tci THE CHALLENGE INITIATIVE INDIA

Increased Postpartum Family Planning Services Results in Improved Maternal and Child Health

Postpartum Family Planning Services Series v.2.0

Gender Intentional

PURPOSE:

This tool coaches on the implementation of post-partum family planning (PPFP) services for offering family planning (FP) basket of choice, including long-acting reversible contraception (LARC) and spacing methods, at urban primary health center (UPHCs), other higher order public facilities and private sector health facilities.

AUDIENCE:

- General Manager-FP and Urban
- Joint Director (JD)/Additional Director (AD)
- Chief Medical Officer (CMO)/Additional Chief Medical Officer (ACMO)
- Chief Medical Superintendents (CMS)
- Divisional Urban Health Consultant (DUHC)/Nodal Officer-Urban Health and Family Planning/District Program Managers (DPM)/ Urban Health Coordinator (UHC)
- Medical Officer In-Charge (MOIC)/Medical Officers (MOs)/Persons In-Charge of Private Facilities/Staff Nurse-In-Chage District Hospital
- Facility Counsellor

BACKGROUND:

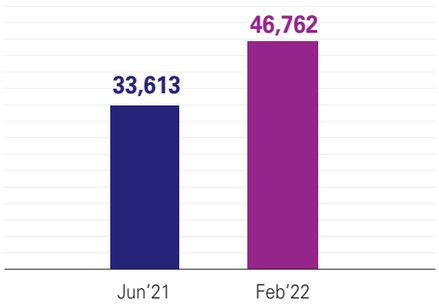
Evidence suggests that 61% of women do not use effective contraception within 24 months. Postpartum to avoid an unintended pregnancy. Because unintended and closely spaced births are associated with increased maternal, newborn and child morbidity and mortality, postpartum women are among those with the greatest unmet need for FP. However, providers, women and their support networks concerns about contraceptive side effects, especially related to effects of hormonal contraceptives on breast milk and the child's health as reasons to avoid contraception during the postpartum period.

It is, therefore, critical to address this grave public health concern so that PPFP can help couple decide which contraceptive they want to use, initiate that contraceptive and continue its use for two years or longer, depending on the reproductive intentions of the woman or couple.

EVIDENCE OF IMPACT:

Investing in FP reduces the maternal mortality rate (MMR) by 30% and the postpartum period is the most opportune time when a couple is actively seeking family planning to avoid a quick and unwanted pregnancy. The Challenge Initiative (TCI) conducted whole-site orientation (WSO) efforts through master coaches, CMS of the district women's hospitals (DWH) oriented all facility staff on the FP basket of choice methods and also became intentional on tapping PPFP. They started reviewing and seeking periodic reports on total delivery load and PPFP acceptors from the DWH counsellor and ensured timely and correct reporting over HMIS. With these efforts, the government witnessed a 39% increase in total PPFP acceptors from the previous year ending in June 2021 (33,613 in June 2021 and 46,762 in February 2022), from the total delivery load.

39% increase in total PPFP acceptors



GUIDANCE ON IMPLEMENTING PPFP

PPFP should not be considered a "vertical" program in isolation. Rather, it should be integrated with existing maternal and child health and FP programming efforts. A successful PPFP implementation strategy keeps people at the center of health care and it is gender intentional. Listed below are steps to implement an effective PPFP strategy:

Step 1: Understand the health system and current Government policies

As a first step, devise a clear understanding of how the health system is organized. Understand private health care facilities/providers along with public health facilities that can offer PPFP service and identify existing gaps and opportunities for offering FP to postpartum women.

Step 2: Make PPFP data visible by estimating the unmet need for FP based on available data

To amplify how health systems must focus on and prioritize PPFP, data from district and private facilities on reported delivery caseload vs. reported PPFP uptake – should be analyzed and discussed with CMS and private providers and also at other appropriate city- and state-level FP monitoring meetings. PPFP uptake data disaggregated by age, parity and method choice is critical for a city to plan its PPFP strategy to reach women with unmet need for PPFP.

Step 3: Integrate PPFP across contact points

As illustrated below, design PPFP interventions around counselling and services, to reach couples at an opportune time when they come in contact with the health system

Service	PPFP Integration
Antenatal Care (ANC)	1. Assessing the woman's contraceptive preferences and needs during the ANC period 2. Offering information and counselling on postpartum contraception options
Labor and Delivery, including Pre-discharge	1. Offering information and counselling on postpartum contraception options during labor and delivery and patient's discharge
Postnatal Care (PNC)	1. Follow-up with PPFP counseling during PNC visits and allay any fear/ concerns related to postpartum contraception 2. Providing contraceptive methods or referrals as needed
Immunization and Child Health Care Visits	1. Integrating PPFP discussions during child health visits 2. Ensuring mothers have access to information about their contraceptive choices 3. Offering contraceptives or referrals as part of routine care

