Partners in Population and Development (PPD)
An Inter-Governmental Organization
Promoting South-South Cooperation

सत्यमेव जयते
Ministry of Health and Family Welfare
Government of India

UNFPA

Introduction and scale-up of PPIUCD services- The India Story

SHARING BEST PRACTICES

Addressing RH, Population and Development Challenges

Case from INDIA

December 2020

Biography of the Consultant

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Dr. Nidhi Bhatt is a science and medical graduate (B.Sc, M.B.B.S) with post-graduation in Public Health. She has more than 12 years of experience working in government and non-government sector on diverse areas viz. RMNCAH+N, Quality assurance, Climate change and microinsurance. With her profound blend of technical knowledge and program skill set she has been instrumental in strengthening National Family Planning Program specifically through development of technical manuals and program strategies for Government of India.

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Acronyms

ANM- Auxiliary Nurse Midwife
ANMOL-ANM Online
ASHA- Accredited Social Health Activist
BCC- Behavior Change Communication
CDRI- Central Drug Research Institute
DP- Development Partner
EAISI-Expanding Access to
IUCD Services in India
EMU-Estimate Method Use
FP-LMIS- Family Planning Logistics Management Information System
FOGSI-Federation of Obstetric and Gynecological Societies of India
GIS-Geographic Information System
HMIS- Health Management Information System
HTSP- Healthy Timing and Spacing of Pregnancies
IEC- Information, Education and Communication
JSSK- Janani Shishu Suraksha Karyakram
JSY- Janani Suraksha Yojana
LARC- Long Acting Reversible Contraceptive
MEC-Medical Eligibility Criteria
MNCH- Maternal, Newborn and Child Health
MoHFW- Ministry of Health and Family Welfare
MPA- Medroxy Progesterone Acetate
NHP-National Health Policy
NTSU-National Technical Support Unit
PAIUCD- Post-abortion Intra Uterine Contraceptive Device
PPIUCD- Postpartum Intra Uterine Contraceptive Device
PHC- Primary Health Center
PIP-Program Implementation Plan
PPFP- Postpartum Family Planning
RCH- Reproductive and Child Health
RMNCAH+N- Reproductive, Maternal, Newborn and Child, Adolescent Health and Nutrition
SRS- Sample Registration Survey
SS-Survey and Statistics
UT- Union Territory

Foreword

Partners in Population and Development (PPD) is an inter-governmental organization of 27 Developing Countries from Asia, Africa, Latin America, and Middle East and North Africa (MENA) regions, launched in 1994 at the International Conference on Population and Development (ICPD) held in Cairo, Egypt with the mandate to institutionalize and promote South-South Cooperation (SSC) in Reproductive Health, Family Planning and Population related issues for the implementation of the ICPD Program of Action. Through exchange of knowledge, experiences and best practices among its member countries and other developing countries, PPD contributed in creating opportunities for launching efficient and transformational SSTC programs, considered as best alternative approaches to achieve ICPD and the 2030 Agenda for Sustainable Development in developing countries.

In 2019, PPD and UNFPA jointly documented 2 best practices from Kenya and Tunisia which were published in UNOSSC South-South Galaxy (Volume 3: South-South and Triangular Cooperation for Sustainable Development). In 2020 and as the whole world experienced the social and economic disruption, particularly in health system caused by COVID-19 pandemic, PPD with the support of UNFPA has documented nine (9) best practices from Bangladesh, China, Egypt, The Gambia, Ghana, India, Morocco, Vietnam and Thailand, highlighting the issues related to reproductive health, family planning, maternal health, adolescent health, gender equality, population and development.

I strongly believe that sharing best practices is a key tool to promote South-South Cooperation and this document will help other countries to adapt and replicate the ideas to solve similar issues in the beneficiary countries.

I wish to express my sincerest thanks and appreciation to the Government of the Republic of India through the Ministry of Health and Family Welfare for their strong engagement to South-South Cooperation and continued support to PPD as witnessed by the documentation of the "***Introduction and scale-up of Postpartum Intra Uterine Contraceptive Device (PPIUCD) services in India***" and the commitment to share it with other developing countries.

Adnene Ben Haj Aissa
Executive Director

Outline of Documentation of Best Practices

	General Information Sheet on the Country and Project setting:	
1.	Name of the Country	India
2.	Name of the State or Province in the Country	All States and Union Territories of India
3.	Kind of Intervention	Government program
4.	Implementing Institution	Ministry of Health and Family Welfare
5.	Details of Institution with e-mail address	nhm.gov.in
6.	Implementation Period	Since 2010
7.	Budget:	Government Funding

Executive Summary

Family Planning program in India has a rich history of more than seven decades (first country in the world to have a national program for family planning). The program since then has witnessed an evolution from population control to improving maternal and child health outcomes.

With the increase in global advocacy and partnerships, postpartum family planning re- emerged as one of the important and effective interventions to ensure Healthy Timing and Spacing of Pregnancies (HTSP). The global advocacy efforts and evidences ignited a unified action in the world to change the fundamental attitude towards Postpartum contraception, especially Post-Partum Intra Uterine Contraceptive Device (PPIUCD). Postpartum period is the most crucial period in determining the health outcomes of mother and child and if health needs are taken care of in this period, the risk of adverse events can be reduced. The studies reveal that unmet need for modern contraception is as high as 65% during the postpartum period[i]. The return of fertility can be as early as four weeks after delivery and within 10 days after an abortion[ii]. This highlights the need for provision of timely contraceptive services in postpartum period. Understanding the need for timely provision of post pregnancy contraception along with the availability of evidences related to global clinical and program approaches, India became a forerunner in institutionalizing PPIUCD services.

The initial efforts started in 2008 when there was a consciousness at the highest level in the country about the unmet need for postpartum family planning services, ensuring contraceptive choices beyond sterilization and improving maternal and child health outcomes. This awareness set the ground for Government of India's initiative to revitalize PPIUCD services in the country. Simultaneously, during the same period, the exponential rise in institutional deliveries due to the huge success of Janani Suraksha Yojana (JSY)- a conditional cash transfer scheme for improving institutional deliveries provided a unique opportunity for the expansion of Postpartum Family Planning (PPFP) services in India. This pace was further accelerated by the integrated approach of the Government, Development Partners and Civil Society organizations towards a common commitment of reducing unmet need by improving access to contraceptive services.

India's story of mainstreaming post-pregnancy contraception has not been limited to trainings and service provision only but is a successful demonstration of multi sectoral collaborative efforts towards overall health systems strengthening with a common objective of reducing unwanted pregnancies and ensuring HTSP.

The paradigm shift, from limiting to spacing births and focusing on long-acting reversible methods like IUCD provided greater momentum to the program for increasing access to PPIUCD services. The successful pilot of PPIUCD program initiated in 2008 reached its scale up in 2013 and has witnessed more than 10 million PPIUCD insertions in the country since inception. The program provided a platform for many innovations/ new strategies (as mentioned in the figure below) which include- Task shifting, Creation of a cadre of RMNCHA Counsellors, Development of PPIUCD forceps, Training methodologies- 'onsite training' with post training mentoring, 'each one train one strategy', unified single window IUCD software for all development partners, improved focus on client follow up etc.

The country programming followed a meticulous approach while addressing all necessary dimensions

Policy - Repositioning FP as MNCH intervention Increasing emphasis on spacing methods Focusing on PPFP, Task Shifting, RMNCH+A Counsellor cadre	**Partnerships -** National and State level advocacy meetings, Development partners/stakeholders meetings
Financing - Proactive financing under National Health Mission Incentive scheme	**Service Delivery-** Infrastructure mapping, staggered roll out in high delivery load facilities, Development of counselling corners, Job aids
Human Resource - Learning resource package, competency-based trainings, onsite trainings, each one train one strategy, post training mentorship	**Demand Generation -** IEC/BCC Campaign, Community mobilization strategies, Strengthening referral systems, Trainings for triple A platform (Community Health workforce)
Supplies and equipment - Designing of PPIUCD forceps with decentralized procurement, FP-LMIS, Logistics guidelines and trainings	**Monitoring and Learning -** System readiness, Monitoring framework with Program/Quality Indicators, Single window IUCD software for monitoring DP field activities, Incorporation in National HMIS/RCH portal, Integrated data review platforms

India's PPIUCD success story doesn't end with scale up as there have been continued efforts to improve the quality of services including counselling, monitoring of the program, creation of new platforms for generating awareness like National helpline etc. The program experience also led to the increased realization of improving use of post pregnancy contraception, which includes postpartum and post abortion services. In addition, a general motivation exists in the health care providers to improve access to other postpartum methods as well. These efforts together with introduction of Injectable MPA and Centchroman in the Family Planning basket has accentuated the use of postpartum family planning methods (FP Division, MoHFW).

