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ACCELERATING ACCESS TO POSTPARTUM FAMILY PLANNING

GLOBAL MEETING

Meeting Report
8–11 June 2015
Chiang Mai, Thailand

PARTNERS

Jhpiego is an international, nonprofit health organization affiliated with Johns Hopkins University. For more than 40 years, Jhpiego has empowered frontline health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidence-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world's most vulnerable populations.

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Jhpiego
Brown's Wharf
1615 Thames Street
Baltimore, Maryland 21231-3492, USA
www.jhpiego.org

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The Maternal and Child Survival Program (MCSP) is a global, United States Agency for International Development (USAID) Cooperative Agreement to introduce and support high-impact health interventions with a focus on 24 high-priority countries with the ultimate goal of ending preventable child and maternal deaths within a generation. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. Visit www.mcsprogram.org to learn more.

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Abbreviations

ANC	antenatal care
CPR	contraceptive prevalence rate
DRC	Democratic Republic of the Congo
FP	family planning
FP2020	Family Planning 2020
HTSP	healthy timing and spacing of pregnancy
IUD	intrauterine device
JHU	Johns Hopkins University
JSI	John Snow, Inc.
LAM	lactational amenorrhea method
MCH	maternal and child health
MCSP	Maternal and Child Survival Program
MEC	*Medical Eligibility Criteria for Contraceptive Use*
MNCH	maternal, newborn, and child health
MNH	maternal and newborn health
MOH	Ministry of Health
MSI	Marie Stopes International
PNSR	Programme National de Santé de la Reproduction
PPFP	postpartum family planning
PPIUCD	postpartum intrauterine contraceptive device
PPIUD	postpartum intrauterine device
PSI	Population Services International
SBA	skilled birth attendant
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	women of reproductive age

Meeting Description

From June 8 to 11, 2015, in Chiang Mai, Thailand, a global, action-oriented meeting, titled "Accelerating Access to Postpartum Family Planning in Sub-Saharan Africa and Asia" (the "PPFP Global Meeting"), was held with family planning (FP) and maternal and newborn health (MNH) delegations from select countries and key international stakeholders coming together to accelerate access to postpartum family planning (PPFP). Designed to bring together the reproductive, maternal, newborn, child, and adolescent health communities to scale up PPFP, this multilateral effort also aimed to fast-track country progress toward Family Planning 2020's (FP2020's) goal of providing an additional 120 million women and girls access to lifesaving contraceptive information, services, and supplies by 2020—without coercion or discrimination—by reaching postpartum women, whose FP needs are frequently overlooked.

Family Planning 2020 (www.familyplanning2020.org) is a global partnership that supports the rights of women and girls to decide, freely and for themselves, whether and when to have children, and how many.

The meeting was a highly collaborative event hosted by FP2020, in technical partnership with Jhpiego and in coordination with the Bill & Melinda Gates Foundation, the United States Agency for International Development (USAID), the Maternal and Child Survival Program (MCSP), the United Nations Population Fund (UNFPA), and the World Health Organization (WHO). Nearly 175 participants from 16 country teams attended the meeting to accelerate efforts on the implementation of PPFP in their countries. Sixty presenters from around the world covered state-of-the-art technical knowledge and programming experiences in PPFP. The meeting was designed with interactive learning sessions, small working groups, and country-specific action plans for PPFP (see daily digests for summaries and highlights of each day's activities at http://www.familyplanning2020.org/articles/8714 and Appendix A for full agenda).

Overall objectives of the meeting were to:

- Gain knowledge about global FP developments, including WHO's most recent recommendations for contraceptive safety issued in the *Medical Eligibility Criteria for Contraceptive Use* (MEC) fifth edition (2015).
- Share progress, experiences, successes, and challenges in implementing quality PPFP programs and services, from initiation through scale-up.
- Discuss the role of policy environments; service delivery strategies including capacity-building, quality improvement, and community engagement; opportunities for collaboration; and introducing change as part of implementing successful PPFP programs.
- Create a country-specific PPFP action plan with indicators and benchmarks to be assessed for progress during the workshop at the upcoming International Conference on Family Planning.

Participant Profile

The PPFP Global Meeting participants included technical experts, program leaders, policy advocates, and representatives from donor agencies and private partners around the world. The technical expertise represented at the meeting included members of the FP/reproductive health and

maternal, newborn, and child health (MNCH) communities. Delegations from the following countries were selected by an international steering committee: Afghanistan, Bangladesh, Burkina Faso, Democratic Republic of the Congo (DRC), Ethiopia, India, Indonesia, Kenya, Madagascar, Nigeria, Pakistan, Philippines, Rwanda, Tanzania, Uganda, and Zambia. In advance of and throughout the four days of the meeting, the country delegations exchanged information with experts and each other to develop context-specific action plans to initiate or expand PPFP.

See Appendix B for a full list of participants and Appendix C for an overview of the countries' action plans.

Background

PPFP is a service delivery strategy that expands access to FP through integration with the existing continuum of MNCH services. There are excellent facility- and community-based programs being implemented, but countrywide scale-up approaches and strategies with national impact and results are lacking.

It is widely recognized that provision of PPFP improves infant and child survival. If the preceding birth interval is shorter than 18 months, mortality risks are increased twofold compared to intervals of three years. Use of FP is an effective strategy to reduce maternal mortality. Studies have shown that if the unmet need for contraception was met, there would be a 29% reduction in maternal mortality in low-resource countries (Ahmed et al. 2012). Data from 27 developing countries showed that women are interested in preventing another pregnancy within the first year postpartum, yet more than 63% do not use FP (Ross and Winfrey 2001). A study in Senegal that looked at women's access to FP information at the time of childbirth prior to discharge from the health facility found that women who received information were more likely to be using FP than those who did not. Additionally, during the exit interviews, a majority of women who did not receive FP information reported that they would have wanted to receive such information (Speizer et al. 2013).

The PPFP Global Meeting was held at an opportune time because, in addition to there being years of learning about how to effectively provide PPFP, new attention to this important area is being highlighted by global initiatives like FP2020 that strive to include postpartum women as a critical population requiring increased attention in country strategies and costed implementation plans. FP2020 is also encouraging increased use of data by global and country partners to optimize impact and effectiveness. The 16 countries that were represented at the workshop had a birth cohort of 62,568,534 in 2014*, which demonstrates an enormous opportunity for PPFP (Figure 1).

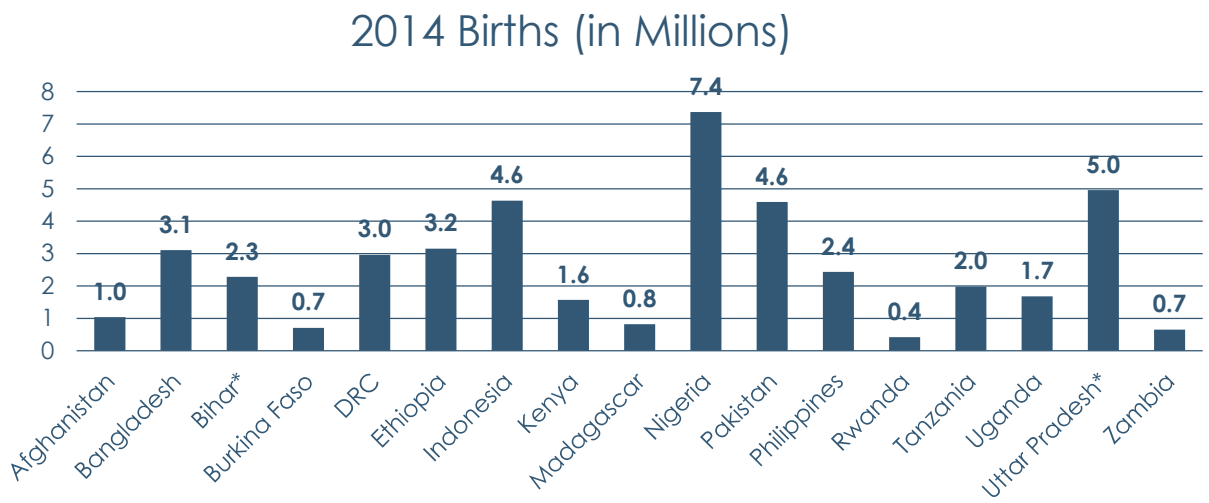
More countries are in the process of working toward meeting FP2020 goals; because of this effort, taking PPFP to scale is increasingly seen as a critical issue for the global public health community.

