

Scaling Up Immediate Postpartum Family Planning Services in Rwanda

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Scale-Up of Postpartum Family Planning

Around the world, the first year postpartum has been identified as a crucial time to provide a wide range of contraceptive methods to women, in line with the World Health Organization's (WHO) Medical Eligibility Criteria for Contraceptive Use (MEC). Postpartum family planning (PPFP) addresses the needs of women and couples who wish to delay having children, as well as those who have reached their desired family size and wish to avoid future pregnancies. Provision of PPFP counseling and services to women prior to discharge from the facility after childbirth is a high-impact practice that can: raise awareness about the benefits of birth spacing, orient women and their partners about their contraceptive options and return to fertility, and improve PPFP uptake among the increasing number of women delivering in health facilities.¹ In 2015, unmet need for family planning (FP) in Rwanda was 19% among all women² and even higher for women in the postpartum period.

Since 2015, the US Agency for International Development's (USAID's) flagship Maternal and Child Survival Program (MCSP) has worked with the Government of Rwanda to scale up PPFP implementation in a phased approach. The country's PPFP package is comprehensive: it begins in the antenatal period with counseling at facility- and community-based antenatal care (ANC) visits and includes strategies for offering FP at various points of contact with the woman and her child up to 12 months postpartum. Within this context, strong emphasis is placed on the immediate postpartum period—while women are still in the maternity ward or within the first 48 hours after childbirth—as an opportunity to reach as many women as early as possible. This brief describes how Rwanda's Ministry of Health (MoH) has expanded PPFP, with a focus on the immediate postpartum period, from 4 to ten districts with MCSP support and outlines considerations for the planned scale-up to all 30 districts in the country.

Rollout and Phased Expansion of the Intervention

The rollout and expansion of PPFP services started in 2016 with building the capacity of health care providers at MCSP-supported health facilities, equipping facilities with FP kits, and expanding PPFP coverage to all facilities in the MCSP-supported districts. In Phase I, MCSP introduced PPFP services in four districts (Musanze, Rwamagana, Kamonyi, and Ngoma). At the start of Phase II in 2017, the program expanded support for PPFP to six more districts (Nyabihu, Nyaruguru, Gatsibo, Huye, Nyamagabe, and Nyagatare).



A national trainer demonstrates insertion of an intrauterine contraceptive device.

¹ High Impact Practices in Family Planning (HIPs). 2017. Immediate postpartum family planning: A key component of childbirth care. Washington, DC: USAID. www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning/

² Ministry of Finance and Economic Planning/Rwanda, MoH/Rwanda, and ICF International. 2015. Rwanda Demographic and Health Survey 2014-15. Kigali, Rwanda: National Institute of Statistics of Rwanda, Ministry of Finance and Economic Planning/Rwanda, MoH/Rwanda, and ICF International. www.dhsprogram.com/pubs/pdf/FR316/FR316.pdf

A stakeholders' workshop was conducted in December 2016 to share lessons learned from Phase I districts and to plan for expansion to the additional six districts. Participants developed recommendations that guided PPFp implementation in the Phase II MCSP districts and led to improvements in the Phase I districts. In addition, the workshop included other implementing partners with existing or potential involvement in scaling up PPFp. To date, the United Nations Population Fund (UNFPA), Partners in Health, and the MoH have initiated PPFp interventions in over 20 districts.

Intervention Strategy for Immediate PPFp

The immediate PPFp intervention strategy has three key components: 1) improve counseling during pregnancy, so that a woman's choice can be recorded and verified at delivery; 2) improve providers' skills in providing a wide range of PPFp methods to suit women's individual preferences; and 3) undertake quality improvement efforts through mentorship (**Box 1**). Together, these strategies are designed to increase the number of women receiving PPFp through improved availability and quality of PPFp counseling and service provision (**Figure 1**).

Competency-based training updates providers on the latest version of the WHO MEC, which expanded the number of PPFp methods that can be initiated prior to women's discharge from the maternity ward to include progestin-only pills and contraceptive implants.³ In addition, PPFp training equips providers for insertion of postpartum long-acting and reversible contraceptives, including implants and postpartum intrauterine contraceptive devices (PPIUDs). The technique used in PPIUD insertion after birth is different from that used in interval IUD insertion. The strategy for improving immediate PPFp services focused first on improving health care providers' skills in counseling and service provision. The rationale was that such improvements would, in turn, lead to more women receiving quality counseling and ultimately a PPFp method of their choice.

