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Maternal and Child Survival Program

SSQH SERVICES DE SANTÉ DE QUALITÉ POUR HAITI

SSQH Program Brief
Family Planning

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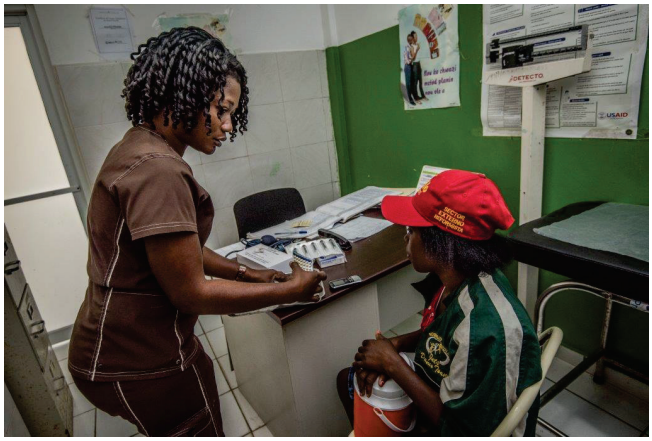
Goal

The USAID Maternal and Child Survival Program (MCSP)'s Services de Santé de Qualité pour Haiti (SSQH) project is working in close conjunction with the Ministry of Health (*Ministère de la Santé Publique et de la Population* or MSPP) and all 10 of the country's health departments (*Direction Départementale de la Santé* or DDS) with the overarching goal of facilitating a sustainable health system. SSQH provides technical, financial, and material support to the DDSs and 164 MSPP- and non-governmental organization (NGO)-supported sites to strengthen health provider capacity, increase utilization of health services, improve the quality of health services and referral networks, develop managerial capacity, and support the formulation and implementation of national and departmental health policies.



A nurse at Marmelade Health Center counsels a woman on FP methods, showing her combined oral contraceptives as one of her options. Photo credit: Karen Kasmauski/SSQH

SSQH's family planning (FP) component addresses significant challenges in Haiti. The country's contraceptive prevalence rate (CPR), or the percentage of women using modern methods of FP, is 31%, and unmet need (women who do not want to get pregnant but are not using an FP method) is estimated at 35%. The total fertility rate in Haiti is estimated at 3.5 children per woman, with 20% of women expressing a desire to limit their number of children.[1]

SSQH addresses Haiti's FP needs by working toward two primary objectives. First, the project has ensured that all 166 SSQH-supported sites that provide FP services are compliant with the United States Government (USG) Abortion and Family Planning Regulations, which includes voluntary uptake of FP services based on full and comprehensible information, without incentives, targets, or coercion. Second, SSQH supports improving knowledge among women, men, and youth about FP options, as well as increasing access and use of FP methods, especially long-acting and reversible contraception (LARCs, typically referring to implants and intrauterine devices [IUDs]) and permanent methods (PMs, typically referring to vasectomies and tubal ligations).

Program Approaches

- **Providing FP training for healthcare providers:** SSQH provides FP training with a focus on LARCs to health facility staff, mobile clinic staff, and community health workers (*Agents de Santé Communautaire Polyvalents* or ASCPs). The program works closely with MSPP staff to organize and deliver this training through three National Training Centers and in health facilities using the MSPP-validated FP curriculum.

- **Organizing mobile clinics to serve hard-to-reach communities:** SSQH works with the DDSs to organize mobile clinics in communities located in remote areas. Two weeks before the clinics, community mobilization campaigns (using ASCPs, announcement trucks, and messages from local leaders) begin to inform the public about available FP services and how to

[1] DHS. 2012.

access them by registering at the clinic. On the first day of the mobile clinic, the visiting staff provide refresher training on FP methods to the local health center staff. Then mobile clinic and health center staff work together to deliver services. SSQH has established mobile clinics in five departments (Northeast, Nippes, Grand'Anse, Center, and Artibonite)