* Data modeled using Spectrum software from Avenir Health (http://www.avenirhealth.org/software-spectrum.php).

Why Postpartum Family Planning (PPFP)? Why Now?

The energetic opening session of the PPFP Global Meeting set the stage for participants to think about why PPFP actions are needed now to support women's right to have the opportunity to plan their families and their lives. Simply put, there are an increasing number of opportunities to provide PPFP; more women are now delivering in facilities and increasing numbers of mothers are bringing children in for growth monitoring. The FP community has proven strategies for integrating PPFP across the continuum of care. Overall, there is more demand and increased attention to the need for PPFP.

Figure 1. Total annual births across countries participating in the PPFP Global Meeting



* Bihar and Uttar Pradesh were the two Indian states represented at the PPFP Global Meeting.
Source: Data modeled using Spectrum software from Avenir Health (http://www.avenirhealth.org/software-spectrum.php).

Members of the PPFP community also know more effort and scale-up needs to happen with investments made at multiple levels. James Kiarie, WHO, spoke about the return on investment yielded through PPFP; as an intervention, PPFP requires little investment but creates lifesaving gains. He also stated that PPFP represents a special opportunity for adolescents, since babies born to adolescent mothers face a substantially higher risk of dying. Monica Kerrigan, FP2020, called for participants to use the PPFP Global Meeting as an opportunity for positive disruption. She stated that participants need to acknowledge the importance of integration across the continuum of care and keep in mind the FP2020 principles of promoting quality, rights, dignity, and respectful care. Members of the PPFP community can now think differently about how we use community-based settings to drive change and optimize contact points to deliver PPFP. These opportunities have the potential to empower women to determine whether and when they want to have another child.

As an example of the impact concerted effort on PPFP can have, a representative from the Ministry of Health and Family Welfare, Government of India, showed how PPFP has become a central feature of FP strategies in India. Success in scaling up the postpartum intrauterine contraceptive device (PPIUCD) in India and subsequent improvements in the method mix are a result of systematic efforts to convince state governments to invest at multiple levels—from policy to training

to task shifting. India attributes its success to the commitment for and implementation of operational road maps down to the district level as well as systems to track women. The representative also noted that with attention on FP2020 goals, the time was right to generate political will.

In Burkina Faso, collaboration with community leaders shows promise for getting commitments on PPFP. An important lesson from the Burkina Faso perspective is that support can be garnered from leaders if they understand how providing FP can help communities meet long-term development objectives.

Key points from this session include:

- Now is the time to invest in PPFP because of advances in learning about what works, the availability of new methods, increases in facility deliveries that offer opportunities for immediate PPFP, and increases in commitments from donors and governments.

"Women and adolescents giving birth have the right to PPFP information, services, and supplies—let's not let systems fail them."
—Monica Kerrigan, FP2020

Update on Global Guidelines and Evidence Review

On June 1, 2015, WHO released the fifth edition of the MEC. The MEC is the global standard on the selection of contraceptive methods—according to pre-existing medical conditions and personal characteristics—for women and men. In many Asian and sub-Saharan African countries, policymakers rely on the MEC guidelines to devise national strategies that determine which FP methods can be offered to their citizens. A panel of WHO scientists elaborated on the new MEC guidance by providing detail on the MEC's development and implications for postpartum women, adolescents, and women living with HIV, as well as the inclusion of four additional contraceptive methods into the guidance. This newest edition of the MEC eases restrictions on the use of hormonal contraceptive methods for women who are fewer than six weeks postpartum and breastfeeding, greatly expanding options for women seeking a contraceptive method following the birth of a child. It also clarifies that adolescents are generally medically eligible to use all effective forms of contraception and emergency contraception. Given the role of the MEC in informing contraceptive use policies around the world, these changes have the potential to alter the FP

The World Health Organization's 2015 Medical Eligibility Criteria Wheel for Contraceptive Use (http://apps.who.int/iris/bitstream/10665/173585/1/9789241549257_eng.pdf?ua=1) was highlighted at the Contraceptive Technology Update Marketplace.

landscape by expanding access to long-acting contraceptives and reducing the unmet FP needs of 225 million women through the newly expanded definition of who is eligible for FP.

Notably, major changes to contraceptive eligibility for breastfeeding women immediately after birth present this opportunity. As compared to previous MEC guidance (World Health Organization 2009), contraceptive implants and progestin-only pills can now be offered immediately postpartum to breastfeeding women, and the levonorgestrel-releasing intrauterine device (IUD) can be inserted within the first 48 hours after delivery (and again starting four weeks postpartum). There are also new methods in the MEC, including Sino-implant (II), the progesterone contraceptive vaginal ring, subcutaneous depot medroxyprogesterone acetate (brand name Sayana Press), and ulipristal acetate for emergency contraception. For more information on the updated MEC guidelines, download the executive summary from http://apps.who.int/iris/bitstream/10665/172915/1/WHO_RHR_15.07_eng.pdf?ua=1&ua=1.

Country representatives also discussed how the new version of MEC guidelines may affect their countries. Among the implications raised was the potential for an expanded method mix and increased client choice, potential for increased contraceptive prevalence rate (CPR) through expanded early postpartum contraceptive method choice, and possibility of further integration of services.

Key points from this session include:

- Updates to the MEC offer more contraceptive options to postpartum women, especially during the immediate postpartum period.
- Changes in the MEC are an opportunity for countries to update or revise guidelines and strategies on FP including PPFP.

PPFP Integration on the Day of Birth

The day of birth and immediately following is an opportune time to deliver PPFP. As a kick-off to the second day, three actors onstage role-played to demonstrate the value of counseling during antenatal care (ANC) or early labor or immediately postpartum. The three mimicked an optimal situation where the pregnant woman had been counseled and chosen a method during ANC. During delivery, she and her newborn were able to receive proper care, while her provider reconfirmed her and husband's choice of PPFP. The couple opted for an immediate IUD insertion.

Demonstrating counseling on postpartum family planning during antenatal care and early labor.

With the updates to the MEC, providers have more options in the 48-hour period following delivery, including the expanded ability to offer long-acting reversible contraceptives. Utilizing a whole-site approach and linking with the continuum of care during this period is important for

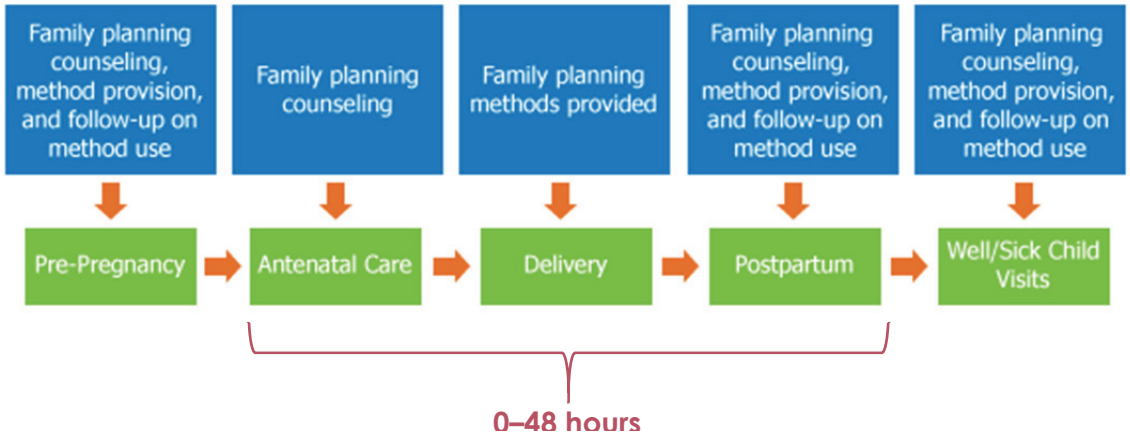
exposing new parents to messages about PPFP and healthy timing and spacing of pregnancy (HTSP) and, above all, to provide methods.

