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MCHIP Maternal and Child Health Integrated Program

Postpartum Family Planning (PPFP) Technical Meeting

Meeting Report

27 May 2013

Women Deliver Pre-Conference Event
Kuala Lumpur, Malaysia

Acronyms

AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric And Newborn Care
CEmONC	Comprehensive Emergency Obstetric And Newborn Care
CHW	Community Health Worker
ELCO	Eligible Couples (mapping)
ENC	Essential Newborn Care
FBO	Faith-based Organization
FFSDS	Fully Functional Service Delivery System
FP	Family Planning
HIP	High Impact Practice
HTSP	Healthy Timing and Spacing (of pregnancies)
ICFP	International Conference on Family Planning
IEC	Information, Education, and Communication
IUD / IUCD	Intrauterine Contraceptive Device
JHU	Johns Hopkins University
LAM	Lactational Amenorrhea Method
LAPM	Long-Acting and Permanent Methods (of family planning)
LARC	Long-Acting Reversible Contraception
M&E	Monitoring and Evaluation
MCHIP	Maternal and Child Health Integrated Program
MIYCN	Maternal, Infant, and Young Child Nutrition
MNCH	Maternal, Newborn, and Child Health
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MSH	Management Sciences for Health
NCMNH	National Committee for Maternal and Neonatal Health
NGO	Non-governmental Organization
NNW	National Nutrition Week
PBC	Performance-based Contracting
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PNC	Postnatal Care
PPFP	Postpartum Family Planning
PPIUD / PPIUCD	Postpartum Intrauterine Contraceptive Device
PPSS	Postpartum Systematic Screening
PPTL	Postpartum Tubal Ligation
PSI	Population Services International
RMNCH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SBA	Skilled Birth Attendant
USAID	United States Agency for International Development
WHO	World Health Organization

Front cover photo credit: Elaine Charurat

Overview

During the first year postpartum, most women want to delay their next pregnancy for at least two years, or not get pregnant at all, yet contraceptive use during this period is typically low. Postpartum family planning (PPFP) refers to FP services provided during the first year postpartum and includes counseling on return to fertility, return to sexual activity, breastfeeding, contraceptive method considerations, and healthy timing and spacing or limiting of the next pregnancy.

On May 27, 2013, the Maternal Child Health Integrated Program (MCHIP) held the 6th annual PPFP technical meeting in Kuala Lumpur, Malaysia, as a satellite event at the Women Deliver Conference. This marked the first time that the PPFP technical meeting has been held outside of Washington, D.C. The meeting provided an opportunity for implementers and field practitioners to share technical updates and progress on implementation of PPFP programs.

Meeting Objective and Methods

The objectives of the meeting were to:

- Provide a forum for participants to share emerging and best practices in PPFP programming;
- Share experiences with integrated programming at the community level in the areas of maternal health, child health, and nutrition; and
- Announce forthcoming resource from the World Health Organization (WHO), entitled *Programming Strategies for Postpartum Family Planning*, to be released in late 2013.

The event included plenary sessions, a marketplace of interactive exhibits, and two sets of concurrent sessions featuring panel presentations on PPFP strategies and tools to support program initiatives. Presenters highlighted PPFP programmatic opportunities and challenges around four main themes:

1. FP integration in antenatal and the immediate postpartum period;
2. FP service integration in the extended postpartum period (including integration with immunization and nutrition);
3. Experiences with community-based PPFP service provision and demand generation for FP in the postpartum period; and
4. Addressing systems issues in integrating FP with maternal, newborn, and child health (MNCH), HIV, and nutrition, including advocacy and policy issues, human resources, recordkeeping and health management information systems, as well as experiences in overcoming structural/bureaucratic barriers.

The Postpartum Family Planning Community of Practice listserv was used to solicit abstracts for meeting presentations and to disseminate information about the meeting.

Participants

Approximately 100 experts and leaders in reproductive health and MNCH from over 40 global health organizations, government agencies, donors, universities, and other groups participated in the meeting.

Gold Nuggets

Moderators and participants distilled key points and insights from each concurrent session.

FP Integration with MNH Services

- Integration is a smart choice for maximizing women's contacts with the health system.
- Integration is possible at all levels (national, facility, community) and across both public and private sectors; advocacy needs to occur at all levels for acceptance.
- Strong health systems are important for sustainable and efficient integration.
- Training of health workers is critical for delivery of integrated services; must focus on pre-service education, not just in-service training.
- Dedicated FP counselors make a difference, but adding a human resource category has cost implications.

Health Systems Issues with PPFP & Advocacy

- There are multiple ways to address human resource gaps:
  - Can bring retired midwives back into practice with not just MNH but FP as part of scope of work;
  - Task-shifting – lower-level community midwives can provide implants;
  - Health workers can effectively offer LARCs, though it takes time to figure out the right approach for the context.
- Commodity security affects scale and sustainability:
  - Without long-range planning in place often encounter stock outs, either from unanticipated need or logistics that prevent commodities from getting to intended users.
  - Free contraceptive services to migrants in Shanghai show there is need outside traditional systems.
- There is a need for separate M&E for both integration components and a need to figure out how best to measure the efficiencies that integration is supposed to generate.

FP Integration with Child Health & Nutrition Services

- Capitalize on all contacts women have with the health system, including seeking services for children, to provide PPFP information and services.
- Consider the "one-stop shop" model of providing same-day services at one place.
- Bolster all services being integrated and monitor key indicators for both services.
- Make sure FP commodity supply can meet increased demand from integration.
- Need for high quality training and refreshers.
- Address provider misperceptions and biases around FP and integrated services.
- Pair integrated services with other activities to build community and partner support.
- Keep sustainability in mind from the beginning of the program—engage with the Ministry of Health and encourage providers/managers to embrace FP from a long term view.

Community-Based PPFP & Demand Generation

- CHWs are a valuable resource that need to be supported financially to be successful.
- Social, personal and cultural beliefs have tremendous impact:
  - Bangladesh FP integration program found it hard to entice women whose husbands were abroad and where women had limited mobility.
  - Do not forget husbands—they do care!
- Having an operational assessment and M&E plan upfront is critical for scale-up, which needs to be done at gradual pace.
- Consider adapting existing tools—a PPFP screening tool developed elsewhere and adapted for Indian context showed significant increase in uptake of FP.

Welcome and Opening Plenary Session

Ms. Anne Pfitzer, MCHIP's Family Planning Team Leader, and **Dr. Koki Agarwal**, MCHIP Director, welcomed participants to the meeting. Dr. Agarwal noted that it was a great pleasure to hold the meeting in Asia, where proportions of unmet need for family planning may be lower than some regions yet sheer numbers of women with unmet need are high. MCHIP's family planning approach seeks opportunities to integrate PPFP across the continuum of care. She stressed the need, as a community, to identify what works most effectively and garner resources to scale up these practices.

Ms. Anuradha Gupta, head of India's National Rural Health Mission, moderated the plenary session. In her opening remarks, she mentioned that interest and investments in family planning had previously been dwindling. The 2012 London Summit on Family Planning generated major support for investing in family planning at the international level. More than just as a population stabilizing issue, family planning is being reframed as central to the rights of women, enabling them to realize their aspirations. "We can't look at family planning in isolation, but rather we need to look at the entire continuum of care," Ms. Gupta emphasized. "It is important to promote spacing of children, especially to the many women who are delivering in facilities — we should capitalize on this opportunity to provide immediate postpartum services. There are still many women delivering at home, and we need to reach them as well." In India, the government has launched a Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+) approach to cohesively improve maternal and child health across life stages.

