of reproductive age in low-income regions want to delay pregnancy, but are not using modern contraception. If all unmet need for modern contraception in developing regions were satisfied, we would see a three-quarter reduction in unintended pregnancies, from 89 million to 22 million per year, a significant drop in unplanned births, and a fall in induced abortions from 48 million to 12 million per year.¹

Alongside our National Member Societies, FIGO is committed to promoting universal access to sexual and reproductive health (SRH) services, reducing maternal mortality and improving perinatal and child outcomes.

Unintended and closely spaced births are a public health concern, as they are associated with increased maternal, newborn, and child morbidity and mortality. The WHO recommends a birth to pregnancy [interval of 24 months](#) for the wellbeing of mother and child.²

Although there has been a rising trend in institutional delivery rates³, this has not translated into an increase in the uptake of postpartum contraception. Of all unmet contraceptive need, on average nearly two fifths falls among women who have given birth within the past year⁴. The immediate postpartum period presents an ideal opportunity to provide these women with a much-needed service, as women delivering in low and middle-income health facilities rarely return for contraceptive services.



CHW training Kenya –FIGO/KOGS

In 2013, FIGO embarked on a pilot project to strengthen postpartum family planning (PPFP) and institutionalise the delivery of postpartum IUD (PPIUD) services in partnership with our national society in Sri Lanka (SLCOG). As a long-acting reversible form of contraception, the copper IUD can be inserted at the point of delivery and provides safe ([MEC category 1](#)) and effective protection for up to 12 years, enabling a woman to plan her family and space pregnancies.

With the success of this pilot, in 2015 we expanded to India, Nepal, Bangladesh, Kenya and Tanzania. Over the last 7 years, we have collaborated with National Member Societies to strengthen local leadership and governance, increase workforce capacity and enhance information management in PPFP, directly establishing PPFP counselling provision and PPIUD service delivery in over 56 facilities.



Mother and baby Nepal - FIGO/Eliza Bell

Our theory of change:

Reduced maternal
mortality

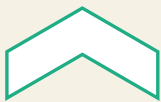


Improved perinatal
outcomes

Increased modern contraceptive rate
better birth spacing

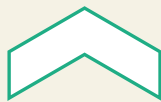
Decreased unintended pregnancies
& unsafe abortions

Health system better equipped to provide PPFP/PPIUD services



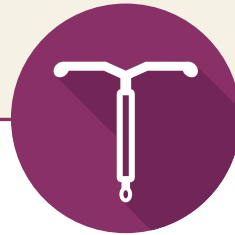
Leadership & Governance

- National and global advocacy
- Embedding PPFP in national guidelines and policy
- Capacity building national OBGYN societies to advocate for and provide PPFP services



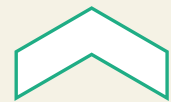
Workforce

- Training service providers in PPFP counselling and PPIUD insertion
- Including PPFP and PPIUD in pre-service curriculum and training
- Promoting task-sharing to increase access



Service delivery

- Establishment of PPFP counselling and PPIUD services at facility level
- Involving communities through engaging various community health cadres
- Supporting demand generation (IEC materials)



Information

- Inclusion of PPFP indicators in government HMIS systems
- Establishing data safety and monitoring boards and regular auditing
- Data feedback loops



Leadership & Governance

Bottom-up advocacy and leadership is crucial for effective long-term change. To achieve this, our initiative worked through National Member Societies as a local implementing partner. At project inception, PPFP was not consistently included in relevant national guidelines, policies and frameworks. Each country developed and led their own context-specific strategies to advocate for wider PPFP provision and institutionalisation of PPIUD services at facility and national levels. National Member Societies called for continued investment in PPFP and PPIUD through national engagement of stakeholders and government bodies and through the dissemination of project successes. Our societies were supported to share their knowledge and experience of PPIUD service development on global platforms by participating in international conferences and authoring publications. Through ongoing capacity building the societies are well placed to continue as strong leaders and advocates for PPFP services beyond the scope of this initiative.

At a global level, we have brought together our partners to share their experiences, encouraging information sharing and learning, fostering south-south leadership and collaboration. Through our global reach, influence and collaboration with partners we have helped to shape global policy, enabling greater access to PPFP and PPIUD. Our published material is available in French, English and Spanish and has been disseminated widely.

Antenatal Care Sri Lanka – FIGO/Suzanna Bright



‘Spotlight’: Nationalisation in Sri Lanka

The need for government buy-in and strong local partnerships with stakeholders is crucial to any initiative. In Sri Lanka, this was key to the adoption by the government of PPIUD into the national contraceptive choice package. A close working relationship between the national member society and the Family Health Bureau, as well as strong working relationships, engagement with members and feedback loops within the society culminated in the Ministry of Health formally adopting PPIUD into the national family planning options in 2017.



