Postpartum Family Planning: Sharing Experiences, Lessons Learned and Tools for Programming—Meeting Report

12 May 2009, Washington, D.C.

Meeting Overview

On May 12, 2009, more than 76 experts and leaders in reproductive health (RH) and maternal, neonatal and child health (MNCH) from more than 22 global health organizations and programs convened in Washington, D.C., for the "Postpartum Family Planning: Sharing Experiences, Lessons Learned and Tools for Programming" meeting.

Meeting Objectives and Methods

The meeting had three objectives:

1. Present and discuss experiences and lessons learned in implementing PPFP in a variety of settings;
2. Share tools and other resources to support PPFP programming; and
3. Discuss progress, continuing priorities for research and advancing MNCH/FP integration.

Participants received a folder of materials, including background information on PPFP, the Lactational Amenorrhea Method (LAM), postnatal care (PNC), and long-acting and permanent methods (LAPMs), as well as a recent annotated bibliography of the PPFP literature produced by ACCESS-FP.

Representatives from a variety of collaborating agencies presented their experiences in panel presentations and through hands-on demonstrations. The day concluded with a small group discussion, followed by a plenary to define a future research agenda. (Presentations are summarized in the table below.)

Opening Session

Mike Burkly, USAID AOTR, welcomed participants. Catharine McKaig, ACCESS-FP Director, followed with a short presentation emphasizing that: 1) the first year postpartum has particular service delivery implications due to varied breastfeeding practices, amenorrhea statuses and levels of sexual activity; and 2) the majority of pregnancies in the first year postpartum are unintended and are at higher risk for adverse outcomes.

Over the past several years, many organizations have made contributions to PPFP learning, including the healthy timing and spacing of pregnancy (HTSP) champions network, the LAM Interagency Working Group, FRONTIERS operational research studies and the MNCH/FP integration group.

Presentation and Demonstration Highlights and Key Recommendations

The following table summarizes the presentations, lessons learned and implications for PPFP programming. The agenda and the presentations are posted on the ACCESS Web site at: http://www.accesstohealth.org/about/pgmnews/20090500d.htm.

	HIGHLIGHTS AND LESSONS LEARNED	IMPLICATIONS FOR PPFP PROGRAMMING
Repositioning LAM		
LAM Interagency Working Group, Jeanette Cachan, IRH	**Approach:** The LAM Interagency Working Group was formed to promote the use of LAM as a family planning (FP) method and as a gateway to continued use of other modern FP methods. Composed of more than 20 organizations, the group is co-chaired by ACCESS-FP and IRH. The group aims to increase awareness of LAM as a safe, effective method and increase integration of LAM with FP, MNCH and other programs, and develop consensus around LAM measurement. **Tools:** Consensus Statement on the Rationale for Operationalizing LAM Criteria; Repositioning LAM; LAM job aid and client card; inventory of job aids and materials **Outcomes:** Strategy for repositioning LAM includes simplifying LAM services and messages without changing the LAM criteria. These simplified messages include: menses has not returned, breastfeed only and baby is less than six months old.	**The strategy for repositioning LAM includes:** ▪ Emphasizing the timely transition to other FP methods. ▪ Improving LAM services by simplifying LAM messages. ▪ Broadening the program context for offering LAM, beyond FP programs to be integrated with MNCH services.
Operationalizing LAM Messages, Robin Anthony Kouyate, ACCESS-FP	**Approach:** Integrating LAM and transition counseling with community-based MNH programs in Bangladesh and Nigeria **Tools:** Information, education and communication (IEC) materials; counseling schedules that integrate LAM with community MNH household visits; strategies for creating supportive environments for exclusive breastfeeding (EBF) and LAM via "LAM Ambassadors" and community-based advocacy **Lessons Learned:** ▪ The promotion of LAM helped to extend EBF period. ▪ Sufficient time for LAM counseling must be alloted for women to understand LAM criteria and the transition. ▪ The presence of other community "influentials" during household visits should be considered to encourage the use of LAM. ▪ Knowledge of return to fertility does not equate to beliefs of personal susceptibility to pregnancy. ▪ A strong belief in menses as an indicator of fertility is present, despite LAM knowledge.	**Integration is feasible:** ▪ LAM can serve as a natural platform for integration of PPFP with MNH. ▪ The integration of LAM with MNH programs can help to facilitate awareness of healthy spacing of pregnancies, return to fertility and PPFP use. **Timely transition needs to be emphasized:** ▪ Highlight transition in IEC materials and messages. ▪ Tailor messages by context—return to fertility; breastfeeding status, etc. ▪ Determine critical moment of risk for counseling. ▪ Discuss transition in community mobilization meetings. ▪ MNH referral systems for sick children may not be adaptable for PPFP services. ▪ Distribution of methods may be important for improving access to transition.
Integrating LAM with the Pragati Project, India, Adrienne Allison, World Vision	**Approach:** Timed and targeted counseling approach—Integration of LAM counseling with a community-based child survival project **Tools:** IEC messages; volunteer registers; standard kit of job aids; simple job aids to dispel myths and highlight benefits of FP method **Findings:** ▪ All initiated breastfeeding within one hour of birth.	**Three requisites for success:** ▪ A cadre of community volunteers trained to identify women in early pregnancy and track them over time to deliver counseling. ▪ Registers to track conception, birth cohorts and outcomes, and simple job aids that detail the benefits of each behavior and

