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TECHNICAL REPORT

Using Collaborative Improvement to Enhance Postpartum Family Planning in Niger

MAY 2016

This report on Using Collaborative Improvement to Enhance Postpartum Family Planning in Niger was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Maina Boucar, Djibrina Sabou, Zakari Saley of URC and Kathleen Hill of Jhpiego. The work was implemented under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is made possible by the generous support of the American people through USAID.

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DISCLAIMER

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For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

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Acronyms

ANC	Antenatal care
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
FP	Family planning
HTSP	Healthy timing and spacing of pregnancy
HCI	USAID Health Care Improvement Project
IUD	Intrauterine device
MNCH	Maternal, newborn, and child health
MOPH	Ministry of Public Health
NGO	Non-governmental organization
PPFP	Postpartum family planning
QI	Quality improvement
URC	University Research Co., LLC
USAID	United States Agency for International Department
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

Family planning (FP) is known to be one of the highest impact interventions for reducing maternal and child mortality. However, unmet demand for family planning services remains high in many countries, resulting in a failure to achieve healthy timing and spacing of pregnancies (HTSP) and indirectly contributing to high rates of maternal and child mortality.

From June 2013 to March 2015, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project worked with the Ministry of Public Health in Niger to promote HTSP via improved integration of FP counseling and services into routine public and private sector maternal and child health (MNCH) services in 16 facilities in two urban and one rural district. Baseline data collected in June-July 2013 from 28 facilities demonstrated significant gaps in the quality of postpartum FP services, including: weak counseling and knowledge about HTSP; lack of choice of FP method; low availability of long-acting reversible contraceptives; low integration of FP into key maternal and child health services; poor commodity availability related to weak procurement and supply chain management; low provider competency and confidence; and a lack of community interventions targeted towards male partner and husbands.

By working with 16 quality improvement (QI) teams (including teams in two hospitals and 14 health centers), ASSIST promoted client-centered FP services to improve client choice and adherence with selected FP methods of choice. The intervention also contributed to the reduction of unmet FP need and achieving healthy timing and spacing of pregnancies.

Results

USAID ASSIST-supported sites increased the proportion of women who received FP counseling as part of routine postpartum care from 9% in December 2013 to 86% in August 2014. The 16 facilities also made gains in increasing the percentage of postpartum women discharged with a modern FP method of choice (from 0% in December 2013 to 31% in August 2014) and in increasing the percentage of couples counseled for FP (from 0% in December 2013 to 9.4% in August 2014). Progress was more gradual for method provision and couple counseling due to system constraints identified in the baseline assessment, including lack of FP commodities and lack of provider skills and motivation.

Conclusions and Recommendations

The intervention yielded sizeable gains in PFP counseling and services in a short period of time. Implementation of improvement activities required innovative changes toward providers, clients, and couples. Gender considerations also influenced client and provider expectations of PFP services. The work highlighted the need to develop an explicit government policy on PFP and demonstrated the feasibility and value of integrating FP into routine postpartum care with women and couples, tackling cultural barriers, and raising awareness among providers on missed opportunities to address PFP.

Moving forward, we recommend that the Ministry of Public Health integrate PFP as a local and national priority in relevant documents and plan the scale-up of best practices within target districts and target regions. There is a need to bring together clients, providers, and managers to define and test changes to PFP care processes and to develop simple mixed method approaches to evaluate services, including qualitative measures that regularly capture client experience, expectations, and priorities. Lastly, improving PFP services requires understanding and addressing equity and gender challenges that clients face in accessing PFP services.

I. INTRODUCTION

Niger's high population growth rate remains an obstacle to development efforts. The persistent disparity between high population growth and weak economic growth contributes to the deterioration of living conditions of households in the country (Niger DHS, 2012). Niger's population could reach 55 million by 2050 (PRB, 2011), which would make it the second most populous country in West Africa after Nigeria (Government of Niger, 2006).

Women in Niger have one of the highest fertility rates in the world, with an average of 7.6 children during their lifetime (INS and Macro International, 2012). Contraceptive prevalence has increased slightly from 5% in 2006 to 8% in 2012. Overall, only 14% of married women currently use contraception: 12% use a modern method, and 2% a traditional method. Nearly one in six (16%) married women want to space or limit future births but are not using family planning (FP) (Niger DHS, 2012). Among current users of FP, 60% use the pill, 30% use injectables, and only 8% use long-acting methods such as an implant or intrauterine device (IUD). According to the Ministry of Public Health (MOPH), 6% of Nigerien women report using a traditional method of FP (Niger MOPH, 2011).