Ms. Patricia MacDonald, Service Delivery Improvement Programme Advisor at USAID, presented on "Postpartum Family Planning: Rationale and Integration Models." The presentation highlighted a continuum of PPFP contact points, from antenatal services to birth, postnatal, and childhood visits. She detailed several successful integration models including building FP into antenatal care (ANC) as well as maternal and newborn health (MNH) services at health facilities, which provide an opportunity for insertion of postpartum intrauterine contraceptive devices (PPIUDs) after facility deliveries. At the community level, community health workers (CHWs) have successfully provided integrated MNH-FP counseling and services. Finally, PPFP can be effectively integrated with nutrition, immunization, well child visits, postnatal care (PNC), and prevention of mother-to-child transmission of HIV (PMTCT) services at the community or facility levels.

Dr. Mary Lyn Gaffield, WHO, announced the new WHO resource, *Programming Strategies for Postpartum Family Planning*. In this presentation, Dr. Gaffield described WHO's recent efforts to advance PPFP, including the Statement for Collective Action for PPFP, which highlights the importance of family planning programs reaching postpartum women and offers broad strategies to address unmet need among these women. This supporting document to the Statement, *Programming Strategies for Postpartum Family Planning,* presents strategies for integrating PPFP into antenatal care, labor and delivery, postnatal care, and infant health and immunization services. The official launch of the document is planned for the 3rd International Conference on Family Planning (ICFP) to be held in Addis Ababa in November 2013.

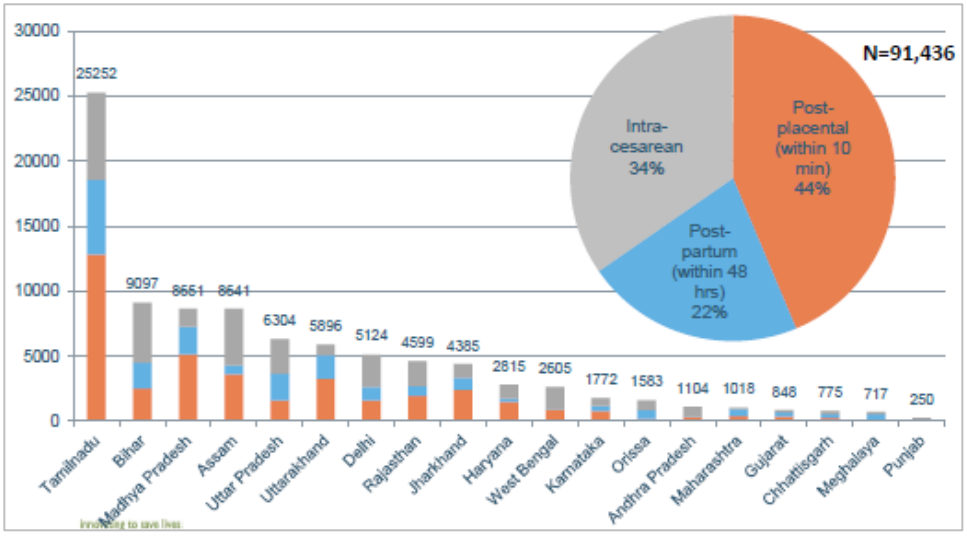
To view and endorse the Statement for Collective Action for PPFP, visit http://www.mchip.net/ppfp/

Concurrent Sessions

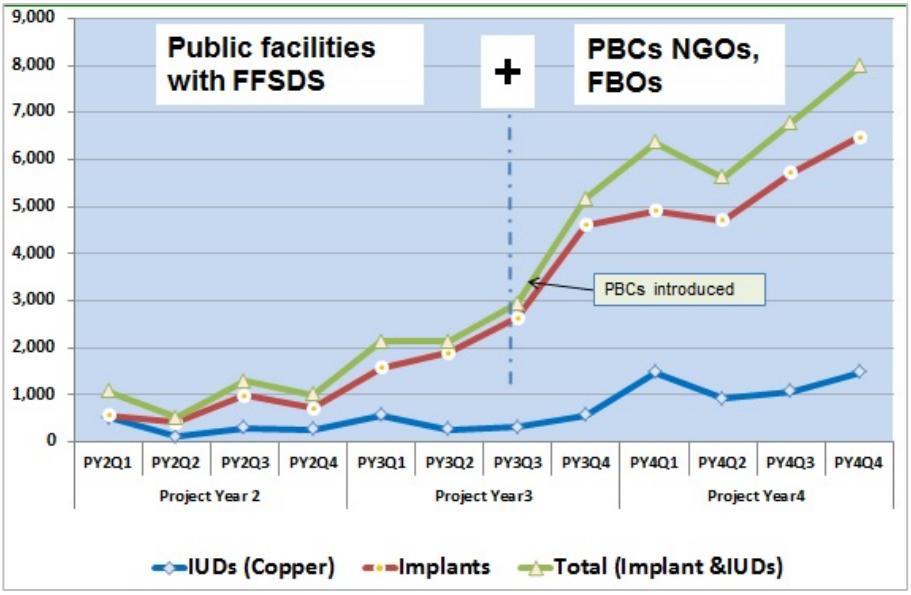
Four sessions were conducted, with two concurrent sessions held in the morning and two concurrent sessions held in the afternoon. The morning sessions presented experiences with 1) FP Integration with MNH Services, and 2) Integration with Child Health and Nutrition Services, while the afternoon sessions covered 3) Community-based PPFP and Demand Creation, and 4) Health Systems Issues with PPFP and Advocacy. The table below summarizes the presentations, results and findings from program research, and lessons learned and implications for PPFP programming.

For full copies of each presentation, please visit:
http://www.k4health.org/toolkits/ppfp/ppfp-technical-meetings

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
CONCURRENT SESSION 1	**FP INTEGRATION WITH MNH SERVICES**
Comprehensive Postnatal Care: Integrated Postpartum Family Planning and HIV Services in Swaziland and Zambia Timothy Abuya Population Council	Two programs, one in Swaziland and one in Zambia, integrated standard postnatal care (PNC) with PPFP to create more comprehensive PNC services that could then be integrated with HIV services. PPFP counseling and service provision were provided during increased PNC contact points. This integrated model also aimed to build provider capacity, improve data collection and recording, and strengthen referral systems. Evaluations examined demand for and quality of comprehensive PNC services. Quality measurements included appropriate counseling for PPFP and proper examination of the mother and infant. In Swaziland, client-provider interactions were observed at four points during the 1-year intervention. In Zambia, intervention effects were assessed with a cluster randomization design; client-provider observations were conducted at baseline and end line (6 months) in intervention facilities with integrated HIV-PNC vs. comparison facilities providing standard care. **Findings** The interventions in both countries had modest positive effects on the quality of PNC services. **Lessons Learned** • Engaging with pre-service education institutions to standardize and institutionalize comprehensive PNC services and using focused antenatal care (ANC) as a platform may help achieve higher quality. • Challenges included inadequate provider knowledge, skills and practice on PNC; staffing shortages; and limited demand among mothers for PNC services.
Training for and Institutionalization of Post-Placental Insertion of IUCD (PPIUCD) in Selected Public Hospitals of Pakistan Laila Shah & Azra Ahsan	This presentation reported on the first 12 months of an ongoing intervention to institutionalize PPFP/PPIUCDs in two tertiary care hospitals in Karachi, Pakistan. From April 1, 2012 to April 30, 2013, NCMNH trained 9 master trainers, 21 trainers, and 186 other skilled birth attendants (SBAs) in PPIUCD insertion and instituted a trainee follow-up support system. Clients were counseled on PPFP in ANC clinics, the labor room, and the postnatal ward. Providers inserted IUDs after vaginal delivery and during caesarian delivery, with post-insertion follow-up at 6 weeks and 6 months.