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	▪ All LAM users stayed at home. ▪ Many were first-time users of a modern method. ▪ LAM increased confidence in breastfeeding skills. Noted ease of use, no cost, no need for heating, no clash with religious beliefs.	help dispel myths. A standard kit of job aids to ensure that messages were consistent across time and location.
Facility-based Country Experiences		
Assessing the Quality of Comprehensive Postnatal Care, Saumya Ramarao, Population Council	**Approach:** Used Assessing Integration Methodology (AIM) manual to evaluate the quality of comprehensive PNC (including PPFP) in Kenya, Lesotho and Swaziland **Data Collection Tools:** Facility inventory, observation guide, questionnaires and focus group discussions **Selected Outcomes:** ▪ Composite score in FP and fertility counseling for six-week postpartum (0–4) increased significantly in Kenya. ▪ Composite score in PNC quality of care (0–32) increased in three countries.	**Results from three countries demonstrated that:** ▪ AIM is a useful tool for planning and monitoring facility readiness, as it provides an overview of the components of integrated care and can compare quality of care over time. ▪ Interest in integrating PPFP and PNC do exist, and integrated care models are feasible.
Initiating PPFP in Albania, Altina Peshkatari, ACCESS-FP	**Approach:** Introduced immediate postpartum (PP) and postabortion (PA) FP prior to discharge through ob/gyns and midwives at maternity hospitals, and extended PPFP through pediatric services with the focus of demand generation in four maternity hospitals and 22 health centers in Albania. **Tools:** Job aids for providers and client materials including leaflets, pre-discharge brochures and posters **Selected Outcomes:** ▪ Contraceptive uptake increased from 0% to 76% (PP) and from 1% to 38% (PA) at discharge at one year post-intervention. **Lessons Learned:** ▪ IEC materials help clients to internalize messages and understand contraceptive options. ▪ Pretesting of materials shows that women need more information than illustrations. ▪ In addition to training, supervision visits and job aids help providers to comply with newly introduced approaches. ▪ Support from key persons at facilities paves the way for newly introduced approaches.	**In Albania, opportunities exist to improve PAFP and PPFP:** ▪ Physicians' motivation to provide high-quality FP services is hampered by their perception of personal benefit, although facilities in general are open to change and the new generation of doctors is receptive and enthusiastic to implement new approaches. ▪ Development of national FP protocols opens the possibility for the standardization of FP services, including PP and PA settings. ▪ Constant dialogue with partners and national stakeholders is key to ensure that program efforts are coordinated and sustainable.
Scaling up PPFP in Yemen, Salwa Bitar, ESD	**Approach:** Basic Health Services (BHS) project introduced FP/MNCH best practices—including PPFP/HTSP, Kangaroo Mother Care, immediate EBF and LAM, neonatal infection prevention and distribution of vitamin A to women after delivery—in one Yemeni hospital and expanded to six more hospitals in preparation for a national scale-up. **Tools:** Training guidelines and protocols; PP mother information booklet/brochure and post-miscarriage brochure with HTSP messages **Selected Outcomes:** ▪ PPFP/HTSP counseling rose from 0% to 73% in	**The following opportunities for scale-up emerged as a result of this effort:** ▪ Ministry of Health/Population Sector endorsed scaling up best practices in its 2009 work plan. ▪ Ministry of Public Health and Population (MOPHP) added a working group on best practices to its Reproductive Health Technical Group. ▪ BHS provided MOPHP with best practices training curriculum for