The efforts to ensure uninterrupted PPIUCD service provisioning in the Covid-19 pandemic situation across country is a testimony to commitment in improving access to SRHR services. National guidelines, constant dialogue and advocacy with national and state governments and support to program managers kept the momentum intact on LARC services. Continuation of PPIUCD services during Pandemic is another success for the nation.

The strategic planning and implementation approach are learnings for India as well as other countries. This report details India's efforts to revitalize and mainstream the PPIUCD services in the country.

I. Background

1.1 India's Family Planning Program has witnessed a massive growth and adaptation since its inception. The second largest nation in the world also takes the pride in launching first Nation-wide Family Planning program in the world in 1952. The program was then focused on reducing the birth rate to the extent necessary to stabilize the population at a level consistent with the requirement of the National economy[iii]. Over the past half century, the program has witnessed a paradigm shift in its approach i.e. transitioning from a population control centric approach to a reproductive rights-based approach specifically after International Conference on Population and Development, 1994, Cairo. The introduction of the first phase of Reproductive and Child Health (RCH) program (1997), laid the foundation for integrated health and family welfare services to meet the felt needs of community and considerably reduce preventable maternal, infant and child mortality and morbidity. It was also realized during the same time that increasing the use and access of contraceptives is crucial to address the prevailing high maternal, infant and child mortality substantially. India, thus, took a progressive approach and made reproductive health an important element under an integrated RMNCAH+N strategy.

Health of a mother is cardinal to ensure a nation's health. In recent years, India has made a spectacular progress in reducing the Maternal mortality ratio by 80% (from 556 per 100000 live births to 113 per 100000 live births (SRS 2016-18)).[iv] With almost 18.9% of the world's live births occurring in India, the global contribution to maternal deaths is only 10%v now. Studies also reveal that unsafe abortions account for 8% of total maternal mortalities, of which almost 30% deaths can be prevented by increasing access to family planning methods (Cleland J et al, 2006. Lancet).

Studies also state that risk of child mortality increases three-fold if the birth interval is less than 18 months[vi]. Further, it is accepted that 10% of the child mortalities can be prevented if couples space their pregnancies more than 2 years apart which is an easy and cost-effective alternative[vii].

The policy implications to improve maternal and child health, thus, rests upon an integrated approach to reduce unwanted and closely spaced pregnancies. Evidences further suggest that contraceptive services provided during child birth (postpartum period) has a potential to reduce both unintended and closely spaced pregnancies. Despite this, the unmet need for contraception in postpartum period remains as high as 65%[i]. The same source also reveals that 61% of these women have a specific need for spacing while the remaining 39% have desire to limit child birth.

The postpartum period provides a unique opportunity to meet the reproductive health needs of women, particularly the need for family planning. In addition, women's increased contact with health-care services after childbirth affords the opportunity to offer them postpartum care[viii]. Realizing the potential of integrating postpartum family planning initiatives in improving maternal and newborn health, thrust was laid on promoting post-pregnancy contraception in the country.

The global efforts to mainstream the postpartum family planning services has a recent history when in 2006, a global technical consultation was conducted in Washington DC. This was fueled by the findings from Lancet studies highlighting that 25-40% of maternal deaths could be averted if unplanned and

unwanted pregnancies were prevented[ix]. WHO technical committee recommendation in 2006 on HTSP i.e. spacing between birth and next pregnancy by at least 24 months, also played a pivotal role in re-invigorating emphasis on spacing methods, especially Long Acting Reversible Contraceptive- IUCD.

Goal of PPIUCD program: Aligning with the country's goal of 'improving maternal and child health outcomes by addressing unmet need of spacing, especially in Postpartum period', India introduced PPIUCD in its basket of contraceptives in 2009.

With the consistent efforts and achievements along the way, ensuring healthy timing and spacing of pregnancies is now considered one of the most important interventions under India's RMNCAH+N strategy.

1.2 India's RMNCH+A strategic document delineates the country's strategic priority of protecting the lives and health of women, adolescents, and children. Post ICPD 1994 in Cairo, India was one of the 179 governments that embraced a bold vision for ensuring rights and well-being of its citizens. Further under ICPD+25, India reaffirmed its commitments to sustain gains and achieve the stipulated SDGs. As PPIUCD is a strategy to promote healthy birth intervals it has a direct impact on maternal and child nutrition, morbidity and mortalities, therefore helps in directly addressing SDG 2, 3 and 5.

Text Box 1.2: Concerted efforts to improve contraceptive basket under the National Family Planning program- India

As a step towards improving healthy spacing between births, the Family Planning program in India was expanded to include more spacing options in the basket of contraceptive choices. Each decade has brought in something new for the program since its launch.

In 1963, India became the first country to introduce male condoms under the brand name 'Nirodh'. This was also the time when 'Lippe's Loop' (an intrauterine contraceptive device) was introduced in the program as a first reliable birth spacing method for women

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Further in the year 1976, oral contraceptive pills were added to the basket. Efforts to provide safe contraceptive choices to the couples under the National FP program continued and in the year 2002, the contraceptive basket was again expanded with newer version of IUCD (IUCD 380 A) and Emergency Contraceptive pills.

Later, the introduction of Cu 375 (known as IUCD 375) in the year 2012 proved to be a breakthrough in the duration of contraception provided to couples through IUCD. Prior to introduction of Cu IUCD 375 India already started its efforts for bringing in postpartum IUCD.
The country did not rest here and in 2016 Injectable MPA and Centchroman (non-hormonal contraceptive pills- Developed by Central Drug Research Institute Lucknow-India) was added in the contraceptive basket, which are safe in postpartum period.

II. India's PPIUCD Program- Interventions, Achievement and Scale up

India's long-standing efforts on Family Planning have largely been identified to be sterilization centric. The country with the second largest population base in the world, thus, had an uphill task to strengthen the spacing services further with an emphasis on postpartum period. As mentioned above, the global efforts for streamlining Postpartum Family Planning started in 2006 and India proactively adopted this strategy. In 2008, the initial dialogues started to revitalize postpartum IUCD in the country (FP Division, MoHFW). Backed by the fact that the women do not prefer use of modern contraceptives during the postpartum period due to sociocultural and gender norms that guide postnatal practices, timing of return to sexual activity, breastfeeding practices and misconceptions regarding lactational amenorrhea, and lack of access to postpartum contraceptive services, Government of India envisioned a holistic approach to provide quality family planning services to its citizens. As a major step towards identifying platforms to improve uptake of IUCD and utilize opportunities to improve client's knowledge and address myths and misconceptions, the program capitalized on the opportunity provided by the increasing number of institutional deliveries (due to schemes like JSY and JSSK). This led to the initiation of PPIUCD services in a pilot mode in the year 2009. The hospital-stay during the postpartum period provided necessary time for counselling and improved ability of providers to make more comprehensive assessment of women's reproductive health needs.

2.1 PPIUCD Pilot- Key Interventions:

In 2009, Jhpiego started providing technical assistance to the GoI for strengthening PPFP/PPIUCD services in the states of Jharkhand and Uttar Pradesh through the support of USAID. The pilot began with first batch of clinician training in the same year at Queen Mary Hospital, Lucknow. Simultaneously, National Training Centre at Safdarjung Hospital in New Delhi and 3 regional training centers in Mumbai, Jabalpur and Lucknow in 2009-2010 were established. These were competency-based trainings with clinical practicum on humanistic model and supervised clinical sessions with clients. The overall roll out was a testimony to Government of India's strategic approach on gathering program learnings and planning further scale up. The focus was to build technical competency, rationally utilize existing human resource and infrastructure, ensure quality counselling services and build a post training mentorship model.