Postpartum intrauterine contraceptive device station at the Contraceptive Technology Update Marketplace.

Meeting participants from Zambia, Philippines, and India discussed experiences with PPFP integration on the day of birth. In Philippines, much work has been done to create an enabling policy environment and centers of excellence. The Philippines participants cited engagement with the Ministry of Health (MOH) and the development of champions within the centers of excellence as important factors for garnering support. Panelists discussed how providers should start early with counseling on birth spacing and then talk about the most effective methods first.

In India, the government strategically decided to increase opportunities for birth spacing to improve maternal and newborn survival. The PPIUCD is gradually being scaled up using a phased approach, as illustrated in Figure 2.

Figure 2. India's presented strategy for integrating family planning across the pregnancy timeline



Adapted from: Ringheim K. 2011. "Integrating Family Planning and Maternal and Child Health Services: History Reveals a Winning Combination." Population Reference Bureau.http://www.prb.org/Publications/Articles/2011/family-planning-maternal-child-health.aspx.

Key points from this session include:

- While PPFP counseling should begin during ANC, the day of birth and first 48 hours are also important for additional counseling and provision of methods.
- Data on PPFP counseling and service provision should be collected at the point of care and during follow-up to track the proportion of women who adopt an effective method of PPFP prior to discharge and to track complications including expulsions and removals by six weeks.

Opportunities for Synergies in the Extended Postpartum Period

Much of the second half of day two of the PPFP Global Meeting was devoted to learning about opportunities in the extended postpartum period and included hearing from experts in the fields of immunization and nutrition. From the nutrition standpoint, participants learned that optimal birth spacing has many benefits for nutrition including the reduction of low-birthweight births, maternal nutritional depletion, and malnutrition in children. On the immunization side, providing FP information and services to postpartum women during their infants' immunization visits provides an opportunity to reach women with unmet need for FP. FP/immunization integration models should be designed with input from FP and immunization staff and monitored for effects on both services to ensure no negative impact on immunization.

One speaker presented on how the lactational amenorrhea method (LAM) is a modern, temporary method that has been proven time and again to be a gateway method for continued contraceptive use. Meeting participants learned about results from the Healthy Fertility Study, in which PPFP messages were successfully integrated into an existing community-based MNH program (United States Agency for International Development and Maternal and Child Health Integrated Program 2014). Community health workers carried out home visits to pregnant and postpartum women to promote LAM and effective methods of PPFP. Results showed no negative effect on coverage of home visits, increased duration of exclusive breastfeeding and PPFP, longer birth intervals, and a drop in preterm births.

Key points from this session include:

- Integrating PPFP into MNH services, such as immunization or wellness exams, reduces missed opportunities to address or fulfill women's unmet need for PPFP.
- As a modern, temporary method, LAM has been proven to be a gateway method. Messages about LAM can be integrated with PPFP.
- Every point of contact with a mother, from ANC through postnatal care and even onward into routine immunization visits, is a potential opportunity for FP counseling and action.
- Quality PPFP services contribute to increased satisfaction and uptake.

Healthy Timing and Spacing for All Populations: Postabortion, Youth, Marginalized Groups

The fourth and final day of the PPFP Global Meeting shone a light on the issues of reaching special populations—including first-time parents, postabortion care clients, and women of high parity or advanced maternal age—and also addressed the topic of contraceptive discontinuation.

One speaker commented that first-time parents often lack information about HTSP and that there are many factors on both the demand and supply sides that impede these parents' access to information and services. Country panelists who discussed experiences with HTSP in Afghanistan

and Nigeria cited the importance of proper education and engagement with the community; all agreed that countries need to determine which messages resonate with clients in their specific settings. Among populations across the age spectrum, couple communication is key, as are social norms and acknowledgment of what women or couples intend for their family. It is important that couples understand that HTSP:

- Improves maternal and child health (MCH)
- Lowers risk of maternal, newborn, and child death
- Reduces small for gestational age and low-birthweight births
- Reduces maternal depletion, giving mothers more time to recover physically and nutritionally (for example, building iron stores)
- Reduces malnutrition in children—there is a direct link between birth spacing and the nutritional status of children

Another speaker presented on what is known about contraceptive discontinuation and stated that while more research is needed in this area, if programs include the following it will help reduce discontinuation:

- Improve provider counseling skills to help women choose the method best suited to their needs.
- Increase availability of a full range of methods to facilitate preferred choice and immediate switching by improving referral mechanisms, eliminating stock-outs, and introducing new methods.
- Increase range of service delivery points, contacts, and providers to increase timely access to more methods and enable clients to engage with empathetic providers.

Regarding postabortion FP, a panelist highlighted the best practice of providing counseling and services at the same time and same location, before women leave the facility where they receive services related to spontaneous or induced abortion.

Key points from this session include:

- Demand- and supply-side issues need to be addressed to ensure HTSP becomes a reality.
- Couples communication is critical for HTSP.
- There continues to be a great need to improve provider counseling skills to help women choose the method best-suited to their needs.
- The global health community needs to pay special attention to the groups that are often neglected in HTSP messaging, including women of advanced maternal age or high parity and limiters of any age or parity.

Reimagining PPFP: The Power of Bold Ideas

Jose "Oying" Rimon presenting on the role of positive disruption in postpartum family planning.

Amid the PPFP Global Meeting's panel sessions was a day during which participants were encouraged to reimagine PPFP. This third day kicked off with Jose "Oying" Rimon from the Bill & Melinda Gates Institute for Population and Reproductive Health delivering a powerful talk on the role of positive disruption in PPFP. Rimon challenged the crowd to disrupt the norm at scale and fundamentally change things for good. He spoke of Melinda Gates, Margaret Sanger, and Performance Monitoring and Accountability 2020 as examples of promoters of positive disruption. **"Positive disruptions don't have to be new technologies, they have to be new ideas,"** he said.

Francophone insights on accelerating postpartum family planning.

Following the challenge Rimon issued to the crowd, the day was spent in several group activities. Selected representatives served as catalysts to assist in identifying barriers, developing problem statements, and developing innovative, transformative solutions to accelerate PPFP. Game-changing ideas ran the gamut from "shock and awe" communications and advocacy campaigns—including sending a text message to policymakers every time a death occurs—to organizing site visits so policymakers can see the tragic realities of the situation.

Additional game-changing ideas included:

- Using a private sector approach, such as that used by big companies like Coca-Cola
- Promoting and marketing PPFP
- Creating a culture of data use and transparency
- Developing "user watch groups" for accountability
- Changing the definition of skilled birth attendants (SBAs) to include the provision of PPFP

Figure 3 represents how participant-generated insights became solutions through a three-part process of collecting insights, formulating problem statements based upon those insights, then developing transformative solutions.

