Supplementary Information

During the webinar presentations we were asked a few reoccurring questions. For the benefit of those who are listening to the recordings, we have provided brief supplementary information to the presentations.

At what stages did counselling take place? What was the benefit of this?

The counselling took place at multiple points: through ANC if the woman attended the facility, or sometimes at satellite facilities; in some cases through Community-based service providers; and in the very early stages of labour, if appropriate. If counselling did not occur during the antenatal period, we also took the opportunity to counsel them during the immediate postnatal period as PPIUD can be inserted safely up to 48 hours after birth. Our counselling was comprehensive, informing the women on all methods available, including PPFP. We also provided language appropriate informative videos to play in antenatal waiting rooms and leaflets that the women could take back to their homes. The promotion of family planning during antenatal care is crucial to women being able to make an informed choice on their options for family planning.

Through comprehensive counselling at multiple stages we found that women were able to make an informed decision. Our study in the PPIUD supplement focusing on uptake across four countries highlighted that multiple counselling sessions was the only consistent factor that increased uptake of PPIUD.

Were the counsellors streamlined in the system, or separately employed by the project?

Where possible, any project should be integrated into the national service. During our initiative, we worked with the governments advocating for dedicated family planning counsellors where ANCs were too busy for quality counselling to take place with the existing staff. These would then be integrated into the health system. This was based on the country specific contexts and included Bangladesh, India and Nepal. In Bangladesh, the new costed implementation plan now includes the provision of a Family Planning counsellor in all sites where deliveries occur. In India, these positions were already included at the facility level and we simply enhanced them.

What is required for national scale up?

Perhaps most important is to have clear leadership, advocacy and processes/structures to support discussion of postpartum contraception as a standard part of antenatal care. This includes getting providers 'on board', as well as supporting women and families to discuss contraception as part of their planning for family health and wellbeing. However, there also needs to be corresponding 'supply side' improvements to ensure that any demand generated can be met, e.g. pre-service and in-service training to include PPFP, PPFP 'champions' at facilities, ensuring consistent availability of the methods as well as equipment required to provide them. It is critical that quality PPFP counselling is provided at all points of antenatal and postnatal care, and that PPFP is part of the wider discussion around

contraception. It would also be helpful if routine data collection could differentiate between postpartum and interval contraception so that uptake in each can be tracked more effectively and action taken as needed as support increases.

FIGO worked in partnership with the national OBGYN societies in each country. Strengthening these professional organisations to advocate for contraceptive services and in particular PPIUD was a key and highly successful strategy used in this initiative. Strong professional organisations working with their governments allow for positive and sustainable changes in policies to improve women's health.

What were some of the sustainability measures used and at what point in the project lifecycle?

Sustainability was part of the initiative from the outset and different measures were brought in throughout the project period. The commodities were not purchased by the initiative, but by the government, allowing for normal feedback on supplies. On the whole, the initiative worked within government hospitals and systems. For example in Bangladesh and India, incentives were paid to providers and to women by the government for contraceptive method uptake, as this was standard practice prior to the start of the initiative. No incentives were paid in any of the other countries.

Once the method was shown to be safe and effective in the country context, we worked with partners to ensure PPFP indicators were collected in the national Health Management Information Systems. Simultaneously, we worked with medical schools where it was possible to modify Family Planning Curricula and Midwifery/Nursing Scopes of Work/Practice to ensure that PPIUD was included for all pre-service training for incoming medical and nursing/midwifery students.

What was the M&E system used and how was quality ensured?

Monitoring and Evaluation was central to the project. During phase 1 and 2, Data Collection Officers (DCOs) interviewed all women following birth prior to their discharge and, for those accepting PPIUD, also interviewed women following their 6-week checkup. Questions were asked about their counselling experiences and on their knowledge regarding family planning, to ascertain whether they had received quality counselling. At the 6-week checkup, data was collected on complications, removals and expulsions.

