PPIUCD Services: Start-Up to Scale-Up Regional Meeting Zambia

April 9-12, 2013

Meeting Report

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Acronyms and Abbreviations

ANC	Antenatal care
BCC	Behavior change communication
CCM	Community case management
CHW	Community health worker
DHS	Demographic and Health Survey
FP	Family planning
HMIS	Health management information system
HTSP	Healthy timing and spacing of pregnancies
I/EBF	Immediate and exclusive breastfeeding
IUCD	Intrauterine contraceptive device
LAM	Lactational amenorrhea method
MCHIP	Maternal and Child Health Integrated Program
M&E	Monitoring and evaluation
MoH	Ministry of Health
MIYCN	Maternal, infant, youth, and child nutrition
MMR	Maternal mortality ratio
PA	Postabortion
PAC	Postabortion care
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PP	Postpartum
PPFP	Postpartum family planning
PPIUCD	Postpartum intrauterine contraceptive device
PSI	Population Services International
RH	Reproductive health
SFH	Society for Family Health
SIFPO	Support for International Family Planning Organization
TFR	Total fertility rate
TOR	Terms of reference
TWGs	Technical working groups
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

Meeting Description

The Maternal and Child Health Integrated Program (MCHIP) and Population Services International's (PSI) Support for International Family Planning Organization (SIFPO) program, with funding from the U.S. Agency for International Development (USAID), convened a regional meeting in Africa to bring together international and regional experts together to advance integration of postpartum intrauterine contraceptive device (PPIUCD) services into maternal health services. A total of 59 participants from 10 countries actively engaged in South-to-South learning, sharing successes and challenges based on their country experiences. Countries represented at the meeting included Ethiopia, Kenya, Liberia, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe.

OVERALL MEETING OBJECTIVES

Through South-to-South exchanges, the meeting served to strengthen participants' capacity to accelerate the integration of postpartum family planning (PPFP)/PPIUCD into maternal health services. The meeting entailed:

- Focused discussions on the role of advocacy, community engagement, and service delivery strategies within programs that offer PPIUCD, grounded in the use of evidence and guided by the use of program data
- An opportunity for participants to observe PPIUCD services in Zambia and practice PPIUCD insertion on models
- A forum to share successes and discuss challenges to implementing quality PPIUCD services, from initiation to scale up
- An opportunity to develop tools for drafting country-team action items

PARTICIPANT PROFILE

Meeting attendees included staff from Ministries of Health (MoH), professional associations, health facilities, USAID, United Nations Population Fund (UNFPA), as well as representatives from EngenderHealth, IRC, Jhpiego, MCHIP, MSI, Plan International, Planned Parenthood Association of Zambia, Scaling Up Family Planning (SUFP) (UKAid funded), and PSI and its affiliates PACE and Society for Family Health (SFH). The participants function as:

- Policymakers and champions
- Maternal health providers
- Program managers working in maternal health
- Global agencies and donors

Of the 59 total participants, 11 were from the MoH, eight were providers or represented professional organizations, 37 were from projects, two were from USAID and one was from the UN (see Annex 2 for a detailed list of participants).

Background

The insertion of an intrauterine contraceptive device (IUCD) within 48 hours following childbirth is called postpartum IUCD, or PPIUCD. There are three times for PPIUCD placement—postplacental, intracesarean, and immediate postpartum. Intracesarean IUCDs are placed just prior to suturing up the uterus, postplacental IUCDs are inserted within 10 minutes of the delivery of the placenta, and immediate postpartum IUCDs are placed after the first 10 minutes but within the first 48 hours following childbirth.

Recently, the global community experienced a resurgence of interest in PPIUCDs and as a result, programmatic experience has expanded. Globally, more women are delivering in facilities, which provide increased opportunities for PPFP, including PPIUCD services. Offering IUCDs during the immediate postpartum period provides mothers with an effective, long-acting contraception method prior to leaving the facility. The insertion technique has improved so that expulsion rates are low. Other advantages of PPIUCDs include that the side effects of IUCD insertion are masked by the routine process of involution following childbirth and IUCDs have no impact on breastfeeding. Copper IUCDs (380 A) can be used for up to 12 years for birth spacing or limiting. Most PPIUCD users are satisfied with their method.

While there are countries with a range of experiences, PPIUCDs still represent a small proportion of long-acting reversible contraceptive service delivery, and there is still more to do to make this option available to every woman who delivers in a facility. PSI, MCHIP, and other partners have collaborated with a number of country partners and supported the introduction of services, but only a few countries—India being one of them—have taken services to scale. A regional meeting in Africa was intended to allow countries with a solid base of programming to learn from each other and gain insights as they help less-experienced countries advance their programs.

Country Experiences

Table 1 describes the experience of the represented countries in introducing PPIUCD. During the course of the meeting we asked each country to share an update on their program as well as their challenges and lessons learned.

Selected country presentations are available on the IUD tab of the Postpartum Family Planning K4Health Toolkit at http://www.k4health.org/toolkits/ppfp/postpartum-iud.

Table 1. Country Experiences with PPIUCDs—Introduction of PPIUCDs and Lessons Learned

COUNTRY	SUMMARY OF INTRODUCTION OF PPIUCD	KEY LEARNING HIGHLIGHTS
Ethiopia	**Background (2011 Ethiopia Demographic and Health Survey (DHS)):** Maternal Mortality Ratio(MMR): 676/100,000 live births Total Fertility Rate (TFR): 4.8 Modern Family Planning (FP) Use: 27% Unmet Need: 25% (16% for spacing and 9% for limiting). **Status of PPIUCD Services:** PPIUCD services were initiated in 5 hospitals and 3 health centers in 2012.	• Counseling of women on PPFP, including PPIUCD, is offered to women during antenatal care (ANC), when they arrive at a facility in early labor, and also in postpartum wards, regardless of HIV status. Anecdotally, HIV+ women seem more likely to come back for delivery in facility when they are registered for prevention of mother-to-child transmission of HIV (PMTCT) services. Uptake of PPIUCD is not being tracked separately for HIV+ and HIV- women. • PPIUCD acceptors have shown good return for follow-up either at 6 weeks or at 12 weeks when they bring their child for immunization.
Kenya	**Background (2008-09 Kenya DHS):** MMR: 488/100,000 TFR: 4.6 Modern FP Use: 39% Unmet Need: 26% (13% for spacing and 13% for limiting) **Status of PPIUCD Services:** PPIUCD services were initiated in 2007 and a follow-up study of a sample of acceptors was completed in 2009. Kenya is scaling-up service to two regions, however, currently only two facilities are providing PPIUCD services.	• While a pool of trainers exists and facilities in additional regions have initiated PPIUCD services, uptake has lagged. No current project or government leader is strongly championing this intervention. • Clearly, advocacy must be continued and maintained and key challenges in terms of staff transfers must be addressed.
Liberia	**Background (2007 Liberia DHS):** MMR: 994/100,000 TFR: 5.2 Modern FP Use: 11% Unmet Need: 36% (25% for spacing and 11% for limiting) **Status of PPIUCD Services:** Currently, routine PPIUCD services are not available in Liberia. However, there are plans to roll out services in 2013 in 3 hospitals, 1 health center, and 1 primary health care facility.	• n/a

COUNTRY	SUMMARY OF INTRODUCTION OF PPIUCD	KEY LEARNING HIGHLIGHTS
Malawi	**Background (2010 Malawi DHS):** MMR: 675/100,000 TFR: 5.7 Modern FP Use: 42% Unmet Need: 26% (14% for spacing and 12% for limiting) **Status of PPIUCD Services**: PPICD activities to date include: training of 340 service providers from 16 districts; training of 158 tutors from the 13 pre-service training sites; improving 2 clinical placement sites and 25 health centers through provision of relevant materials; production and distribution of country- wide PPFP information, education, and communication (IEC) materials (10,000 flipcharts, 10,000 posters, and 10,000 leaflets).	• A useful platform for scaling up PPFP and PPIUCD are the health surveillance assistants who are charged with community-level work in immunizations, growth monitoring, and other kinds of surveillance, as well as FP. • A key challenge is maintaining FP as a priority, even though it is called a "vaccine" for maternal mortality.