Figure 3. Transforming participant insights into solutions

	EXAMPLE 1	EXAMPLE 2
Insights 	• Health workers are not properly trained on postpartum family planning (PPFP). • Providers in antenatal care (ANC), child welfare clinics, immunization are not proficient in PPFP counseling and services. • Women do not get family planning (FP) information throughout pregnancy—for example, starting at ANC. • PPFP is not a priority among mothers or service providers. • Coverage of PPFP services is low. • Health care workers are overburdened. • The release of new Medical Eligibility Criteria for Contraceptive Use [fifth edition; World Health Organization 2015] guidelines affords new opportunities for FP uptake in the immediate postpartum period. • Nobody is holding health workers accountable for not offering PPFP to all women upon discharge. • Home deliveries with no ANC and no PPFP counseling are still common.	• There is low utilization of FP services, especially PPFP, because of poor community awareness and women not being supported by their family or male involvement. • Pregnant women in rural communities are poorly counseled on return to fertility and PPFP because they don't attend ANC. • Women do not demand PPFP because they don't know about the return to fertility and they don't know the negative impacts of not spacing. • Women don't know how to access or are unable to negotiate use of PPFP. • Many couples do not discuss reproductive intentions and FP use together before childbirth, leaving them unprepared to start using FP immediately postpartum. • Men are often not provided opportunities for engagement and learning around PPFP. • Some women refuse immediate postpartum contraception due to cultural barriers. • There are sociocultural norms that dictate resumption of sexual activity postdelivery and discourage use of modern FP methods within marriage.
Problem Statement 	How can we ensure that every health care worker can provide high-quality PPFP?	How do we engage men to have the knowledge to support their partners to make a joint/shared decision to use immediate PPFP?
Transformative Solution 	Amend definition of skilled birth attendant to include some capacity to provide or refer for PPFP.	Engage men and various points of contact (home, work, sports, religious settings) with targeted messaging that helps them be informed, motivated, and supportive during the antenatal period so that women have the agency to decide on PPFP.

Abbreviations: ANC, antenatal care; FP, family planning; MEC, *Medical Eligibility Criteria for Contraceptive Use* (fifth edition; World Health Organization 2015); PPFP, postpartum family planning.

Some innovative ideas that emerged from this session:

- Consider amending signal functions or SBA definition to include PPFP
- Develop a curriculum to address provider bias and values clarification around PPFP
- Make PPFP part of universal access
- Inform and motivate supportive men so that women have the agency to make a decision about PPFP
- Tell the PPFP story with numbers—create a data revolution!
- Tailor social and behavior change strategies
- Map stakeholders for tailored advocacy approaches
- Consider rebranding FP for all to understand: Future Protection
- Engage nontraditional champions (e.g., monks at marriage ceremonies, corporations)

- Plan with a marketer's lens (e.g., Coca-Cola approach, passing the torch along the PPFP continuum, information and communications technology for PPFP)
- Include PPFP in national insurance schemes

"Accountability is a potential revolutionary item—the idea of a data revolution—the time has come for data to drive how important PPFP is."
—Oying Rimon, Gates Institute

"PPFP is saving lives every single day."
—Oying Rimon, Gates Institute

Continuing the Conversation and Proactive Sharing of Information

The PPFP Global Meeting was a high-energy, action-oriented event. Participants and organizers need to maintain the momentum, ensuring that all countries are able to implement PPFP action plans and that postpartum women and their families are able to access the most appropriate methods to meet their needs. One way to continue the conversation is to utilize tools that give the global FP community and countries a dynamic platform on which to discover and utilize new information, connect, share, collaborate, and learn. FP2020 invites the global FP community to continue the conversation at www.familyplanning2020.org.

In the coming year, this platform will be useful for viewing action at the country level and gaining insights on how PPFP can be included in the Sustainable Development Goals. The organizers of the PPFP Global Meeting encourage participants to join a community, visit country pages, share information, or ask questions. Additionally, to encourage further dialogue, multicountry webinars will be conducted wherein country representatives can report on action plans and accomplishments since the PPFP Global Meeting. During these webinars, countries will be encouraged to share challenges and identify areas requiring additional follow-up from the international steering committee.

To facilitate further discussion between the FP and MNH communities, an advocacy discussion took place during the Global Maternal and Newborn Health Conference in October 2015 in Mexico City. A follow-up workshop to facilitate deeper discussion on country action plans, implementation efforts, and future goals will also take place at the International Conference on Family Planning in January 2016 in Nusa Dua, Indonesia.

As Maryjane Lacoste from the Bill & Melinda Gates Foundation stated, **"We have an opportunity right now to build on PPFP wins, we know more than ever before and it's time to take action to scale."**

Acknowledgments

Sincere appreciation goes to the members of the international steering committee for guiding the planning of the PPFP Global Meeting and for having the vision to bring bold ideas to this important area that has been neglected in the past.

The meeting organizers are grateful to the governments of Afghanistan, Bangladesh, Burkina Faso, DRC, Ethiopia, India, Indonesia, Kenya, Madagascar, Nigeria, Pakistan, Philippines, Rwanda, Tanzania, Uganda, and Zambia for their leadership in recognizing the importance of PPFP and for their support of the delegates who attended this meeting. These governments' commitment to making PPFP interventions a reality is critical to maintaining the momentum in their countries.

Thank you to the representatives of Population Council, Marie Stopes International (MSI), Population Services International (PSI), International Planned Parenthood Federation, Ipas, MEASURE, Evidence to Action, and the Gates Institute who supported country or regional staff to come and share their expertise with the country teams. The organizers are also grateful to the MCSP partners—Avenir Health, Save the Children, PATH, John Snow, Inc. (JSI), and ICF International—for their continued support, and to WHO, the United Nations Population Fund (UNFPA), EngenderHealth, and the David and Lucile Packard Foundation for their active participation and representation during the course of the meeting.

Special thanks go to Monica Kerrigan, Senior Advisor at FP2020, for her vision in conceptualizing this meeting and for her steadfast dedication to disrupting the norm to achieve improved FP access; to Patricia MacDonald, Senior Technical Advisor in the Office of Population and Reproductive Health at USAID; and to Maryjane Lacoste, Senior Program Officer at the Bill & Melinda Gates Foundation, for their continuing commitment to and promotion of PPFP and the improved livelihood of women and couples around the world. The meeting organizers greatly appreciated their contributions and support in achieving the meeting's objectives.

We would also like to acknowledge the meeting organizers including Lindsay Breithaupt, Elaine Charurat, Megan Christofield, Rehana Gubin, Ricky Lu, Ron Magarick, Angela Nash-Mercado, and Jeff Smith of Jhpiego; Koki Agarwal, Sadie Healy, and Anne Pfitzer of MCSP; and Zahra Aziz of FP2020 for your technical leadership and time in planning the PPFP Global Meeting.

Finally, thank you to the Bill & Melinda Gates Foundation for providing the funding to make this meeting possible and to USAID for supporting MCSP staff time and travel.

Appendix A: Meeting Agenda

For full copies of the meeting materials and presentations, please see http://www.familyplanning2020.org/microsite/ppfp.