Box 1. PPFp intervention strategy components

Demand creation

- Group education sessions by community health workers (CHWs)
- Health provider counseling during ANC and in the immediate postpartum period

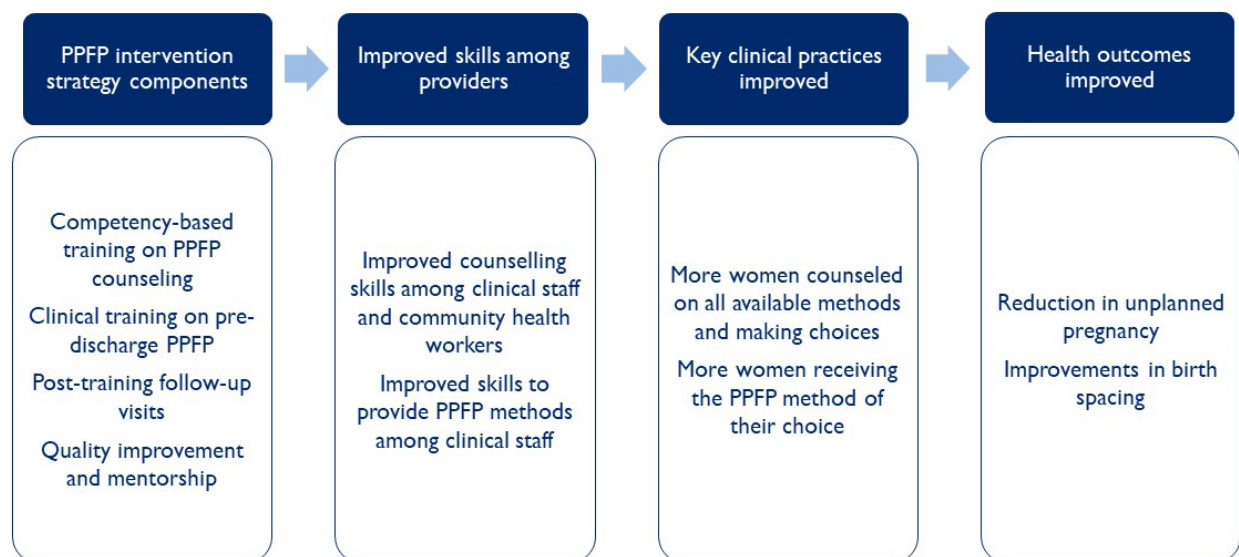
Competency-based training and follow-up

- Train CHWs and health providers on PPFp counseling
- Train nurses and doctors who attend births on how to deliver pre-discharge PPFp methods
 - Initial training (2 days on counseling, 5 days on clinical skills, including practice with anatomic models and practical sessions with patients)
 - 1 month in practice with self-coaching
- Conduct post-training follow-up visits by trainers
- Integrate whole-site orientations during follow-up visits so that all facility staff are aware of PPFp and can contribute to successful service provision

Focused quality improvement/mentorship

- Orient proficient PPFp providers to become district PPFp mentors
- Conduct clinical mentorship visits from district-based mentors to ensure that PPFp skills, knowledge, and attitudes are maintained