Family planning is an essential component of health care provided during the antenatal and postpartum periods that can prevent maternal and child care complications and reduce premature mortality. Postpartum family planning (PPFP), which aims to prevent the high risk of unintended and closely spaced pregnancies during the first year following childbirth, is one of the highest impact interventions to reduce risk of premature birth, low birth weight, fetal and neonatal death, and adverse maternal health outcomes (Niger MOPH, 2011).

Since 2006, FP service delivery in Niger has gained significant advancement. The main gains that have been made include:

- Legislative reforms about FP have passed, ensuring the right of all individuals of reproductive age, regardless of age, to use FP services;
- Better availability and choice of FP products in facilities at all levels of the health system;
- Increased political commitment to promoting FP as a central aspect of the National Health Development Plan 2011-2015 (Niger MOPH, 2011).

However, despite a favorable political environment for FP activities in Niger, many constraints related to demand, access, and use of high-quality FP services still exist. In a survey conducted by the Niger MOPH in 2010, 51% of providers reported they did not feel qualified to provide FP services, and 71% of health facilities' managers reported that they felt unable to provide FP services in their facilities due to insufficient training, skills, and knowledge and unavailability of FP products. Twenty-seven percent (27%) of clients surveyed said they had not received counseling on which FP methods were available. Despite the general availability of short-term methods in most health centers, the 2010 survey demonstrated that availability of long-acting methods was lower, with only 20% of primary health centers reporting having IUDs and 25% having implants (Niger MOPH, 2011). Given the gaps in FP knowledge among providers, the lack of methods available, and weak integration of FP services, there is a great need for improved PPFP services and counseling in the country.

From June 2013 to March 2015, the Applying Science to Strengthen and Improve Systems (ASSIST) Project of the United States Agency for International Development (USAID) Office of Health Systems, in close collaboration with the Niger MOPH, managers and front-line providers, implemented an improvement collaborative to enhance PPFP services in Niger.

The collaborative consisted of 16 facilities (two hospitals and 14 health centers) in three districts to promote healthy timing and spacing of pregnancy (HTSP) via improved integration of FP counseling and services into routine public and private sector MNCH services. This report describes the intervention and results obtained during the implementation of the improvement collaborative.

II. INTERVENTION TO IMPROVE PFP

In 2013, ASSIST began working in collaboration with the Niger MOPH to apply improvement approaches to strengthen postpartum FP services in 16 primary and secondary maternities in three districts (two urban districts in Niamey, the capital city, and one rural district, Birnin Konni, in the Tahoua Region). One of the main objectives of Office of Health System-funded work is to contribute to USAID's goals of Ending Preventable Child and Maternal Deaths and to build learning that can be applied in other settings and USAID priority countries to help governments, implementing partners, and other stakeholders to strengthen client-centered, effective, and safe postpartum FP counseling and services.

To implement this improvement intervention, ASSIST, together with the MOPH, carried out the following activities:

A. Set Up an Enabling Environment for Partnership

As part of the PFP collaborative improvement work in Niger and based on a consensual work plan between ASSIST and the MOPH, ASSIST focused on:

- Working with reproductive health and FP experts from the MOPH to adapt and update the PFP standards. Based on these reviews, several documents were developed: baseline assessment protocol and tools; provisional aims and indicators; plans for training/refresher training; learning sessions; coaches' meetings; and coaching visits.
- Working with the MOPH at the central, regional, district, and facility levels to use local expertise, create ownership, build capacity, and work on institutionalization of PFP improvement efforts. Specifically, ASSIST worked with the National Directorate of Maternal and Child Health, the Regional Directorate of Public Health, and at the district level, the District Health Management Teams (DHMT), and the facility-based providers.
- Focusing on ongoing PFP interventions by other USAID implementing partners in target districts to better coordinate efforts.