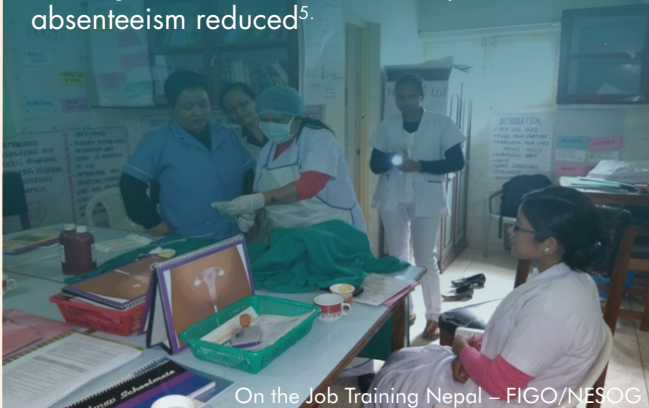
Workforce

Using a train-the-trainer approach, we established master trainers who cascaded training in counselling and insertion, or counselling only to relevant healthcare providers. We trained providers to deliver balanced, non-coercive counselling in all available PPFP methods. Those eligible to provide PPIUD insertions were trained using the long handled 33cm Kelly's forceps on [Mama-U models](#), and were then assessed for competency. Regular refresher trainings ensured trainees were confident in their skills, captured newly rotated-in providers and maintained a workforce whose skills were up-to-date.

Working with regional medical, nursing and midwifery schools, the initiative embedded PPFP and PPIUD into preservice training curriculums and assessment. This vital achievement ensures

'Spotlight': On-the-Job Training in Nepal

Our team in Nepal developed an innovative on-the-job training (OJT) package on PPFP and PPIUD. The 12-day 2-hour a day package was introduced by the society in coordination with the government. Previously, trainings took staff away from their posts, creating a shortage of personnel, but with the new OJT training retention of skills was improved and absenteeism reduced⁵.



On the Job Training Nepal – FIGO/NESOG

'Spotlight': Training the Next Generation in Tanzania

Thanks to the work of FIGO's PPIUD Initiative and collaboration with a broad range of national stakeholders, medical, nursing and midwifery students across Dar es Salaam, Mbeya and Dodoma now receive up-to-date practical and theoretical training and assessment in PPFP.



Training Tanzania – FIGO/TAMA

that generations of students to come will graduate equipped with the skills and knowledge to provide PPFP services.

Although OBGYNs routinely see women at facility level, quality PPFP counselling happens beyond the hospital door. Bridging the gap between facility-care and the community is essential for ensuring the continuum of care and addressing the balance of supply and demand for PPFP services. Our project engaged with community-level workers in Kenya⁶ and Nepal⁷, training on PPFP and supporting antenatal counselling and follow-up for PPIUD users at lower-level facilities as well as in their communities and homes.



Service delivery

Establishing safe and effective PPIUD services has been a central component to our initiative. The project demonstrated to women, their families, service providers and policy makers alike that provision of IUDs in the immediate postpartum period is not only feasible but safe and highly effective.

We worked with 56 facilities across all the countries to integrate PPIUD provision into routine care. Facility coordinators and deputies were identified to act as “champions” in each hospital. In facilities where PPFP counselling was not routinely conducted, we introduced it in both

‘Spotlight’: Quality Counselling in Bangladesh

In Bangladesh, where many myths and taboos remain in the communities about IUDs, designated counsellors help build rapport and provide information to women in a clear and balanced way, this can make all the difference. Najbin Akter uses her personal experience during counselling sessions with women in order to achieve this.

“I had been working here for many months, talking to women about the available methods of contraception and helping them decide which to use. When it came to choosing a method for myself, I needed a long-acting reversible method because I want to have another child in 5 or 6 years, I did not hesitate to choose PPIUD. It is also non-hormonal so I am able to breastfeed my baby, which is important to me.”



‘Spotlight’: Task-Sharing in India

When the PPIUD initiative started in Kalyani facility, India, PPIUD uptake was less than 1%. Once we introduced task-sharing of PPIUD insertion to nurses, access to the method was greatly expanded resulting in an increase in uptake to 37%⁸. Expulsion rates remained within the expected range and comparisons between the nurse and doctor insertion subgroups showed no significant difference.^{8,9}

the antenatal and postnatal care settings, where services existed, information was revised to include PPIUD.

New counselling tools and Information, Education and Communication materials endorsed by the government were introduced, and referral systems established to ensure that labour room staff were easily able to identify women consenting to a PPIUD, allowing a ‘one stop’ procedure to be introduced. Six-week follow-up checks were routinely offered to all women receiving a PPIUD to monitor wellbeing and address any complications.