Step 4: Ensure facility-based counseling and intrapartum services

The MOIC, CMS, facility-in-charge of private facilities should coach facility staff to integrate PPFP at all the contact points listed in step 3 encourage the couple to have open discussion about all the decisions including FP choices. They should emphasize that counseling includes the expanded choice of FP methods, including LARCs and also touches upon elements of gender equality and eradicating gender discrimination, like use of simulation games by counselor/ANM/staff nurse on gender sensitization such as white and black marble game to change the mind-set of son preference, Kranti Bhranti an interactive game of Rashtriya Kishore Swasthya Karyakram (RKSK) and creating awareness on Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT), etc. They should assign responsibilities to ensure that commodities, supplies, equipment, human resource, requisite reporting forms and Information, Education and Communication (IEC) materials are available for PPFP counseling. The service providers should also encourage male partners to promote shared decision-making and support for contraceptive use.

Step 5: Strengthen human resource capacity

Strengthen policies and practices to address staff development and retention to ensure that providers with PPFP skills are available for providing services at the time of ANC, labour, delivery and PNC. This includes:

1. Introducing and strengthening a comprehensive reproductive health (RH) education curriculum that addresses safe motherhood, FP, neonatal and child health training issues.
2. Ensure couple counselling on PPFP Healthy Timing and Spacing (HTSP) during ANC and in teaching curriculum, practical training and examinations.
3. Ensuring that all staff is oriented on gender integration and neutrality.
4. Dispatching mobile outreach teams (while linking referrals to a static facility) to facilities in the short term to provide services while building staff capacity for the long term.
5. Focusing on community-based PPFP interventions, including Exclusive Breast Feeding (EBF), pills, injectable and condoms, FST, NSV etc. while addressing provider capacity needs at the facility level.

Step 6: Ensure adequate trained staff, equipment and supplies, and if possible, ensure their availability 24 hours a day, 7 days a week

The Janani Suraksha Yojana (JSY) scheme has resulted in an increased number of institutional deliveries at facilities across India. This has provided the opportunity to provide LARCs such as PPIUCD to women who desire to use these methods. However, many of these opportunities are missed because providers in the facilities lack the necessary skills to provide immediate postpartum IUCD insertion. Training a core group of providers at the DWH and in medical colleges can create the necessary technical capacity among nurses and other doctors to provide this service. Funding is available through the Program Implementation Plan (PIP) to train doctors and nurses from each public facility conducting deliveries

Wherever feasible, ensure systematic 24x7 PPFP counseling through PPFP-trained providers and their availability during odd hours and on weekends. In addition, CMS should conduct WSO to ensure that staff nurses, traditional health workers or dais, janitors and cleaning staff are properly trained to support PPFP. In addition, organize client flow from OPD, ANC visits,

delivery and postnatal wards to identify appropriate space for counselling. A session on 'values clarifications' is often useful at the time of WSO in debunking provider bias. In addition, preposition supplies and organize client flow through labor, delivery and postnatal wards to identify appropriate space for counseling. For more details, please refer to these WSO training guidelines:

https://tciurbanhealth.org/courses/india-services-supply/lessons/strengthening-provider-capacity/topic/whole-site-orientation-training-guidelines/

Step 7: Ensure clinical safety for the desired method

An important consideration when planning a PPFP intervention is clinical safety, that is, which methods can be used at what point in time following birth and given the mother's breastfeeding status.

According to WHO Medical Eligibility Criteria for Contraceptive Use (2015), women can safely use contraceptive implants alongside most of the other contraceptive options in the immediate postpartum period. This is further broken down for breastfeeding and non-breastfeeding women.

1. **FP options for breastfeeding women:** IUCD, implants, progestogen-only pills, lactational amenorrhea method (LAM), condoms, male sterilization and female sterilization.
2. **FP options for non-breastfeeding women:** IUCDs, implants, injectables, condoms, emergency contraception, combined oral contraceptives (commence 21 days after delivery), male sterilization and female sterilization.

Step 8: Mobilize the community

Orient Accredited Social Health Activists (ASHAs) on PPFP, HTSP, couple counseling, importance of inter-spousal communication to promote shared decision-making and support for contraceptive use.

1. ASHAs should promote ANC visit, institutional delivery, PNC visits and PPFP in the community. They must provide essential newborn care and EBF guidance, and also encourage the expectant parents to have open discussion about all the decisions including FP services. Arogya Mela, Saas bahu beta Sammellan, and urban health nutrition day (UHND) are relevant platforms for couple counselling.
2. Discuss couple's reproductive intentions for spacing or limiting and provide information on contraceptive methods as well as the nearest service delivery points.
3. Promote community-based integrated MNCH and family planning services.