- **Supporting supply delivery in health facilities:** SSQH provides technical assistance (including training and supportive supervision) and supplies needed to offer high-quality FP services and manage FP commodities in all 166 SSQH-supported sites. The program also helps ensure that commodities reports are submitted to the USAID-funded Procurement and Supply Management (PSM) Project and that contraceptives and medicines are replenished in a regular and timely manner. In addition, as needed, SSQH supports health facilities to shift these contraceptives and medicines between locations, and the program provides training on supply and logistics management so that FP personnel can accurately assess stock, both in the health facilities and in their catchment areas, and report on commodities use and needs.
- **Supporting the introduction of postpartum family planning (PPFP) services:** SSQH, in partnership with the MSPP Department of Family Health and the Centers for Disease Control and Prevention (CDC), initiated the expansion of existing FP guidelines to include PPFP. PPFP prevents unintended and closely-spaced pregnancies for the first 12 months that follow childbirth.[2] The policies have not yet been finalized, but SSQH began offering PPFP in supported facilities at the end of December 2016. Initially, clients resisted PPFP services based on the perception that FP methods might negatively impact breastfeeding and child development. However, SSQH reduced this stigma by raising community awareness through community mobilization efforts (e.g. social and behavior change communication [SBCC] sessions, community meetings, and training ASCPs to inform community members about the benefits of FP methods and to reduce misinformation about FP).
- **Promoting community awareness to create demand for FP services:** SSQH staff who are embedded in all 10 DDSs work with ASCPs and their supervisors to organize home visits and educational talks to inform couples and communities on the benefits of healthy timing and spacing of pregnancies, share information on contraceptive methods available and how to access them, and address rumors and other concerns expressed by clients. These conversations also raise awareness about the Zika virus and how to prevent transmission, especially to unborn fetuses.
- **Increasing access to reproductive health services for youth aged 15-25 years:** SSQH works with *Fondation Pour La Santé Reproductrice et L'Education Familiale* (FOSREF), an SSQH sub-grantee, to evaluate and train providers in sites recognized as youth-friendly. This strategy aims to increase health-seeking behaviors among adolescents who are at high risk of unintended pregnancy and includes conducting focus groups with youth, training site staff on reducing stigmatization against youth and their health needs, and recruiting peer educators to promote health-seeking behaviors.

Key Results and Findings

Results

- **Provided a full range of FP methods at all 166 SSQH-supported sites:** SSQH-supported sites provided a total of 419,288 couple years of protection (CYP) between October 2016 and September 2017 through various FP methods and by counselling and referring clients for LARCs and PMs. The basic package of FP services is offered at all sites. SSQH worked with 20 NGOs at 36 of these facilities to expand their FP services from offering limited or no LARCs and no PMs to offering at least one LARC at all facilities and PMs at seven facilities.
- **Strengthened the capacity of 17 health centers to offer PPFP and 27 health centers to offer LARCs and PMs:** As of September 2017, SSQH has trained 13 master trainers in LARCs and 58 health facility staff across 19 facilities in postpartum intrauterine device (PPIUD) insertion and provided supportive supervision in those same facilities to improve LARC/PM competencies. SSQH is currently providing onsite support, instrument kits, and management tools to these facilities to ensure they translate training into PPFP uptake, with a focus on LARCs.
- **Certified FP providers in USG Abortion and Family Planning Regulations in all 10 departments:** SSQH requires that all program-supported FP providers receive training and pass an exam to earn their compliance certification. After providers are certified, SSQH shares a set of FP compliance supervision checklists with the sites to support them in monitoring compliance. By April 2017 SSQH had trained all FP providers working at supported facilities across all ten departments, and these providers are now certified. To ensure that new FP providers receive training, SSQH Facility Services Officers (FSOs) monitor staff turnover as part of their monthly visits to facilities and schedule training and certification as needed.