There remains a significant shortfall in healthcare workers in many contexts, adding additional pressure to the process of providing quality SRH services. Where appropriate, we extended training to our nurse and midwife colleagues, successfully task-sharing counselling and insertion and, ultimately, reaching more women.



Information

Robust data collection and monitoring is critical to ensuring quality services and supporting workforce planning. As an initiative introducing a new component of care, it was imperative that we monitored trainings, tracked counselling and insertions and followed up women to ensure their wellbeing.

Across the facilities, Data Collection Officers documented key information, interviewed women and recorded insertions and outcomes at 6-week follow up. The data they provided was essential to facility coordinators in monitoring their service and allowed in-country teams and FIGO HQ to

track project progress. In each country, Data Safety Monitoring Boards were established that met regularly to review service delivery data and provide guidance as needed. Once safety and quality was documented and published⁹, we moved into our sustainability phase where we worked with national governments to embed core PPFP indicators into their Health Management Information Systems (HMIS). By the end of our initiative all our facilities were routinely collecting PPFP data, and integrating this into their existing national HMIS.

‘Spotlight’: HMIS changes in Kenya

Advocating towards the inclusion of PPIUD indicators into the HMIS data collection registers in Kenya was a key objective throughout the project. This collaborative process was Government-led and inclusive of a variety of stakeholders in addition to the Kenyan Society of Obstetrics and Gynecology. From 2019, Kenyan national data collection was revised to record data on the number and timing of PPIUD insertions, as well as wider PPFP indicators such as counselling. This expanded degree of monitoring allows for more effective feedback loops and planning of PPFP services at facility, county and national levels.

Key PPIUD Initiative milestones

Through the course of the project, 701,715 women received comprehensive PPFP counselling at our facilities and 84,935 women chose to and received an immediate postpartum IUD.

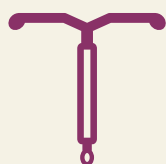


10,641
providers trained
(counselling only)

9,368
providers trained
(counselling and
insertion)

20,009
total providers
trained

1,628
CHWs



1,244,167

women delivered
at our core 48
facilities

701,715

women
counselled

84,935

women
consented

74,417

women received
an PPIUD

**Data recorded from April 2014 in Sri Lanka and from September 2015 to closure in India, Nepal, Bangladesh, Kenya and Tanzania.*

Rates:

Counselled per deliveries	58%
Consented per counselled	12%
Insertions per counselled	11%
Insertions per consented	88%

Research

At FIGO, we are passionate about learning from our work. Our initiative has completed several pieces of research, both to inform our own practice and to demonstrate the safety and impact of PPIUD services on a global level.

In 2018, we published a PPIUD supplement edition in the [International Journal of Gynecology and Obstetrics](#). Pooling data across the six countries demonstrated that infection and perforation rates were minimal and expulsion rates were <3% (equal to interval IUDs). Country level research included: factors influencing acceptability and uptake of PPIUD; task-sharing - the contribution of nurses and midwives in service provision; the effect of training community health workers; the impact of comprehensive training of dedicated counsellors on PPFP uptake; long term outcomes (12 months), as well as on clinical aspects such as Lochia and Anaemia after a PPIUD insertion.

Governments have difficult decisions to make in their resource allocation within health systems. With this in mind, FIGO commissioned an economic evaluation of the initiative in Tanzania and Bangladesh looking at the cost-effectiveness of PPIUD. This research has demonstrated that investing in the national expansion of PPIUD services not only saves lives and improves the health and wellbeing of women and children, but will also result in long-term savings to the government.

Key learnings:

1. **PPIUD is safe and effective.**

Providing IUDs in the immediate postpartum period is a safe and effective way of increasing PPFP uptake and reducing unmet need of family planning.

2. **Quality PPFP counselling is vital.**

Providing comprehensive counselling at multiple time points is a key driver to increase uptake.

3. **Task-sharing insertion accelerates progress.**

PPIUDs can be inserted by a range of healthcare providers, nurses, midwives and doctors with comparable outcomes, significantly increasing uptake and helping to reach more women.

4. **Champions make all the difference.**

Identification of dedicated "champions" for service provision helps maintain continued services, provider motivation and quality of care.

5. **It extends to the community.**

Involving community level workers in trainings is vital to ensure consistent and reliable messages reach all women.

6. **Partnerships foster sustainability.**

Creating new services that are backed by government policy and in line with health system plans ensures their sustainability.

7. **Data drives change.**

Collecting data at all levels is critical for monitoring services, shaping service development, informing practice and directing future plans and policies.