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
National Committee for Maternal and Neonatal Health (NCMNH) Pakistan	**Findings** • Out of the 18,733 deliveries during this time, 27% of women (5,122) accepted insertion of a PPIUCD. Of the nearly 17,000 women contacted by phone at six weeks, 43% indicated they had verbally accepted a PPIUCD, 30% actually received an insertion, and 26% had refused. • Most insertions (66%) were post-placental (within 10 minutes of delivery), 20% were intra-caesarian, and 14% were immediate (within 48 hours of delivery). • At 6 weeks follow-up (n=4,476), over three quarters (78%) of women had no complaints. Rates of complications included: o Missing strings/other complaints (e.g. spotting, cramping): 14.6% o Removal request: 4.1% (on a few occasions, husbands objected to insertions and requested removal). o Expulsion: 2.3% o Infections: 1.3% o 0.1% pregnancy with IUD in situ (one pregnancy) at 6 weeks; another pregnancy was reported at 6 months. • The continuation rate at 6 months was 89.8%. • Insertions were easily performed by midwives but increasingly performed by postgraduates as they gained experience. **Lessons Learned** Results demonstrated that, especially with well-trained providers available for insertion at all times, PPIUCDs were well-accepted, even in a setting that has traditionally had low interval IUCD uptake.
Revitalization of PPFP/PPIUCD Services in India Bulbul Sood Jhpiego/India	This presentation detailed the success of the recent scale-up of PPFP/PPIUCDs in India, where PPIUCDs previously had a negative reputation. A series of policy developments in 2009-2010, including a conditional cash transfer scheme that brought more women to facilities and a policy paradigm shift that promoted FP as an MNCH initiative, created an opportunity to introduce and rapidly expand PPIUCDs to more than 20 Indian states (see chart). Jhpiego/India provided technical assistance, training material and job aids to support service delivery as well as client education materials and data collection registers. *Total Reported PPIUCD Insertions in India, Feb. 2010 - early May 2013* 

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
	During the Q&A, Dr. Sood explained that PPIUCDs were extremely unpopular when the program began because of poor past experience with interval IUCDs. The program started with one medical college and developed a champion there who trained nurses. After documenting that the expulsion rate remained low, they expanded to six high-focus states to work to change perceptions about PPIUCDs, which have slowly but steadily been growing in popularity. **Findings** • From February 2010 to May 2013, more than 90,000 PPIUCDs have been inserted, covering almost 8% of institutional deliveries. • Follow-up findings on safety and efficacy at 6 weeks (n=35,309) have met expectations, with a low expulsion rate of 2.6%. **Lessons Learned** • To minimize the risk of expulsion, perform competency-based training and use the correct technique and instrument to place the IUD. • Strengthening counseling through India's new cadre of "RMNCH counselors" should help dispel remaining myths about PPIUCDs and serve other PPFP needs such as postpartum tubal ligation (PPTL) and comprehensive post-abortion care. • Adequate post-training opportunities and supportive supervision are essential to increase the quality of services from insertion through follow-up visits.
Guinea: Integrated Training for CEmONC and LAPM of Family Planning Blami Dao & Yolande Hyjazi MCHIP	This presentation examined a six-month intervention taking place in five hospitals in Guinea, a country with a maternal mortality rate of 980 per 100,000 live births. Less than one percent of women use long-acting and permanent methods (LAPM) of FP. The intervention integrated existing LAPM training and comprehensive emergency obstetric and newborn care (CEmONC) training into one program. The first phase of training taught basic emergency obstetric and newborn care (BEmONC) alone to ensure provider proficiency; the second phase added CEmONC as well as postpartum LAPM, including PPIUDs and PPTL. CEmONC training was extended in duration to include the FP competencies and the team prepared the training site in advance to ensure sufficient caseloads for each type of service. **Findings** • Both the number of deliveries and partograph use more than doubled at six months after the intervention. Partograph completion increased from 19% to 47%, while C-section rates decreased from 31 to 23%. • Quality of PPIUCD services appeared high, with no cases of infection and an expulsion rate around 2% at six months. While PPIUD insertions decreased at one point, this was probably due to 2-3 months of stock-outs. **Lessons Learned** In addition to stock outs, the intervention struggled to ensure an adequate caseload for trainees; integrated training programs should carefully select higher-caseload sites.
Health Systems Strengthening and Integration of FP/MNCH in Uganda Celia Kakande	The USAID-funded STRIDES project, launched by MSH in 2009, works to build stronger integrated health services in 15 districts in Uganda, a country with a total fertility rate of 6.2, where 16 women die daily from pregnancy-related deaths. The program has confronted the familiar challenges of low-resource settings – crowded health facilities with few well-trained health workers, stock-outs of essential commodities, and limited private sector involvement.

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
STRIDES-Uganda & Fabio Castano Management Sciences for Health (MSH)	The STRIDES approach follows the WHO building-blocks model for health systems strengthening with interventions at multiple points on the continuum of care: national-level technical working groups, district-level health facilities, and community-level village health teams (VHTs). One intervention, the performance-based contracting (PBC) program, promotes private sector leadership of integration opportunities. Contractors receive additional funds for achieving certain mutually agreed upon performance targets. Those additional funds are used to both make investments in improving service delivery and to reward team members. **Findings** • Facilities supported under the PBC program have shown greater uptake of LAPM than public facilities with fully-functioning service delivery systems. Between PY1 (baseline) and PY4, new users of FP in project sites rose from 136,272 to 193,910 and revisits from 85,154 to 135,798. • About 11,200 women in STRIDES intervention areas are now using long-acting methods, up from about 1,200 three years before. *Effect of FFSDS and Performance-Based Contracts on Implants and IUDs*  **Lessons Learned** • Strategies that helped the project exceed targets included effective community mobilization for FP services and PBCs, which led to significant involvement of seven STRIDES subcontractors (whose reported numbers accounted for 98% of implants and 94% of IUDs). • Village health teams can effectively manage integrated services but there is need for strengthening supervision and referral systems.
Afghanistan Community-Based PPFP Nasratullah Ansari Jhpiego/Afghanistan &	A community-based PPFP initiative was introduced in Afghanistan because most women deliver at home and do not visit facilities for PNC, so the best opportunity for PPFP outreach is through CHWs. The intervention had four components: advocacy to create an enabling environment for PPFP services, capacity-building to train CHWs, house-to-house PPFP counseling by CHWs, and supportive supervision and monitoring. Delivery of PPFP services was contracted to other NGOs.