Mozambique	**Background (2011 Mozambique DHS):**
	MMR: 408/100,000
	TFR: 5.9
	Modern FP Use: 11.3%
	Unmet Need: 29% (16% for spacing and 13% for limiting)
	
	Status of PPIUCD Services:
	PPIUCD was initiated 2011, with the first training of trainers taking place in May 2012 for 16 providers from 7 health facilities. By March 2013, 242 insertions were performed during the postpartum period and 94 IUCDs were inserted postabortion. Mozambique has a Modern Maternity Initiative though which 94 health facilities are supported for PPIUCD and guidelines on training and supervision exist.
		• Counseling is a key challenge. Planned approaches include:
		  • Providing intensive information and counseling in the ANC and maternity wards so that counseling takes less time in the labor ward; and
		  • Investing more to ensure that staff have accurate information and strengthened counseling skills.

Rwanda	**Background (2010 Rwanda DHS):** MMR: 487/100,000 TFR: 4.6 Modern FP Use: 45% Unmet Need: 19% (10% for spacing and 9% for limiting) **Status of PPIUCD Services**: The Rwanda MoH introduced PPIUCDs through an acceptability study. Training and initiation of PPIUCD began in 2010. Currently, 1,147 PPIUCD insertions have been performed in 13 facilities.	• PPFP counseling is done in ANC and in labor and delivery, including the immediate postpartum period. ANC provides an opportunity to counsel couples. • MoH coordination and support enabled this project to be successful and it has been well received at both hospitals and health centers. • Follow up is a key challenge: return for follow up at 6 weeks or 3 months was low (55%).

COUNTRY	SUMMARY OF INTRODUCTION OF PPIUCD	KEY LEARNING HIGHLIGHTS
Tanzania	**Background (2010 Tanzania DHS):** MMR: 454/100,000 TFR: 5.4 Modern FP Use: 27% Unmet Need: 25% (16% for spacing and 9% for limiting) **Status of PPIUCD Services:** Tanzania's PPIUCD program began in 2011 in 5 pilot sites (public and private sector) in Dar es Salaam. PPIUCD was integrated into the newly developed, national postpartum care and integrated community maternal, newborn, and child health guidelines and the ANC curriculum. A strategy for expansion to all district hospitals is underway.	• Having trained staff, supplies, and equipment available 24/7 facilitated program success. • Support staff should be sensitized on PPIUCD and the role of PPFP in saving lives. • Challenges included limited resources for scale-up, high rates of home deliveries (49%), few deliveries in the private sector, negative perception of IUCDs among clients and providers, a shortage of skilled personnel, and low male involvement.
Uganda	**Background (2011 Uganda DHS):** MMR: 438/100,000 TFR: 6.2 Modern FP Use: 26% Unmet Need: 34% (21% for spacing and 14% for limiting) **Status of PPIUCD Services:** Nationwide training on PPIUCD began in late 2010 with the establishment of a pool of trainers. The intent was to increase PPIUCD insertion services in 40 private facilities, 3 regional and one national referral hospital (Mulago, Gulu, Mbale, and Mbarara Hospitals). By December 2012, services were available in 4 regions through 280 providers at 53 public and private facilities.	• Staff turnover is the greatest challenge to continuity of service delivery. • An integrated model allows providers to reach large numbers of women with FP information and services. • Involvement of government from the start of program implementation increased buy-in, with MoH plans to scale up PPIUCD nationally.
Zambia	**Background (2007 Zambia DHS):** MMR: 591/100,000 TFR: 6.2 Modern FP Use: 33% Unmet need: 26.5% (17.1% for spacing and 9.4% for limiting) **Status of PPIUCD Services:** PPIUCD services were initiated in 2009, with the training of 9 nurse midwives. As of 2013, PPIUCD services are available in 4 provinces through 32 trained providers. In addition, in Mansa District, 17 providers and mentors were recently trained and are undergoing supervised practice to become competent in immediate postpartum IUCD insertion.	• Overall, expulsion rates were lower than previously reported, particularly for immediate postpartum insertions. • Trainees required an average of 4 PPIUCD placements before reaching competency. Training stressed the importance of high fundal placement. • Although the MoH has developed an in-service training curriculum on long-acting FP methods, support for training public sector providers has been limited. • Training and continuous mentorship is necessary for scale-up and quality assurance.

COUNTRY	SUMMARY OF INTRODUCTION OF PPIUCD	KEY LEARNING HIGHLIGHTS
Zimbabwe	**Background (2010-11 Zimbabwe DHS):** MMR: 960/100,000 TFR: 4.1 Modern FP Use: 57% Unmet need: 13% (7% for spacing and 6% for limiting) **Status of PPIUCD Services:** Interval IUCDs have been available for the last 10 years; however, Zimbabwe is currently in the initial stages of PPIUCD start-up.	• Zimbabwe currently has successful examples of integrated health programs with solid experience in engaging stakeholders, as well as strong community-based programs to help promote PPIUCD at community level. • Zimbabwe plans to select central and provincial hospitals with a high volume of deliveries for initiation of PPIUCD services. • Though a national FP implementation plan is currently underway, ongoing efforts to institutionalize and roll out PPIUCD services, such as a communications strategy, remain critical.

In addition to the country experiences above, participants benefited from the experiences of a technical expert from MCHIP's India program, who shared India's extensive experience of scaling up PPIUCD from four training sites to 71 hospitals in 19 states. The India experience proved valuable for small group discussions of lessons learned, during practice on models, as well as during the knowledge exchanges.

SUMMARY OF PPIUCD ACTIVITIES IN INDIA

- Nationally, very large unmet need exists: 65% of women in the first year postpartum have an unmet need for FP, but only 26% are using any contraceptive (Source: USAID/ACCESS, India, 2009).
- The PPFP/PPIUCD program started in 2009 in four training sites (two hospitals and two medical colleges) with USAID's support through the ACCESS-FP Program.
- After the success of the initial phase, there was a rapid expansion of PPIUCD services during 2010-12. With support from national and state governments and from multiple donors (USAID, Bill and Melinda Gates Foundation, Norway–India Partnership Initiative, Packard), PPIUCD services were scaled up in 19 states.
- More than 100,000 PPIUCD insertions were reported from program sites in 19 states since the routine data collection system was introduced in February of 2010.
- New PPIUCD government policies:
  - Dedicated counselors were formalized in the government system, as of 2010
  - Task shifting: nurses are allowed to insert PPIUCD, as of late 2012
- Further scale-up of PPIUCD services will take place at 248 district hospitals in six high focus states (2013-14).

India Key Learning Highlights

- The involvement of the government throughout the implementation process and advocacy efforts whenever there was a change in government officials contributed to government engagement.

- Successful strategies included:
  - Engaging with champions
  - Supporting experienced providers to make presentations in reputable national forums
  - Having nurses follow up with clients via phone
  - Using dedicated government-paid counselors.

The use of facility-based counselors has been the main approach used to increase demand for PPIUCDs in India's program.

Common Barriers to PPIUCD Service Delivery

To set the context for meeting discussions, participants were asked to identify common barriers across their programs. The following table groups those barriers into categories. Solutions to many of the identified barriers came out during the knowledge exchange discussions, which are detailed later in this report.

Table 2. Common Barriers to PPIUCD Service Delivery

• Community myths and misconceptions about IUCDs • Provider bias • Overburdened providers • Unmotivated providers • Lack of confidence among providers **Attitudes/Beliefs Values**	• Staff attrition • Scarcity of HR/lack of task-shifting • Lack of ongoing supportive supervision • Inadequately trained staff • Supply and commodity shortages or maldistribution • Poor physical infrastructure **Operational**	• Poor/cumbersome data collection processes and tools • Lack of translation into decision-making/actions to improve services • Systems do not capture PPFP/PPIUCD info • Qualitative data is not collected • Lack of integration into health management information system (HMIS) **Monitoring & Evaluation**
• Lack of male involvement • Written consent requirement • Little sensitization on PPIUCD or PPFP prior to delivery • Providers lack skills or time to conduct comprehensive FP counseling **Informed Choice**	• Inadequate government (MoH) buy-in • Weak policy framework & governance • Lack of PPIUCD champions **Advocacy**	• High % of home deliveries • Poor integration of PPFP across facilities and services **Health System**

Observation & Participation

Participants were provided the opportunity to observe PPIUCD insertion and to gain hands-on practical experience in using a variety of anatomic models. Midwives from SFH and MCHIP led these sessions, demonstrated common insertion techniques, answered questions, and guided interested participants who practiced insertion techniques on the different models. To aid their practice, participants were given a clinical skills checklist, which guided them through the process step-by-step and allowed them to evaluate their skills.