The program initially started in the district level facilities in a controlled manner. The positive inputs of the pilot in 2 high focus states of India resulted in expansion of PPIUCD service in 19 states as an extension of Pilot (Uttar Pradesh, Uttarakhand, Jharkhand, Delhi, Haryana, Punjab, Rajasthan, Bihar, Madhya Pradesh, Assam, Meghalaya, Chhattisgarh, Orissa, West Bengal, Gujarat, Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh) by the end of 2012[x].

Global Focus and commitment: The year 2012 may also be noted as historic for India's FP programme as this was the time when India was witnessing a paradigm shift; a new integrated RMNCH+A approach was being institutionalized and globally there was a positive shift with a focus on Family Planning through FP 2020. All these put together resulted in strong advocacy with the state governments and other stakeholders.

2.1.1 Achievements of the pilot:

It is imperative to mention here that India was actively implementing the alternate training methodology for interval IUCD services, but for PPIUCD, a new innovative approach in the form of onsite trainings and mentoring was initiated.

The key interventions in pilot phase that laid foundation for effective scale up strategies (2010- 2012) were.

1. Involvement of National and State Government in finalization of resource materials including the endorsement and dissemination of Standard Resource material and technical specification (PPIUCD).
2. Finalization of Service Delivery Tools wherein learning resource package of PPIUCD, Counselling training, Job-Aids, Behavioral Change communication materials were endorsed by Government of India. Finalization of performance standards by key representatives from all states and area experts and approval and dissemination of Specifications of PPIUCD insertion forceps by GoI.
3. Field Implementation with onsite technical support where focus was given to high case load facilities (average 2 facilities per state), Decentralization of trainings (17 training sites established in 12 states), On-site orientation and providing insertion forceps, registers, IEC materials to service providers.
4. Institutionalization of Services at Facilities through on-job/ need-based classroom training of all providers, strengthening of counseling by hiring and training of counselors, preparing job-aids for counselors, Strengthening follow-up of PPIUCD clients after 6 weeks of insertion

Text Box 2.1.1: Innovative and strategic steps taken during pilot

- Onsite trainings and onsite post training mentoring and follow up
- Decentralization of trainings
- Strategically designed learning resource packages
- Development of job aids for counselling and onsite trainings for the same
- Planning and mapping of high delivery load facilities for service provision
- Involvement of states and other stakeholders in finalization of performance standards for monitoring
- Innovation and development of specifications for PPIUCD forceps

Trainings complemented by post training support ensured quality and sustainability of efforts undertaken during this pilot resulting in 79,802 insertions by the end of 2013.This approach also supported the identification and increase in PPIUCD training sites from 31 (2010) to 71 (2012)xi.

This also brought GoI's Policy Shift in 2012 which laid foundation for further Scale Up:

1. Dedicated counselors in the govt system: A new cadre of dedicated counselors for busy facilities in all states
2. Task shifting: Nurses were allowed to insert PPIUCD.
3. Scale-up of PPIUCD services at 248 district hospitals in 6 high focus states (2013-14)

2.1.2 Learnings from the pilot:

PPIUCD Pilot provided learnings which were replicated in many other program interventions and also proved instrumental in expansion/scale up of PPIUCD across India. The key learning that proved effective in addressing various challenges in timely manner were collaboration and coordination of GoI and state government which included immediate consultation and feedback on phone, conducting Monthly meeting, sharing of reports and responding to Govt's requests Multiple donors support helped in providing financial and technical support through partner organization and brought the desired focus on the intervention to witness the results. Any new intervention requires response to programmatic, technical and financial concerns and engaging experts from the start of pilot proved effective strategy. Well curated strategies and systematic planning led to implementation in a controlled manner ensuring quality in training complemented by post-training supportive supervision.

2.2 Scale up of PPIUCD Services:

Later in 2013, the program was expanded to the sub-district level facilities. The expansion of pilot was in a collaborative spirit where the development partners technically supported the public health facilities. During this phase, the overall objective was to consolidate the learnings, improve quality of services in the facilities where PPIUCD services have begun and introduce PPIUCD in the primary care facilities (Primary health Centers-PHCs). The National and State government and implementing partners took a deeper dive in identifying the PHCs for the expansion of services.

Encouraging results from PPIUCD pilot paved the path for rolling out the intervention across all states of India in the year 2014. Technical, Financial, Monitoring and Evaluation aspects were meticulously incorporated in the roll out plan for PPIUCD. The pace of uptake of PPIUCD program across states were varied and special emphasis was laid on the states with TFR above the National average.

A multi-pronged strategy was adopted for the Nation-wide roll out. Before expanding the PPIUCD program to all states/UTs of India following parameters were worked upon- Expanding the pool of service providers, influencing provider's perspective, Emphasizing on Counselling Services, Logistics and infrastructure, Demand Generation, Monitoring, Learning and advocacy with the States/UTs.

Text Box 2.2: Collaborative Efforts (Establishment of National Technical Support Unit-Family Planning (NTSU-FP)):

In the year 2014, under the guidance of MoHFW and donor support, a dedicated Technical Support Unit was formed at the national level which acted as an extended wing of Government of India in strengthening Family Planning program and institutionalizing quality in all aspects of FP services. Extensive program monitoring, techno managerial capacity building sessions, updating and development of technical material, regularizing government and non-government review mechanism and aligning program priorities with FP2020 commitment resulted in pathbreaking success of adding 15.3 million FP users (Track 20, factsheet 2019). State-wise analysis and monitoring tool were developed which was an elaborative exercise wherein the status of functionality of all levels of facilities, service providers, and the capacity of state and district was assessed to guide the development of ambitious but realistic district-wise action plans. Operationalization of PPIUCD services at all the delivery points was institutionalized through this activity and quality of data reporting was specifically emphasized.

2.2.1 Scale Up Strategies:

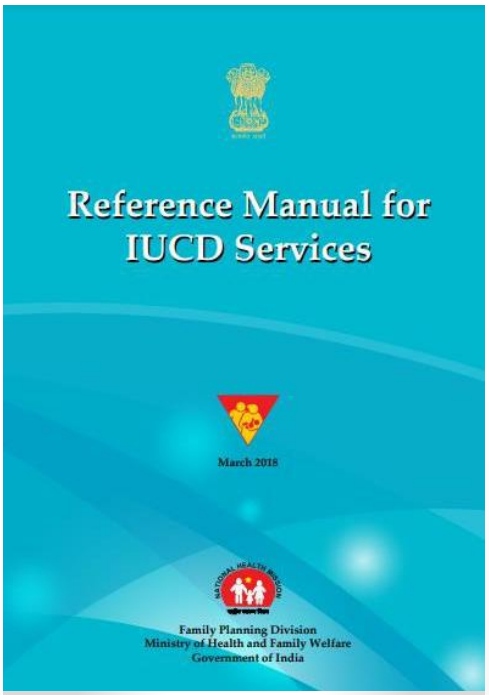
Learning and timely proactive responses substantiated the success of PPIUCD scale up through strengthened supply and demand side interventions.

2.2.1.1 Supply Side Interventions:

A. Development of Learning Resource Package and strategies:

Development of standardized training packages for all level of service providers on PPIUCD helped in ensuring quality and adhering to national standards. These training packages and tools were designed to enhance technical knowledge and skills on the clinical procedures and counselling in accordance with the established protocols and guidelines. The packages were based on technological advancements and developments made in the arena of family planning as Government of India generates evidences and makes necessary revisions to the training packages and job aids from time to time. Subsequently, a comprehensive training package was developed, in consultation with development partners, for trainers (facilitators' guide) and service providers (including alternate medicine practitioners- AYUSH) detailing the technical information as well as training agenda and session plans.

