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Technical Brief:
Implementing postpartum intrauterine device (PPIUD) services in healthcare facilities

PPFP Counselling Nepal – FIGO/Eliza Bell

Introduction

It is estimated that 214 million women of reproductive age in low-income regions want to avoid pregnancy, but are not using a modern contraceptive method.[1] Access to comprehensive family planning counselling and contraceptive choice enables a woman to delay or space her pregnancies and hence plan her family, in turn bringing a wealth of health benefits to herself and to her baby, as well as greater life opportunities.

As rates of institutional deliveries are increasing and maternity services are often the only healthcare facilities women come into contact with, the postpartum period presents an ideal opportunity to increase women's access to contraceptive counselling and provide them with the choice of family planning.[2]

The FIGO PPIUD Initiative was implemented across six countries, with the aim of addressing this gap in the continuum of maternal healthcare, providing for the postpartum contraceptive needs of women, by increasing the capacity of healthcare professionals to counsel in postpartum family planning (PPFP) and offer PPIUDs. Pooling data across the six countries demonstrated that infection and perforation rates were minimal and expulsion rates were <3% (equal to interval IUDs).[3] This brief presents a 'how-to' guide for societies and/or clinicians interested in implementing PPFP counselling and PPIUD service provision in their own facilities, or at regional or national levels.

Types PPFP available

The updated version of the Medical Eligibility Criteria (2015)[4] has outlined the following contraceptive methods as safe (MEC 1 and 2) in the immediate postpartum period (within 48hrs) for breast-feeding and non-breast feeding women:

- Condoms
- Lactational Amenorrhoea
- Progesterone only pill
- Intrauterine Copper Coil (PPIUD)
- Intrauterine system (containing Levonogestrel)
- Progesterone Implant
- Surgical sterilisation

Details on the advantages and disadvantages of each method can be reviewed in the relevant literature.[4,5,6]

Why PPIUD devices?

- IUDs are a long acting, and reversible contraceptive method (LARC).
- The IUD is a low cost method.[7,8]
- IUDs can be inserted immediately after the placenta is delivered, **by normal or operative vaginal delivery, or at caesarean section delivery.**
- PPIUDs are a particularly useful method of birth spacing in situations where access to health care may be limited, as they last 5 to 12 years depending on the type.
- Once trained, PPIUDs can be inserted by mid-level providers through task sharing.[9,10]
- PPIUD does not interfere with breast-feeding.
- PPIUD is relatively painless when inserted immediately postpartum as compared to the interval IUD.
- The risk of uterine perforation and infection are extremely low.[3]

FIGO PPIUD Initiative Data

701,715
Women counselled

74,417
Women received a PPIUD

9,368
Providers trained in insertion & counselling

10,641
Providers trained in counselling only

PPIUD Service Provision

PPFP/PPIUD services should be integrated into maternity services, and embedded into existing health system structures. For sustainability, incorporating PPIUD service provision into the training of existing staff is highly recommended, unless there is agreed commitment from the government for continued funding of newly appointed staff. Both pre-service and On the Job training are essential to maintaining provision, as is ensuring adequate general staffing levels. There are two aspects to PPIUD service provision: PPFP Counselling and PPIUD Insertion.

PFFP Counselling: A PPFP counselling service that educates women on PPIUD, alongside other forms of postpartum contraceptive methods available in the country should be established. The service should provide balanced counselling on all available methods and ensure that women are provided with enough information to make an informed decision regarding their family planning options. This service can be provided during antenatal appointments, although it is also possible to counsel women during early labour or in the immediate post-natal period. PPIUD can be inserted safely up to 48 hours after delivery. PPFP counselling should be incorporated into the roles of all service providers, to increase access of women to the service. Research conducted on FIGO's PPIUD Initiative showed that receiving multiple counselling sessions and, therefore, increased exposure to counselling, is the only consistent factor associated with an increased uptake of PPIUD, as opposed to other factors, such as cadre type.[11]

PPIUD Insertion: A woman can receive a PPIUD at the time of caesarean section or within 48 hours of vaginal delivery. PPIUD insertion is not recommended between 48 hours and 6 weeks following delivery. Designing a routine system that clearly identifies women who have consented to PPIUD during counselling is recommended, for example, recording a mothers consent to her chosen method of contraception on her pregnancy notes. This means that a 'one stop' procedure is possible, which is greatly advantageous and convenient for women.

KEY RECOMMENDATION

Task Sharing: Task sharing is strongly recommended, especially in facilities where women will only come into contact with midwives during delivery. During the FIGO PPIUD Initiative, introducing task sharing in India increased PPIUD uptake from <1% to 37%[9] and in Tanzania more than 58% of insertions were conducted safely by midwives.[10]

Facility Selection

Hospitals should be selected based on their capacity to provide PPIUD services (both counselling and insertion) and to train providers. For the greatest impact, large teaching hospitals are recommended due to the high number of deliveries, staff, access to trainee providers and ability to impact medical and nursing criteria. However, this has to be balanced with the need to provide postpartum family planning in peripheral communities, where the smaller structure often makes it easier to establish new services. Please see Table 1 for detailed facility selection criteria.

