

Monitoring Postpartum Family Planning

A challenge for routine information systems

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Capturing pre-discharge PFP

Facility registers rarely capture if a woman is postpartum when she receives family planning. As a result, the number of women receiving postpartum family planning (PFP) is not reported in health management information systems, making it difficult to track how many women get family planning during this time of high need.

Postpartum family planning is critical to reaching FP2020 targets

PFP coverage can be measured through surveys such as national Demographic and Health Surveys¹ or sub-national Performance Monitoring and Accountability 2020 surveys², but surveys are expensive and not feasible to do frequently or in all areas of a country. Also, facility and district managers need to monitor the provision of PFP at the service delivery points they oversee. Routinely tracking the number of postpartum women receiving a family planning method could provide critical information to help with management decisions and improve services.

PFP can be provided to women immediately after birth or to mothers in the postnatal and extended postpartum periods. PFP may be integrated into delivery services, postnatal care, immunization, or other child health services. PFP can be delivered at facility and community level. Tracking uptake of PFP at all of these various contact points can be complex for routine monitoring systems. Still, tracking uptake of family planning at even one of these time points can yield important information for improving service delivery.

The purpose of this brief is to share examples of how to capture the number of women who receive family planning before discharge after giving birth in a facility – one important element of PFP. Below are examples from four countries. These approaches are used in facilities where the USAID-funded Maternal and Child Survival Program supports PFP implementation. They are not yet part of national health management information systems (HMIS).

Rwanda: Using the Delivery Register

To capture pre-discharge PFP, a column is manually added (by hand) to the Maternity Register margin. Therefore, there is no need to print registers for this pilot program. Using codes, the provider documents if PFP counseling is done (Y) and outcome:

- Y/code for method accepted (MJ=jadelle, P=pills, etc)
- Y/Refuse
- Y/Plan
- Column remains empty if no counseling was done

Rwanda's modified Delivery Register

RESULTAT DE LA GROSSESSE PREGNANCY OUTCOME		
Resultat de grossesse	Pregnancy outcome	En haut: Lieu de naissance Location of delivery
1. Né vivant 2. Mort-né 3. Avortement	1. Live birth 2. Stillbirth 3. Abortion	F=Facility H=Home En bas: Date
		Y MJ
		Y P
		Y MJ

¹ <http://www.dhsprogram.com/>

² www.pma2020.org/

Kenya: Using the Family Planning Register

Timing of FP initiation is recorded in the “Remarks” column in the Family Planning Register using codes:

- 1 = Immediate Postpartum (<48 hrs)
- 2 = Postpartum (2day-6wk)
- 3 = Extended Postpartum (6wk-1yr)
- 4 = >1yr since birth or No previous birth
- 5 = Post-abortion (<48 hrs)

The total for each timing category is tallied at the bottom of the page in a table. Each facility was given a stamp to create this table at the bottom of each page. Additional copies of the FP Register are kept in Labor & Delivery and/or Postnatal wards to capture PPFp at these points of service.

Kenya’s modified FP Register

Referrals: 3=TO other HF 4=TO CU		REMARKS (include reasons for referral)	
		FP Timing	
AJ		AK	
4	5	TCA 1st/2nd	1
4	2	TCA 1st/2nd	2
4	5	TCA 1st/2nd	3
4	5	TCA 1st/2nd	4

FP Timing (ALL FP methods)	TOTALS
1=Immediate Postpartum <48 hrs	0
2=Postpartum 2day-6wk	01
3=Extended Postpartum 6 wk-1yr	11
4=Post-abortion <48 hrs	1
5=>1yr since birth/No previous birth/ >48hrs post-abortion (Interval)	13

Madagascar: An individual form

An individual form is used to record the timing of PPFp counseling, method (IUD, implant, or other), timing of insertion, and complications at 6 weeks.

Nigeria: A separate register

New registers were developed to capture PPFp. Both registers are kept in the Labor & Delivery ward.

- A PPFp Daily Register is used to record information for each woman receiving PPFp, including details of IUD insertion.
- A PPFp Follow-up Register is used to record type of follow-up (phone or at facility), timing, and findings/complications.