Figure 1. Immediate PPFp intervention logic model

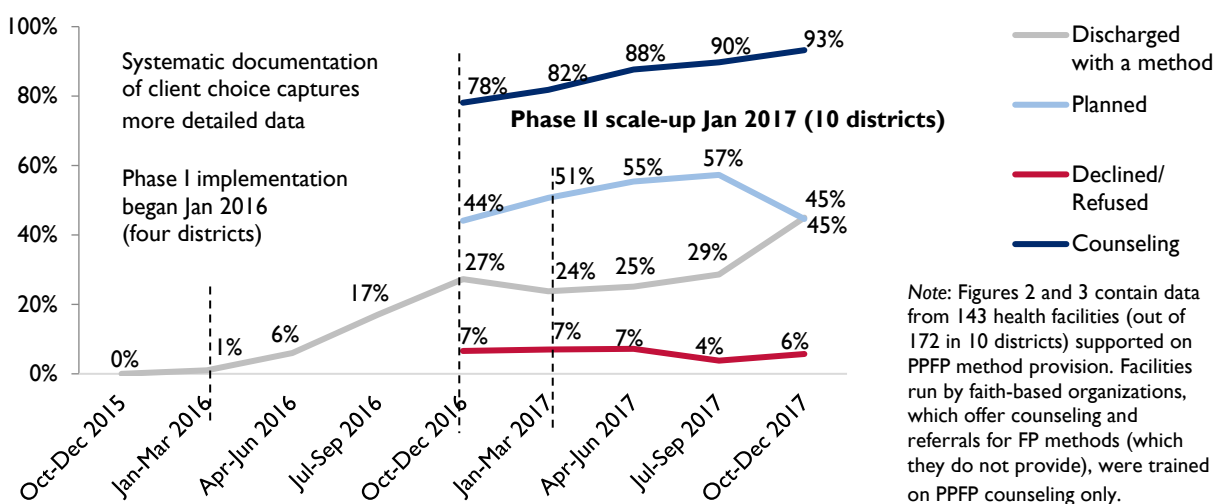


³ WHO. 2015. Medical Eligibility Criteria for Contraceptive Use, 5th ed. Geneva: WHO. www.apps.who.int/iris/bitstream/handle/10665/181468/9789241549158_eng.pdf

Key Results

During 2016–2017, MCSP trained 308 providers on PPFp counseling and 320 providers (including 12 national trainers) on PPFp clinical skills. The integrated strategies of competency-based training for counseling and technical skills, followed by mentorship and quality improvement activities, improved the providers' knowledge and skills. In turn, there has been a rise in rates of PPFp counseling and immediate PPFp uptake in MCSP-supported facilities where providers were trained to offer a full range of PPFp methods (versus facilities run by faith-based organizations, which generally provide PPFp counseling only). Provision of PPFp counseling to pregnant women in the facilities across MCSP-supported districts increased from 78% in October–December 2016 to 93% by the same quarter of 2017. Before the intervention, PPFp uptake prior to discharge was not routinely measured. Since implementation began in January 2016, there has been a marked increase in PPFp uptake before discharge, from less than 1% at the start of the implementation period to 45% by October–December 2017 (Figure 2).

Figure 2. Outcomes of PPFp counseling and proportion of postpartum women who initiated a PPFp method before discharge



Among women discharged with an FP method, a rising proportion are selecting long-acting and permanent methods (Figure 3). The most popular methods used are implants, followed by progesterone-only pills (Figure 4).

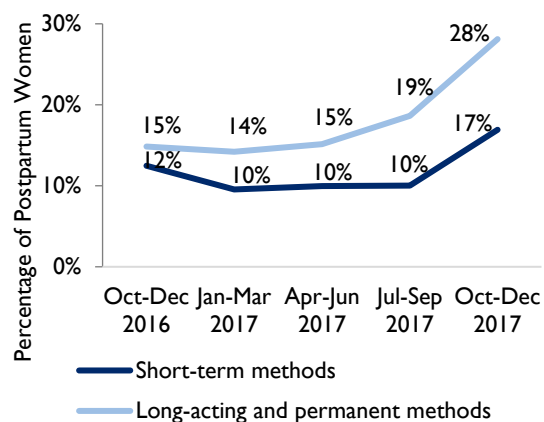
Lessons for Achieving and Sustaining Gains

During stakeholder workshops, several key themes emerged as lessons learned during implementation to inform PPFp interventions and sustainable national scale-up. Selected themes/lessons are described below.

Increase community awareness and demand for PPFp

To increase demand for PPFp, information on the benefits of healthy timing and spacing of pregnancy should be shared with communities. Actions must be taken at the household, community, and facility levels to maximize the likelihood that couples are aware of all their FP options.

Figure 3. Pre-discharge uptake of short-term methods vs. long-acting and permanent methods



Source: MCSP/Rwanda program data (complementary reports).

Community health workers can play a vital role in sensitizing communities. In addition, couples communication and male engagement in FP decisions should be encouraged, especially during ANC visits and when choosing a method.