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	six months, and post-miscarriage counseling increased from 0% to 33% in three months.	training providers from 67 districts as part of MOPHP's health systems strengthening project (funded by GAVI). ▪ MOPHP appointed an Improvement Collaborative (IC) Coordinator to assist in national scale-up. ▪ The IC teams will develop a plan for national scale-up in collaboration with Directors of Health and support from the Secretary General. ▪ MOPHP is approaching other donors to scale up nationally.
Postpartum Long-acting and Permanent Methods Demonstrations		
PPIUCD-Manual Insertion, Rosemary Kamunya, Jhpiego/Kenya	▪ Postinsertion counseling is different from interval insertion. ▪ An advantage of the PPIUCD is that some side effects from insertion are masked by normal PP physiological changes (e.g., lochia and after-birth cramping). ▪ Midwives have modified gloves to protect the forearm (by cutting off one digit and pulling over first pair of gloves up to the cuff). ▪ In maternity wards, instruments needed for PPIUCD are frequently in the surgical suites and are not readily available for midwives. ▪ Many myths about IUCDs still exist in the community and need to be overcome.	▪ Good communication is required among ANC, labor and delivery (L&D), and PNC providers (both for manual and instrumental IUCD insertions). ▪ When a client presents to L&D ward, a review of the records is needed to see if she is a candidate for a PPIUD (if she has expressed an interest and is medically eligible).
PP No-Scalpel Vasectomy, Carmela Cordero, RESPOND	▪ The No-Scalpel Vasectomy (NSV) does not use a scalpel to cut the skin; the provider secures the tube using ring forceps and then pierces the skin of the scrotum. ▪ The tubes can be reached and blocked in the same manner as a conventional vasectomy by gently stretching the opening, and sutures are not needed because the scrotal skin opening is small. ▪ No-scalpel vasectomy offers several advantages over the conventional vasectomy: fewer complications, less pain and earlier resumption of sexual activity after surgery. And the NSV procedure takes about half the time as a conventional vasectomy because it requires no scrotal incision. ▪ NSV is also believed to decrease men's fear of vasectomy. ▪ The procedure has been introduced in more than 60 countries. In the United States, more than 15 million men have had a NSV.	▪ Multiple service contacts during pregnancy, delivery and postpartum offer multiple opportunities for the man to hear about the benefits of pregnancy spacing, which is an important factor since the man often has substantial influence on a couple's decision to use FP. ▪ For couples who have completed their families, the offer of NSV during the PP period is ideal since couples need to wait 12 weeks before the man has cleared sperm from his reproductive tract for effective FP. For women who practice EBF, they can use LAM as a back-up method. ▪ Effective counseling about NSV is needed to reassure men that there is no decrease in their masculinity.