Sunday, June 07, 2015	
14:00–18:00 Level 1 Pre-Function Hall	**Registration**
14:00–15:00 Level 1, VIP Lounge	**Country Facilitators' Meeting (by separate invitation)**
15:00–16:00 Level 1, VIP Lounge	**PPFP Innovation Workshop Catalysts' Meeting (by separate invitation)**
18:00–18:30 Lanna Ballroom 1	**Opening Session and Remarks** Master of Ceremonies: Monica Kerrigan, Family Planning 2020 (FP2020) Leslie Mancuso, Jhpiego Aly Cameron, United States Agency for International Development (USAID) Nuriye Ortayli, United Nations Population Fund (UNFPA) Maryjane Lacoste, Bill & Melinda Gates Foundation James Kiarie, World Health Organization (WHO) Khunying Kobchitt Limpaphayom, Professor Emeritus, Chulalongkorn University, Thailand
18:30–20:00 Ballroom Lobby	**Welcome Reception**
Monday, June 08, 2015	
8:30–9:00 Lanna Ballroom 1	**Meeting Overview** Ron Magarick, Jhpiego Isaac Malonza, Jhpiego Megan Christofield, Jhpiego Sadie Healy, Maternal and Child Survival Program (MCSP)/Jhpiego
9:00–10:10 Lanna Ballroom 1	**Plenary: Why PPFP? Why Now?** Moderator: Aly Cameron, USAID James Kiarie, WHO Monica Kerrigan, FP2020 Country perspectives panel
10:10–10:30 Ballroom Lobby	Break

Monday, June 08, 2015, *continued*	
10:30–12:00 Lanna Ballroom 1	**Plenary: Update on Global Guidelines and Evidence Review** Moderator: James Kiarie, WHO Mary Lyn Gaffield, WHO Petrus Steyn, WHO Monica Dragoman, WHO Country perspectives panel
12:00–13:00 Hotel Restaurant	Lunch
13:00–14:15 Lanna Ballroom 1	**Setting the Stage: Introduction to Country Action and Scale-Up** Moderator: Nuriye Ortalyi, UNFPA Saifuddin Ahmed, Johns Hopkins University (JHU)/Healthy Fertility Study Bulbul Sood, Jhpiego/India Suzanne Reier, WHO Rehana Gubin, Jhpiego Patricia MacDonald, USAID
14:15–15:30	**Country Team Group Work**
Phayao 1	Afghanistan, Bangladesh
Phayao 2	Burkina Faso, Democratic Republic of Congo
Phayao 3	Indonesia, Kenya
Lanna Ballroom 1	Ethiopia
Auditorium	India
Sukothai 1	Madagascar, Nigeria, Pakistan
Sukothai 2	Philippines, Rwanda, Tanzania
Sukothai 3	Uganda, Zambia
15:30–16:00 Ballroom Lobby	Break

Monday, June 08, 2015, *continued*

16:00–17:30 Ballroom Lobby and Foyer	**CTU Marketplace** 1. Lactational Amenorrhea Method and Emergency Contraceptive Pills: Clifton Kenon, USAID 2. Postpartum Implants: Paul Nyachae, Jhpiego/Kenya; Mona Sagarsih, Jhpiego/Indonesia; and Marc Eric Razakariasy Jhpiego/Madagascar 3. Postpartum IUDs: Jully Chilambwe, Jhpiego/Zambia; Tigist Worku Jhpiego/Ethiopia; and Vivek Yadav, Jhpiego/India 4. Postpartum Tubal Ligation: Mark Hathaway, MCSP/Jhpiego, and Bernabe Marinduque, Jhpiego/Philippines 5. No-Scalpel Vasectomy: Ricky Lu, Jhpiego, and Tsigue Pleah, Jhpiego 6. Progesterone Contraceptive Vaginal Rings: Wilson Liambila, Population Council, and Salisu Ishaku, Population Council 7. Social and Behavioral Change Communication Toolkit: Chelsea Cooper, MCSP/Jhpiego 8. Pre-Discharge Checklists Postpartum Systematic Screening Tools: Farid Midhet, Jhpiego/Pakistan, and Hannatu Abdullahi, Jhpiego/Nigeria 9. Mama-U and Other Anatomic Models: Jennifer Gilbertson, Laerdal 10. Medical Eligibility Criteria Wheel (online version): Mary Lyn Gaffield, WHO 11. PPIUD long inserter: Maxine Eber, Population Services International (PSI) 12. Pathway of Opportunities for PPFP Tool: Megan Christofield, Jhpiego

Tuesday, June 09, 2015

8:30–9:00 Lanna Ballroom 1	**Recap and Agenda** Maryjane Lacoste, Bill & Melinda Gates Foundation
9:00–10:30 Lanna Ballroom 1	**Bundle of Love, Part 1: Integration on the Day of Birth (0–48 hours)** Moderator: Koki Agarwal, MCSP/Jhpiego Ricky Lu, Jhpiego Anne Pfitzer, MCSP/Jhpiego Country perspectives panel
10:30–11:00 Ballroom Lobby	Break

Tuesday, June 09, 2015, *continued*

11:00–11:40	**Concurrent Sessions: Block 1**
Phayao 1	1. La mise à échelle pour la PFPP: Suzanne Reier, WHO
Phayao 2	2. Bihar experience and successes with comprehensive PPFP involving both community and facility providers: Anand Kishor, Secretary Health Executive Director, Bihar State and Anand Sinha, Packard Foundation
Phayao 3	3. Considerations for first time and adolescent parents: Lessons from Nepal's My First Baby: Michelle Prosser, Save the Children, and Aidee de Gallardo, MCSP/Save the Children
Sukothai 1	4. Debunking menstruation requirements: Overcoming a critical barrier for PPFP: Mark Hathaway, MCSP/Jhpiego, and Gloria Shirima, Jhpiego/Tanzania
Sukothai 2	5. Engaging the private sector in PPFP: Maxine Eber, PSI, and Julie Taft, Marie Stopes International (MSI)
Sukothai 3	6. Introducing the WHO Compendium: Mary Lyn Gaffield, WHO, and Nancy Kidula, WHO
Auditorium	7. Approches diverses à la formation en PFPP: Tsigue Pleah, Jhpiego
Lanna Ballroom	8. The role of community health workers in delivering PPFP: Saifuddin Ahmed, JHU, and Chelsea Cooper, MCSP/Jhpiego
11:40–11:50	Change over
11:50–12:30	**Concurrent Sessions: Block 2**
Phayao 1	1. Scale-up of PPFP: Suzanne Reier, WHO
Phayao 2	2. Monitoring and evaluation: Data, registers, record-keeping, health management information systems, major data sources, clinical governance: Elaine Charurat, Jhpiego, and Anne Pfitzer, MCSP/Jhpiego
Phayao 3	3. Controversies with PPFP methods choice: Ricky Lu, Jhpiego
Sukothai 1	4. New method specifically for postpartum women, the progesterone contraceptive vaginal ring: Wilson Liambila, Population Council, and Salisu Ishaku, Population Council
Sukothai 2	5. L'engagement du secteur privé pour la PFPP: Maxine Eber, PSI et Julie Taft, MSI
Sukothai 3	6. Introducing the WHO Compendium: Mary Lyn Gaffield, WHO, and Nancy Kidula, WHO
Auditorium	7. Alternative training and mentoring approaches: Somesh Kumar, Jhpiego/India
Lanna Ballroom	8. Sukothai 3: Shipra Srihari, Avenir Health; Nuriye Ortalyi, UNFPA; and Rehana Gubin, Jhpiego

Tuesday, June 09, 2015, *continued*	
12:30–13:30 Hotel Restaurant	Lunch
13:30–5:00 Lanna Ballroom 1	**Bundle of Love, Part 2: Opportunities for Synergies in Extended Postpartum** Moderator: Maggwa Ndugga, Bill & Melinda Gates Foundation Rae Galloway, MCSP/PATH Clifton Kenon, USAID Rebecca Fields, MCSP/John Snow Inc. S.K. Sikdar, Ministry of Health and Family Welfare, Government of India Country perspectives panel
15:00–15:30 Ballroom Lobby	Break
15:30–17:30 Previously Designated Rooms	**Country Team Group Work**
Wednesday, June 10, 2015	
8:30–17:00 Lanna Ballroom 1	**PPFP Innovation Workshop: Reimagine PPFP (Facilitated, Interactive Session to Generate Transformative Solutions for PPFP at Scale)**
Thursday, June 11, 2015	
8:30–9:00 Lanna Ballroom 1	**Recap and Agenda**
9:00–10:30 Lanna Ballroom 1	**Plenary: Healthy Timing and Spacing for All Populations** Moderator: Jose "Oying" Rimon, Gates Institute Carina Stover, Evidence to Action Patricia MacDonald, USAID Joan Healy, Ipas Ian Askew, Population Council Country perspectives panel
10:30–11:00 Ballroom Lobby	Break