B. Conducted Baseline Assessment

1. Methodology

From June-July 2013, ASSIST conducted a baseline assessment of the quality of PFP services in 28 health facilities in the three selected health districts. The specific objectives of the baseline assessment were to:

- Measure health care workers' levels of adherence to standards in the delivery of PFP
- Assess clients' level of knowledge on PFP
- Assess beliefs among clients on benefits related to PFP
- Measure the availability of commodities, resources, and materials needed to implement PFP services
- Collect MOPH routine statistical data available about PFP at the facility level

The health facilities consisted of one Regional Hospital (CHR), one district hospital, three private clinics, and 23 peripheral facilities. (**Appendix I** provides the list of health facilities, the methodology of the assessment, sampling, exclusion/inclusion criteria, and data collection.) MOPH assessors trained by ASSIST carried out the assessment, observing 292 FP client and provider interactions during PFP service delivery (immediate postpartum at discharge, six weeks' postpartum checkup, and during child growth monitoring). Assessors also conducted 283 exit interviews.

2. Findings

The baseline assessment demonstrated significant gaps in the quality of postpartum FP services. The main findings are outlined below; detailed findings are presented in **Appendix II**.

Summary of quality gaps in PFP service delivery

- **Greeting and welcoming – a crucial step for any FP clinical consultation – was lacking.** Only 61% of providers greeted their clients appropriately. Moreover, while all facilities offered FP services, only 57% of them provided a space for FP where quality care could be provided.
- **There was inadequate quality and effectiveness of provider counseling.** For example, few providers asked clients about birth spacing (3%), whether they used FP methods (47%), or partners' understanding of FP (6%) or talked to them about the benefits of HTSP (27%) or whether a chosen method provided protection against HIV/AIDS or sexually transmitted infections (4%). Only 69% gave instructions for using FP methods, and even fewer discussed the effectiveness of the selected FP method (33%) or side effects (25%) with their clients.
- **Provider medical assessments were not conducted according to standards.** Only 62% of providers took their client's height and weight.
- **Few providers recommended long-lasting contraceptive methods to their clients.** Most providers recommend pills (69%), with fewer recommending long-lasting modern methods, such as injectables (25%), intrauterine devices (IUDs) (5%), and implants (1%).
- **Most service providers advised to use FP 40 days after delivery,** not taking into consideration that the FP planning needs of postpartum women during the 12-month period after birth will differ according to breastfeeding patterns, resumption of sexual activity, return of menses, and return to fertility.
- **While almost all women (96%) knew where to get contraceptives, places did not always provide quality products** (e.g., street vendors, girlfriends).
- **Few (37%) women were aware of side effects of their chosen method of contraception.** Most (80%) wanted to have more information on FP.

Quality gaps linked to the health care system

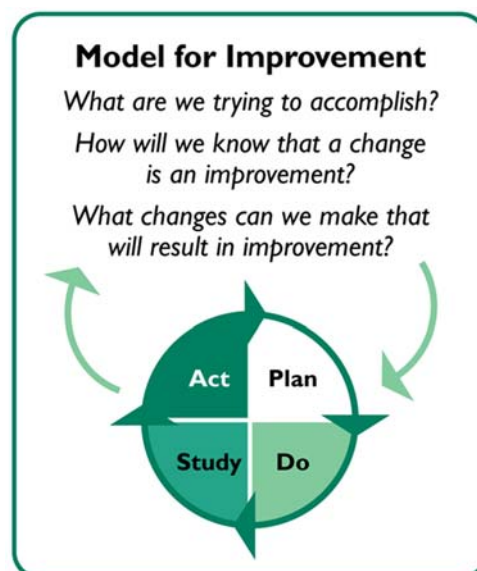
- **Essential supplies were missing in some health facilities** (e.g., FP picture box, insert case, IUDs withdrawal, and implants).
- **There was a gap in availability and storage of modern contraceptives at health facilities.** Only 61% of the health facilities had contraceptive commodities available. Storage for products was adequate in 79% of facilities.
- **Stock-out of essential FP materials and equipment was experienced by most (68%) sites.**
- **Health worker training on FP was lacking.** Only 36% of health workers were trained in contraception, and only 25% on FP logistic management.
- **Existing supervisory visits were found not to be observation-based.**

C. Designed the Improvement Effort

The quality improvement intervention for PFP in health centers in Niger was based on the Model for Improvement, which poses three questions: i) What are we trying to accomplish? ii) How will we know that a change is an improvement? and iii) What changes will result in improvement?

The model involves several steps, including setting improvement aims, developing indicators to measure outcomes, and testing ideas by facility-based quality improvement (QI) teams to find out the most suitable change to yield improvement. Given the quality gaps identified in the baseline assessment (listed in **Appendix II**), the following aims were developed in collaboration with the MOPH group of experts:

1. Improve women's informed choice of preferred FP method by improving quality of PFP counseling and provider-client interaction;
2. Increase the percentage of postpartum women discharged with their FP method of choice by integrating FP services into routine immediate and extended postpartum care;
3. Increase couple involvement in FP counseling to increase uptake, sustain adherence, and improve couple satisfaction with FP services;
4. Improve safety of FP services by improving adherence with FP method medical eligibility criteria.