In order to provide a broader perspective on PPIUCD service delivery in Zambia, participants took part in a visit to one of four Lusaka facilities where SFH provides PPFP services—Chawama, Kanyama, Chipata, and George. Participants toured the facilities' antenatal and postnatal clinics and observed group health talks, scheduling of PPIUCD clients, and counseling. Some also had the opportunity to interview mothers who underwent insertion and to observe insertion procedures.

Benchmark Tool—Assessing Readiness for Scale

MCHIP has created a scale-up readiness benchmark tool for PPFP (see Annex 3), based on a newborn health version.[1] The tool includes eight benchmarks to assess aspects of policy, health systems, sustainability, and resources availability. During the meeting, participants were asked to complete the tool based on their knowledge of PPIUCD programming in their countries and to indicate their results on a paper version posted on the wall. However, the time allotted for this activity was too short. Furthermore, several of the benchmarks request information about country policies and guidelines and thus participants did not have an adequate opportunity to consult these documents. So while the activity was not entirely successful, the benchmark tool was introduced to the participants and its use may help guide programs in identifying health systems integration areas to work on to improve the readiness of scale up.

Knowledge Exchanges

In order to engage in South-to-South learning and uncover knowledge on programs that include PPIUCD services, participants engaged in a series of knowledge exchange sessions.[2] The sessions were held on two consecutive days, with the first day's topics related to introduction of PPIUCD services and the following day's topics related to program scale-up of PPIUCD. Each session consisted of four stations, each with a facilitator and a note-taker. At each station, participants assembled in groups of 10-12 people, representing a mix of countries and organizations, and they rotated through the stations every 20-25 minutes.

The knowledge exchange sessions were preceded by plenary "igniters," during which representatives from different countries presented on each topic. Then the facilitators guided the groups through the topics, using a list of three prepared questions. If one group did not finish discussing all three questions, the facilitator changed the order with the next group. Note

1 Moran AC et al. 2012. Benchmarks to measure readiness to integrate and scale up newborn survival interventions. Health Policy and Planning. 27(Suppl. 3).

2 The methodology for these knowledge exchanges was adapted from Pugh KB. 2011. *Sharing Hidden Know-How: How Managers Solve Thorny Problems With the Knowledge Jam.* Jossey-Bass.

takers synthesized the results of all four rounds of discussion to share with the group the next day.

The knowledge exchanges were appreciated by participants, nearly 70% of participants ranked the knowledge exchanges as their favorite sessions.

> *"Knowledge Exchanges accorded me an opportunity to learn from other countries what they did differently which could be replicated in my country"*
>
> *"…the sessions were highly interactive, respectful of time during the sessions and it allowed all countries to share experience and learn from each other. "*
>
> *"[I] learnt the best practices from other countries and also what was not working so well."*

The following table outlines key learning that emerged around each topic.

Table 3. Knowledge Exchanges—Key Learnings

SITE SELECTION FOR INTRODUCTION OF PPIUCD SERVICES AND WHOLE-SITE ORIENTATION
Site selection: Participants debated whether site selection for introduction of PPIUCD services should occur from the teaching hospital down to the district level, to first have demonstrated results at the district level before trying to integrate PPIUCD services in referral/tertiary hospitals, or whether a mixed approach should be employed, where referral and district hospitals, or lower-level facilities, introduce PPIUCDs at the same time. Each approach has advantages and disadvantages and context-specific factors will inform decisions, taking into account political and technical considerations. With either approach, government support (documented in the form of a letter) was seen as critical, even for initiating services in the private sector. **Essential criteria for site selection:** • High volume of deliveries • Adequate infrastructure • Receptive district and facility managers • Availability of staff (fewer shortages relative to other sites) One program introduced movable partitions to overcome the cramped conditions common in high-volume sites. These screens created private spaces for PPIUCD insertions. **Whole-site orientation** involves all facility staff—upper management, providers, support staff, and other potential "gate keepers," including guards. While it may be overlooked because it is time-intensive, whole-site orientation needs to be tailored to different types of workers in the facilities and offered at multiple times to engage staff working at different hours. Whole-site orientation is very useful, particularly when the innovation being introduced is culturally sensitive. **Whole-site orientation facilitates sustainability via**: • Motivating staff (e.g., pride in supporting an innovative practice) • Allowing staff to learn new information/skills • Addressing staff myths and misconceptions (about PPFP and PPIUCD in specific) • Enabling all staff to engage in education and counseling around PPFP and PPIUCD in relevant units (ANC, labor and delivery, and postnatal care (PNC)); often any person working in a facility is seen as a credible source regardless of role and lower-skilled staff may be seen as more approachable. **A strong orientation should cover basic topics* for all staff, including:** • What is a PPIUCD • When in postpartum can an IUCD be inserted (postplacental, intracesarean, immediate postpartum/within 48 hours) • Who will provide the service (or where in the facility can you get more information) *For service providers, the information will be more advanced.

SITE SELECTION FOR INTRODUCTION OF PPIUCD SERVICES AND WHOLE-SITE ORIENTATION

Engaging Stakeholders and Advocacy

Key considerations prior to start-up:

- Government support is crucial for the success of any program that includes PPIUCD services.
- It is crucial to map out what assets are already in place for PPIUCD, including what partners and stakeholders exist, what technical working groups (TWGs) exist, geographical coverage, donor support, etc.
- Do not create new platforms for engagement. Instead, look at how to engage existing maternal health and FP stakeholders around PPIUCD, including integration into existing TWGs.

Other key considerations:

- At the beginning of a project, it is key to create a communication strategy that includes standard advocacy messages for PPIUCD, which are context-specific and tailored to the intended audiences.
- In instances where there is a lack of government support for PPIUCD, ensure creation of advocacy messages for high-level stakeholders that align with country priorities.
- Data is central to advocacy efforts. Where local data is not readily available, international data is a useful substitute.
- Pilot projects are useful for collecting and documenting data on program successes and can be used to garner support from the MoH as well as other influential partners.
- Advocacy and engaging stakeholders takes place at all levels, from the national level down to the village.
- It is essential to identify and engage champions at each of these levels.
- Remember that users are also stakeholders and need to be included in outreach and advocacy!

How to Initiate PPIUCD Training and Motivating and Supervising Providers

Advanced preparation is critical to PPIUCD training; a needs assessment should lead to the selection of both a service delivery site (from where trainees are selected) and the training facility. Ideally, community sensitization and ANC counseling should begin at least two months prior to training. Also, supplies and equipment have to be available. **Training should translate into actual practice** and should be facilitated by placing and maintaining trained providers in the labor and delivery, ANC, and postnatal wards. After training, providers should have continuous opportunities to practice so that they do not lose their skills.

Cascaded competency-based training can be a strategy used to achieve larger numbers of trained staff. A structured, well-defined, on-the-job training approach, complete with knowledge and skills assessments, would be beneficial to cover large numbers of staff in a facility. **PPIUCD champions** who are skilled in adult learning methods can be used as coaches and can effectively train others. Eventually, PPIUCD training should be included in **pre-service education** so that all providers who perform deliveries are well-informed.

In addition to trainers, having **mentors** in the field is also important, and ongoing hands-on mentorship will help establish services and maintain the quality of those services. **Recognition** of high-performing providers is a useful strategy, including acknowledging their performance with paraphernalia, such as special aprons, a recognition ceremony, and well-designed performance-based financing. Routine **supportive supervision,** monthly or quarterly, will improve performance and ideally should include proficient providers or mentors.