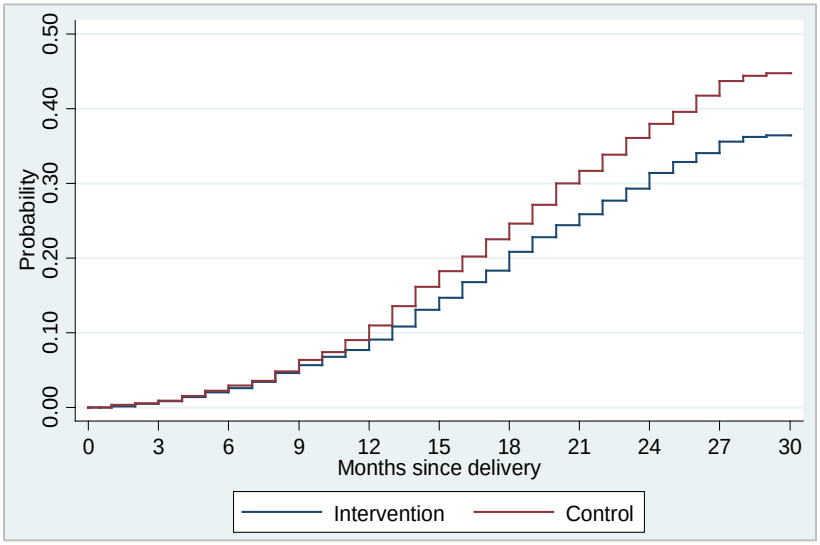
Presentation	Summary, Key Findings, and Lessons for PPFP Programming
Shafiq Mirzazada Aga Khan Health Services/Afghanistan	**Findings** Advocacy by religious leaders was essential to the success of this initiative, in which knowledge of FP methods increased to almost 70%. **Household Counseling Visit** **Key Messages** / Pregncy / 24-48 Hrs / w/in 7 days / 6 wks PP / 3-4 mos PP HTSP: x x x x x Essential newborn care, EBF: x x x x LAM: x x x x x Return to fertility: x x x x Transition to FP from LAM: x x x x x Discussion FP side effects: x x x Referral to HF contraceptive methods: x x x *Highlights from the Audience Q&A* CHWs delivered key messages through household counseling visits at various times over 3-4 months (see chart, left). One participant noted that other programs also use a 3-4 month counseling period because it reaches women several months after pregnancy, when they begin to realize the timing limitations of LAM. In Afghanistan, counseling is bolstered by service provision since CHWs can provide pills and injectables. An audience member commented that a similar situation exists in Uganda, where village health teams can deliver short-term FP methods like injectables, then refer women to facilities. **Lessons Learned** Counseling strategies that used the lactational amenorrhea method (LAM) as an entry point to discuss transitioning to other FP methods appeared effective and should be considered in other religiously conservative settings, where these messages are culturally well-accepted.
CONCURRENT SESSION 2	**Integration with Child Health and Nutrition Services**
Making Progress with Family Planning & Immunization Integration: Results from the PROGRESS Project* Kate Rademacher FHI 360	PROGRESS focused on increasing access to FP in underserved populations, looking to take advantage of multiple and timely opportunities to reach mothers, including integration of FP with immunization services. This presentation provided a snapshot of PROGRESS' FP-immunization integration work and results of cluster randomized trials in Ghana/Zambia and Rwanda. In both Ghana and Zambia, the project evaluated introduction of a job aid for immunization providers on individual risk/need assessment for family planning (based on LAM criteria), with provision of same-day FP services at the same location. In Rwanda, the intervention also included group talks, brochures, and supportive supervision. **Findings** • Individual FP consultations with women did not always happen as planned. In Ghana/Zambia, the job aid was frequently used as part of group health talks as opposed to individualized counseling. • In Rwanda, immunization rates were not negatively affected by the intervention. Immunization data were not reported for Ghana.

* This study on "Integrating family planning messages into immunization services: a cluster-randomized trial in Ghana and Zambia" has been published by Vance, G. et al. in *Health Policy and Planning* 2013;1–8.

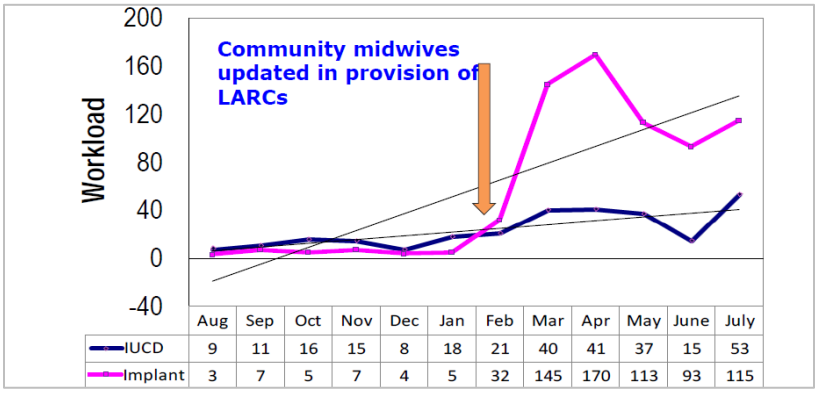
Presentation	Summary, Key Findings, and Lessons for PPFP Programming
	Lessons Learned • In Rwanda, engaging Ministry of Health (MoH) personnel in supportive supervision was important to successful implementation. Refresher training was required to address the issue of provider attrition. • Using LAM criteria to screen for risk may be problematic if messaging reaches women too late, when LAM is no longer an option. Messages should be refined to target persistent misperceptions that women need to wait for return of menses after giving birth to initiate an FP method. • Collecting immunization and cost-data is key to inform future scale-up of family planning and immunization models.
Family Planning and Immunization Integration in Liberian Health Facilities Nyapu Taylor MCHIP/Liberia	In 2011-2012, MCHIP collaborated with the Liberian Ministry of Health and Social Welfare to implement a pilot initiative focused on integration of FP with immunization services. In this integrated service delivery model, vaccinators provided one-on-one immunization and FP information and referrals for same-day FP services during routine immunization contacts at fixed facilities. **Findings** • The pilot, implemented in 10 health facilities in Bong and Lofa counties, found that the number of new contraceptive users at participating facilities increased by 73% in Bong and 90% in Lofa compared to the previous year's figures. • In Lofa, the number of Penta 1and 3 doses administered at participating facilities increased substantially during the intervention period compared to the previous year, while the number of Penta 1 and 3 doses decreased across all other non-participating facilities in the county. • In Bong County, Penta 1 and 3 doses experienced a modest increase, both at participating and nonparticipating facilities. **Lessons Learned** • Key features of the approach were workable, and contributed to strong increases in FP uptake among women in the extended postpartum period. • Factors that impede success of integrated service delivery include staff turnover, unreliable supplies of key commodities, and awkward physical layouts from the EPI to FP areas. • Routine immunization data was not as reliable as expected, making the immunization results harder to interpret.
Senegal Family Planning and Vaccination Integration at Health Posts Rebecca Kohler IntraHealth	In Senegal, IntraHealth is working on FP and immunization integration at the health post level (the lowest level health center). Initially begun in 4 districts, the project has now rolled out to 39 districts. At the health post level, immunization programs offer services once a week. This integrated model is implemented on days when immunization services are provided at the health posts, using the same provider for both immunization services and FP services (or referrals to a nurse for insertion of IUDs and implants). **Findings** From April 2012 to March 2013, 27% of women adopted modern methods of contraception (4,773 women out of 18,000 visiting immunization services). **Lessons Learned** Quality of interpersonal communication is critical to success – new FP user rates varied with the quality of counseling provided.