Nigeria’s PPFp Daily Register

Maternal and Child Survival Program (MCSP), Nigeria
POSTPARTUM FAMILY PLANNING REGISTER (DAILY PRE-DISCHARGE)

Hospital Reg. No	Date	Name of Client	Age	Phone No	No. of Living Children	Counseling during (Tick appropriate column)		PPFP counseling provided on (Tick columns done)		PPFP method given to client prior to discharge		Name of Provider who inserted PPIUD or implant	Type of PPIUD insertion (Tick appropriate column)		PPIUD instrument Used	Due date for Follow-Up
						Antenatal Care	Early Labor	Postpartum Period	HTSP	EBF	LAM +EC		Implant (IUD/ IM)	IUD		

Using PPFp data

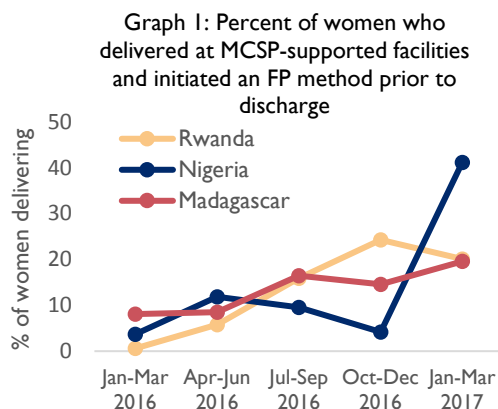
Pre-discharge PPFp uptake – the percentage of women who deliver in a health facility and initiate a modern contraceptive method prior to discharge – can be used to assess PPFp program performance at a macro (national or regional) level. This indicator can be used to identify lagging regions that may need training or leadership support or a need for large-scale efforts to change community perceptions or behaviors on family planning. Disaggregation by method can provide additionally useful information to identify training or commodity needs. This indicator is also useful at an operational level – facility or district – for managing commodities and human resources and identifying training needs. Disaggregation by method can reveal if one method is favored, suggesting a problematic provider bias or gap in competencies. Additional indicators may also be useful at an operational level to assess facility or team performance, especially in the early stages of implementation. For example, tracking the proportion of ANC clients receiving PPFp counseling or the proportion of delivery clients receiving pre-discharge PPFp counseling can identify if a facility is giving clients timely information to encourage healthy birth spacing.

Outcomes can be tracked and may be particularly important for certain methods, such as the proportion of women who received a postpartum IUD or implant that had a follow up visit or the IUD expulsion rate.

Graph 1 shows macro level PPFp coverage among facility births in Rwanda, Madagascar, and Nigeria from January 2016 to March 2017. Graphs 2 and 3 show PPFp uptake by method in Rwanda and Nigeria. Kenya data are not yet available because providers started recording timing of FP initiation late in the MCSP program, concurrent with a training on postpartum IUD insertions. Data will be extracted from registers in late 2017 during assessments in a subset of facilities.

Rwanda

PPFP uptake increased over 15 months to 20% of women delivering. Implants are the most popular method (nearly 50% of all uptake). Few women are recorded as initiating lactational amenorrhea (LAM), although many women exclusively breastfeed in Rwanda. Program staff learned providers hesitate to record LAM since women may not continue exclusive breastfeeding, although other short-acting methods (such as condoms and pills) can also be easily discontinued. Rwanda had a large number of records with an undocumented method, mostly due to not reporting the number of woman accepting oral contraceptive pills. MCSP continues to support improvements in data quality.

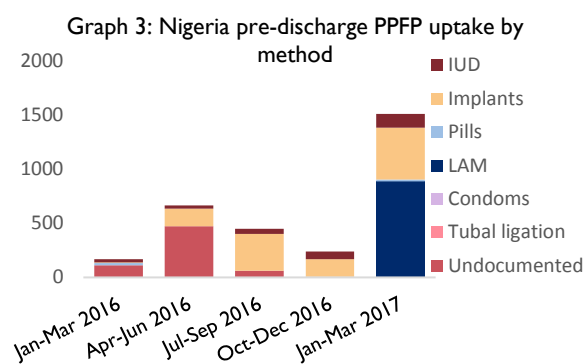
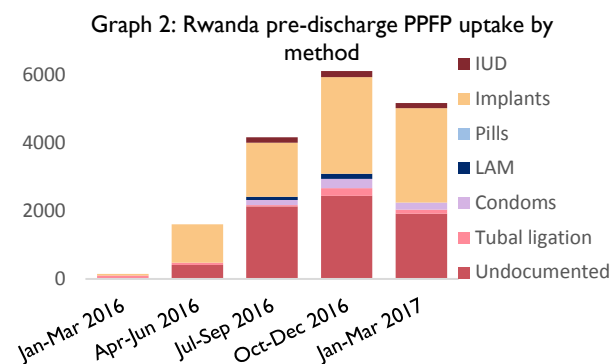


Madagascar

PPFP uptake increased, reaching 20% in the most recent quarter. MCSP-supported facilities use SMS to report data monthly. This platform allows fast reporting of PPFp uptake, but not disaggregation by method.