Table 1: Recommended criteria for facility selection

Essential	Desirable
• Ability to conduct providers training on PPFP and PPIUD • PPIUD services are not already provided • There is a maternity service/ANC service • There is already an IUD supply chain • Supportive local/national government policy	• Access to the biggest pool of interns/trainee providers • Widest impact of doctors rotating out • Facilities with high delivery numbers • Ability to impact medical and nursing training • High unmet need for contraception

Geographical location of facilities:

Often women do not deliver in the same facility they attend for pre-natal visits, or return to the same facility they delivered in for post-natal visits. This can result in women consenting to PPIUD but not being able to access it, as well as difficulties with follow-up after insertion. To address this, a mapping exercise could be conducted during facility selection to ensure service provision is spread geographically. Where possible, PPIUD training and service provision should be rolled out at multiple levels to help address this.

KEY RECOMMENDATION

Customisation: PPIUD service provision, including training modalities and implementation, will need tailoring to the local health system context. This will vary by country, region and facility.

Training of Providers

A training-of-trainer (TOT) approach can be used for both PPIUD counselling and insertion training, whereby master trainers cascade the training down to all members of staff eligible to provide counselling on family planning and/or insert PPIUDs in the facility.

Regular refresher trainings are advised to ensure newly rotated-in providers are captured and those previously trained have up-to-date skills and knowledge. Another format of training which was highly successful in the FIGO PPIUD Initiative in Nepal was an 'On the Job' training methodology which allows for training to occur without removing providers from their normal daily work setting.[12] Both these methodologies can be built in to ongoing Continual Medical Education (CME) within the hospitals or National Member Society. Materials on provider counselling and insertion training can be found here.

KEY RECOMMENDATION

Training: The modality of trainings should be adapted to local needs, context and national guidelines.

Counselling Training:

Training model recommended:
The GATHER MODEL

Providers should be trained to offer balanced counselling on all available methods of postpartum family planning, including PPIUD. Counselling only training can be provided to cohorts of service providers who would not be expected to insert PPIUDs. During the FIGO PPIUD Initiative the role of well-trained lay family planning counsellors was demonstrated to be invaluable in some countries, namely Bangladesh and India and should be considered in settings where antenatal patient flow in facilities is very high, making quality counselling impossible if left to doctors and midwives only. Similarly, in Kenya and Nepal, Community Health Volunteers were also trained to counsel women and their partners on family planning in their communities, which resulted in greater acceptability of the method.[13,14]

Equipment required: Case scenarios for role play, information on the advantages and disadvantages of all types of postpartum contraception. Providing visual aids to women, such as leaflets, posters, flipcharts and videos in local languages, alongside counselling services is recommended where possible.

Insertion Training:

Insertion training should include both methods (vaginal/caesarean) as appropriate to the provider.

Vaginal Delivery: Providers should be trained on Mama-U models; using long handled 33cm curved Kelly forceps, to ensure the IUD reaches the top of the fundus. Long handled Kelly forceps are recommended, rather than 24cm tissue or sponge forceps, which do not reach the fundus of the uterus leading to a higher chance of expulsion.

Caesarean Delivery: This can be achieved by hand or using a tissue forceps, and is under direct vision in order to achieve a fundal placement.

Equipment required: Long handled 33cm curved Kelly forceps, Laerdal's Mama-U models, IUDs, sponge holding forceps, kidney dish/gulley pot, Simms speculum, light source, flip charts, resources and video's.

Figure 1: PPIUD Vaginal Insertion

(A) Tissue forceps (24 cm, left) compared with long Kelly forceps (33 cm) used for fundal placement of the intrauterine device (IUD) in the postpartum uterus; **(B)** Insertion of the IUD with tissue forceps reaches the isthmic region of the uterus; **(C)** Insertion with long, curved Kelly forceps to place the IUD at the fundus.[6]

KEY RECOMMENDATIONS

Training Community Health Volunteers: In countries where health systems have Community Health Volunteers, drawing upon their networks in the community can be highly beneficial and we recommend that PPFP Initiatives are linked to community development programmes.

Designated Family Planning Counsellors: In countries with a very high flow of antenatal patients in facilities, designated family planning counsellors can improve counselling in both quantity and quality and should be considered if sustainable by the government in the long run.

Assessment of Provider Training

A consistent set of minimum training standards and competencies should be designed to assess provider competency, based on national training packages. These could include:

- Length and content of the training
- Number of successful insertions on models and supervised insertions on live patients

Data Collection and Auditing

Data collection should be set up within existing Health Management Information Systems (HMIS) in order that quality of the service can be guaranteed. As studies have suggested that IUD performance, including expulsion rates, vary by clinical experience,[15] it is important to proactively monitor the quality of training and provision through established tools and standardised processes. Data collecting systems should include: counselling rates on PPFP, consent for PPIUD, insertion of PPIUD, complication rates (infection, perforation, failure rate), and follow up at 6 weeks which includes expulsion and removal.

Data should be readily available for use at facility level for service planning and to support the management of trained staff. It is advisable to establish a "data safety monitoring board" consisting of experienced providers/managers to regularly review service data. Additional training of staff in data collection and analysis may be required.

A regular (6 monthly) audit of structure and process is recommended to ensure implementation is successful. This should include: required equipment, IEC materials, human resources, etc. An example can be found here.

KEY RECOMMENDATION

Collaboration; Strong collaboration is needed between all stakeholders, National Member Societies, government departments and facility-level leadership. Ensuring all are involved in decision-making processes increases motivation and encourages providers at all levels to change their practice and incorporate PPIUD services into their routine healthcare.

Find out more: figo.org/ppiud-project

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