Improve quality of PPFp counseling and services

For providers to successfully counsel pregnant and postpartum women on their PPFp options, sufficient time and privacy during counseling must be ensured at the facility. The approach is most effective when staff working in ANC, maternity, and postnatal care services all have adequate PPFp counseling skills and providers who attend births are trained on and able to offer all PPFp methods.

Support quality improvement and mentorship

Mentors and FP focal points serve as role models in their facilities, with mentorship integrated as a routine part of their schedules. Hospital directors and mentors should coordinate mentorship plans with health center managers to avoid disruption of health center activities.

Document, track, and act on PPFp data

Small adjustments to existing registers can enable better documentation of PPFp services. To improve and maintain quality while expanding these services, health care providers at the facility and district levels have used dashboards to visualize and track data on key indicators, including the number of providers trained on PPFp, stockouts of FP commodities, counseling outcomes (client accepts a method, plans to initiate a method later, or refuses FP), and progress on the facility PPFp action plan. In such publicly displayed dashboards, data are presented in a graphical format to show progress and highlight gaps that require corrective actions, which are then regularly reviewed and analyzed by staff.

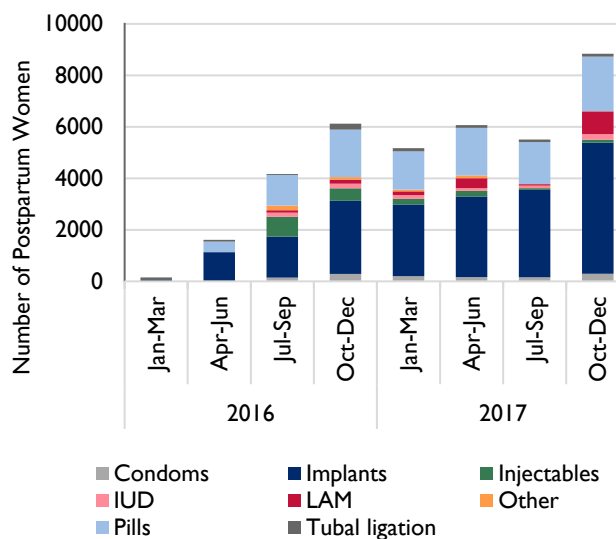
Identify leaders and managers at all levels to prioritize the intervention

Having updated, key data available is only effective when decision-makers regularly review and use it. During scale-up from Phase I to Phase II and throughout the quality improvement process, focal people were identified and appointed at the facility and district levels to routinely monitor the intervention's progress. At the national level, it is important to identify a team to prioritize, manage, and lead the scale-up process. In Rwanda, the MoH leads the PPFp scale-up sub-committee of the FP technical working group, which brings together members from key partner organizations and identifies needs for assistance to districts.

Be flexible in planning and use lessons learned to inform scale-up efforts

As the MoH was preparing to expand PPFp from four to 10 districts with MCSP assistance, they convened a stakeholder workshop in December 2016 with participants from all 10 districts. Phase I districts presented their results, innovations, and challenges, and all participants developed action plans for implementation and scale-up. To maintain progress, the MoH, in collaboration with MCSP, convened the first semi-annual experience-sharing workshop in September 2017 to understand, implement, and sustain PPFp services in MCSP-supported districts, as well as those supported by other partners and the MoH. This bottom-up approach put the providers and managers who were closest to the process at the center of the effort to effectively scale-up services. Experience-sharing sessions allowed participants to learn from one another, share what worked and what did not work for them, avoid duplication of efforts, and discuss strategies to address common implementation challenges.

Figure 4. Pre-discharge PPFp uptake by method



Source: MCSP/Rwanda program data (complementary reports); LAM = lactational amenorrhea method

Conclusion

The Government of Rwanda is committed to scaling up PPFp to all 30 districts by 2020, a commitment reaffirmed at the 2017 Family Planning Summit in London. The MoH has succeeded in scaling up immediate PPFp and is on track to meet its ambitious vision of nationwide coverage by encouraging coordination and experience sharing among implementing partners and donors, embracing the use of data dashboards to monitor and maintain progress, and using a flexible planning process. As PPFp counseling and services become more widely available in Rwanda, this high-impact practice can empower women and couples during a critical period in their lives, support them in averting unplanned pregnancies and establishing healthy birth spacing, and reduce maternal and child morbidity and mortality throughout the country.

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