The trainings were initiated in a cascade manner; not only updating the providers on necessary technical information but also ensuring standardization of trainings and practices throughout. The training package was constructed for 5 days (comprehensive IUCD training package) and 3 days (PPIUCD training package for providers already trained in Interval IUCD) with a maximum of 10-12 providers per batch to allow for adequate hands-on experience and maintain quality of the training. With revitalization of Post-abortion family planning, PAIUCD was also included in the package with additional 1-day orientation on PAIUCD for those providers already trained in interval and PPIUCD. The uniqueness of the entire training package was the competency-based checklist that helped the facilitator determine the learning acquisition of the trainee and plan intervention (successful certificate/ re-training) accordingly. (FP Division, MoHFW).



One stop reference material for IUCD (nhm.gov.in)

There has been a continuous effort to revise the curriculum as per the field observations. The initiation of the program witnessed multiple guidelines for different cadres. Government of India subsumed all the existing IUCD manuals into one (one-stop reference material for Interval IUCD, PPIUCD and PAIUCD) in the year 2018.

B. Strengthening training sites and criteria:

Programmatic guidelines were also issued to the states for maintaining uniformity and quality of services. These entailed (but not limited to) criteria for selection of training sites, criteria for selection of

service sites, eligibility of providers, training need assessment and accordingly securing budget in State Project Implementation Plans annually. These programmatic guidelines provided a roadmap for the states/ districts while planning and implementing the services without compromising on the quality.

At the same time, under the RMNCH+A integrated approach, Government of India took a major initiative to create and operationalize skills labs and undertake assessment and training of the health workers who are providing RMNCH+A services in the public health institutions. Each skill lab was equipped with necessary training material/ mannequins wherein PPIUCD was also made an integral part of skill lab curriculum[xii].

C. Standardization of Equipment:

Availability of Standardized PPIUCD forceps was a prerequisite for quality of PPIUCD insertion. As a first step towards ensuring correct insertion (fundal placement) and preventing infections, specifications of already existing Kelly's forceps were modified and PPIUCD insertion forceps were designed. The product was a result of in-depth discussions and brainstorming by domain experts, engineers, Program managers etc. with an intent to give the service providers an alternative to using hands/ sponge forceps which could either lead to increased incidence of expulsion (due to low placement) or land the clients with infections. All these technical specifications of PPIUCD insertion forceps were uploaded on national information portal to decentralize purchasing and ensure uniform service delivery across all states[xiii].

D. Strengthening Supply chain for FP commodities:

In the year 2017, MoHFW developed an innovative unified management information system – FP LMIS (Family Planning Logistic Management Information System) with an aim to manage supply chain from national level till ASHA level, reduce the supply disparities and regulate the flow of family planning supplies to the end users. Quantities of IUCD 375 and IUCD 380 A are estimated, supplied and monitored at national level. This software was rolled out across all states of India for which a detailed roll-out plan was developed covering areas like advocacy, finance, capacity building, Infrastructural requirement and monitoring[xiv].

E. Expanded Pool of Service Providers:

As mentioned earlier, the high caseload due to increased institutional deliveries (owing to JSY and JSSK) generated the need to increase providers' pool and improve the provision of PPIUCD services. As a response to address this need and to overcome the shortage of trained human resource for providing IUCD services at public health facilities, Government of India took a policy decision to train doctors from alternate medicines (AYUSH- Ayurveda, Siddha and Homeopathy) for IUCD service provision. Task shifting was ensured wherein AYUSH/ nursing personnel could insert PPIUCD and resultantly a greater number of trained nurses (Staff Nurse/ Midwife/ Lady Health Visitor/ ANM) are currently available to provide the Interval and Postpartum IUCD services.

Another milestone in expanding pool without disrupting existing services was the conception of the concept of 'Each One Train One' which the Ministry of Health and Family Welfare endorsed. This was developed to address the difficulty faced by district authorities in letting service providers leave clinical duty for training (due to limited number of service providers). In this concept, one trained provider from the health facility trains other eligible providers from the same facility without compromising on the clinic

timings and ensuring round the clock service provision. The specific certification criterion was developed for such trainees.

2.2.1.2 Demand Side Interventions:

A. Capacity Building of Frontline workers:

To accentuate demand generation within the community, frontline workers (ASHAs) were extensively roped in the National Program. MoHFW developed multiple schemes for ASHAs to promote HTSP by ensuring early detection of pregnancy (provision of Pregnancy Testing Kits), Home delivery of contraceptives, and promoting delaying and spacing of pregnancies (Ensuring spacing at birth scheme). Further, performance linked payments were introduced for service providers and ASHAs for mobilization of clients. Technical content for PPIUCD was incorporated in existing ASHA training modules which resulted in institutionalization of regular PPIUCD trainings.

B. Development of Mass Media and IEC materials:

360-degree approach was adopted to generate awareness on PPIUCD and foster informed decision making for the same. IEC/BCC materials (Video, posters, leaflets etc.) for promotion and uptake of post-pregnancy contraception, especially PPIUCD were developed and widely disseminated. The material was uploaded on the ministry's web portal which was a free source for all the stakeholders and provided opportunity to the states to adapt the material into local language for transmission. These IEC/BCC materials were developed with the technical experts in field of communications.

IEC material developed for promotion of PPIUCD (Pyar mei Doori/Phir se dulhan developed with the support of Donor partners (nhm.gov.in))

2.2.1.3 Quality in Service Provisioning:

A. Emphasis on Informed Voluntary Consent:

Despite having a programmatic focus, ensuring voluntary informed decision making was a challenge. Government of India, therefore, laid emphasis on informed verbal consent in all the guidelines, standard operating procedures, review and technical workshops. Further, sample checks of exit client interviews and interviews with clients admitted in PP wards were conducted from time to time to substantiate adherence to these guidelines.

B. Data recording and monitoring:

It was imperative to monitor the program implementation for ensuring quality as well as make necessary changes (if any) along the way. Therefore, dedicated facility-based registers for monitoring PPIUCD service provision were developed along with IUCD client card in year 2013. Before the indicators could be incorporated in the National Health Information Portal, performance monitoring was initiated on a quarterly basis through an excel based tool. It encompassed data on not only service provision and provider trainings but also provider-wise service performance (to match the financial bearing of the program). However, realizing the issue of multiple registers for data recording, the mechanism was simplified in 2018 with only two facility-based registers (IUCD insertion and IUCD follow up registers) and IUCD client card (detailing client information and warning signs), whose counterfoil is retained at the health facility. Gradually, PPIUCD service indicators became a part of the Health Management Information System (HMIS) and quarterly excel based reports were discontinued only after the data in National data portal (HMIS) was stabilized. (FP Division, MoHFW).

IUCD Card (nhm.gov.in)

C. Adequate financing:

To ensure smooth conduction of trainings and service provision to the clients, the budget for trainings, equipment, printing of registers, technical manuals and incentives (for clients, providers and motivator) were included in annual state costed plans since inception of the PPIUCD program (through National Health Mission). This encouraged the states/ districts to plan the pace of program implementation according to the local prevailing situation, while at the same time maintain strides with other states/ districts.

These strategies, innovations and adaptions based on learning helped in repositioning of IUCD (including its use as postpartum and post-abortion contraceptive) and making this less invasive option widely available to the couples. The above-mentioned strategies and intensified efforts also helped the national program in securing a special place for IUCD as a 'Long acting reversible contraceptive' (LARC) in the contraceptive basket and identifying it as an alternative to limiting methods for many couples who don't want to adopt them. This also resonates with India's FP 2020 global commitment to increase modern contraceptive use, expand the basket of choices and increase funding towards family planning needs of the country.

Text Box 2.3: PPIUCD program – Offering solutions to all

It can be inferred that a comprehensive planning was an integral part for the roll out of PPIUCD in India and it entailed all program strategies. The program had something to offer to all stakeholders.