Model courtesy of Associates in Process Improvement

Table 1 lists the indicators that were developed by ASSIST and the MOPH for each improvement aim.

Table 1: Aims and indicators for the PFP improvement intervention in Niger

What are we trying to accomplish?	How will we know that a change is an improvement?
<i>Aims</i>	<i>Indicators</i>
1. Improve the informed choice of women and the selection of the preferred method by improving the quality of PFP counseling and provider-customer interaction	% of women who received immediate PFP counseling before discharge
2. Increase the percentage of women receiving a modern FP method of their choice through the integration of FP services into routine postpartum care	% of postpartum women who have chosen a modern FP method before release
	% of women in the immediate postpartum period who left with a modern FP method of their choice
3. Increase the involvement of couples in FP counseling to increase utilization, adherence, and satisfaction of couples with FP services	% of couples in the immediate postpartum period who received FP counseling before discharge
	% of postpartum follow-up visits (0-12 months) during which couples were counseled on modern FP methods
4. Improve the safety of FP services by improving adherence to medical eligibility criteria for FP methods	% of new clients registered in PFP (0-12 months) for which the medical eligibility criteria have been met

For all these indicators, a monitoring plan (**Appendix III**) was developed and explained to the QI teams. The monitoring plan specifies for each indicator the numerator and denominator, the sources of data collection, frequency of data collection, and the person in charge of the collection. FP activities'

documentation forms that already existed in the field (records, registers, notebooks, etc.) were considered or adapted as data collection sources.

D. Carried out the Improvement Effort

All 16 target sites had QI teams set up by the MOPH, which consisted of 6 to 10 members including physicians, midwives, nurses, social workers, traditional birth attendants, and community representatives. Members came from all points of services which PFP women use (e.g., child growth monitoring visits, curative care, immunization, antenatal care, and/or maternity services).

Quality improvement teams at each target site spent most of their time and efforts on continuously identifying and testing ideas to answer the question “What changes will result in improvement?” But for many challenges, they realized that in order to produce different results, changes at a system level were required.

As part of the PFP intervention in Niger, ASSIST in partnership with the MOPH experts in FP, MNCH, and clinicians, drafted a change package (**Appendix IV**). The package was launched in January 2014 and was implemented until the project ended in March 2015. It provided QI teams the first steps to begin their improvement work. QI teams used these change ideas to identify and test the specific changes they implemented in their sites.

To support the site-level QI teams, ASSIST supported regional and district managers to develop an action plan (**Appendix V**). The plan outlines activities to be carried out by the managers to support the QI teams’ improvement work, such as testing an idea, collecting and analyzing data, and documenting a best practice.

These managers provided support for improvement by conducting coaching visits on a quarterly basis and organizing three learning sessions as well as on-site training. **Table 2** summarizes the main improvement changes per improvement aim that were implemented by most of the QI teams. Aim 4 on “improving the safety of FP services by improving adherence to medical eligibility criteria for FP methods” was not implemented due to the sudden end of the project and lack of funding.

Table 2: Summary of changes implemented per improvement aim

Improvement aim	Changes implemented
1. Improve women’s informed choice and selection of the preferred method by improving the quality of counseling and FP postpartum provider-customer interaction	<ul style="list-style-type: none"> • Bigger selection of modern FP methods in counseling box • Identification of a room devoted to FP counseling • Establishment of a FP counseling station • Screens set up to ensure privacy
2. Increase the percentage of women receiving a modern FP method of their choice through the integration of FP services into routine FP care	<ul style="list-style-type: none"> • Adaptation of data forms to facilitate data collection • Staff orientation on FP data reporting • Division of FP tasks among providers • Involvement of women in raising awareness among peers • Involvement of doctors in the integration of PFP during consultations • Involvement of staff in other positions at the facility to refer clients to FP services • Counseling pregnant women on PFP services and recording this counseling in their medical records • Raise PFP awareness of neighborhood leaders and health workers • Plan rotation of staff to support counseling sessions • Internal redeployment of staff during busy days to reduce wait time of

