International Journal of Gynecology and Obstetrics 130 (2015) S54–S61

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

SUPPLEMENT ARTICLE

# A facility birth can be the time to start family planning: Postpartum intrauterine device experiences from six countries

Anne Pfitzer [a,*], Devon Mackenzie [a], Holly Blanchard [a], Yolande Hyjazi [b], Somesh Kumar [c], Serawit Lisanework Kassa [d], Bernabe Marinduque [e], Marie Grace Mateo [e], Beata Mukarugwiro [f], Fidele Ngabo [g], Shabana Zaeem [h,1], Zonobia Zafar [h], Jeffrey Michael Smith [i]

[a] Jhpiego/MCHIP, Washington, DC, USA
[b] Jhpiego, Conakry, Guinea
[c] Jhpiego, New Delhi, India
[d] Jhpiego, Addis Ababa, Ethiopia
[e] Jhpiego, Manila, Philippines
[f] Jhpiego, Kigali, Rwanda
[g] Ministry of Health, Kigali, Rwanda
[h] Jhpiego, Islamabad, Pakistan
[i] Jhpiego, Baltimore, MD, USA

ARTICLE INFO

*Keywords:*
Intrauterine device
Postpartum family planning
Postpartum care
Prenatal care
Program implementation

ABSTRACT

Initiation of family planning at the time of birth is opportune, since few women in low-resource settings who give birth in a facility return for further care. Postpartum family planning (PPFP) and postpartum intrauterine device (PPIUD) services were integrated into maternal care in six low- and middle-income countries, applying an insertion technique developed in Paraguay. Facilities with high delivery volume were selected to integrate PPFP/PPIUD services into routine care. Effective PPFP/PPIUD integration requires training and mentoring those providers assisting women at the time of birth. Ongoing monitoring generated data for advocacy. The percentages of PPIUD acceptors ranged from 2.3% of women counseled in Pakistan to 5.8% in the Philippines. Rates of complications among women returning for follow-up were low. Expulsion rates were 3.7% in Pakistan, 3.6% in Ethiopia, and 1.7% in Guinea and the Philippines. Infection rates did not exceed 1.3%, and three countries recorded no cases. Offering PPFP/PPIUD at birth improves access to contraception.


## 1. Background

In 2012, an estimated 222 million women in low-resource countries wanted to avoid pregnancy but were not using modern contraception [1]. For many of these women, childbearing begins at an early age, intervals between pregnancies are too short, and lifetime fertility is high [2]. The resulting fertility patterns lead to excess mortality and morbidity for both mothers and offspring [3–5]. Although family planning services are intended to address desires to space and limit births, typically they are offered separately from maternity services. The providers who work in family planning units frequently are not the same individuals who care for women prenatally, at birth, and postnatally, so opportunities for integrating these services are limited. In many countries, institutional births are on the rise, and there is strong policy support for the use of skilled birth attendants. Thus, initiation of family planning during a facility stay at the time of birth is particularly opportune, especially since few women who give birth in a facility return for further postnatal care [6–8].

According to the World Health Organization (WHO), "postpartum family planning (PPFP) focuses on the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth" [9]. Operationalizing PPFP requires integration of family planning with maternal, newborn, and child health services (see Fig. 1). In the present paper, we define "immediate postpartum" as the first 48 hours after birth, "early postpartum" as the six weeks after a birth, and "extended postpartum" as the 12 months after a birth. The provision of a contraceptive method before discharge ensures that women are protected against pregnancy before they resume sexual activity or return to fecundity. Family planning programs with a wide range of contraceptive choices are associated with greater use and lower costs [10]. Yet, according to current WHO

* Corresponding author at: Jhpiego/Maternal and Child Health Integrated Program, 1776 Massachusetts Avenue NW, Suite 300, Washington, DC 20036, USA. Tel.: +1 202 835 6072.
*E-mail address:* Anne.Pfitzer@jhpiego.org (A. Pfitzer).
[1] (retired).