- Program Managers- Specific program guidelines, Advocacy meetings, Review meetings
- Service Providers- Technical Guidelines (learning resource package), Onsite trainings, Post training mentorship, Annual Program orientation sessions, facility-based skill labs with mannequins, Competency based checklists, Incentive scheme, Empanelment
- Counsellors- Learning resource package, onsite trainings and post training mentorship, job aids, counselling corners, refresher trainings
- Field functionaries (ASHAs)- ASHA leaflets, resource material, biannual/quarterly orientations (with special budgetary provisions), Job aids, Incentive scheme
- Store keepers- Logistics management system, annual orientations and review

III. Fostering Partnerships

The success of Postpartum IUCD in India is a manifestation of concerted efforts from Ministry of Health and Family Welfare (MOHFW), Government of India and State governments together with several development partners who supported the service scale up through various projects. Currently the government is harnessing the expertise of various agencies in the field of advocacy, capacity building, IEC and BCC, program management, quality improvement, evaluation and assessments, feasibility studies, development of resource material and E-learning modules as well as software development for successful implementation of the program. Technical organizations were instrumental at various levels of implementation and capacity building to revitalize focus of postpartum family planning, especially PPIUCD. The overwhelming response to PPIUCD as a choice of contraception in postpartum period across the states is a testament to these efforts over the years.

As detailed earlier, USAID supported the Pilot phase of the program in Jharkhand and Uttar Pradesh which later with the multi-donor assistance (USAID, BMGF, NIPI, Packard) under '**Rapid Expansion of PPIUCD Services in India**' led to the program implementation through a multipronged approach. To overcome the initial procurement glitches, the newly designed PPIUCD insertion forceps were made available to all the trained service providers as a part of the training package by development partners following the instructions of Ministry of Health and Family Welfare.

Technical agencies worked in close collaboration with Government of India for capacity building of vast human resource pool. Initially, there was a huge challenge of managing inflow of donor money through multiple partners (which initially resulted in overlapping of work areas in different states) along with achieving harmonization of the efforts of involved development partners that came with the program intensification. At this time, Government of India's extraordinary leadership helped in rationalizing all the efforts into one direction and aligning commitments among all stakeholders. With a view to galvanize the unified efforts, a single platform was created for all the partners. Also, a road map for desired actions

and areas of work were then delineated. For e.g.: For capacity building through support of technical agencies, a well-defined plan with allocation of work areas was developed. In order to keep uniformity and transparency among them, the agencies were roped in to develop a single window software which helped the implementing states as well as National government to monitor project progress periodically.

To keep up the government's engagement, a biannual meeting was conducted which also witnessed the participation of agencies field staff. These platforms also served as a cross learning opportunity for the partner agencies and helped them in keeping abreast with the current government priorities. The feedback and program improvement loop were completed with the participation of the agency representatives in state level reviews.

In addition to a dedicated software, 'PPIUCD insertion video' was developed comprehensively by the partners to ensure continued training of service providers. The projects also marked inclusion of some innovative solutions to persistent problems which proved extremely beneficial in making the interventions sustainable.

The collaborative efforts also provided an opportunity to the government to endorse the technical material and reduce the effort of developing multiple technical materials and job aids.

With time, the ongoing partnerships witnessed an increase in efforts towards health systems strengthening. For eg. Under EAISI project, intensified efforts to scale up PPIUCD services were taken in six high focus states through Jhpiego (Chhattisgarh, Odisha), Engender Health (Rajasthan and Gujarat) and IPAS Development Foundation (Madhya Pradesh and Jharkhand). This support continued in phase 2 of the project starting 2017 and also complemented the achievement of the FP2020 goals. In addition to phase 1 activities, capacity building in commodity management and data handlers' trainings were also incorporated. The project came to close in October 2020.

The carefully navigated collaboration led to increase in number of PPIUCD state level service delivery sites and fostered institutionalization of quality services by improving the supportive supervision capacity of district health managers and improve data for decision making within the health system.

Health systems' strengthening has always been an integral part of India's policy framework under National Health Mission. National Technical Support Unit for family planning services provided strategic leadership, advocacy, technical support and guidance for all programmatic interventions related to family planning from 2014 to 2018. As mentioned, the unit was instrumental in not only scaling up PPIUCD but also bringing back focus on quality of service provision and evidence-based decision making by means of regular supportive supervision visits, on-site handholding support, in-depth data analysis, updating the learning resource packages, and review meetings. The 'Reference Manual for IUCD Services' was comprehensively updated (including interval IUCD/ PPIUCD/ PAIUCD) and data recording and reporting mechanisms were simplified for ease of use.

The course of the PPIUCD journey indeed witnessed many roadblocks which warranted the conception of various innovative solutions, from central, state and local level and from both MoHFW and development partners. These, in turn, made the program managers as well as service providers better equipped to manage local challenges and implement context-based solutions.

IV. Monitoring and Evaluation

Mechanism to monitor and evaluate the interventions under India's Family planning program existed since its inception. However, the breakthrough in program monitoring came with the advent of District health information system and later with the introduction of "Health Management Information System" (HMIS) in the year 2008. Currently, around 2 lakh health facilities (across all States/UTs) are uploading facility wise service delivery data on monthly basis, training data on quarterly basis and infrastructure related data on annual basis on HMIS web portal[xv]. This web-based application captured service delivery data from the facility level for the multiple national programs including family planning on monthly/quarterly/ annual basis.

After successful implementation of HMIS system, India has now developed a beneficiary tracking system to facilitate timely delivery of healthcare services. The Ministry has rolled out an upgraded version, namely RCH Portal, which is designed for early identification and tracking of the individual beneficiaries throughout the reproductive lifecycle and promote, monitor and support the reproductive, maternal, newborn child and adolescent health (RMNCAH) schemes/ program delivery and reporting. It also helps the health worker in generation of work plan for delivery of various services in his/her catchment area.

4.1 Service Delivery monitoring:

Regular monthly reporting of facility-wise service data has been encouraged since introduction of HMIS. For initial 2 years of PPIUCD roll out, excel based quarterly reports for the same were captured from all states. These reports included training data, provider-wise performance tracking, timing of PPIUCD insertion (intra-caesarean/ post- placental/ within 48 hours), mode of insertion (manual/ PPIUCD forceps/ kelly's forceps) etc.

4.2 Ensuring data quality:

A fortnightly analysis of HMIS data was initiated at the National level (for state/ district level data), and its triangulation with state submitted reports and findings from supportive supervision visits were undertaken. Simultaneously, for the dissemination of FP 2020 commitment to all states of India, state-wise workshops were organized in the year 2014. These workshops were later institutionalized to provide techno-managerial updates and strengthen data quality by means of a robust feedback mechanism wherein the data gaps were highlighted. Not only service delivery but quality indicators like IUCD removal/ expulsion, PPIUCD acceptance rate etc. were also reviewed and shared with State/ district program managers, service providers and data personnel. From 2014 onwards, a separate budget line was also created in State PIPs, provisioning for similar reviews at the sub-state level (by state teams).

4.3 Capacity Building on data capturing and monitoring:

National and state teams conducted independent as well as integrated visits to districts and health facilities wherein emphasis was laid on use of new developed standardized registers (Insertion and follow up registers), IUCD client cards and quality of data recording and reporting. On-site capacity building of personnel in service delivery and stock maintenance (IUCD-375 and 380A) as well as

matching of financial and program performance (for ensuring optimum utilization of resources) were undertaken. These supportive supervision visits also included mandatory interaction with frontline functionaries and client exit interviews on quality parameters of service delivery, informed verbal consent, continuation/ discontinuation of method in addition to assessing awareness and demand for services. Further, these visits provided pivotal opportunities in addressing technical queries of service providers and other personnel, thereby strengthening program implementation at all levels. Annual Common Review Mission has been one of the important monitoring mechanisms under NHM. The unique feature of this monitoring mechanism is that a multidisciplinary team comprising national and state government officials, development partners, academicians and civil society organizations visit the states. This gives a widened view of service delivery. In addition, there is a system of feedback to the visited district as well as states. PPIUCD, being an integral part of the FP program, was made a part of monitoring tool in these visits. Twelve Common Review Missions (CRMs) undertaken so far have provided valuable understanding of the strategies which were successful and those which warranted mid-course adjustments.

4.4 Review platforms for Technical Partners:

As stated earlier, the review of technical partners not only helped in obtaining status update, understand and address challenges and suggest course corrections, but also align the project with the national program priorities.