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[2] WHO. 2013. Programming Strategies for Postpartum Family Planning. Geneva: World Health Organization. http://apps.who.int/iris/bitstream/10665/93680/1/9789241506496_eng.pdf

Findings and Lessons Learned

- **Mobile clinics promote demand for services in the community and support health centers in providing FP services.** Demand for mobile clinics has been high, with clients waiting for long periods of time for services. Because the mobile clinics deliver services in coordination with health center staff, the health centers learn more about how to deliver services, see the demand, and realize that many services can be delivered even in low-resources settings.
- **Mobile clinics are most successful when they adapt scheduling to the community's needs.** For example, clinics now prioritize services first to women with small children at home, since those women cannot wait for long periods of time. Clinics are also organized to provide vasectomy services and couples counseling (when both partners are present) in the afternoon because men often work in the early mornings.
- **PPFP counseling is most effective when it addresses fears regarding breastfeeding.** Regular, monthly community sensitization around PPFP and breastfeeding, which serves to decrease taboos and misconceptions around FP, is key to creating demand for PPFP services.

Recommendations

- **Future programs should emphasize PPFP counseling and services.** The postpartum period is an ideal time to counsel women on FP methods, but in Haiti, women are reluctant to use FP services at that time, and providers are not comfortable in counselling women on PPFP. More training, including whole-site orientations at the facility level, are needed to ensure that all staff can provide education, counseling, and sensitization on PPFP, even when providing other health services (e.g., immunizations).
- **Sites need to ensure follow-up communication for inter-facility referrals.** Access to LARCs and PMs is not widespread across facilities; thus, referrals to LARC/PM facilities are key to ensuring that those who seek these services are able to receive them. Referrals between facilities require follow-up, and to achieve this follow-up, ongoing communication, largely via phone, between the referring facility and the referral facility to manage the referral through to completion is essential. This communication displays a sense of ownership and accountability to the community, ensures that records are kept updated, and empowers facilities to follow up with patients based on accurate information. SSQH is currently piloting a Model Referral Network approach in three departments that includes a protocol to address the issue of cross-facility communication. As part of this pilot, SSQH-supported trainings will explain the importance of this communication, and it will be reinforced during supportive supervision visits. SSQH has also provided phones and plans to the providers and community health workers at participating facilities to enable ongoing communication. SSQH will evaluate the effectiveness of the approach and, if successful, work with the MSPP to roll it out across the country.
- **Future programs, in conjunction with the MSPP, should continue efforts to increase understanding of and access to FP to reach more people with unmet needs.** To compliment current community-level interventions, continued efforts are needed to sensitize the community, including youth, by increasing community awareness of the FP options available, educating community members to help demystify FP, and engaging men to reduce barriers for women. Future programs should also leverage Zika virus awareness and prevention activities such as media campaigns to raise awareness about the importance of FP in Zika virus prevention (e.g. the use of condoms to protect pregnant women, the provision of FP options for people who choose to delay pregnancy during the Zika virus epidemic). To increase access at the community level, future programs, in conjunction with facilities and the DDSs' leadership, should increase the frequency and spread of community-level activities or provide transport stipends to support those wishing to access services in facilities. At the facility level, informational materials should be made available and be complemented by regular SBCC sessions, and more facilities should receive training and take the steps necessary to become youth friendly. At the national level, an FP ambassador should be appointed to raise the profile of the population's unmet needs and help promote and inform decision-making around FP services and policies.
- **Future programs need to ensure the appropriate supply of consumables for FP to satisfy unmet need for LARCS and PMs.** While the different commodities for FP methods themselves (i.e. IUDs, Depo-Provera injections, etc.) are provided to facilities free of charge, the consumables (i.e., gloves, cotton buds, lidocaine, etc.) needed to administer these methods are not. Consequently, clients who wish to access these options must pay for the consumables. In general, the cost of short-term methods is therefore more affordable, so women opt for them instead. To address this issue, either a third-party supply needs to be established or, ideally, future programs may consider assisting the DDSs in analyzing their budgets to determine whether more funds can be allocated for this purpose.