Counseling and Informed Choice

Common Barriers to Counseling and Informed Choice:

- Overburdened staff find it difficult to spend sufficient time on FP counseling. IUCD counseling, because of the many myths and misperceptions, is especially time consuming.
- Provider biases and lack of confidence in insertion skills keep many providers from discussing PPIUCD with their clients.
- Lack of male involvement may inhibit some women from getting a PPIUCD, especially if they are first learning of it at the delivery site and have not had a opportunity to discuss it with their partners.

Potential Solutions:

Make counseling less time consuming for providers through:

- Prior sensitization through community outreach or group education sessions during ANC
- Integration of PPIUCD with existing counseling given in ANC and postdelivery

SITE SELECTION FOR INTRODUCTION OF PPIUCD SERVICES AND WHOLE-SITE ORIENTATION

- Whole-site orientation to sensitize all staff to PPIUCD so that they can support clients rather than perpetrate myths that providers must then address.
- Use dedicated or lay counselors

Improve quality of counseling:

- Emphasize counseling skills during training
- Standardize and create job aids and checklists
- Include counseling in supportive supervision visits and on-the-job training
- Offer recognition and other non-monetary incentives for quality counseling

Demand Generation and Community Engagement

All countries represented at the meeting had existing **community engagement and demand generation** strategies into which PPFP and PPIUCD messages could be integrated. In particular, involving **community health workers** of all types is a promising strategy, including male motivators or social marketing promoters. Another avenue includes **women's groups** (e.g., safe motherhood action groups in Zambia or mother support groups in Ethiopia). **Satisfied users are particularly credible and influential** in community settings. Two countries had tried community theater (one with PPIUCD as a focus) and abandoned it for different reasons.

How much focus on demand generation is needed depends on whether an internal facility approach (group talks and counseling in ANC) is reaching women and the capacity of facilities (e.g., human resources and commodities) to absorb an uptick in demand. Use of mass media involves risks given the misconceptions about IUCDs, but including messages about postpartum insertion into a larger campaign supporting long-acting methods or FP, where opportune, makes sense.

Participants are reminded to share their PPIUCD communication materials on the K4Health PPFP toolkit at toolkits@k4health.org *or* http://www.k4health.org/toolkits/ppfp/feedback

Continuity of Care

Continuity of care for PPIUCD services begins during ANC counseling and carries through to insertion at the delivery site, postnatal follow-up visits, and beyond in order to ensure on-going access to information, side effects management, and removal services.

Key Considerations:

- Many women access ANC and PNC near their homes, but deliver at a different site. Often there is no link between these sites.
- Providers at ANC and PNC sites may be unaware of PPIUCD or only have basic knowledge or skills to provide follow-up care.
- Women counseled in ANC who chose a PPIUCD may not be able to get it at the time of delivery.

Potential Solutions:

- Sensitize all PNC providers on PPIUCD, including answers to common questions, what to look for, and when and where to refer clients
- Ensure that clients understand what to expect, where to go, and timing and importance of postnatal follow-up
- Ask women to return to delivery site for PNC, if possible
- Coordinate PNC with other visits to the health center, such as immunizations, to make it more convenient for the client
- Include community health workers in follow-up and referral for PPIUCD clients
- Explore mHealth technologies to follow up with clients, or to link delivery facilities with local PNC sites and community health workers
- Establish a clear referral structure and strengthen referral tracking
- Train a select number of champions in regions of origin for women who deliver far from home, and refer women to these providers for their follow-up visits
- Include PPIUCD in pre-service education and integrate into national PPFP guidelines
- Ensure that commodities are available at delivery sites so that women opting for PPIUCD during counseling can get it

SITE SELECTION FOR INTRODUCTION OF PPIUCD SERVICES AND WHOLE-SITE ORIENTATION

Integration into Maternal Health at Scale

Key Point: for proper integration to happen, it should start at the beginning of the program, not at scale-up.

Common themes that emerged:

Advocacy:

- Key figures can be used as PPIUCD champions. Ethiopia, for example, reported leveraging the support of the First Lady. Uganda used professional organizations to facilitate integration.
- Other professional bodies such as the International Confederation of Midwives and International Federation of Gynecology and Obstetrics (FIGO) can also facilitate integration.
- The London FP Summit served as a catalyst for many countries.
- PPIUCD should be integrated into Saving Mothers Giving Life, which is a new group working in several countries.

Policies:

- Coordination among all units that target maternal and reproductive health (including HIV) at the MoH level is key.
    - There should be clear guidelines and standards for integration into existing maternal health guidelines. Similarly, FP guidelines can call for integration of PPIUCD into other programs.

Facility Level:

- PPIUCD should be included in pre-service education for relevant cadres.
- PPIUCD is a new method and requires additional training.
- All staff should be oriented and sensitized through a whole-site orientation. Also, maternal health staff working in the labor ward, ANC, and PNC should all be trained in PPIUCD counseling, and a provider trained in insertion should be available daily.
- Supportive supervision will help to keep providers motivated to provide PPIUCD services.
- ANC should include PPFP (PPIUCD) counseling.
- Immunization appointments are another opportunity to follow up with PPIUCD users.
- Within the facility, PPIUCD service delivery should be harmonized with supplies and record-keeping, and data should be captured in registers and the HMIS.

Community:

- Community groups (e.g., village chiefs and community health workers) can be mobilized around demand generation at the community-level.
- Expectant women and mothers attending well-baby visits should be sensitized.

Monitoring and Evaluation

The group identified a myriad of challenges in developing robust monitoring and evaluation (M&E) for PPIUCD services, particularly around the type and quality of data captured and how it is used.

Common Challenges:

- Providers are asked to collect too much data, using multiple registers for multiple projects.
- National systems (HMIS) often do not capture PPFP- or PPIUCD-specific indicators.
- Many providers do not feel compelled to collect data that is not in the HMIS, and without their buy-in, there is no incentive to translate data into action.
- Most systems only record quantitative data and there is no M&E on the quality of services provided.
- On a broader level, data is not used and analyzed for the purpose of improving services or for decision making.
- Data collection systems for adverse events/complications and PPIUCD removal both need to be strengthened.

Suggested Solutions:

- Advocate at the national level for inclusion of PPIUCD indicators in the HMIS. But first, there needs to be consensus on which tools should be used (especially those for capturing adverse events).
- TWGs can play a role in serving as a united voice to the MoH on what PPFP/PPIUCD data the HMIS should collect, as well as advocating that all programs/facilities use the same tools.