4.5 Formalizing monitoring and reporting documentation system:

Realizing the importance of documentation of program efforts, development of comprehensive quarterly and annual reports on Family Planning have been institutionalized in the government system. These reports include data of service delivery from various sources, data on FP schemes, supportive supervision visits and report of technical partners supporting the program; which act as a ready-reckoner to the FP program performance and are used at relevant platforms for sharing information.

4.6 Independent/ In-house Evaluation of the program:

Independent evaluations have been conducted from time to time and India has been open and willing to adapt/ address the challenges identified in these evaluations. MoHFW is also actively undertaking internal assessments for quality improvement in program. One such assessment was undertaken to understand the influencing factors affecting PPIUCD uptake wherein awareness and knowledge of 682 ASHAs were assessed along with 92 client interviews from 4 high focus states namely Rajasthan, Bihar, Assam and Madhya Pradesh (FP Division, MoHFW)

4.7 Monitoring Commodities and ensuring supplies:

FPLMIS equipped all levels of stakeholders in the public health system to monitor the inflow and outflow of FP commodities and make timely decisions regarding placing demand, issuance of commodities and reducing stock outs. The commodities supplied to the states were corroborated with service performance of the states. Efforts for accurate reporting and recording of commodities started with baseline assessment of store warehouses, available commodities and store personnel. Institutionalization of standardized mechanism of commodity reporting helped in streamlining supply chain and identify bottlenecks and take corrective actions.

V. Impact of PPIUCD Services

The benefits of contraception go beyond health, affecting demographic and economic environment, thereby impacting all 17 sustainable development goals (SDGs) either directly or indirectly. As part of the Sustainable Development Goals (SDGs), "Ensuring universal access to sexual and reproductive health (SRH) services by 2030" was determined to have one of the two highest benefit-cost ratios (Kohler & Behrman, 2014).

Impact of Family Planning efforts in India over the years can be witnessed from the reduction in country's TFR which has halved from 4.5 in 1984 to 2.2 as of 2017 (SRS). Recently, the National Health Policy (NHP) 2017 which sets out indicative and quantitative goals for the country also included achievement of Replacement Fertility level (2.1) by 2025 as one of its prime objectives. One of the major reasons behind this inclusion is the considerable influence that contraception has on the maternal and child health outcomes.

PPIUCD, a focused and strongly emerged method of contraception, has played a major role in contributing to this fact and ensuring better spacing between births. The percentage of adequately spaced births witnessed an increase of 17% from 2011 to 2018 (SRS) (Birth spacing of 36 months and more has increased from 42.4% to 49.6%). Furthermore, India averted 49.6 million unintended pregnancies and 1.7 million unsafe abortions in 2012 which increased to aversion of 55.6 million unintended pregnancies and 1.9 million unsafe abortions in 2019. The overall magnitude of the impact of Family Planning is extremely encouraging with aversion of almost 30,000 maternal deaths each year due to use of contraception. (Track 20).

A focused approach in high TFR states (6 states through support of technical partners: 2015- 2020) also paid its dividends by averting 3.9 million unintended pregnancies, 1.3 million unsafe abortion, 2780 maternal deaths,20294 child deaths and saving an estimated USD 193 million USD** (INR 14.2 billion) in direct health care spending.[1][xvi]

As mentioned earlier, India made a conscious decision to capitalize on the increased number of institutional deliveries (from 38.7% in NFHS-3 to 78.9% in NFHS-4) and adopted a strategic approach resulting in an increase in the overall PPIUCD acceptance rate from 2% in 2013-14 to 17% in 2019-20 (Graph 1)

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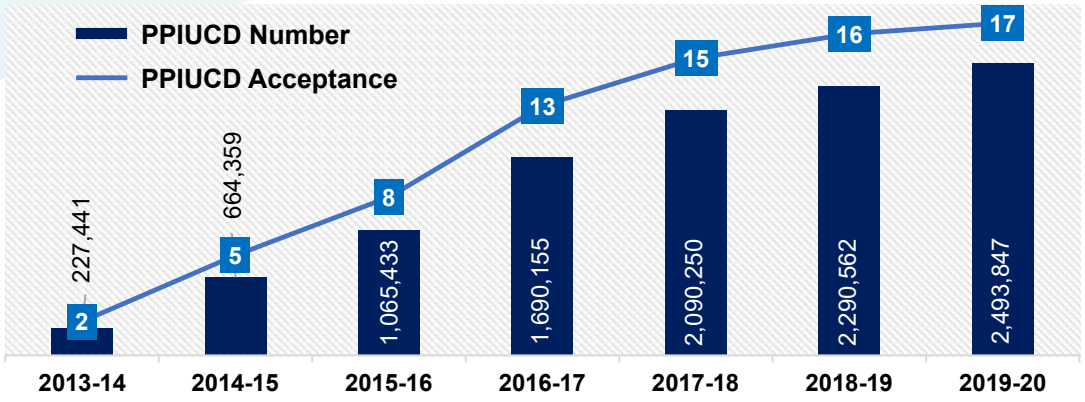
[1] *(** Costs saved to families and health care systems on pregnancy related care (e.g. ANC, safe delivery, treatment of complications including PAC). The default estimate for costs saved are based on "full coverage" - i.e. all women needing care receive it. Estimates calculated using Impact 2, Marie Stopes International, 2018)*

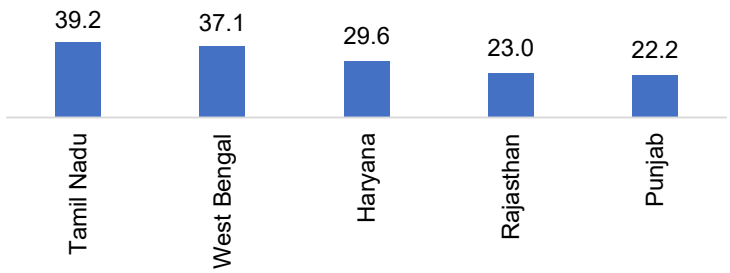
Graph1. No. of PPIUCD inserted and PPIUCD Acceptance percentage
(% PPIUCD insertions out of institutional deliveries) : HMIS



progress in improving contraceptive access in postpartum period led to reportedly more than 10 million PPIUCD insertions since the inception of the program (till 2019-20)[xvii]. Each year has been eventful for expansion of PPIUCD services in the country.

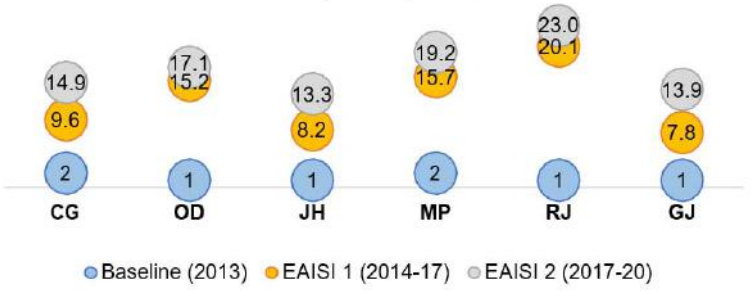
States have enthusiastically picked up the PPIUCD program; Tamil Nadu and West Bengal report PPIUCD acceptance of 39.2% and 37.1% in 2019-20 (Graph2).

Graph 2: PPIUCD Acceptance in high performing states (2019-20) (HMIS)



Not only the state governments but the efforts of development partners are also noteworthy. The graph below highlights the increase in overall PPIUCD acceptance rate from baseline in the six states supported by Development Partners (Graph 3).

Graph3: EAISI Phase 1 and 2 progress (PPIUCD acceptance) (HMIS)



** CG-Chhattisgarh, OD-Odisha, JH-Jharkhand, MP-Madhya Pradesh, RJ-Rajasthan, GJ-Gujarat*

As a programmatic thrust, India laid special emphasis on promotion of post placental IUCD considering the IUCD insertion has less complications and less expulsions if inserted in this period. In initial phases of PPIUCD roll out, post placental method was readily acceptable with almost 43% insertions occurring in post placental phase.[xviii] The complications associated with PPIUCD were also less with only 1% infection and 2% expulsions [xviii]. This also led to higher acceptance of the method as the program was scaled up in India.