Improvement aim	Changes implemented
	FP clients <ul style="list-style-type: none"> • Designate a midwife to monitor FP activities • Update the FP calendar to be available on a 24-hour basis
3. Increase the involvement of couples in FP counseling to increase utilization, adherence, and satisfaction of couples with FP services	<ul style="list-style-type: none"> • Facility providers invite all husbands to attend the discharge of their wife from maternity (advantage in PPFP couple counseling) • Provide FP couple education on the day of maternal discharge • Conduct PPFP awareness sessions in the community to mobilize the involvement of husbands with neighborhood leaders, female community health workers, and local non-governmental organizations (NGOs) • Involvement of NGOs (e.g., Marie Stopes International) in raising awareness

III. RESULTS

A. Improvement in PPFP Quality and Uptake

After health facility improvement teams began improvement activities in January 2014, the ASSIST-supported sites rapidly improved the integration of FP counseling into routine postpartum care for women, from 9% in December 2013 to 86% in August 2014 (**Figure 1**). The 16 facilities also increased the percentage of postpartum women discharged with a modern FP method of choice (0% in December 2013 to 31% in August 2014) and increased the percentage of couples counseled on FP (from 0% in December 2013 to 9.4% in August 2014). Progress was more gradual for method provision and couple counseling due to the system constraints identified in the baseline assessment, including lack of FP commodities and lack of provider skills and motivation.



Family planning group counseling session. Photo by Zakari Saley, URC

Gains by the 16 facilities included an increase in the percentage of:

1. Postpartum women counseled on PPFP methods
2. Postpartum women counseled on PPFP methods and who identified a modern FP method of choice
3. Postpartum women discharged with a modern FP method of choice
4. Couples counseled for FP

The intervention also supported managers and providers to apply improvement approaches to identify and overcome critical system barriers that impede delivery of high-quality PPFP services. For example, improvement teams in the 16 facilities used local data to identify gaps in provider performance and the supply chain and tracked provider performance as they introduced changes such as observation of simulated FP counseling using a simple checklist.

The project demonstrated that even in a severely resource-constrained environment, gains are possible when managers and front-line providers work together to solve local system challenges and make changes to care delivery processes to implement best practices known to reduce preventable child and maternal mortality. One of the key features of an improvement collaborative is producing results in a faster manner and at some scale. Another key feature of such a collaborative is the “change package”, i.e. the tested and implemented changes, considered as best practices that are spread to new sites (see **Appendix IV**). Scaling up will result in higher speed in getting the same or improved performance.

- Examples of changes implemented by facility teams**
- Reinforced essential equipment
 - Created special space for counseling
 - Conducted systematic counseling to all postpartum women
 - Conducted providers’ refresher training on HTSP
 - Provided clear job descriptions to health providers
 - Rotated midwives and assigned one in charge
 - Documented counseling in partogram
 - Provided FP counseling to both mothers and partners before discharge
 - Counseled community leaders in FP and HTSP
 - Used traditional birth attendants as village counselors

Figure 1: Percentage of women counseled for PFPF, selecting a modern FP method, and discharged with a modern FP method of choice, 16 sites, Niamey and Konni districts, Niger (Oct 2013-Aug 2014)