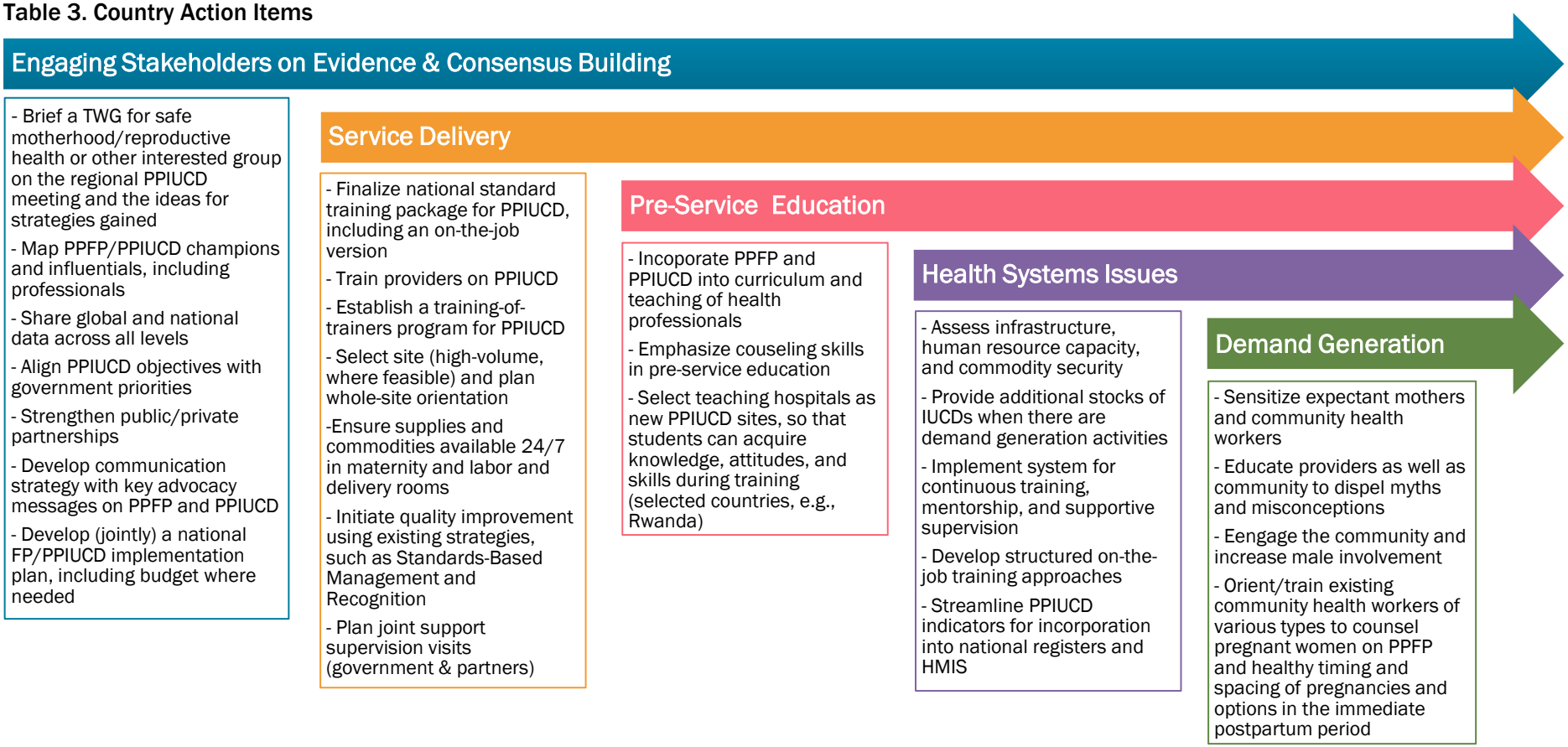
SITE SELECTION FOR INTRODUCTION OF PPIUCD SERVICES AND WHOLE-SITE ORIENTATION
• Train staff on how to collect data and include training in pre-service education so that health care providers understand its importance early on and pay attention to data quality. • Simpler tools that do not require providers to use multiple registers are ideal. Use electronic records wherever feasible. • Hold periodic facility-based data audits and regular facility-level M&E meetings to help improve data quality and to identify training needs. • Facilities and providers who improve M&E systems should be recognized to keep them motivated. • Supervision can also include unannounced visits to spot-check record keeping and data quality. In addition to visits, supervisors can make unscheduled phone calls to health facilities. **Key M&E Considerations for Scale-Up:** • Streamline tools (including joint supervision and supportive supervisions tools). • Integrate tools/indicators at the national level.

Country Actions Items

During the course of the meeting, participants were divided into country teams that met regularly to exchange ideas and apply lessons learned towards developing a set of action items to undertake in their respective countries. At the end of this exercise, the teams 1) drafted a vision of success, 2) shared some fresh ideas they had gained from attending the meeting, 3) outlined constraints to the vision and newly learned strategies to overcome the constraints, and 4) identified areas to be addressed, the required actions, the responsible individual(s), and developed a timeline.

The following figure is a synthesis of common action items that appeared in several countries' action plans. Each arrow represents a category of action items, which taken together, lead toward successful program scale-up. Not every country plan includes all the action items listed below; these items can be implemented in whatever order suits each country's contexts. Timeframes are not represented here; but, in general, the plans had ambitious deadlines.

Table 3. Country Action Items



Closing and Next Steps

Integration of PPIUCD into maternal health services offers countries an enormous potential to expand the reach of PPFP programs and offers women a safe, effective, long-lasting, convenient method that they can use to space or limit their pregnancies. Recognition of this potential is evidenced in the diverse range of attendees at the meeting—including representatives of donors, ministries of health, professional organizations, and nongovernmental organization—from 10 countries across Africa with commitments to introduce or scale up PPIUCD services.

Despite this potential, PPIUCD is an option for only a small minority of women in the African region and new strategies are needed to bring services to scale. The knowledge and experience needed to do this lies within the region, as evidenced by the successes and lessons learned of the individual programs represented at the meeting. The meeting was designed to tap into this wealth of expertise and allow participants to systematically share common challenges and potential solutions, which they could apply to their own programs. The richness of the exchanges and lessons that emerged and the resulting action plans are a testament to years of experience and commitment to making these services a reality for more women in the Africa.

For participants, the next step is to translate these lessons and ideas into action. The action plans helped participants prioritize and outline concrete steps to scale up PPIUCD in their countries, but making these plans a reality will require mobilization of resources and stakeholders in country. The meeting was a starting point, and additional exchanges are needed to ensure continued momentum. Priority areas that emerged include:

- Support for developing scale-up strategies, including advocacy as a key aspect of continued expansion and scale up
- Adaptation and dissemination of tools and procedures to support PPFP counseling, including PPIUCD
- Client and provider communication strategies and key messages
- M&E support, especially tracking and following up with clients, and using findings to drive advocacy and programmatic decisions

Meeting organizers are exploring low-cost ways to facilitate continued exchange, including virtual meetings and follow-on sessions at the International Family Planning Conference in Addis Ababa in late 2013.

Copies of all presentations, detailed notes of knowledge exchanges, action plans, can be obtained from either MCHIP or PSI upon request. Furthermore, MCHIP and PSI have committed to following up with country teams six- to-12 months after the end of the meeting and assessing progress towards meeting items in countries' action plans.

For further information, please contact Maxine Eber (meber@psi.org) or Andrea Thomas at PSI (athomas@psi.org) and Anne Pfitzer, Holly Blanchard, or Leah Elliott at MCHIP (lelliott@mchip.net).

Annex 1 – Meeting Agenda

PPIUCD Services: Start-up to Scale-up Regional Meeting Zambia April 9-12, 2013	
Meeting Overview	The Maternal and Child Health Integrated Program (MCHIP) and Population Services International's (PSI) Support for International Family Planning Organization (SIFPO) program, with funding support from the U.S. Agency for International Development (USAID), will convene a regional meeting to bring international and regional experts to advance integration of PPIUCD into maternal health services. Representatives from ten countries will engage in South-to-South learning, sharing successes and challenges based on their country experiences. Focused discussions on program learning areas such as advocacy, community engagement and service delivery strategies will provide tools for developing country-action plans. Participants will have the opportunity to observe PPIUCD services being delivered at busy maternities in Lusaka.
Background	PPFP services are an ideal platform to reposition family planning. The vast majority of women want to avoid another pregnancy for at least two years after delivery. PPIUCDs can reduce the proportion of unintended pregnancies/births and abortions because it is one of the most effective family planning methods. Maternal and Child Health Integrated Program (MCHIP), and Population Services International (PSI) have initiated PPIUCD services through integration of maternity services. Collectively they have successfully introduced PPIUCDs to more than 65,000 postpartum women around the world. While there are countries with a range of experiences, PPIUCD still represent a small proportion of long-acting reversible contraceptive service delivery, and there is still more to do to make this option available to every woman who delivers in a facility. A regional workshop in Africa will allow countries with a solid base of programming to learn from each other and gain insights, as they also assist countries with less experience to advance.
Meeting Objectives	Participants will gain insight and learn to accelerate their integration of PPFP/PPIUCD into maternal health services through South-to-South exchanges. • Provide a forum for participants to observe PPIUCD services in one country, and share successes and discuss challenges to implementing quality PPIUCD programs from initiation to scale up. • Discuss the role of advocacy, community engagement and service delivery strategies within PPIUCD programs, grounded in the use of evidence and guided by the use of program data. • Draft country-team action items for "PPIUCD Services: Start-Up to Scale-Up".