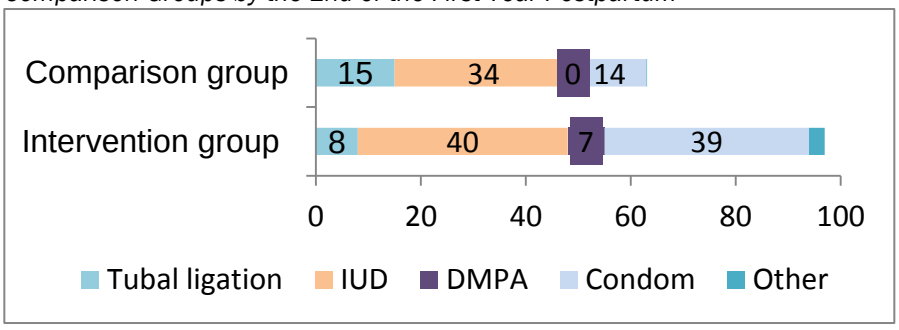
Presentation	Summary, Key Findings, and Lessons for PPFP Programming
Integrating Maternal, Infant & Young Child Nutrition (MIYCN) and FP Services in Kenya Evelyn Matiri MCHIP/Kenya	In collaboration with the Kenyan MoH (both the Division of Nutrition and the Division of Reproductive Health), MCHIP is implementing a pilot project in six health facilities in Kenya focused on integrating FP and maternal, infant and young child nutrition (MIYCN) services at the facility and community levels. The project capitalizes on mutually beneficial and similar timing of nutrition and FP messages, developing strategic MIYCN/FP information, education and communication (IEC) materials to complement existing nutrition and reproductive health materials. *Mutually Beneficial Messages around FP and MIYCN* **LAM ⟷ Exclusive breastfeeding** **Fertility return ⟷ Complementary feeding** **Maternal nutrition ⟷ Infant health & nutrition** **Maternal survival → Infant survival** **Findings** Counseling on MIYCN and FP in all service delivery areas increased, leading to increased uptake of FP and MIYCN services. **Lessons Learned** • Involvement of the District Health Management Team is key for the sustainability and success of the intervention. • To optimize integrated service delivery and promote uptake of FP, address infrastructure, human resources, and commodity supply challenges as well as myths and misconceptions around FP and promote male involvement in FP decision-making.
Family Planning Counseling During Nutrition Weeks (Vitamin A, Deworming) in Mali Lisa S. Nichols Abt. Associates, Inc.	In Mali, nearly four out of five postpartum women have an unmet need for FP. While women have numerous contacts with health services, one of the most successful activities is the National Nutrition Week (NNW). The NWW is held every six months and reaches 70% of postpartum women with vitamin A and deworming services. Led by the MoH in partnership with ATN Plus (a consortium of partners), this pilot project tested integration and acceptance of FP messages via the National Nutrition Week setting. The pilot used nutrition topics such as exclusive breastfeeding and infant health as a gateway to discuss return to fertility and FP choices. **Findings** • Over 98% of postpartum women reached by the NNWs participated in interpersonal counseling sessions on FP. • The number of new FP users increased when comparing the six-months before and after the pilot project, almost doubling in some sub-districts.  **Lessons Learned** • The pilot was well-accepted by communities, providers, and clients. Local community and stakeholder support along with use of local radio to broadcast messages were major factors leading to success. • Providing women with FP information in a nutrition setting is feasible and can be scaled up at low cost, since women are already seeking nutrition services.

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
FP & Child Immunization in Mali: Path Toward Sustainability Rodio Diallo PSI/Mali	While use of FP is low in Mali, high immunization attendance provides a good opportunity to promote FP methods for postpartum women. PSI sent dedicated service providers to immunization clinics to ensure a one-stop-shop for women's needs. To gauge sustainability, PSI transitioned 10 community health centers to monthly supportive supervision and 10 to coaching during vaccination days, with 35 centers still receiving service provision. All centers received an initial stock of commodities, training, quality assurance support, and demand creation assistance. This PSI-supported program was documented and results shared widely. USAID then requested that PSI explore different scenarios for transitioning the supported facilities from external support. The findings below reflect the phase of partial withdrawal of PSI dedicated providers and support supervision. **Findings** Six months after the transition, the program experienced big drops in services for long-term methods. Only 60% of clinics re-stocked after the initial stock was provided by PSI. Nonetheless, service provision at six months remained higher than the starting point prior to initial pilot support. **Lessons Learned** In addition to working with health facilities, it may be necessary to provide procurement planning support to the MoH to address stock issues.
CONCURRENT SESSION 3	**Community Based PPFP and Demand Generation**
Integration of PPFP into Mother Support Groups for PMTCT in Ethiopia Bizunesh Tesfaye IntraHealth Ethiopia	This presentation highlighted a PMTCT program in Ethiopia which used mother support groups as a mechanism for providing PPFP services. The program assessment gauged whether PPFP service integration into support groups for HIV positive pregnant women and lactating mothers increased access to FP services. **Findings** • Mother support groups were found to be an effective entry point. The program was successful in encouraging many women to use dual protection methods. • Among new contraceptive users, many were dual method users and the predominant method other than condoms was injectables. There is a need to strengthen the use of long acting methods. **Lessons Learned** As long as counseling is linked to service delivery, FP and HIV counseling can successfully be task shifted to community-based lay health workers, in this case mother mentors, to provide integrated services.
PPFP Qualitative Assessment: Improving Postpartum Care for Mothers and Newborns in Pakistan Mobina Fatima Jhpiego/Pakistan	In Pakistan, only 22% of women use any kind of FP in the year following delivery. Jhpiego conducted a qualitative assessment to inform the development of a cluster randomized trial of a postpartum care package and service model. The assessment examined the factors influencing utilization of postpartum care and FP through FGDs and in-depth interviews with women who gave birth in the past six months, their husbands and mothers-in-law, and facility and community health providers. **Findings** • Community respondents perceived community-level providers as the most socially acceptable option for provision of PPFP due to their regular contact with mothers. While couples felt postpartum care was unnecessary, they welcomed home visits from Lady Health Workers.