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PPIUCD, Instrumental Insertion, Jeffrey Smith, Jhpiego/Asia	▪ Job aid developed for PPIUCD insertion is helpful; there are few restrictions for use of PPIUCD; insertion is not difficult, but correct technique is essential and special training is required. ▪ Physicians and decision-makers need to be a part of PPIUCD training sessions to allow them to understand the service delivery requirement. ▪ Training sessions do not need to be long but should be competency-based. ▪ PPIUCD is a well-accepted method for postplacental or intracesarean insertion after mother has given consent.	▪ Effective counseling should occur during ANC or prior to active labor. Alternatively, women can be counseled prior to a scheduled cesarean section or during the immediate PP period on the PP ward within the first 48 hours. ▪ Indication of the woman's interest in PPIUCD should be written on the woman's ANC card. Confirmation that they still desire this method must occur prior to insertion (both for manual and instrumental).
PP Tubal Ligation, Ricky Lu, Jhpiego/MCHIP and Tsigué Pleah, Jhpiego	▪ The minilaparotomy tubal ligation procedure under local anesthesia is relatively easier to perform during the immediate PP period than an interval tubal ligation, especially when done within the first 48 hours PP. ▪ During the PP period, the uterus and its fallopian tubes are much more accessible through a thinned-out abdominal wall, making the procedure easier to perform. However, the risk of complications such as bleeding and failure is greater due to increased vascularization and engorgement of the tubes. ▪ Ligation needs to be secure to ensure hemostasis and prevent slippage of the tubes. ▪ There are differences in technique for performing interval tubal ligation compared to PPTL.	▪ Client needs to be informed and voluntarily accept PPTL prior to onset of active labor. ▪ Training can incorporate a PPFP update, counseling and infection prevention practices in a 1–2 week competency-based refresher or new provider PP minilap under local anesthesia clinical skills training course. ▪ Clinical skill learning guides and checklists, and pelvic models with relevant postpregnancy accessories should be used to develop skill competence in the minilap technique prior to developing competency with clients.
Revitalizing PPIUCD		
Experience from Kenya, Rosemary Kamunya, Jhpiego/Kenya	▪ IUCD use in Kenya has fallen from 30% to 7% in last 20 years, so it is important to address myths and provide effective counseling. ▪ PPIUCD use could be an opportunity to revitalize IUCDs; PPIUCD counseling may increase interval use (anecdotal evidence only). ▪ In Kenya, training programs are midwife-focused since they are more likely to attend normal deliveries in hospitals and in lower-level facilities. ▪ High demand for DMPA and implants makes PPIUCDs a third choice for long-acting methods.	▪ Midwives in lower-level facilities can insert postpartum IUCDs, thus broadening contraceptive options.
Experience from India, Jeffrey Smith, Jhpiego/Asia	▪ PPIUCDs offer an alternative to female sterilization. ▪ India has a PPFP program that relies heavily on sterilization; among all women, 37% use female sterilization while only 2% use IUCDs for contraception. ▪ The use of the PPIUCD in Uttar Pradesh has been through the medical college. ▪ A trend toward intracesarean as opposed to postplacental insertion has been noted.	▪ Systematic PPFP counseling is "stamped" into ANC records, so it can't be omitted. ▪ Job aids and standards have helped to assure standardized care. ▪ For women who are not "booked" through ANC, they can still opt for PPIUCD within 48 hours after delivery.

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Discussion/small group work: "Should we re-vitalize PPIUCD?"	**PPIUCD better opportunity for IUCDs than interval:** ▪ Fewer accessories than interval ▪ Immediate protection where 95% want to avoid pregnancy for at least two years ▪ Cost-effective ▪ Importance of involving capable midwives at delivery	▪ Need for infection prevention instruction and counseling. ▪ Woman should return for PPIUCD check once at her six-week visit, then annually. ▪ Several participants suggested forming a PPIUCD working group.

Defining a Research Agenda

This session, which included an overview of the PROGRESS Program, was facilitated by John Stanback, a PROGRESS/FHI representative. Six small group discussions were focused around six topics: FP integration with PMTCT, community-based services for PPFP, maximizing LAM and transition to other methods, FP integration with MNCH services, immediate PP services, and FP integration with immunization services. There appeared to be overlap among the groups with regard to identified research questions. These questions can be grouped into five major areas: 1) timing of FP services during the PP period, 2) impact of PPFP on other services, 3) cost and cost-effectiveness of integrated services, 4) management of provider workload, and 5) services for women delivering at home versus those delivering in health facilities.

Consensus and Next Steps

Virginia Lamprecht, USAID Senior Technical Advisor, summarized highlights from the meeting and highlighted next steps, which included:

- Increase use of PPFP and EBF by increasing emphasis on LAM;
- Improve counseling on the return to fertility and develop better understanding about the risk of pregnancy before menses returns and the timely transition to other modern methods;
- Utilize all contacts with women at all MNCH visits—from ANC through PP and PNC visits;
- Ensure providers are prompted to provide long-acting and permanent methods; and
- Utilize tools to assess the integration of FP with other reproductive health services.

Selected Resources

- PPFP Toolkit: www.ppfp-toolkit.org
- ACCESS-FP Web site: www.accesstohealth.org
- PPFP Community of Practice: www.my.ibpinitiative.org/public/ppfp/

ACCESS-FP, a five-year, USAID-sponsored global program, is an associate award under the ACCESS Program. ACCESS-FP focuses on meeting the family planning and reproductive health needs of women in the postpartum period. Interventions are designed to complement those of the ACCESS Program in the promotion and scale-up of postpartum family planning through community and clinical interventions. ACCESS-FP will reposition family planning through integration with maternal, newborn and child health programs, including the prevention of mother-to-child transmission of HIV. For more information about ACCESS-FP, please visit www.accesstohealth.org/about/assoc_fp.htm, or contact Catharine McKaig, ACCESS-FP Program Director, at cmckaig@jhpiego.net

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