Profile of Participants	• Policy makers & champions (MoH, professors of OB/GYN & Midwifery, and their professional organizations) • Maternal Health Providers (directors of maternities, staff who do deliveries) • Program Managers working in Maternal Health (including staff from other NGOs) • Global Agencies (USAID, UNFPA)
Participating Countries	Ethiopia, Kenya, Liberia, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe

AGENDA

DAY 1: Tuesday, April 9

Time	Session
8:30-9:30	**Welcome**
9:30-10:00	**Setting the Stage**: Global Evidence & PPIUCD Technical Update
10:00-10:15	**Break**
10:15-10:30	**Welcome by Guest of Honor**
10:30-12:00	**Country Experiences Panel:** • Zambia • Uganda • Rwanda
12:00-1:00	**Lunch**
1:00-2:00	**Elements of Scale Up**: Discussion & Activity
2:00-3:15	**Country Presentations: Examples of Scale Up:** • Tanzania • Kenya • India
3:15-3:30	**Break**
3:30-4:15	**Video & Introduction to Insertion Techniques**
4:15-4:30	**Recap & Closing of Day 1**
4:30-5:00	**Day 2-4 Logistics**

DAY 2: Wednesday, April 10

6:30-10:00	**Site Visits to Facilities with PPIUCD Services**

10:00-10:30	**Break**
10:30-11:15	**Site Visit Report Out**
11:15-12:00	**Group Activity**: What are the challenges PPIUCD Programs face?
12:00-1:00	**Lunch**
1:00-2:30 **Panel & Round 1 Rotations** 2:30-2:45 **Break** 2:45-3:45 **Round II Rotations**	**Knowledge Exchange: How to Initiate PPIUCD?** Plenary Igniters: • Zimbabwe • Mozambique Station Rotation: • Station 1: Choosing a Facility & Whole Site Orientation • Station 2: Engaging Stakeholders - Advocacy • Station 3: How to Initiate PPIUCD Training, Motivating & Supervising Providers • Station 4: Counseling and Informed Consent
3:45-4:00	**Recap & Closing of Day 2**
DAY 3: Thursday, April 11	
8:30-8:45	**Welcome & Introduction to Country Group Work**
8:45-9:30	**Report out from Day 2 Knowledge Exchange**
9:30-10:00	**Small Group Work on Country Action Items** • Focus on Day 2 Knowledge Exchange topics
10:00-10:15	**Break**
10:15-11:30	**Demonstration & Practice on Models**
11:30-12:00	**Knowledge Exchange (Part 1): Programmatic Considerations for PPIUCD** Plenary Igniters: • Ethiopia • Malawi
12:00-1:00	**Lunch**
1:00-3:00	**Knowledge Exchange (Part II): Programmatic Considerations for PPIUCD** Station Rotation: • Station 1: Demand Generation & Community Engagement • Station 2: Continuity of Care • Station 3: Integration into Maternal Health at Scale • Station 4: Monitoring and Evaluation
3:00-3:15	**Break**

3:15-4:00	**Small Group Work on Country Action Items** • Focus on Day 3 Knowledge Exchange topics
4:00-4:45	**Report Out from Knowledge Exchange**
4:45-5:00	**Recap & Closing Day 3**
5:00-5:30	**Discussion with Zambian PPIUCD Champions**
Evening	**Diner**
DAY 4: Friday, April 12	
8:30-8:45	**Welcome**
8:45-9:30	**Toolkit Presentation**
9:30-12:00	**Small Group Work to Finalize Country Action Items**
12:00-1:00	**Lunch**
1:00-2:15	**Present Country Action Items**
2:15-2:30	**Evaluation Forms**
2:30-3:00	**Closing & Presentation of Certificates**

Annex 2 – Participant List

PARTICIPANT NAME	ORGANIZATION/TITLE
Ethiopia	
Abdela Abdosh	Shashemene Hospital – Midwife/PPIUCD service provider
Rahwa Belay Hagos	MoH – FP Officer
Serawit Lisanework	MCHIP– FP Advisor
Dr. Dereje Negussie	EngenderHealth – Senior Clinical Advisor
Mr. Kasahun Mormu	EngenderHealth – Regional Team Leader
Kenya	
Dr. Agnes Nakato	MoH – Division of RH
Joygrace Muthoni	MCHIP – Program Officer
Ruth Jahonga	APHIAplus KAMILI – RH/FP/PMTCT Technical Advisor
Prisca Duro N'ok	MoH – Bondo District Hospital
Liberia	
Dr. Rigo Muhayangabo	IRC – Hospital Medical Coordinator
Malawi	
Ms. Joyce Wachepa	Jhpiego – Senior Technical Advisor for FP
Nenani Kantwanje	MoH – Nursing Officer at Bwaila Hospital in Lilongwe
Mozambique	
Dr. Kachangane Rosa de Jesus Maduele	Beira Central Hospital – Gynecologist/Obstetrics specialist working in Maternity
Dr. Ernestina David	MCHIP – Head of the Maternal/Neonatal and Child Health
Rwanda	
Dr. MUHIRE Mathias	MoH – Gynecologist at MUHIMA Hospital
Ms. MUKANZIZA Vestine	MoH– Midwife at BUTARE University teaching Hospital
Mrs. MUHAWENIMANA Immaculee	MoH – Midwife at KIGALI University teaching Hospital
Beata Mukarugwiro	MCHIP – MNH Senior Technical Advisor
Tanzania	
Dr. Joseph Mashafi	PSI – Medical Advisor
Mr. Maurice Hiza	MoH – National Family Planning Coordinator
Christom Lipingu	Jhpiego – Technical Advisor
Joseph Kanama	EngenderHealth – Medical Director
Uganda	
Sam Asiimwe	PACE – Regional Health Services Manager
Dr. Michael Balikuddembe	Association of Obstetricians and Gynecologists Uganda – OB/GYN
Dr. Zainab Akol	MoH – FP Focal Point
Zimbabwe	
Nindi Shoko	PSI– SRH Quality Assurance Coordinator
Dr. Munyaradzi Murwira	Zimbabwe National Family Planning Council (ZNFPC) – Executive Director
Nohlupo Pfupajena	Plan International – Health Coordinator

PARTICIPANT NAME	ORGANIZATION/TITLE
Mrs. Margaret Guwira	MoH– District Nursing Officer
Agnes Makoni	UNFPA – Programme Analyst Emergency Obstetric Care
Dr. Bernard Madzima	MoH – Director Family Health
Dr. Simbarashe Mabaya	ZNFPC – Medical Officer
Dr. Hillary Chiguvare	MCHIP – Technical Director
Zambia	
Dr. Bellington Vwalika	University Teaching Hospital – Head of Obstetrics and Gynecology
Ms. Rhoda Amafumba	University Teaching Hospital – Sister in Charge (Labor Ward)
Martha Ndhlovu	MCHIP – MNH Advisor
Brenda Mubita	MCHIP – MNH Officer
Constance Choka	MCHIP – MNH Officer
Michelle Wallon	MCHIP – Project Manager
Nomsa Siamwanza	SFH/PSI – Quality Assurance and Training Manager
Jully Chilambwe	SFH/PSI – Reproductive Health Program Manager
Dr. Namwinga Chintu	SFH/PSI – Executive Director
Dr. Christopher Mazimba	Scaling Up Family Planning (SUFP) (UKAid funded) – Country Program Director
Genevieve Musokwa	SUFP – Midwife
Maggie Sinkamba	Communications Support for Health (CSH) (USAID communications bilateral) – Saving Mothers Giving Life Coordinator
Sophie Baumgartner	Planned Parenthood Association of Zambia (PPAZ) – Program Manager
Dr. Ameck Kamanga	Marie Stopes – Regional Medical Advisor
Dr. Stephen Mupeta	Marie Stopes – Policy and Clinical Services Director
Irene Singogo	Boston University/ZCAHRD – Saving Mothers Giving Life Project Director
Dr. Cherry Liu	CIDRZ – OB/GYN
Dr. Masuka Musumali	USAID – FP/MNCH Advisor
Dr. Jorge Velasco	USAID – Deputy Director (Deputy Team Leader)
HQ/Technical Team	
Anne Pfitzer	MCHIP (HQ) – FP Team Leader
Holly Blanchard	MCHIP (HQ) – Senior RH/FP Technical Advisor
Leah Elliott	MCHIP (HQ) – FP/RH Advisor
Saswati Das	MCHIP (India) – Senior Advisor: Clinical Services and Training
Rosemary Kamunya	MCHIP (East Africa Regional) – Senior Technical Advisor
Maxine Eber	PSI (HQ) – Deputy Director SIFPO
Andrea Thomas	PSI (HQ) – Sexual and Reproductive Health Consultant