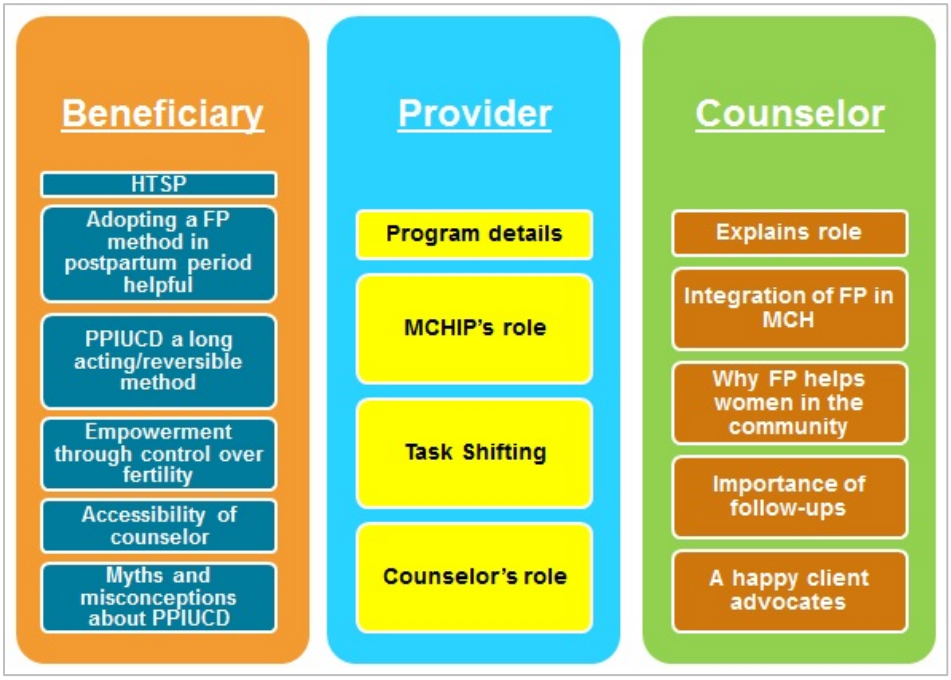
Presentation	Summary, Key Findings, and Lessons for PPFP Programming
	• Capacity building is needed for health providers, who felt they lacked knowledge and confidence to provide PPFP services. **Lessons Learned** • Programs should address cultural factors such as privacy of female clients during the postpartum period. Lady Health Workers can serve an important role in mobilizing demand for PPFP.
The Effect of Postpartum Family Planning Integration within a Community-based MNH Program in Rural Bangladesh Salahuddin Ahmed JHU Bangladesh	The Healthy Fertility Study used a cluster randomized design to evaluate a community-based maternal and newborn care intervention package involving CHW antenatal and postnatal home visits. Control sites received MNH home visits and intervention sites received home visits which included MNH plus PPFP. The cohort of women (2247 in intervention sites and 2257 in comparison sites) was followed from pregnancy to 36 months postpartum. Dr. Ahmed noted during the discussion following the session that in Bangladesh, CHWs (mostly local, unmarried women who are respected in the community) can also provide injectables. The project in Bangladesh trained CHWs on provision of injectables following the government training curriculum and gave CHWs a salary to enable better service provision. **Findings** • There was a statistically significant improvement in contraceptive use in the intervention area during the period of 24 months after delivery, with 18% of women ever having used contraception before the index pregnancy vs. 46% using contraception at 24 months postpartum. • In the intervention arm, the probability of becoming pregnant by 30 months postpartum was lower and length of exclusive breastfeeding was greater. *Probability of Becoming Pregnant 30 Months Postpartum by Study Arm*  **Lessons Learned** The Healthy Fertility Study shows the feasibility of integrating PPFP with a community-based MNH program. The model effectively increased modern FP method use with no notable negative effects on delivery of MNH services.

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
Reaching Women and their Partners with Family Planning Information and Services during the Postpartum Period: Innovation and Scale-up in India and Egypt Ian Askew Population Council	This presentation described how operations research studies conducted in India and Egypt were subsequently scaled up. This summary provides both a synopsis of the original studies results but the focus of the discussion was on scaling up from an operations research study. In India, trained CHWs communicated messages on healthy timing and spacing of pregnancies (HTSP), LAM, and PPFP to pregnant and recently delivered women, their mothers-in-law, and husbands and male opinion leaders. The research used a randomized experimental pre- and post-test design. Women who were 4 to 7 months pregnant, under 25 years old, and had one child or less were interviewed at recruitment, 4 months, and 9 months postpartum (477 women in the intervention group and 482 in the control group). In Egypt, the operations research tested two models – one included birth spacing messages during prenatal services and postpartum home visits, and another included the same activities plus awareness-raising for men. Using a randomized experimental post-test design, the study randomly assigned one district in each governorate to model 1, model 2, or control. Women in their 3rd trimester of pregnancy with 0-1 parity were recruited for interview (470 per site). **Findings** • In India, contraceptive use at 9 months was higher in the intervention site than the control site. • In Egypt, both intervention models showed higher contraceptive use at 10 to 12 months than the control site (48% in model 1 and 43% in model 2 compared with 31% in the control group). **Lessons Learned about scaling up** The operations research demonstrated positive results and credible evidence for the effectiveness of the interventions, leading to funded to provide TA for scale-up. Key enablers of scale-up included sufficient funding to support scale-up over three years, buy-in from the government to fund systems for scale-up, and careful monitoring and evaluation (M&E) planning to monitor scale-up.
Kyautatawa Iyali: Building Community Demand for PPFP in Northern Nigeria Laurette Cucuzza Plan International USA	Kyautatawa Iyali ("Family Welfare"), a community-based family planning project, included peer health education, re-positioning FP as family welfare and birth spacing (emphasizing return to fertility, LAM criteria, and timely transition to another modern method), integration with MCH and HIV, Eligible Couples (ELCO) mapping, community mobilization, mass media, and distribution of contraceptives. Family planning became a more accepted term during the project period; by the end of the project, people used the terms "family planning" and "birth spacing" interchangeably. **Findings** • ELCO mapping was successful in allowing CBDs to track and identify women before birth to increase uptake of PPFP. • Links between CBDs and clinic staff were critical in increasing demand for long-acting reversible contraceptives (LARCs), and sustainable demand creation required use of multiple approaches. **Lessons Learned** There is need to ensure that commodity supply is sufficient to meet increased demand.

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
Postpartum Systematic Screening in India Sudharsanam Balasubramaniam MCHIP/India	This presentation described a study on postpartum systematic screening (PPSS) during community-based child immunization and nutrition days in Jharkhand, India. USAID has identified offering FP services to postpartum women, including screening during immunization, as a promising High Impact Practice for FP. This quasi-experimental, mixed methods study aimed to assess whether the PPSS tool increased PPFP counseling and provision/referral for PPFP services. The project provided a two-day PPFP counseling training for CHWs and Anganwadi workers in both intervention and comparison sites, with PPSS tool training added in intervention areas only. **Findings** • Based on service statistics, the PPSS tool improved uptake of FP counseling, provision, and referral services without compromising immunization services. • There was no reduction in immunization services offered during village health and nutrition days. **Lessons Learned** The use of a Postpartum Systematic Screening tool or job aid may reinforce provider behaviors beyond training alone, as evidenced by this experience during village health and nutrition outreach events.
CONCURRENT SESSION 4	**Health Systems Issues with PPFP and Advocacy**
Strengthening the Delivery of PPFP through the Community Midwifery Model in Kenya Postpartum Charlotte Warren Population Council	In Kenya, community midwives who are not connected to the formal health system frequently perform home deliveries, providing a key link to postpartum women in the household and an opportunity for postpartum family planning at the community level. The intervention described in this presentation enhanced community midwives' skills through a multi-step process, first building safe delivery skills, then PPFP counseling skills, and finally PPFP service delivery skills. **Findings** Once the community midwives were trained to provide long-acting reversible contraceptives, the intervention found a significant increase in postpartum clients using LARCs (from 5% to 21%) and a large increase in the community midwives' family planning workload, particularly in the provision of implants. *Family Planning Workload Trend for Community Midwives in Kenya*  **Lessons Learned** Investment in community midwives and other resources outside the formal health system could be a promising strategy to increase LARC uptake.