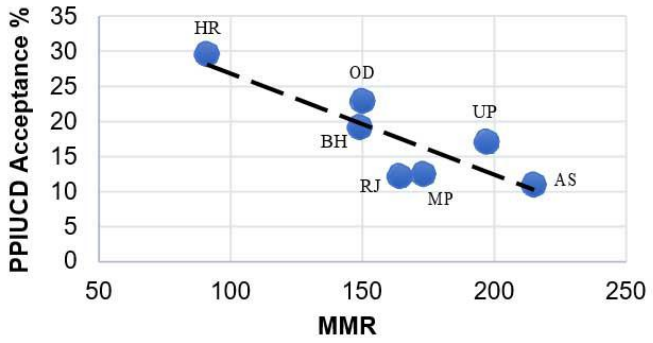
Since India doesn't have a homogenous population, it is also important to note that in terms of health parameters, state-wide variations exist. Majority of the population share is contributed by the high fertility states, where challenges in terms of access to health care and services exist. Therefore, Government of India, as a part of the RMNCH+A strategy is focusing its efforts in these states with allocation of high budgetary share (FP Division, MoHFW).

On comparing the Maternal Mortality Ratio and PPIUCD acceptance in these high fertility states (Assam, Madhya Pradesh, Haryana, Bihar, Uttar Pradesh, Odisha and Rajasthan), an inverse relationship between the two is evident. (Graph 4)

These are the states where the MMR decline from the year 2011-13 to 2016-18 is to the tune of 20-30% and at the same time the PPIUCD acceptance has increased by 14-15% (Sample Registration Survey-SRS, HMIS-MoHFW).

Graph4: Relation between PPIUCD acceptance and MMR

(Source- SRS, HMIS-MoHFW)



In addition to PPIUCD, postpartum sterilization performance also witnessed a boost in the country. This substantiates the fact that while promoting the concept of family planning, the overall emphasis was to be given to the basket of choice instead of method specific promotion.

VI. Way Forward and Extensions that are Currently being Implemented

Periodic interventions, revisions of guidelines and program monitoring are entrenched in quality improvement process of all contraceptive services under National Family Planning Program. India has been diligently making consistent efforts to strengthen IUCD program and improve access for the same in more ways than one. Some of the recent initiatives are:

6.1 Strengthening Post Abortion Family Planning, especially Post Abortion IUCD:

India has steered its IUCD program towards ensuring Post-pregnancy contraception wherein PPIUCD efforts are being sustained and provisions have been made to address Post Abortion Family Planning (PAFP) needs also. Recently, the program focus has been directed towards IUCD in Post Abortion period (PAIUCD).

- Technical and Operational reference material for PAFP has been prepared with the experts and partners.
- Inclusion of data element on PAIUCD in Health Management Information System and regular monitoring of the same.

- Standardization of service delivery guidelines for PAIUCD following first and second trimester abortions
- Capacity building of new cadre of 'Community Health Officers' posted at Health and Wellness centers under 'Ayushman Bharat' initiative for promotion of PAFP.
- Training of medical students on PPIUCD to ensure sustainability.
- Indian adapted version of WHO -MEC wheel (2015)[xix] developed for strengthening service providers' decision making based on eligibility criteria

6.2 Updating of Integrated RMNCAH+N Counselor manual:

MoHFW is in the process of revising the existing 'Handbook for Reproductive Maternal Neonatal and Child Health Counsellors (RMNCH)[xx]' for counselors posted at high case load health facilities. Post Abortion Family Planning is being incorporated and special emphasis is being laid on Importance of Healthy Timing and Spacing of Pregnancies, role of nutrition and Adolescent Sexual and Reproductive Health.

6.3 Periodic Reviews and Monitoring:

Since its introduction in the year 2018, monitoring of PAIUCD indicators has become an integral part of the program review process. India has also initiated beneficiary wise tracking of services that will ensure better follow up. A special online system has been developed (ANMOL- ANM Online) for the same and PPIUCD/ PAIUCD messaging is a part of this system.

6.4 E-modules for ongoing trainings in pandemic times:

To ensure sustainability and ongoing capacity building amidst the pandemic, the current technical material is being converted into e-modules. In addition, a training methodology to guide states is underway

6.5 National Family Planning Helpline:

A National helpline is being strengthened to ensure better information services to the citizens on family planning services. This is envisioned to address myths and misconception, conduct online survey to assess client satisfaction and act as awareness generation platform for all level of stakeholders

6.6 Integrated monitoring of Survey and Service Delivery Indicators along with GIS mapping:

As a step towards better utilization of data by equipping policy makers and program managers with ready and customized data analysis, MoHFW is working in close collaboration with Track 20 for development of FP dashboard (as a part of Survey Statistics(SS) to Estimated Method Use(EMU) tool) entailing analysis and GIS mapping of states/ districts on various family planning services and indicators. The same is updated monthly and provides background for area specific interventions, if required.

VII. Successes and Lessons Learnt from the PPIUCD Program

A comprehensive 360 degree approach resulted in the success of PPIUCD program. Within the decade of introduction as a pilot project PPIUCD has been accepted as a reliable Postpartum option by service providers and community which helped in securing a special place for IUCD as 'Long acting reversible contraceptive' (LARC) in the contraceptive basket.

Focus on monitoring and evaluation in PPIUCD program changed the way the program management was perceived and resultantly shifted from vertical to a horizontal approach. Consistent collaborations between government and development partners at all levels, from policy to implementation level, helped in bridging the anticipated gaps and prepare better for the unanticipated situations. Following dimensions were taken care of from planning to roll out and monitoring which are successes of the program

- ***Governance:*** Policy focus and response to the constant emerging challenges at national level and dissemination at subnational level with follow up for addressing challenges. Involvement of program managers at state and sub state level gave desired focus and course correction at all levels of implementation.
- ***Health Workforce:*** Creation of cadre of workforce strengthening counselling at high delivery case load facilities, task shifting, Involvement of frontline workers in demand generation and follow up steered the success of the program
- ***Financing:*** Multi-donor support at various stages and development and approval of decentralized costed plan for training and demand generation activities.
- ***Service Delivery:*** Uninterrupted service provisioning through availability of trained service providers at all levels of facility, capacity building of counsellors and field functionaries, Development and roll out of Standardized learning resource package and equipment, IUCD card. The conception of the concept of 'Each One Train One' strategy as well as task shifting in the PPIUCD program were some of the most unique successes of the program which became evidence-based examples for other programs grappling with dearth of providers and stringent training schedules (competing with service provision).
- ***Health Information System:*** Use of Regular reporting and monitoring framework, Facility-wise data recording and reporting in national data portal, Institutionalization of standard indicators and quality checks for program review and strengthening.
- ***Access to commodities:*** Family Planning Logistics information system to build capacity of states in demand estimation, unified platform for ensuring uninterrupted supplies and reduce stockouts

PPIUCD has brought many learning in its journey of roll out and before becoming one of the established component of India's Family Planning program, many learnings were simultaneously translated to actions to ensure quality in service provisioning and setting an example world-wide:

1. Constant need of demand generation activities for entire basket of Family Planning choices especially post-pregnancy contraception
2. Developing mechanisms to bust several myths and misconceptions around IUCDs equally

among service providers and community.
3. Strengthening Quality of care and periodic monitoring of service delivery (post training follow ups, onsite visits, data quality checks, client interviews etc)
4. Institutionalization of program strategies within the country costed plans.
5. Equal emphasis on PAIUCD for strengthening Post Pregnancy contraception

7.1 Continuation of IUCD services during and Post Pandemic Covid-19:

It is well documented that in a scenario of a pandemic, RH services are one of the first which need to be restored. The essential RH services focus primarily on provision of modern short and long-acting reversible contraceptives, information, counselling and services (including emergency contraception). Regulating fertility is thus an imperative. Government of India emphasized on the need of ensuring essential RH services during and post Covid-19 and developed 'Guidance note for provision of Reproductive, Maternal, Newborn, Child, Adolescent Health plus Nutrition (RMNCAH+N) services during & post covid-19 pandemic' [xxi]. Special emphasis was laid on continuation of LARC services (PPIUCD and PAIUCD) and generating awareness on its benefits (like one-time procedure, duration, limited facility visits) were highlighted during reviews. The guidelines also mentioned the health system approach for delivery of these essential services including facility mapping and planning, alternate service delivery mechanisms (Telehealth, modified outreach, home visits), Triaging, Management of human resources, ensuring supplies of medicines and diagnostics, program management (including monitoring), finances and accountability systems.