Step 9: Update national service delivery guidelines and clarify the role of service providers

This is particularly critical if existing guidelines reflect delayed start of progestin-only methods, like implants, which are now an option for immediate PPFP use according to WHO's 2015 Medical Eligibility Criteria for Contraceptive Use (5th edition). Guidelines as well as job descriptions should clearly articulate that all antenatal and maternity care providers have a role in PPFP, and that it is not just the responsibility of a few trained providers. The role of community health workers in promoting PPFP can also be

ROLES RESPONSIBILITY

1. JD/AD/GM FP and Urban

1.1 Review PPFP data of urban facilities – UPHCs, higher order facilities and private facilities
1.2 Issue guidance to all the dvistricts/cities to refer to this tool as one of the guidance documents for implementation of PPFP for all methods at all public and private sector health facilities

2. CMO/ACMO

2.1 CMO should organize WSO for orienting and sensitizing facility staff on the importance of PPFP, gender integration and debunking myths of clinical staff and non-clinical staff
2.2 Approve and allocate resources for PPFP trainings.
2.3 Encourage all private facilities to provide PPFP counseling well in advance, starting from first ANC and 24/7 service provision
2.4 Ensure that empaneled providers are available for PPFP services, whenever needed
2.5 Review PPFP method-wise data by facility in district level review meetings

3. CMS/MOIC/Private Facility In-Charge

3.1 Ensure availability of trained designated PPFP counsellor, service provision teams 24x7 and facility readiness
3.2 Ensure informed choice and method-specific couple counseling as per guidelines through trained designated counsellor
3.3 Analyze PPFP data by method and by year/month and present in review meetings
3.4 Monitor the quality of counselling, PPFP services and ensure timely and correct reporting

4. Nodal Officer- Urban Health and FP/DUHC/DPM/UHC

4.1 Lead in planning and organizing 24x7 PPFP counseling and service provision in the district
4.2 Manage the PPFP service provision, including team deployment and logistics
4.3 Analyze PPFP data by facility and method by year/month
4.4 Coordinate and oversee all quality parameters and work as an interface between district leadership and facilities
4.5 Ensure a smooth supply of commodities and supplies

5. Staff Nurse/Facility Counsellor

5.1 Ensure wage loss compensation for sterilization clients
5.2 Provide informed choice and method-specific counseling to clients
5.3 Do post-procedure follow-up of clients

6. Community Health Worker (ANMs, ASHAs, etc.)

6.1 Generate awareness and mobilize clients for PPFP through home visits and group meetings
6.2 Prepare potential client list for PPFP services
6.3 Use IEC materials to provide information to about PPFP and specific contraceptive methods

MONITORING PPFP SERVICES

PPFP counselling and services can be monitored by including this as a regular agenda item for discussion in the meetings convened by the CMS and CMO. The following indicators should be reviewed:

1. Number of facilities providing PPFP
2. Number of service provider's capacity built (trained) on PPFP
3. Number/percentage of ANC clients who received information and counselling regarding PPFP
4. Number of PPFP services adopted against total deliveries, and their method-mix distribution

COST ELEMENTS

The elements required for PPFP are mentioned below along with their Program Implementation Plan (PIP) codes for easy reference. They may be covered under existing budget line items, but if not, they should be incorporated through the PIP process:

Cost element	FMR Code
Counselor hiring	FMR-HSS.9.184.C.S0522
Training	Comprehensive PPIUCD Training for CHOs/SNs/ ANMs- FMR-RCH.6.44.CB.1
Incentives Sterilization, PPIUCD	PPIUCD incentive to ASHA- FMR-RCH.6.44.ASHA.1 Antara incentive to ASHA FMR-RCH.6.45.ASHA
Compensation to client	PPIUCD Compensation to client FMR-RCH.6.44.DBT.2 PPFST Compensation to client FMR-RCH.6.42.DBT.01.b)
Performance-based incentives for providers	PPIUCD insertion incentive for MO/SN/ANM in Urban FMR- HSS(U).5.143.OOC.1
Performance-based incentives for counsellors	FMR-HSS(U).5.143.OOC.3

Source: NHM PIP Guideline 2022-2024

SUSTAINABILITY

Integrating family planning counseling and modern contraceptive options into childbirth services and pre-discharge protocols significantly boosts postpartum contraceptive utilization. Strategies that identify and address barriers to PPFP uptake, such as personalized home visits for new and young parents and early contraceptive education during antenatal visits, are key for enhancing service sustainability. Encouraging male participation in FP can improve maternal health outcomes and mitigate postpartum depression. It's essential to maintain healthcare providers' competence through ongoing training in contraceptive methods and to challenge myths with values clarification sessions, ensuring the long-term sustainability of PPFP services.

For downloading and referring this tool visit: https://tciurbanhealth.org/courses/india-services-supply/lessons/india-postpartum-family-planning-services/ and to refer other tools visit: https://tciurbanhealth.org/india-toolkit/

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