Thursday, June 11, 2015, *continued*	
11:00–12:30 Previously Designated Rooms	**Country Team Group Work**
12:30–13:30 Hotel Restaurant	Lunch
13:30–14:45 Previously Designated Rooms	**Country Team Group Work**
14:45–15:30 Lanna Ballroom 1	**Overview of FP2020 and Context Setting Post 2015** Beth Schlachter, FP2020 **Continuing the Conversation: Demonstration of FP2020's New Knowledge Platform** Zahra Aziz, FP2020
15:30–16:45 Ballroom Lobby	Break with Gallery Walk
16:45–17:00 Lanna Ballroom 1	**Closing Plenary: Synthesis of Country Actions and Way Forward** Koki Agarwal, MCSP/Jhpiego Beth Schlachter, FP2020

Appendix B: Participant List

Given Name	Family Name	Organization	Country
Abdul Malek	Faize	UNFPA	Afghanistan
Rasheda	Furmoli	Ministry of Public Health	Afghanistan
Nezamuddin	Jalil	Ministry of Public Health	Afghanistan
Mohammad	Roshani	MSI	Afghanistan
Mila	Sarwari	Ministry of Public Health	Afghanistan
Faridullah	Atiqzai	Jhpiego	Afghanistan
Mohammad	Alim	Ministry of Health and Family Welfare	Bangladesh
Samina	Choudhury	USAID	Bangladesh
Nahid	Chowdhury	Pathfinder International	Bangladesh
Abu	Faisel	EngenderHealth	Bangladesh
Abu Sayed	Hasan	UNFPA	Bangladesh
Md. Lutful	Kabir Khan	District Family Planning Office	Bangladesh
Youssef	Tawfik	Jhpiego	Bangladesh
Reena	Yasmin	Marie Stopes Bangladesh	Bangladesh
Nasreen	Zaman	Directorate General of Family Planning	Bangladesh
Isabelle	Bicaba	MOH	Burkina Faso
Adama	Dembele	MOH	Burkina Faso
Michel	Nassa	UNFPA	Burkina Faso
Yacouba	Ouedraogo	Jhpiego	Burkina Faso
Zan	Souleymane	WHO	Burkina Faso
Hyacinthe	Zamane	University of Ouagadougou	Burkina Faso
Albert	Chikuru	PSI	DRC
Brigitte	Kini	WHO	DRC
Vickie	Mbutu	Programme National de Santé de la Reproduction (PNSR)	DRC
Marie-Claude	Mbuyi	Pathfinder International	DRC
Lamy	Mithano	PNSR/Ministère de la Santé Publique	DRC
Claudine	Monganza	EngenderHealth	DRC
Mame	Niang	PSI	DRC
Berhane	Assefa Merdassa	Federal MOH	Ethiopia
Tigist	Belete	Jhpiego	Ethiopia
Alemitu	Hailemariam	Family Guidance of Ethiopia	Ethiopia
Mengistu	Kibret	Pathfinder International	Ethiopia
Tsigereda	Mengistu	Marie Stopes Ethiopia	Ethiopia
Tuijje	Negussie	EngenderHealth	Ethiopia
Ekram	Seid	Federal MOH	Ethiopia
Gamachis	Shogo	UNFPA	Ethiopia
Fatim	Tall	WHO	Ethiopia
Zewditu	Tessema	USAID	Ethiopia
Haimanot	Workineh	WHO	Ethiopia

Given Name	Family Name	Organization	Country
Ghislaine	Conombo	WHO	Gabon
Mohammad	Ahmad	State Health Society, Bihar	India
Sachin	Juneja	Marie Stopes India	India
Somesh	Kumar	Jhpiego	India
Meeta	Mahar	International Planned Parenthood Federation	India
Arvind	Mishra	State Innovations in Family Planning Services Project Agency, Uttar Pradesh	India
Atul	Mittal	Jhpiego	India
Suranjeen	Pallipamula	Jhpiego	India
Minati	Rath	Jhpiego	India
S. K.	Sikdar	Ministry of Health and Family Welfare	India
Anand	Sinha	Packard Foundation	India
Bulbul	Sood	Jhpiego	India
Mahesh	Srinivas	Pathfinder	India
Asish	Srivastava	Jhpiego	India
Vivek	Yadav	Jhpiego	India
Biran	Affandi	University of Indonesia	Indonesia
Robert	Ainslie	Johns Hopkins Center for Communication Programs	Indonesia
Irma	Ardiana	National Population and Family Planning Board, Indonesia	Indonesia
Melania	Hidayat	UNFPA	Indonesia
Ipin	Husni	Biro Perencanaan	Indonesia
Ruri	Ichwan	National Population and Family Planning Board, Indonesia	Indonesia
Leo	Prawirodihardjo	District Hospital Makassar	Indonesia
Arietta	Pusponegoro	Faculty of Medicine, University of Indonesia	Indonesia
Mona	Saragih	Jhpiego	Indonesia
Ian	Askew	Population Council	Kenya
Lynn	Kanyuuru	Jhpiego	Kenya
Nancy	Kidula	WHO	Kenya
Joyce	Lavussa	WHO	Kenya
Wilson	Liambila	Population Council	Kenya
Isaac	Malonza	Jhpiego	Kenya
Wangui	Mutigani	MOH	Kenya
Angeline	Mutunga	Jhpiego/Advance Family Planning	Kenya
Jumba	Nakato	MOH	Kenya
Paul	Nyachae	Jhpiego	Kenya
Velonirina	Andrianifahanana	PSI	Madagascar
Haingonirina	Ramananjanahary	MOH	Madagascar
Baholisoa	Randrianasolo	Marie Stopes Madagascar	Madagascar
Edwige	Ravaomanana	UNFPA	Madagascar
Christine	Ravaonoro	MOH	Madagascar

Given Name	Family Name	Organization	Country
Marc Eric	Razakariasy	MCSP/Jhpiego	Madagascar
Hannatu	Abdullahi	Jhpiego	Nigeria
Fatima	Bunza	PSI/Society for Family Health Nigeria	Nigeria
Salisu	Ishaku	Population Council	Nigeria
Moriam	Jagun	USAID	Nigeria
Elizabeth	Mamodu	Kogi State MOH	Nigeria
Kate	Oboke	Ebonyi State MOH	Nigeria
Kingsley	Odogwu	Marie Stopes Nigeria	Nigeria
Emmanuel	Ololorin	Jhpiego	Nigeria
Taiwo	Oyellade	WHO	Nigeria
Jennifer	Gilbertson	Laerdal Global Health	Norway
Shabir	Chandio	USAID	Pakistan
Syed	Hussaini	Marie Stopes Pakistan	Pakistan
Zafar	Ikram	USAID DELIVER	Pakistan
Aminah	Khan	Greenstar Social Marketing	Pakistan
Farid	Midhet	Jhpiego	Pakistan
Nelofer	Rashdi	Health Department, Government of Sindh	Pakistan
Anjum	Rizvi	Rahnuma-Family Planning Association of Pakistan	Pakistan
Syed	Shah	Government of Sindh	Pakistan
Iftikhar	Soomro	Packard Foundation	Pakistan
Zahida	Syeda	Policy and Strategic Planning Unit	Pakistan
Azmat	Waseem	Population Welfare Department, Government of Sindh	Pakistan
Amelia Anastasia	Ang	Davao Regional Hospital	Philippines
Maria Teresa	Carpio	USAID	Philippines
Maria Joyce	Ducusin	Department of Health	Philippines
Lennybeth	Engay	Department of Health	Philippines
Patricia	Gomez	Integrated Midwives Association of the Philippines, Inc.	Philippines
Mary Beth	Hofer de los Santos	Vicente Sotto Memorial Medical Center	Philippines
Bernabe	Marinduque	Jhpiego/Mindanao Health	Philippines
Minerva	Molon	Department of Health Regional Office	Philippines
Jessica	Valentin	Population Services Pilipinas, Inc.	Philippines
Victor	Mivumbi	MOH	Rwanda
Maria	Mujawamariya	WHO	Rwanda
Beata	Mukarugwiro	Jhpiego	Rwanda
Daphrose	Nyirasafali	UNFPA	Rwanda
Monica	Dragoman	WHO	Switzerland
Mary Lyn	Gaffield	WHO	Switzerland
James	Kiarie	WHO	Switzerland
Suzanne	Reier	WHO	Switzerland