Nigeria

There were increases in the number of postpartum women choosing implants (from 4 women Jan-Mar 2016 to 479 women Jan-Mar 2017) and IUDs (from 30 Jan-Mar 2016 to 127 women Jan-Mar 2017). However, the spike in early 2017 was mainly due to recording bias, since providers started to capture the number of women choosing LAM in January 2017. LAM was the most popular method, chosen by nearly 60% of all women adopting PPFp Jan-Mar. The dip in Oct-Dec 2016 was likely due to health system disturbances, including a health worker strike in one of the two states where MCSP operates.

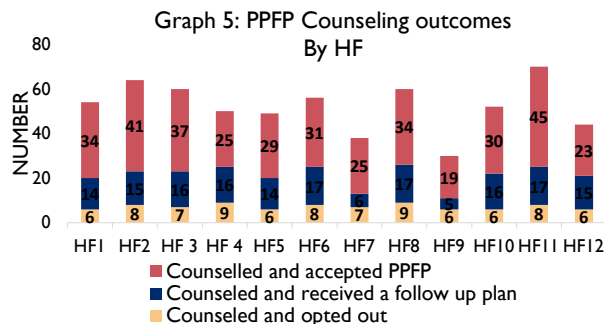
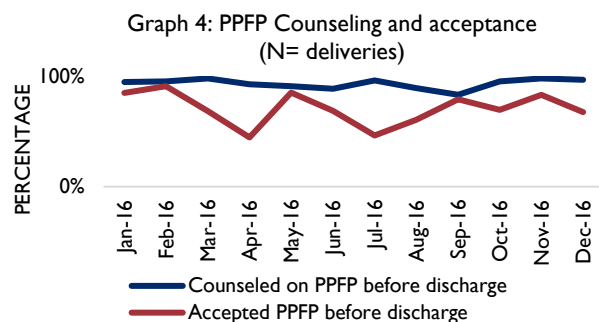


District and facility use of PPFp data

As mentioned, additional data may be used at an operational level to inform program management. **Rwanda** has proposed facility and district dashboards to review PPFp program performance. Dashboards would track:

- Provider skills level (assessed during supervision)
- Commodity stock-outs
- Pre-discharge PPFp counseling and acceptance (mock-up shown in Graph 4)
- PPFp counseling outcomes by month or facility (mock-up shown in Graph 5)

- Pre-discharge PPFPP uptake by method
- Management actions and responsible person



In **Nigeria**, MCSP supported 20 sentinel facilities to form Quality Improvement (QI) teams. Dashboards were tested by the QI teams and will be used to regularly review 16 key indicators of quality of care on the day of birth, including pre-discharge PPFPP counseling and uptake.

Summary

PPFP is critical to reaching the FP2020 goals adopted by 50 countries, so measuring the number of women who receive PPFPP must be incorporated into national registers and reporting systems to track facility or program performance. Collecting pre-discharge PPFPP uptake has shown to be feasible, and a notable proportion of women choose to start a family planning method immediately after delivery, if services are available. Thus coverage of pre-discharge PPFPP is a suitable indicator for national health management information systems.

Changing existing registers is a lengthy process that requires advocating to the MOH, who must balance numerous requests for more data elements without overburdening their records and their health workers. Increasingly, indicators must be tested for feasibility and usefulness, before they can be added to registers. Still, we have demonstrated several ways in which pre-discharge PPFPP can be captured in the interim, without revising and reprinting existing registers. Assessing how well health workers manage these proposed changes can also inform permanent changes to the national HMIS.

Recommended indicator for national HMIS:
Proportion of women delivering at facility who initiate a modern contraceptive method prior to discharge

Rwanda’s solution for recording pre-discharge PPFPP requires minimal documentation burden for providers because they do not need to record the same information (client name, age, etc.) in multiple registers. It is also cost-effective because multiple registers do not need to be printed. However, it has challenges that need to be considered when revising registers and writing new instructions for providers and HMIS personnel: using codes for each method can be difficult to tally, so data quality must be regularly checked. In addition, adding one or two columns to a delivery register does not allow systematic recording of follow up or bad outcomes, such as infections or IUD expulsions.

MCSP will continue to support testing PPFPP indicators and advocate for inclusion into national health management information systems. In addition to facility-based, pre-discharge PPFPP, MCSP is also exploring how to capture PPFPP at other points of contact after a birth and PPFPP referrals given to postpartum women accessing other health services.

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