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
Bondo District Experience with PPFP Jullie Odongo Ministry of Public Health and Sanitation, Bondo District, Kenya	This presentation reviewed the facility- and community-based health systems interventions applied in one district in Kenya, Bondo, which has a much higher maternal mortality rate than the national average (620 vs. 480). At the facility level, district-level health staff built the capacity of service providers through mentorship to improve FP skills and counseling competencies in a wide range of methods (countering preferences for FP methods such as injectables that were perceived to be "quick" to administer). The district also supported procurement of FP equipment and dissemination of IEC materials within facilities. At the community level, a daily activity register for community health workers was introduced to systematize data reporting and management. Community dialogue days were also held to address popular misconceptions about FP methods and overcome cultural barriers, such as a 42-day postpartum restriction on the mobility of the mother and low male involvement in postpartum health choices. **Findings** • Data management of FP services at health facilities improved, with 87% of health facilities in Bondo reporting FP data. • Between 2011 and 2012, service provision and uptake of long-acting FP commodities such as implants and IUDs increased. **Lessons Learned** For both facility- and community-based interventions, community education and demand creation were essential for increased uptake.
Free Perinatal and Postpartum Contraceptive Services Decreases the Incidence of Unintended Pregnancy Among Rural-to-Urban Migrant Women in Shanghai YongMei Huang Population Council/China	China's urban development has led to vast rural-to-urban migration and internal migrants are generally not covered by the free or low-cost health services that are extended to permanent city residents. In 2004, the Shanghai government began to expand free contraception to married migrant couples. At the time, 86% of unintended pregnancies among migrant women resulted from non-use of contraception, especially in the early postpartum period where women might not have perceived a return-to-pregnancy risk. To address unmet need, a prospective study began in 2006 to enhance FP counseling and service provision to migrant pregnant women in one of Shanghai's maternal health centers. Prior to discharge following delivery, women in the intervention group (n=840) received contraceptive counseling and health leaflets. Women were offered: tubal ligation during Caesarean section, IUD insertion immediately after delivery, injectables (for non-breastfeeding women), or two boxes of 20 male condoms. The women were then followed up by phone five times during the first year postpartum. *Contraceptive Prevalence among Shanghai Migrant Women in Intervention and Comparison Groups by the End of the First Year Postpartum* 

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
	Findings • The intervention significantly decreased the incidence of unintended pregnancy (2.4 per 100 women year vs. 9.6 per 100 women year in the comparison group, $p<0.05$) • The intervention also significantly increased prevalence of contraceptive use during the first year postpartum (see figure). **Lessons Learned** Shanghai now provides free FP services and dedicated FP counselors in all 24 of its maternal health centers.
Monitoring & Evaluation for PPFP Elaine Charurat & Leah Elliott MCHIP	New models of integration require new M&E approaches that can compare effectiveness of PPFP programming across programs in different countries and using different integration strategies. This presentation reviewed three country examples of PPFP integration – Liberia with immunization, Tanzania with prevention of mother-to-child transmission of HIV, and India with ANC. **Lessons Learned** • Typical FP reporting approaches like monthly registers of the number of FP services provided are not able to account for the combined coverage and potential efficiencies achieved by integration; instead, indicators tracking FP provision during the integrated service as well as indicators on quality, access to care, and policy changes must be developed. • It is important to obtain national government support for collecting and incorporating integration indicators and for adapting M&E tools to the integrated service context, given that routine M&E tools do not always have the capacity to collect integrated information for special programs. The session discussion highlighted several ongoing efforts to measure integration models. The Integra Initiative at the London School of Hygiene and Tropical Medicine is looking at integration efficiencies and plans to publish its first results later this year (see www.integrainitiative.org for more information). In addition, there are several USAID-sponsored working groups on integration for those who would like to learn more about integration projects and help design indicators.
Task Sharing for Implants in Rural Areas in Mali Aissata Tandina & Winnie Mwebesa MCHIP	This presentation described a program in two districts in Mali, Diema and Kita, working with *matrones* or auxiliary midwives (the typical pre-service education program for *matrones* is 6 months long). Stemming from a new national policy that permits *matrones* to provide contraceptive implants in addition to short-acting contraception, the program trained *matrones* and health facility supervisors in the insertion of implants at community health centers. *Matrones*' supervisors were also trained on an integrated package of active management of the third stage of labor (AMTSL), essential newborn care (ENC), and PPFP along with competency-based training on LARCs. The competency-based training for *matrones* included two days of classroom time and practice on models and three days of clinical practice. **Findings** • During supportive supervision visits six weeks following the training, the *matrones* achieved 95% on a checklist of the insertion procedure. • In both Diema and Kita, implant use appears to have increased following the *matrone* training. Of the women serviced by all providers in the two districts in the quarter after the trainings, one in five (20%) received an implant, up from four to seven percent in previous quarters.

Presentation	Summary, Key Findings, and Lessons for PPFP Programming
Video Contest Winner: How Video was Developed and How it is to be Used in India Indrani Kashyap MCHIP/India	Explaining the design and production behind the winning video from MCHIP's PPFP video contest, "Family Planning for Health and Happiness," this presentation demonstrated the level of detail and planning required by any communications strategy, especially one that discusses a complex health intervention such as PPFP. The video focused on the story of one beneficiary of India's PPFP program, which has had over 90,000 acceptors of postpartum intrauterine contraceptive devices (see B. Sood presentation from Session 1). The video aimed to reach policymakers by combining the personal story of the beneficiary with a "program story" from the beneficiary, provider, and counselor's perspectives. The production team was able to create the video in fewer than ten days and for less than $400 because they used simple equipment, engaged local video editing services, and carefully prepared the story's messages in advance. *Program Story Components*  **Lessons Learned** Effective communications products do not necessarily need large budgets and lengthy production schedules: find stories worth telling, avoid breaks in production, and capture memorable moments.

Marketplace

The marketplace featured a display of learning stations and exhibits. Participants were invited to rotate to each of the stations for short interactive discussions and demonstrations.

Jhpiego
Postpartum Tubal Ligation Demonstration
Yolande Hyjazi & Blami Dao

Bayer Pharma/Jadelle Access Program and International Contraceptive Access Foundation/LNG-IUS
Annette Velleuer

Implementing Best Practices: USAID High Impact Practices Briefs
Ados V May

Visit the HIP Map at:
www.fphighimpactpractices.org

MSD: Efforts to Expand Access to Implanon
Maggie Kohn, Beatrice Mutali, & Brett Johnson

Population Council Materials Station
Ian Askew & Charlotte Warren

MCHIP PPIUCD New Training Model Demonstration
Tsigue Pleah & Lastina Lwatula

IntraHealth Religious Leaders Communication Aids
Perle Combary

Closing Plenary Session

The PPFP technical meeting concluded with closing remarks from the four moderators, Patricia MacDonald from USAID, Mary Lyn Gaffield from WHO, Dr. Arvind Mathur of WHO, and Chelsea Cooper of MCHIP, who summed up gold nuggets or key points from their respective concurrent session. These summaries allowed participants to gain insights from sessions that they had not attended and to compare various country and field experiences.

Suggestions for next steps from meeting participants included holding a similar session during the 2013 International Conference on Family Planning in Addis and examining new ways to design and evaluate programs for FP integration. To continue to share evidence and best practices to guide PPFP integration, the WHO, in partnership with USAID and MCHIP will officially release the *Programming Strategies for Postpartum Family Planning* document at the 2013 ICFP. Concurrently, MCHIP plans to explore M&E of PPFP in greater depth by hosting an online discussion forum on measurement of PPFP integration.

The Last Word

The number and breadth of speakers presenting programs or research on the topic of postpartum family planning represents a clear evolution for this area of work, especially when compared to earlier annual meetings. Furthermore, this diversity of voices along with the participation of USAID, WHO, and a senior official in the Indian government helped to give even greater credibility to PPFP.

The MCHIP Family Planning team wishes to thank USAID, and in particular Patricia MacDonald, for the support to hold this meeting in Kuala Lumpur and making the long trip despite a busy travel schedule. We also appreciate Mary Lyn Gaffield for representing WHO at this event and Anuradha Gupta for her words of wisdom, encouragement and grace as a moderator. Finally, a special word of thanks to all speakers and marketplace "vendors" for your contributions and enthusiasm and to all participants for selecting this session, when we know you had many alternatives!

To continue the conversation on Postpartum Family Planning, join our community of practice!

To become a member, go to http://knowledge-gateway.org/ppfp and click on "register" in the upper right corner of the screen.