http://dx.doi.org/10.1016/j.ijgo.2015.03.008

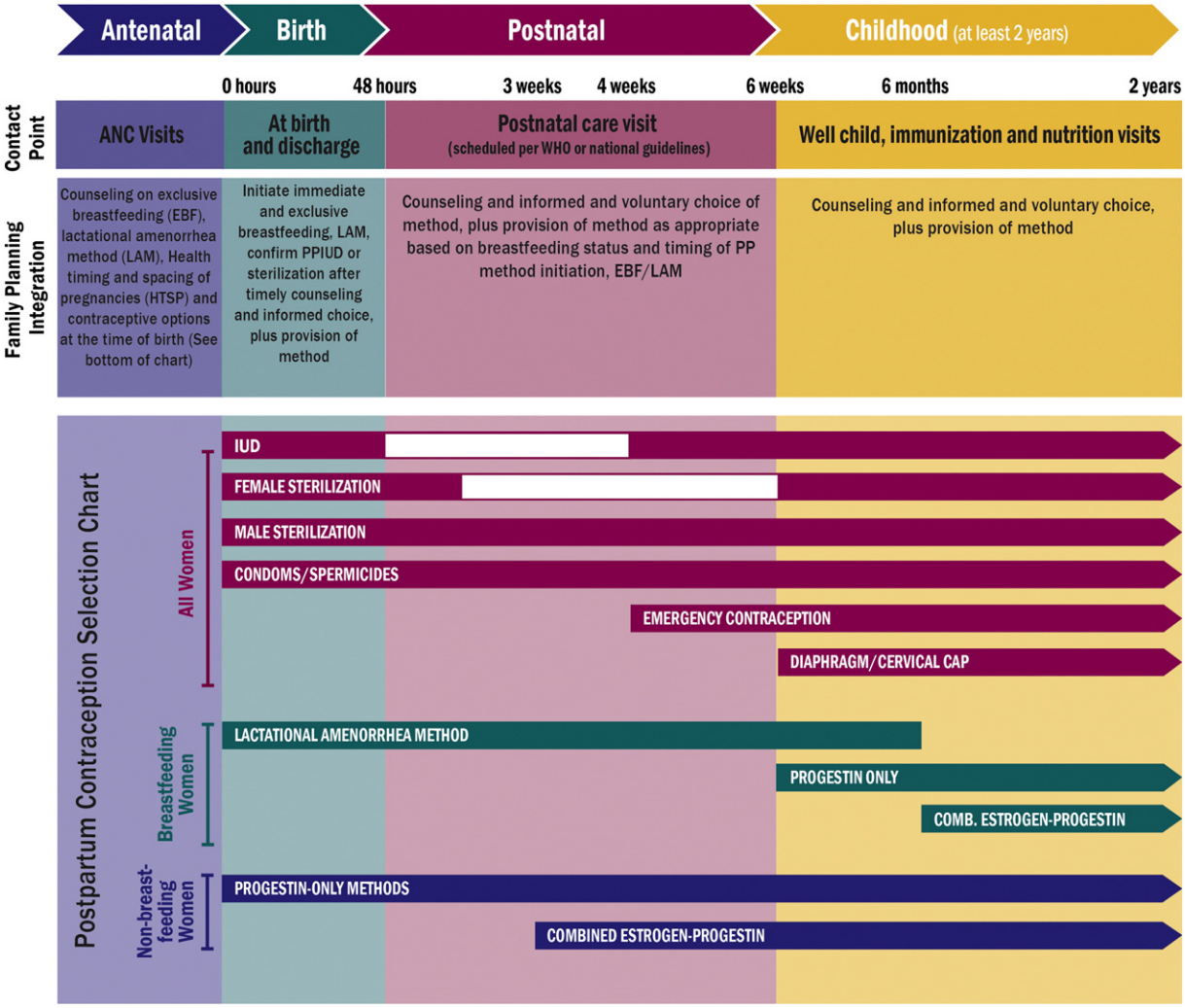


**Fig. 1.** Health-related contact points from pregnancy to the extended postpartum period and opportunities for family planning integration. Adapted with permission from World Health Organization [9].

recommendations, contraceptive choices are more limited during the early postpartum period, in particular for hormonal methods, if a woman follows recommendations to exclusively or predominantly breastfeed her baby [11,12]. Some countries allow progestin-only hormonal methods in the immediate postpartum for lactating women, but many follow the WHO's recommendation to delay initiation of these methods for at least six weeks. Exclusive breastfeeding for the first six months, without resumption of menses—the lactational amenorrhea method (LAM)—is a highly effective method of family planning in the short term [13]. Other immediate contraceptive options include the postpartum intrauterine device (PPIUD), which is an intrauterine device (IUD) inserted soon after delivery, as opposed to the interval IUD inserted later, or postpartum tubal ligation. PPFP includes any contraception used during the extended postpartum, regardless of timing of initiation, of which PPIUD is one option and is limited to the 48 hours after a birth. Quality programs always counsel women on all their PPFP options. Box 1 describes modalities for PPIUD insertion.

As a result of this convenient timing, PPFP/PPIUD services can be organized to take advantage of prenatal care and labor and delivery as prime opportunities to address postpartum contraceptive needs. In many countries, PPFP/PPIUD services also align with national efforts to promote facility-based births. However, early studies of PPIUDs that have examined different types and timings of insertion (up to seven days after birth) have found high expulsion rates, from 3.7% to over 30%, with mixed conclusions concerning post-placental or early postpartum insertion. These studies did not describe the PPIUD insertion technique used other than to indicate hand or instrumental insertion [14–17].

In the present article, we present program experiences from six countries where Jhpiego or the Jhpiego-led and USAID-supported Maternal and Child Health Integrated Program (MCHIP) integrated PPFP into maternal care, with PPIUD services offered. We describe the rollout and implementation of the programs, present service data on uptake and follow-up, and discuss operational challenges and solutions to support the scale-up and replication of PPIUD services in other countries. All six of the country programs used the Copper T 380A IUD. The Copper T is reversible and effective for 12 years, requires very little routine follow-up, and can be inserted within 10 minutes of placental expulsion, during cesarean deliveries, or within 48 hours after childbirth [18].

## 2. Methods and context

The authors reviewed program documentation, country-level monitoring and evaluation databases, and monthly summary reports from participating health facilities to assess commonalities and differences in program implementation. In Pakistan, Jhpiego staff obtained data compiled by facilities from the district or regional headquarters, while in Ethiopia, India, and the Philippines, data were obtained from monthly facility reports to program staff. In Guinea, monthly reports were sent to program staff at the same time as to the ministry of health (MOH). The