Given Name	Family Name	Organization	Country
Petrus	Steyn	WHO	Switzerland
Maurice	Hiza	Ministry of Health and Social Welfare	Tanzania
Neema	Kyamba	Regional Health Management Team- Kagera	Tanzania
Ahmad	Makuwani	Ministry of Health and Social Welfare	Tanzania
Feddy	Mwanga	EngenderHealth	Tanzania
Mwemezi	Ngemera	Marie Stopes Tanzania	Tanzania
Gloria	Shirima	Jhpiego	Tanzania
Samson	Winani	Regional Secretariat of Mara	Tanzania
Khunying Kobchitt	Limpaphayom	Chulalongkorn University	Thailand
Lucy	Asaba	EngenderHealth	Uganda
Susan	Atuhairwe	Mulago National Referral Hospital	Uganda
Josaphat	Byamugisha	Makerere University	Uganda
Emily	Katarikawe	Jhpiego	Uganda
Mildred	Latigo	Management Sciences for Health Strengthening TB and AIDS Response – Eastern Region/STRIDES for Family Health	Uganda
Placid	Mihayo	MOH	Uganda
Olive	Mugisa	WHO	Uganda
Jennifer	Wanyana	PSI	Uganda
Julia	Taft	MSI	United Kingdom
Koki	Agarwal	MCSP/Jhpiego	USA
Saifuddin	Ahmed	JHU	USA
Zahra	Aziz	FP2020	USA
Janine	Barden-O'Fallon	MEASURE Evaluation	USA
Lindsay	Breithaupt	Jhpiego	USA
Elaine	Charurat	Jhpiego	USA
Megan	Christofield	Jhpiego	USA
Arzum	Ciloglu	Johns Hopkins Center for Communication Programs	USA
Chelsea	Cooper	MCSP/Jhpiego	USA
Elizabeth	Creel	JSI	USA
Adelaida	DeGregorio	MCSP/Save the Children	USA
Maxine	Eber	PSI	USA
Rebecca	Fields	MCSP/JSI	USA
Rae	Galloway	MCSP/PATH	USA
Rehana	Gubin	Jhpiego	USA
Mark	Hathaway	MCSP/Jhpiego	USA
Joan	Healy	Ipas	USA
Sadie	Healy	MCSP/Jhpiego	USA
Monica	Kerrigan	FP2020	USA
Maryjane	Lacoste	Bill & Melinda Gates Foundation	USA

Given Name	Family Name	Organization	Country
Ricky	Lu	Jhpiego	USA
Patricia	MacDonald	USAID	USA
Ronald	Magarick	Jhpiego	USA
Leslie	Mancuso	Jhpiego	USA
Angela	Nash-Mercado	Jhpiego	USA
Maggwa	Ndugga	Bill & Melinda Gates Foundation	USA
Nuriye	Ortayli	UNFPA	USA
Anne	Pfitzer	MCSP/Jhpiego	USA
Tsigue	Pleah	Jhpiego	USA
Michelle	Prosser	Save the Children	USA
Jose	Rimon	Gates Institute/JHU	USA
Shipra	Srihari	Avenir Health	USA
Carina	Stover	Pathfinder International	USA
Jully	Chilambwe	Jhpiego	Zambia
Dyness	Chinyama	Ministry of Community Development, Mother and Child Health	Zambia
Joseph	Nikisi	Jhpiego	Zambia
Nikile	Njovu	Marie Stopes Zambia	Zambia
Caroline	Phiri Chibawe	Ministry of Community Development, Mother and Child Health	Zambia

Appendix C: Overview of Country Action Plans

Statistics are taken from the most recent Population Reference Bureau (http://www.prb.org/) and Demographic and Health Surveys Program (http://www.dhsprogram.com/) data.

Afghanistan

Basic Statistics
- Total population (mid-2014): 31,281,000
- Population of women ages 15–49: 6,800,000
- CPR any method: 13.8%
- Place of delivery: health facility (births in three years preceding the survey): 30%

Existing Efforts
- PPIUCD
- LAM

Highlights from Country Action Plan
- Update guidelines to include changes in MEC
- Organize advocacy workshop for improving FP services including PPFP
- Increase community, household, and individual demand for PPFP

Bangladesh

Basic Statistics
- Total population (mid-2014): 158,513,000
- Population of women ages 15–49: 43,900,000
- Total fertility rate: 2.3
- Percentage of unmet need among women of reproductive age (WRA): 13.5
- Percentage of postpartum prospective unmet need: 40
- CPR any method: 52.1%
- Percentage of women who receive at least one ANC visit: 68
- Place of delivery: health facility (births in three years preceding the survey): 27%

Existing Efforts
- Public sector service delivery
- Nongovernmental organizations and private sector

Highlights from Country Action Plan
- Immediate PPFP service delivery at the facility with counseling and referral at the community level
- Widen immediate PPFP options (implants)
- Reach out to men and in-laws
- Use every opportunity to reach postpartum couples

Burkina Faso

Basic Statistics
- Total population (mid-2014): 17,886,000
- Population of women ages 15–49: 3,900,000
- Total fertility rate: 6.0
- Percentage of unmet need among WRA: 24.5
- Percentage of postpartum prospective unmet need: 81
- CPR any method: 15%
- Percentage of women who receive at least one ANC visit: 96
- Place of delivery: health facility (births in three years preceding the survey): 72%

Existing Efforts
- Training providers in PPFP technologies, skills, and counseling
- Training of trainers for insertion of PPIUD

Highlights from Country Action Plan
- Integrate PPFP into pre-service education for providers
- Integrate PPFP into national guidelines for maternal and infant health services
- Engage key decision-makers at all levels to support PPFP

DRC

Basic Statistics
- Total population (mid-2014): 77,433,744
- Population of women ages 15–49: 16,261,086
- Total fertility rate: 4.6
- Percentage of unmet need among WRA: 28
- Percentage of postpartum prospective unmet need: 71
- CPR any method: 8.1%
- Percentage of women who receive at least one ANC visit: 90
- Place of delivery: health facility (births in three years preceding the survey): 80%

Existing Efforts
- Scale-up of pilot PPIUD program

Highlights from Country Action Plan
- Revise national communication strategy to include PPFP
- Revise national data sheets to include PPFP
- Include PPFP as a standard service in provider curriculum
- Increase access to immediate PPFP
- Integrate PPFP into monitoring and evaluation efforts
- Conduct operational research on sociocultural barriers to the use of PPFP

Ethiopia

Basic Statistics
- Total population (mid-2014): 95,933,000
- Population of women ages 15–49: 6,800,000
- Total fertility rate: 4.8
- Percentage of unmet need among WRA: 25.3
- Percentage of postpartum prospective unmet need: 74
- CPR any method: 27.3%
- Percentage of women who receive at least one ANC visit: 42
- Place of delivery: health facility (births in three years preceding the survey): 11%

Existing Efforts
- ANC
- Labor and delivery
- Infant health and immunization

Highlights from Country Action Plan
- Utilize contact points for PPFP including ANC, immediate postpartum period, and infant and child immunization
- Use champions for advocacy and awareness creation
- Conduct operational research