Opportunities like institutional deliveries and client availing walk in services for reproductive health are prioritized and with consistent guidance and support from national level resulted in continuation of IUCD services.

VIII. India: Harbinger of PPIUCD (South-South cooperation)

Regions/ countries try to learn from interventions that have been successfully implemented elsewhere to realize their own objectives of health. These objectives may include (but not limited to) reducing burden of disease/ health risks, reducing health inequalities, promoting favorable social, economic and environmental determinants of health, encouraging participatory approaches, and ultimately moving towards attainment of Sustainable Development Goals[xxii]. Therefore, program leaders and public health specialists are often involved in scaling up effective and proven interventions to reach more people and/ or broaden the effectiveness of that intervention.

As discussed above, with persistent and intensive efforts, India soon became a forerunner in provision of PPIUCD services across all states of the country and all levels of facilities. Carefully crafted and navigated, India's PPIUCD journey. To ensure that other countries in the region learn from PPIUCD intervention in India, as a key member of South-South learning cooperation, the country participated in cross-learnings and exposure platforms.

Ministry of Health and Family Welfare, Government of India together with development partners working in the area of family planning made collective efforts to ensure maximum learnings from other country programs and invited delegations from other countries of the region for exploring possibility of scale up

of good programmatic interventions. This exchange of ideas is accomplished through various platforms like exposure visits, Conferences, training programs and cross-country learning visits etc[xxiii]. India conducted a cross-country learning exposure visit with Indonesia in 2018, wherein the Indian delegation learnt about implants as a potential contraceptive method for National Family Planning Program while the officials from Indonesia learnt about the implementation and roll-out success of the PPIUCD program. Similarly, experience sharing is done through 'International Conference on Family Planning', wherein delegates from different countries come together for a common cause; increasing universal access to contraceptives

These platforms enabled the countries to think about possible steps for replicability and showed the way to many countries for maximizing benefits of the intervention [xxiv]:

- The first and foremost step is to assess the intervention which determines if and to what extent an intervention is replicable. Assessing PPIUCD example for scalability involves assessing the need for intervention, extent of scale, political will, administrative situation, system readiness, required resources (both monetary and human; from inside the system and external support), opportunities and constraints etc.
- The second step is to develop an intervention plan based on the assessment. The plan details the roll-out design (detailing roles and tasks for each level), budgeting, defining clear goals and objectives as well as relevant stakeholder analysis. An in- depth scale up plan is extremely crucial as it allows better dealing with unprecedented and unexpected bottlenecks during the intervention.
- The following step is to prepare for the intervention scale up. This usually encompasses preparation of the technical and administrative team in terms of deployment, trainings/orientation, incentive provision (if any), equipping them with necessary technical/ SBCC material; preparation and mobilization of resources; preparing the health facilities; ensuring availability of necessary equipment etc. for uninterrupted service provision.
- The last step is the result of careful planning accomplished in first three steps; i.e. actual implementation of the intervention as planned. However, while implementing the strategy, it must be considered that experiences may sometimes warrant slight changes in the plan and sticking to the roll out plan completely may not be in interest of the intervention. Therefore, having a latitude and resources to make necessary changes mid-way is always helpful. Also, in addition to the implementation, concurrent monitoring and evaluation is also an integral part of the last step of replicability. A robust monitoring and evaluation system help in ensuring program quality and measuring impact of the intervention from time to time.

India was vigilant in following these steps with not only partnership from development partners but also convergence with other relevant government departments like Ministry of Women and Child Development and Ministry of Panchayati Raj (Local Governance). This convergence resulted in better awareness generation through their platforms (Anganwadi Centres- Early Childhood Care and Development Centre) and their orientation on the subject.

These strategies became a harbinger and paved the way for the success of India's PPIUCD journey. The learnings and experiences not only helped in improving access to IUCD in postpartum period (PPIUCD) but also revitalize IUCD in post-abortion period (PAIUCD) and expand the basket of contraceptive choices.

IX. Details of implementing institutions

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X. References

i Ross J, Winfrey W. Contraceptive use, intention to use and unmet need during the extended postpartum period. Int Family Planning Perspect 2001;27(1):20–7

ii Reference Manual for IUCD Services, MoHFW, Government of India; March 2018

iii http://planningcommission.gov.in/; Accessed on 29th Sept 2020

iv https://www.who.int/southeastasia/news/detail/10-06-2018-in dia-has-achieved-groundbreaking- success-in-reducing-maternal-mortality. Accessed on 25th Sep 2020.

v Derived from- World Health Statistics, 2019; CIA World fact book 2016; RGI TGPP Report 2020; Sample Registration Survey 2018

vi Rutstein; DHS Working papers; 2008; https://dhsprogram.com/pubs/pdf/WP41/WP41.pdf; Accessed on 4th Sep 2020

vii Cleland J etal; Family Planning-The Unfinished agenda. Lancet, Vol.368, Issue9549, Pg.1810-1827, Nov. 2006

viii Kaydor et.al; Barriers to Acceptance of Postpartum Family Planning among Women in Mont serrado County, Liberia. Nigerian Postgraduate Medical Journal, Volume 25, Issue 3, July-Sept ember 2018

ix Postpartum Family Planning Technical Consultation-Meeting Report, Washington DC; 14Nov 2006; http://resources.jhpiego.org/system/files/resources/ppfp_meetingreport.pdf; Accessed on 12th Sep 2020

x PPIUCD Services in India: The Journey from Start to Scale-up; https://toolkits.knowledgesuccess.org/toolkits/ppfp/ppiucd-services-india-journey-start-scale; Accessed on 3rd Sep 2020.

xi PPIUCD services in India: The journey from start to scale up: https://toolkits.knowledgesuccess.org/sites/default/files/India%20Experience%20in%20 PPIUCD_Presented%2 0at%20PPIUCD%20Zambia%20Mtg_April%202013.pdf Accessed on 2ndAugust 2020.

xii Daksh Skill Labs for RMNCH+A services; nhm.gov.in; Accessed on 6th Sep 2020

xiii https://nhm.gov.in/images/pdf/programmes/family planing/schemes/24%20Standards%20for%20PPIUCD%20INSERTION%20FORCEPS.pdf; Accessed on 5th Sep 2020

xiv https://nhm.gov.in/images/pdf/programmes/family-planing/guidelines/LMIS/Operational_guidelines_LMIS.pdf ; Accessed on 5th October 2020.

xv Annual Report MoHFW- 2019-19; https://main.mohfw.gov.in/sites/default/files/02%20ChapterAN2018-19.pdf

xvi EAISI Dissemination 2020: MoHFW.

xvii MoHFW HMIS Portal; https://nrhm-mis.nic.in/hmisreports/frmstandard_reports.aspx

xviii Program Learning for PPIUCD integration with Maternal Health Services- Programatic experience from multiple countries; USAID-MCHIP

xix MEC Wheel; https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=963&lid=470: Accessed on 27th October 2020

xx https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=963&lid=470 : Accessed on 27th October 2020

xxi Guidance note for provision of reproductive, maternal, newborn, child, adolescent health plus nutrition (RMNCAH+N) services during & post covid-19 pandemic:24th May 2020: https://www.mohfw.gov.in/pdf/GuidanceNoteonProvisionofessentialRMNCAHNServices 24052020.pdf

xxii Improving the Replication Success of Evidence-Based Interventions: Why a Pre implementation Phase Matters; Elaine M. Walker, et.al; Journal of Adolescent Health 54 (2014) S24- S28

xxiii https://www.partners-popdev.org/about-ppd/partner-institutions/national-institute-of-health-and-family-welfare-nihfw/ accessed on 5th October 2020

xxiv https://www.euro.who.int/__data/assets/pdf_file/0004/318982/Scaling-up-reports-projects-concepts-practice.pdf; accessed on 3rd September 2020

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