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

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Appendix 1: Meeting Agenda

Postpartum Family Planning Technical Meeting

Monday, 27 May 2013
8:30am – 5:00pm
Kuala Lumpur Convention Center, Rooms 406/407

8:30 **Registration & Continental Breakfast**

9:15-9:30 **Welcome & Overview**

Anne Pfitzer, MCHIP-FP and Koki Agarwal, MCHIP Program Director

9:30-10:30 **PLENARY SESSION**

Moderator: Mrs. Anuradha Gupta, Head of National Rural Health Mission, India

Postpartum Family Planning: Is it Smart Integration?	Patricia MacDonald, USAID
Announcing WHO *Programming Strategies for Postpartum Family Planning*	Dr. Mary Lyn Gaffield, WHO
Viewing of PPFP Video Contest Winner and presentation of award certificate to Ms. Indrani Kashyap	Anne Pfitzer, MCHIP

10:30-10:45 **Break**

10:45-12:30 **MORNING CONCURRENT SESSIONS**

Concurrent Session 1: FP Integration with MNH Services (Room 406)

Moderator: Dr. Arvind Mathur, WHO SEARO

Comprehensive postnatal care: integrated postpartum family planning and HIV services in Swaziland and Zambia
Timothy Abuya, Population Council

Training for and Institutionalization of Post-Placental Insertion of IUCD in Selected Public Hospitals of Pakistan
Laila Shah and Azra Ahsan, NCMNH Pakistan

Revitalization of PPFP/PPIUCD services in India
Bulbul Sood, Jhpiego India

Guinea: Integrated training for CEmONC and LAPM of family planning
Blami Dao and Yolande Hyjazi, MCHIP

Health Systems Strengthening and Integration of FP/MNCH in Uganda
Celia Kakande, STRIDES-Uganda & Fabio Castano, MSH

Afghanistan Community Based PPFP
Nasratullah Ansari, Jhpiego/Afghanistan & Dr. Shafiq Mirzazada, Aga Khan Health Services/Afghanistan

Concurrent Session 2: FP Integration with Child Health and Nutrition Services (Room 407)

Moderator: Chelsea Cooper, MCHIP

Making Progress with Family Planning & Immunization Integration: Results from the PROGRESS Project
Kate Rademacher, FHI 360

Family Planning and Immunization Integration in Liberian Health Facilities
Nyapu Taylor, MCHIP/Liberia

Senegal Family Planning and Vaccination Integration at Health Posts
Rebecca Kohler, IntraHealth

Integrating maternal, infant & young child nutrition (MIYCN) and FP services in Kenya
Evelyn Matiri, MCHIP/Kenya

Family Planning counseling during Nutrition Weeks (vitamin A, deworming) in Mali
Lisa S. Nichols, Abt. Associates, Inc

FP & Child Immunization in Mali: Path Toward sustainability
Rodio Diallo, PSI/Mali

12:30-1:30 **Lunch**

1:30- 2:30 **MARKETPLACE**

MCHIP PPIUCD New Training Model Demonstration	Tsigue Pleah & Lastina Lwatula
Jhpiego Postpartum Tubal Ligation Demonstration	Yolande Hyjazi & Blami Dao
Population Council Materials Station	Ian Askew & Charlotte Warren
Bayer Pharma/Jadelle Access Program and International Contraceptive Access Foundation/LNG-IUS	Annette Velleuer
IntraHealth Religious Leaders Communication Aids	Perle Combary
Implementing Best Practices: USAID High Impact Practices Briefs	Ados V May
MSD: Efforts to Expand Access to Implanon	Maggie Kohn, Beatrice Mutali & Brett Johnson

2:30-2:40 **Mini-Break to close partitions**

2.40-4.30 **AFTERNOON CONCURRENT SESSIONS**

Concurrent Session 3: Community Based PPFP and Demand Generation (Room 406)

Moderator: Mary Lyn Gaffield, WHO

Integration of PPFP into Mother Support Groups for PMTCT in Ethiopia
Bizunesh Tesfaye, IntraHealth Ethiopia

PPFP Qualitative Assessment in Pakistan
Mobina Fatima, Jhpiego/Pakistan

The Effect of Postpartum Family Planning Integration within a Community-based MNH Program in Rural Bangladesh
Salahuddin Ahmed, JHU Bangladesh

Reaching women and their partners with family planning information and services during the postpartum period: innovation and scale-up in India and Egypt
Ian Askew, Population Council

Kyautatawa Iyali: Building Community Demand for PPFP in Northern Nigeria
Laurette Cucuzza, Plan International USA

Postpartum Systematic Screening in India
Sudharsanam Balasubramaniam, MCHIP/India

Concurrent Session 4: Health Systems Issues with PPFP and Advocacy (Room 407)

Moderator: Patricia MacDonald, USAID

Strengthening the delivery of PP-FP through the community midwifery model in Kenya postpartum
Charlotte Warren, Population Council

Bondo District Experience with PPFP
Ms Jullie Odongo, the District Reproductive Health Coordinator, Bondo District, Kenya

Free Perinatal and Postpartum Contraceptive Services Decreases the Incidence of Unintended Pregnancy Among Rural-to-Urban Migrant Women in Shanghai
YongMei Huang, Population Council/China

Monitoring & Evaluation for PPFP
Elaine Charurat & Leah Elliott, MCHIP

Task Sharing for Implants in rural areas in Mali
Aissata Tandina & Winnie Mwebesa, MCHIP

Video Contest Winner: How video was developed and how it is to be used in India
Indrani Kashyap, MCHIP/India

4:30-5:00 **PLENARY AND CLOSING REMARKS**

Gold Nuggets from each session-Plenary - USAID, WHO and the MCHIP-FP Team
Closing remarks and invitation to 40th Jhpiego event - Anne Pfitzer

Appendix 2: Speaker List

Name	Organization / Program
Aissata Tandina	MCHIP
Anuradha Gupta	National Rural Health Mission, India
Azra Ahsan	National Committee for Maternal & Neonatal Health, Pakistan
Bizunesh Tesfaye	IntraHealth/Ethiopia
Blami Dao	MCHIP
Bulbul Sood	Jhpiego/India
Celia Kakande	Management Sciences for Health – STRIDES/Uganda
Charlotte Warren	Population Council
Elaine Charurat	MCHIP
Evelyn Matiri	MCHIP/Kenya
Fabio Castano	Management Sciences for Health
Ian Askew	Population Council
Indrani Kashyap	MCHIP/India
Jullie Odongo	Ministry of Public Health and Sanitation, Kenya
Kate Rademacher	FHI 360
Laila Shah	National Committee for Maternal & Neonatal Health, Pakistan
Laurette Cucuzza	Plan International USA
Leah Elliott	MCHIP
Lisa S. Nichols	Abt. Associates, Inc.
Mary Lyn Gaffield	World Health Organization
Mobina Fatima	Jhpiego/Pakistan
Nasratullah Ansari	Jhpiego/Afghanistan
Nyapu Taylor	MCHIP/Liberia
Patricia MacDonald	U.S. Agency for International Development
Rebecca Kohler	IntraHealth
Rodio Diallo	Population Services International/Mali
Salahuddin Ahmed	Johns Hopkins University/Bangladesh
Shafiq Mirzazada	Aga Khan Health Services/Afghanistan
Sudharsanam Balasubramaniam	MCHIP/India
Timothy Abuya	Population Council
Winnie Mwebesa	MCHIP
Yolande Hyjazi	MCHIP
YongMei Huang	Population Council/China