The team at the national OBGYN society reviewed all data collected and provided feedback to the facilities involved, allowing for quality improvement if issues were detected. Data Safety Monitoring Boards were set up in every country to review the data on a six monthly basis. These included representatives from the national society, government level, other stakeholders in Family Planning, and facility representation.

At an international level, data across the six countries was analysed in order that lessons could be learnt between contexts, and also pooled together to inform global policy on postpartum family planning and PPIUD services.

How was the intervention tracked using HMIS? Did the registers need to be amended in order to capture PPIUD indicators?

From the outset, we worked through the national societies and with other stakeholders to try to ensure that HMIS were updated to capture PPFP record keeping. We used our monitoring data to show the importance of measuring counselling and uptake of all postpartum methods including PPIUD in the national HMIS. This was prioritised in countries where HMIS reviews were due to occur. In those countries where HMIS changes were not due, we encouraged clinical teams to disaggregate data in their existing records or provided new simple formats in order for this data to be available at facility level.

What were the complication and expulsion rates?

Across all countries, 52% of women came for their 6-week follow up appointment. Expulsion rates were < 3% across all our sites, which is similar to that recorded for the interval IUD. Expulsion rates did vary between countries and over time, in particular when new providers arrived who were not skilled at the technique. Expulsion rates can be kept low by ensuring a high fundal placement in the uterus using 33cm Kelly forceps, and ensuring that inserters keep their experience up. There were few recorded complications during insertion and no perforations. Removal rates averaged at 3.7% across all countries. Please refer to the supplement article for more information.

What did the project do towards promoting task sharing?

Task sharing has been a key component. It became clear at the start that task sharing with nurses and midwives increased accessibility of the method to all women, including those who had uncomplicated normal deliveries and would never see a doctor during their birth. In Kenya and Tanzania, midwives in fact did the majority of insertions and analysis of our data across all countries demonstrated that there was no increase in complication rates. Throughout the initiative, we have worked closely with OBGYN societies, Midwifery Associations and government departments to advocate for multidisciplinary training and provision of services. In the webinar series, the Tanzanian, Indian and Bangladeshi presentations all touched on this aspect of service provision. The PPIUD supplement articles provide further information about task sharing, in Tanzania and India.

Is PPIUD cost effective and does task sharing help with costs?

In Bangladesh and Tanzania, we looked at the cost effectiveness of PPIUD service provision and it was clear that in both countries national expansion means PPIUD is highly cost effective, creating more savings for the government than costs. The third session in our webinar series presents the results in detail, and can be found here.

In Bangladesh, we looked into the cost effectiveness of PPIUD and the impact of more midwives being included in the provision of PPFP and PPIUD. The midwifery cadre in Bangladesh is relatively new and still being rolled out nationally and currently only plays a small role in terms of PPFP/PPIUD services. Nevertheless, our estimates show that with national roll out, costs would decrease if services were provided by other cadres of

healthcare workers, including nurses. This is because the salary costs will be lower or, in economic evaluation terms, the cost per minute for clinical tasks is lower.

How has the COVID-19 pandemic affected counselling and insertion?

The obstetric encounter has become incredibly important during the COVID-19 pandemic. This has become a unique opportunity for women to access many other forms of health care – of which contraception should be a top priority. Institutional birth rates have dropped and uptake of short acting contraceptive methods has also dropped as women are fearful of going to hospitals and contracting COVID-19. With this in mind, postpartum LARCs are of particular value during the pandemic given their low failure rates due to user independence, and the fact that women do not need to return for constant re-supplies but rather can have reliable contraception for 10 to 12 years if they choose to. Currently, a central challenge is the reduced footfall at facility level due to COVID-19 and restrictions on movement are in place in many countries. FIGO encourages continued antenatal counselling on FP methods through telemedicine including a discussion on the advantages of LARCs inserted immediately after birth, such as PPIUID. It is safe to insert PPIUD during the COVID-19 pandemic as long as PPE and the recommended hygiene measures are employed, as would be the case for birth.

FIGO recommends that family planning services are essential services and therefore advocate for the continued provision of contraception (inclusive of PPIUD) during this time. More information can be found through on the FIGO website and at IJGO.