Annex 3 – MCHIP PPFP Country Integration and Readiness for Scale Benchmarks

Country: _____

Date last updated: _____

Updated by: _____ _____

(Name) (Affiliation)

With input from: _____ _____

(Name) (Affiliation)

Instructions:

1. Select the appropriate ranking for each benchmark (use drop down menu);
2. Indicate the year of finalization if benchmark refers to a document (as appropriate)
3. Some Comments/Notes cells request specifying information (move cursor into that cell), please add
4. Include any other comments/questions (e.g., if benchmark difficult to use, please give feedback on this)
5. For all items in which you select "Yes," provide supporting information/materials as outlined in the final column, to be used to independently verify information

NO	AREA	BENCHMARK	DEFINITION	CRITERIA FOR RANKING	RANKING YES/PARTIAL/NO	YEAR CRITERIA MET	COMMENTS/ NOTES	SUPPORTIVE DOCUMENTATION – LIST TITLE/LINK OF DOCUMENT(S)
1a	Generating evidence	Operations research or program evaluation of family planning (FP) integration into maternal and newborn health services conducted in country	At least one study or experience with robust documentation within country	**Yes** - study/evaluation completed and results shared in country **Partial** - Study or demonstration project designed or initiated but not yet completed/documented **No** - no study or demonstration in country				

NO	AREA	BENCHMARK	DEFINITION	CRITERIA FOR RANKING	RANKING YES/PARTIAL/NO	YEAR CRITERIA MET	COMMENTS/ NOTES	SUPPORTIVE DOCUMENTATION – LIST TITLE/LINK OF DOCUMENT(S)
1b		Operations research or program evaluation of FP integration into child health services conducted in country	At least one study or experience with robust documentation within country. Examples would include: FP/immunization integration; maternal, infant, youth, child nutrition (MIYCN)/FP; integration with community case management (CCM) for sick children; or postpartum systematic screening	**Yes** - study/evaluation completed and results shared in country **Partial** - Study or demonstration project designed or initiated but not yet completed/documented **No** - no study or demonstration in country				
2a	Policy	National reproductive health (RH) policy/strategy specifically includes postabortion (PA) and/or postpartum (PP) family planning (PAFP/PPFP)	By PPFP, we mean initiation of a contraceptive method by a woman or her partner before her return to fertility in the postpartum period. By PAFP, we mean FP counseling and services prior to discharge from postabortion emergency treatment	**Yes** - national policy/strategy with PAFP/PPFP finalized and endorsed by MoH **Partial** - National policy/strategy in process of revision, not yet finalized or endorsed **No** - National policy/strategy makes no mention of FP in postabortion or postpartum period				
2b		National RH policy/strategy/service delivery guidelines includes key aspects of PAFP/PPFP	National document includes: FP counseling in ANC, L&D or immediate PNC, post-treatment for abortion and LAM is considered in range of effective FP methods if 3 criteria are met. Methods offered in immediate PP include IUDs and tubal ligation and LAM+transition to another method (all methods for PAC). Consistent with WHO Medical eligibility criteria	**Yes** - national policy/strategy with PAFP/PPFP finalized and endorsed by MoH and includes all key aspects of PAFP/PPFP **Partial** - National policy/ strategy in process of revision, not yet finalized or endorsed OR content of guidelines not consistent with WHO MEC or is missing key elements **No** - National policy/strategy makes no mention of FP in postabortion or postpartum period or has none of the key elements of PAFP/PPFP				

NO	AREA	BENCHMARK	DEFINITION	CRITERIA FOR RANKING	RANKING YES/PARTIAL/NO	YEAR CRITERIA MET	COMMENTS/ NOTES	SUPPORTIVE DOCUMENTATION – LIST TITLE/LINK OF DOCUMENT(S)
2c		National RH policy/strategy/service delivery guidelines encourages immediate and exclusive **breastfeeding** (I/EBF) at birth	Immediate BF refers to within 1 hour of birth. Recommendation is regardless of place of delivery.	**Yes** - national policy/strategy with PPFP finalized and endorsed by MoH and includes I/EBF and LAM is discussed (I/EBF not just beneficial to baby) **Partial** - National policy/strategy in process of revision, not yet finalized or endorsed **No** - National policy/strategy makes no mention of FP in postabortion or postpartum period or lacks emphasis on breastfeeding				
3		A RH technical working group (TWG) exists at national level and has PAFP and PPFP in its terms of reference (TOR)	Names may vary, e.g., Safe Motherhood, or RH, or FP TWG. If there are separate FP and maternal health TWGs, then does at least one of them include integration of FP with maternal and child health in its TORs or agenda?	**Yes** - At least one TWG exists and has PAFP/PPFP in its TOR (e.g., discussion of evidence for PA/PPFP integration) **Partial** - TWG exists but does not include PA/PPFP in its TOR nor has the subject been addressed **No** - National RH TWG or equivalent does not exist				
4		National Child Survival strategy/policy includes integration of family planning into child health services	Examples would include: FP as a child survival intervention (that improves child survival outcomes), FP/immunization integration, MIYCN-FP, integration with CCM for sick children or postpartum systematic screening	**Yes** - National policy/strategy with Child Survival/FP integration finalized and endorsed by MoH **Partial** - National policy/strategy in process of revision, not yet finalized or endorsed **No** - National child health policy/strategy makes no mention of FP				
5		A national behavior change communication (BCC) for health or RH includes key messages for healthy timing and spacing of pregnancies (HTSP) and PPFP	Here PPFP definition is for extended 24 month HTSP. Ideally, strategy would include specific messages about return to fertility (specify in comments)	**Yes** - National BCC strategy exists and includes PPFP, is finalized and endorsed by MoH **Partial** - National BCC strategy does not explicitly mention PPFP, or is not yet finalized or endorsed **No** - No national BCC strategy exists that covers FP				
6a	Human	National RH or other		**Yes** - Nurses and/or midwives				

NO	AREA	BENCHMARK	DEFINITION	CRITERIA FOR RANKING	RANKING YES/PARTIAL/NO	YEAR CRITERIA MET	COMMENTS/ NOTES	SUPPORTIVE DOCUMENTATION – LIST TITLE/LINK OF DOCUMENT(S)
	Resource Policy	policy established to authorize nurses and/or midwives to insert and remove IUCDs (interval, postabortion, and postpartum) if trained		authorized to carry out tasks **Partial** - Task sharing is under study but not yet endorsed **No** - Nurses and midwives not authorized to carry out procedure				
6b		National RH or other policy established to authorize nurses and/or midwives to insert and remove **implants** (interval, postabortion, and at 6 weeks postpartum) if trained		**Yes** - Nurses and/or midwives authorized to carry out tasks **Partial** - Task sharing is under study but not yet endorsed **No** -Nurses and midwives not authorized to carry out procedure				
7a		National strategies/policy regarding community health workers (CHWs) include counseling for PAFP and PPFP	CHW training should include awareness of FP needs of postpartum and postabortion women, **lactational amenorrhea method (LAM) criteria**, messages on HTSP and need to adopt an effective method of FP prior to menses return. In addition, for PAFP, CHWs encourage women to go to the health facility if they experience bleeding during pregnancy	**Yes** - National strategy/policy endorsed and includes PAFP and PPFP in scope of CHWs **Partial** - CHWs perform PPFP/PAFP related activities, but a policy does not yet exist (e.g., under a demonstration study) **No** - CHWs are either not recognized as a health cadre or do not carry out PPFP or PAFP work				
7b		National strategies/policy regarding CHWs allow provision of contraceptive at community level	Comments should specify whether this includes: 1) condoms, 2) oral contraceptives, 3) **DMPA**, 4) cycle beads (for PAFP), and 5) other	**Yes** - National strategy/policy endorsed authorizes CHWs to offer contraceptive methods to PP clients **Partial** - CHWs offer contraceptive methods, but a policy does not yet exist (e.g., under a demonstration study) **No** - CHWs are not authorized to offer contraceptives to PP clients				