India

Basic Statistics
- Total population (mid-2014): 1,296,245,000
- Population of women ages 15–49: 323,600,000
- Total fertility rate: 2.7
- Percentage of unmet need among WRA: 13.9
- CPR any method: 48.5%
- Percentage of women who receive at least one ANC visit: 77
- Place of delivery: health facility (births in three years preceding the survey): 40%

Existing Efforts
- Scaling up PPIUCD services
- Strengthening postpartum sterilization services in health facilities
- Demand generation and integration in the MNH platform

Highlights from Country Action Plan
- Scale up PPIUCD services to all delivery points in public sector
- Expand access to more PPFP methods at public sector health facilities
- Strengthen demand generation by involving community and frontline health workers
- Introduce new methods

Indonesia

Basic Statistics
- Total population (mid-2014): 251,452,000
- Population of women ages 15–49: 66,900,000
- Total fertility rate: 2.6
- Percentage of unmet need among WRA: 11.4
- CPR any method: 57.9%
- Percentage of women who receive at least one ANC visit: 97
- Place of delivery: health facility (births in three years preceding the survey): 67%

Existing Efforts
- Improving access and quality of PPIUD
- My Choice
- Hospital-based FP programs

Highlights from Country Action Plan
- Integrate PPFP in the continuum of care
- Track and trace with information and communication technology
- Engage community
- On-the-job training/mentoring and follow-up
- Include PPFP in existing rights-based FP strategic platform

Kenya

Basic Statistics
- Total population (mid-2014): 43,210,000
- Population of women ages 15–49: 10,800,000
- Total fertility rate: 4.6
- Percentage of unmet need among WRA: 25.6
- Percentage of postpartum prospective unmet need: 57
- CPR any method: 39.4%
- Percentage of women who receive at least one ANC visit: 93
- Place of delivery: health facility (births in three years preceding the survey): 43%

Existing Efforts
- Postnatal care
- Tupange

Highlights from Country Action Plan
- Update FP guidelines to reflect changes in MEC
- Develop PPFP addendum to facilitate acceleration into relevant services and training packages
- Integrate PPFP into immediate postpartum care in facilities
- Increase community-based distribution of FP commodities

Madagascar

Basic Statistics
- Total population (mid-2014): 22,445,000
- Population of women ages 15–49: 5,500,000
- Total fertility rate: 4.8
- Percentage of unmet need among WRA: 19
- Percentage of postpartum prospective unmet need: 65
- CPR any method: 29.2%
- Percentage of women who receive at least one ANC visit: 90
- Place of delivery: health facility (births in three years preceding the survey): 35%

Existing Efforts
- LAM
- PPIUD

Highlights from Country Action Plan
- Develop strategies and communication to support sensitization and orientation to PPFP
- Scale up implants in public sector facilities
- Reinforce LAM at the community level

Nigeria

Basic Statistics	Existing Efforts	Highlights from Country Action Plan
• Total population (mid-2014): 177,542,000 • Population of women ages 15–49: 39,200,000 • Total fertility rate: 5.5 • Percentage of unmet need among WRA: 16.1 • Percentage of postpartum prospective unmet need: 65 • CPR any method: 9.8% • Percentage of women who receive at least one ANC visit: 66 • Place of delivery: health facility (births in three years preceding the survey): 37%	• MCSP • MCH interventions in private facilities	• Update guidelines, protocols, and training materials with PPFP content • Support MOH to map PPFP activities for improved coordination • Make printed PPFP information, education, and communication materials available

Pakistan

Basic Statistics	Existing Efforts	Highlights from Country Action Plan
• Total population (mid-2014): 193,979,000 • Population of women ages 15–49: 47,300,000 • Total fertility rate: 3.8 • Percentage of unmet need among WRA: 20.1 • Percentage of postpartum prospective unmet need: 60 • CPR any method: 26.1% • Percentage of women who receive at least one ANC visit: 77 • Place of delivery: health facility (births in three years preceding the survey): 53%	• Punjab PPFP initiative • Sindh–Maternal and Child Health Integrated Program PPFP initiative	• Develop national policy guidelines for integrating PPFP into MNCH services at the facility and community level in both public and private sectors • Establish provincial task forces for PPFP in each province • Initiate changes within the management information system of relevant programs

Philippines

Basic Statistics	Existing Efforts	Highlights from Country Action Plan
• Total population (mid-2014): 100,096,000 • Population of women ages 15–49: 25,300,000 • Total fertility rate: 3.0 • Percentage of unmet need among WRA: 17.5 • Percentage of postpartum prospective unmet need: 51 • CPR any method: 37.6% • Percentage of women who receive at least one ANC visit: 96 • Place of delivery: health facility (births in three years preceding the survey): 66%	• Centers of excellence • Referral system for PPFP services • FP in hospitals	• Review and harmonize FP and maternal forms to support policy issuance • Pilot integration of FP/Expanded Programme on Immunization in three selected provinces • Harmonize PPFP tracking system

Rwanda

Basic Statistics
- Total population (mid-2014): 11,080,000
- Population of women ages 15–49: 2,900,000
- Total fertility rate: 4.6
- Percentage of unmet need among WRA: 20.8
- Percentage of postpartum prospective unmet need: 51
- CPR any method: 45.1%
- Percentage of women who receive at least one ANC visit: 98
- Place of delivery: health facility (births in three years preceding the survey): 77%

Existing Efforts
- PPFP
- PPIUCD

Highlights from Country Action Plan
- Update strategic plan to add PPFP
- Scale up PPFP/PPIUCD services
- Create PPFP/PPIUD functional task force

Tanzania

Basic Statistics
- Total population (mid-2014): 50,757,000
- Population of women ages 15–49: 11,200,000
- Total fertility rate: 5.4
- Percentage of unmet need among WRA: 22.3
- Percentage of postpartum prospective unmet need: 62
- CPR any method: 27.4%
- Percentage of women who receive at least one ANC visit: 98
- Place of delivery: health facility (births in three years preceding the survey): 50%

Existing Efforts
- Postpartum care
- PPFP
- PPIUCD

Highlights from Country Action Plan
- Conduct PPFP stakeholders meeting
- Map PPFP interventions countrywide
- Finalize development of PPFP guidelines and policies
- Build capacity of service providers in PPFP
- Integrate PPFP with other interventions
- Strengthen linkages with community for continuum of care

Uganda

Basic Statistics
- Total population (mid-2014): 38,845,000
- Population of women ages 15–49: 8,300,000
- Total fertility rate: 6.2
- Percentage of unmet need among WRA: 34.3
- Percentage of postpartum prospective unmet need: 68
- CPR any method: 26%
- Percentage of women who receive at least one ANC visit: 96
- Place of delivery: health facility (births in three years preceding the survey): 59%

Existing Efforts
- Training
- Service delivery

Highlights from Country Action Plan
- Revise relevant policy and service delivery guidelines
- Increase multistakeholder involvement in PPFP programming
- Integrate PPFP into ANC, postnatal care, adolescent, immunization, and other relevant services
- Improve monitoring, evaluation, and accountability

Zambia		
Basic Statistics • Total population (mid-2014): 15,111,000 • Population of women ages 15–49: 3,300,000 • Total fertility rate: 6.2 • Percentage of unmet need among WRA: 26.6 • CPR any method: 32.7% • Percentage of women who receive at least one ANC visit: 99 • Place of delivery: health facility (births in three years preceding the survey): 48%	**Existing Efforts** • Limited PPIUD and LAM • PPFP counseling in ANC integrated into prevention of mother-to-child transmission for HIV-positive couples • Interval and extended PPFP	**Highlights from Country Action Plan** • Reposition LAM in PPFP • Make PPFP counselling available to all clients during ANC sessions • Accelerate accountability through improved data systems for PPFP

References

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