8. **Nationalising services benefits the economy.**

Not only do women and their families benefit from access to PPIUD services, it also leads to healthcare cost-savings and benefits the economy of the entire country.

Our initiative has made it possible for women to access long-acting reversible contraceptives for birth spacing, reducing the need for permanent methods such as sterilisation and increasing access to women who would otherwise not have benefitted from any contraception. Women are now also being offered a range of PPFP methods including PPIUD, as part of routine care - providing them with greater choice. Putting local leadership at the heart of our work, FIGO partnered with National Member Societies to take up the issue as part of their professional responsibility, which has been key to the initiative's long-term impact.



Annie Spratt-135307-Unsplash

Acknowledgements

We would like to thank the National Societies: SLCOG (Sri Lanka College of Obstetricians and Gynaecologists), NESOG (Nepal Society of Obstetricians and Gynaecologists), OGSB (Obstetrical and Gynaecological Society of Bangladesh), KOGS (Kenya Obstetrical Gynaecological Society), AGOTA (Association of Gynaecologists and Obstetricians of Tanzania), FOGSI (Federation of Obstetric and Gynecological Societies of India), as well as TAMA (Tanzania Midwives Association) and AVNI Health Foundation for their commitment and hard work in implementing this initiative.

We would like to thank the Ministries of Health of the Governments of India, Nepal, Tanzania, Bangladesh, Kenya and Sri Lanka. Furthermore, we wish to acknowledge all the other stakeholders who were key in the implementation of the

initiative, from participating facilities, government training and data departments, medical schools and other non-governmental organisations.

Special thanks to Sir Professor Sabaratnam Arulkumaran for his ongoing tireless support, direction and guidance throughout the project, from initial conception to final closure. At the same time, we wish to acknowledge the past and present members of the PPIUD team at FIGO headquarters and each country team that have worked hard to make this initiative the success that it has been.

Finally, we would like to thank our anonymous donor for their generous grant and continued support.



References

- 1 Guttmacher Institute. Adding it up: Investing in Contraception and Maternal Newborn Health, 2017. 2017. <https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017>. Accessed May 20, 2020.
- 2 WHO. Report of a WHO Technical Consultation on Birth Spacing [WHO website]. 2005. https://www.who.int/maternal_child_adolescent/documents/birth_spacing05/en/ Accessed 22nd May 2020.
- 3 Montagu, D et al (2017). "Where women go to deliver: understanding the changing landscape of childbirth in Africa and Asia" Health Policy and Planning, Volume 32, Issue 8, October 2017, 1146–1152. <https://doi.org/10.1093/heapol/czx060>
- 4 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.
- 5 Thapa K, Dhital R, Karki Y B, Rajbhandari S, Amatya S, Pande S, Tunncliffe EA. Institutionalizing postpartum family planning and postpartum intrauterine device services in Nepal: Role of training and mentorship. International Journal of Gynecology and Obstetrics. 2018. <https://obgyn.onlinelibrary.wiley.com/doi/10.1002/ijgo.12604>
- 6 Odongo B.E, 2Kihara A.B, Shena W, Mwenda G, Muyabwa J, Muthigani W, Achia T, Gathara D, Kosgei R.J. COMPARISON OF COUNSELLING RATES BEFORE AND AFTER COMMUNITY HEALTH VOLUNTEERS (CHV) ENGAGEMENT IN COUNSELLING ON FAMILY PLANNING AND PPIUD IN KENYA. 2019. 30 (1). <https://jogeca.or.ke/folder/journal/articles/3rd%20Article-Odongo%20BE.pdf>
- 7 Thapa K, Dhital R, Rajbhandari S, Mishra S, Subedi S, Dotel BR, Vaidya S, Pande S, Tunncliffe E-A, Makins A & Arulkumaran S. Improving post-partum family planning services provided by female community health volunteers in Nepal: a mixed methods study. BMC Health Services Research. 2020. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7027278/>
- 8 Bhadra B, Burman S, Purandare C, Divakar H, Sequeira T, Bhardwaj A. The impact of using nurses to perform postpartum intrauterine device insertions in Kalyani Hospital, India. 2018. <https://obgyn.onlinelibrary.wiley.com/doi/10.1002/ijgo.12602>
- 9 Makins A, Taghinejadi N, Sethi M, Machiyama K, Munganyizi P, Odongo E, Divakar H, Fatima P, Thapa K, Perera G, Arulkumaran S. FIGO's postpartum intrauterine device initiative: Complication rates across six countries. International Journal of Gynecology and Obstetrics. 2018. <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.12600>



figo.org

@FIGOHQ

FIGO House, Unit 3, Waterloo Court,
10 Theed Street, London, SE1 8ST, UK