NO	AREA	BENCHMARK	DEFINITION	CRITERIA FOR RANKING	RANKING YES/PARTIAL/NO	YEAR CRITERIA MET	COMMENTS/ NOTES	SUPPORTIVE DOCUMENTATION – LIST TITLE/LINK OF DOCUMENT(S)
8		Job descriptions for midwives (or obstetric nurses) and/or other skilled birth attendants includes specific mention of FP counseling and services in PA and PP context		**Yes** - Midwives job description specifically mentions her role in PAFP and PPFP **Partial** - Job description only mentions FP without specificity to postabortion or postpartum period **No** - Job description either does not exist or fails to mention provision of FP services				
9		Core competencies of midwives (or obstetric nurses) defined in national documents or in the national pre-service education curriculum includes PA and PP counseling and provision of family planning services		**Yes** - midwives pre-service curriculum or core competencies are consistent with integrated case management and specifically mentions role in PAFP and PPFP **Partial** - Curricula/core competencies only mentions FP without specificity to PA or PP period **No** - Core competencies/curricula fail to mention provision of FP services				
9a		National in-service training package exists for PPFP	Training package should include specific needs of women in PP including 1) return to fertility 2) which methods of contraception she can use at what time period in the postpartum. Note: Training can be stand alone or integrated with other materials	**Yes** - National training package exists and contains two elements listed in definition **Partial** - One or more training packages that contain two elements have been used in country but are not yet national **No** - No training package exists for PPFP or existing training materials fail to specify return to fertility and timing of eligibility for methods in the postpartum				

NO	AREA	BENCHMARK	DEFINITION	CRITERIA FOR RANKING	RANKING YES/PARTIAL/NO	YEAR CRITERIA MET	COMMENTS/ NOTES	SUPPORTIVE DOCUMENTATION – LIST TITLE/LINK OF DOCUMENT(S)
9b		National in-service training package exists for postabortion care (PAC)/FP	Training package should include content on: 1) management of bleeding and other abortion complications and 2) FP counseling and service delivery within the unit where abortion complications are managed. Note: Training can be stand alone or integrated with other materials	**Yes** - National training package exists and contains two elements listed in definition **Partial** - One or more training packages have been used in country but are not yet national **No** - No training package exists for PAC/FP				
10a	Health System/ Monitoring	Health facility registers include specific details regarding PPFP clients	In antenatal care (ANC) settings, register includes space for FP counseling given and whether an IUCD or **tubal ligation** (TL) has been selected. In maternity settings, postnatal care (PNC) registers include information about FP counseling provided and a method adopted. In FP clinics, register allows for notation of referrals from child health, nutrition, or immunization clinics. **(Specify PPFP-specific content and which register in comments box)**	**Yes** - National registers have been adapted to capture PPFP details within existing registers **Partial** - Select facilities are testing/using modified registers in country but these are not yet reviewed or adopted at national level **No** - No tracking of PPFP clients exists in health facilities				
10b		Health facility registers or FP monthly reports include specific details regarding PAFP clients	Health facilities track FP acceptors from postabortion services and report on them	**Yes** - National HMIS guidance requires PAC facilities to report on FP acceptors **Partial** - Selected facilities are testing/using modified registers or reporting on PAC FP acceptors but these are not yet reviewed or adopted at national level **No** - No tracking of PAFP clients exists in health facilities				

NO	AREA	BENCHMARK	DEFINITION	CRITERIA FOR RANKING	RANKING YES/PARTIAL/NO	YEAR CRITERIA MET	COMMENTS/ NOTES	SUPPORTIVE DOCUMENTATION – LIST TITLE/LINK OF DOCUMENT(S)
11		CHW registers track PPFP activities	Activities could include: 1) health talks, 2) community awareness events, 3) home visits and counseling during pregnancy (HTSP, LAM, return to fertility), 4) home visits and counseling postnatally, and 5) either provision of oral pills, condoms, **IUCDs**, or injectables, or referrals of individual women	**Yes** - Nationally endorsed CHW tools include tracking of FP activities specifically geared to postpartum women or HTSP **Partial** - CHWs supported through projects have CHW tools that include tracking of FP activities specifically geared to postpartum women or HTSP but are not yet national **No** - No CHW tools exists that capture PPFP				
12		FP provision in postpartum is tracked in HMIS	Monthly reports from facilities into the HMIS disaggregate FP indicators by PP and/or PA status of client	**Yes** - National HMIS guidance includes disaggregates of FP data by PA or PP status **Partial** - Selected facilities are testing PA and/or PP FP acceptors but these are not yet reviewed or adopted at national level **No** - No tracking of clients by PA or PP status exists in health facilities				
13		Commodity supplies routinely available for PAFP and PPFP service provision	Supplies are available in **the specific service area where FP is integrated**, not generally at the facility	**Yes** - Health care workers and CHWs (in their specific area of service delivery for PAFP and PPFP services) are not reporting difficulties obtaining contraceptives **Partial** - Commodities are available in the integrated service areas, but process to obtain them is reported to be cumbersome and leads to gaps in service availability **No** - Clients must themselves obtain commodities from facility pharmacy or FP unit, as commodities are not available in PAC/maternity/etc.				

NO	AREA	BENCHMARK	DEFINITION	CRITERIA FOR RANKING	RANKING YES/PARTIAL/NO	YEAR CRITERIA MET	COMMENTS/ NOTES	SUPPORTIVE DOCUMENTATION – LIST TITLE/LINK OF DOCUMENT(S)
14	Sustainability	Champion for PAFP/PPFP exists within the MoH	A champion is someone who speaks publically in support of PAFP and PPFP (e.g., as a means of addressing unmet need for contraception, or achieving Millennium Development Goals 4 and 5)	**Yes** - Champion exists and is in a position to affect movement on the issue **Partial** - Champion exists but is not in position to affect change or take decisions **No** - no PAFP and PPFP champion exists in either FP, maternal and newborn health, or child health sections of MoH				
15		One or more country-level champions exist outside the MoH	Examples might be in professional associations, local or international nongovernmental organizations, donors, etc. Comments section should specify	**Yes** - Champion exists and is in a position to affect movement on the issue **Partial** - Champion exists but is not in position to affect change or take decisions **No** - No champion has yet emerged				
16	Resources	Donor support for PAFP/PPFP contribute to national program	Support could be financial or technical	**Yes** - Donors are helping to raise issue for PAC/FP and PPFP and thus contributing to dialogue about role of FP integration **Partial** - Donors have educated themselves on PPFP, but this has not yet translated into concrete funding (could also mean they acquiesce to use existing donor funds to include PPFP or PAC/FP) **No** - PAC/FP and PPFP not present in funding portfolio of donors and external partners				
17		MoH or host government fund new costs for expanding PAFP/PPFP access	Examples of government funding would be for training/refresher training, procurement of supplies (e.g., long forceps), printing of BCC materials, salaries for dedicated counselors, etc., in scale-up areas (specify in comments)	**Yes** - Government commitment is reflected in cost covered out of own budget **Partial** - Government has indicated plans to incur costs, but this has not yet materialized **No** - PAC/FP and PPFP entirely dependent on support from external partners				

NO	AREA	BENCHMARK	DEFINITION	CRITERIA FOR RANKING	RANKING YES/PARTIAL/NO	YEAR CRITERIA MET	COMMENTS/ NOTES	SUPPORTIVE DOCUMENTATION – LIST TITLE/LINK OF DOCUMENT(S)
18		Commercial or private sector entities offer PAFP and/or PPFP services	Presence of private sector outlets for PAC and PPFP (give examples)	**Yes** - Private sector providers offer services and these types of service exists or are likely to continue even without donor or project support **Partial** - Private sector providers offer services but is highly dependent on subsidies or external support **No** - PAC/FP and PPFP is not yet available in the private sector				

Annex 4 – Meeting Photos

Opening Remarks and Country Experience Presentations

PPIUCD Demonstration and Practice Sessions

Small Group Work & Knowledge Exchanges

Clinical Site Visits

Closing & Presentation of Certificates