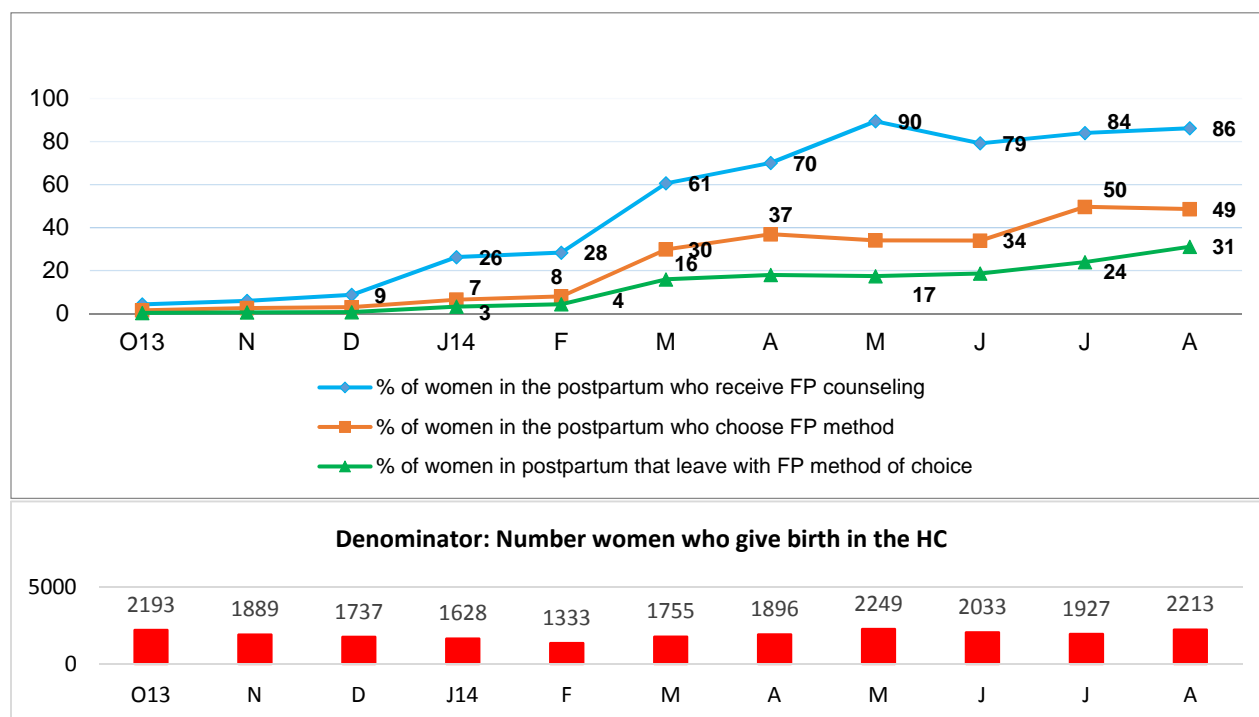
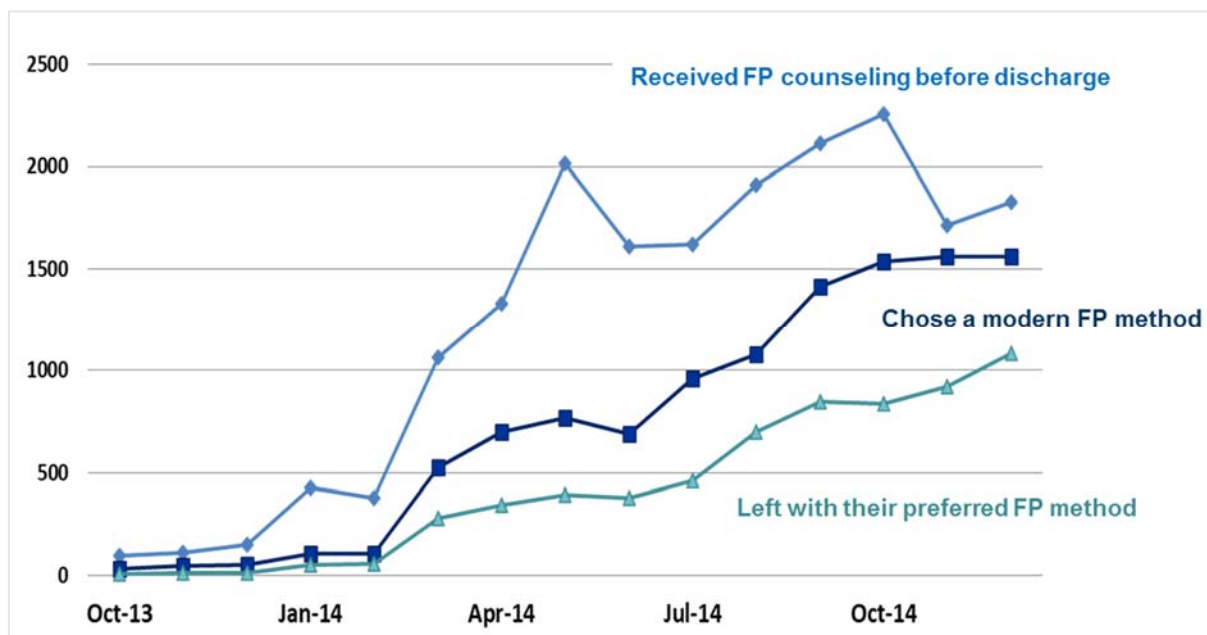


Figure 2 shows the large gains made in providing FP counseling to postpartum women and their acceptance of a modern family planning method. To achieve these results, many changes were implemented, including the following:

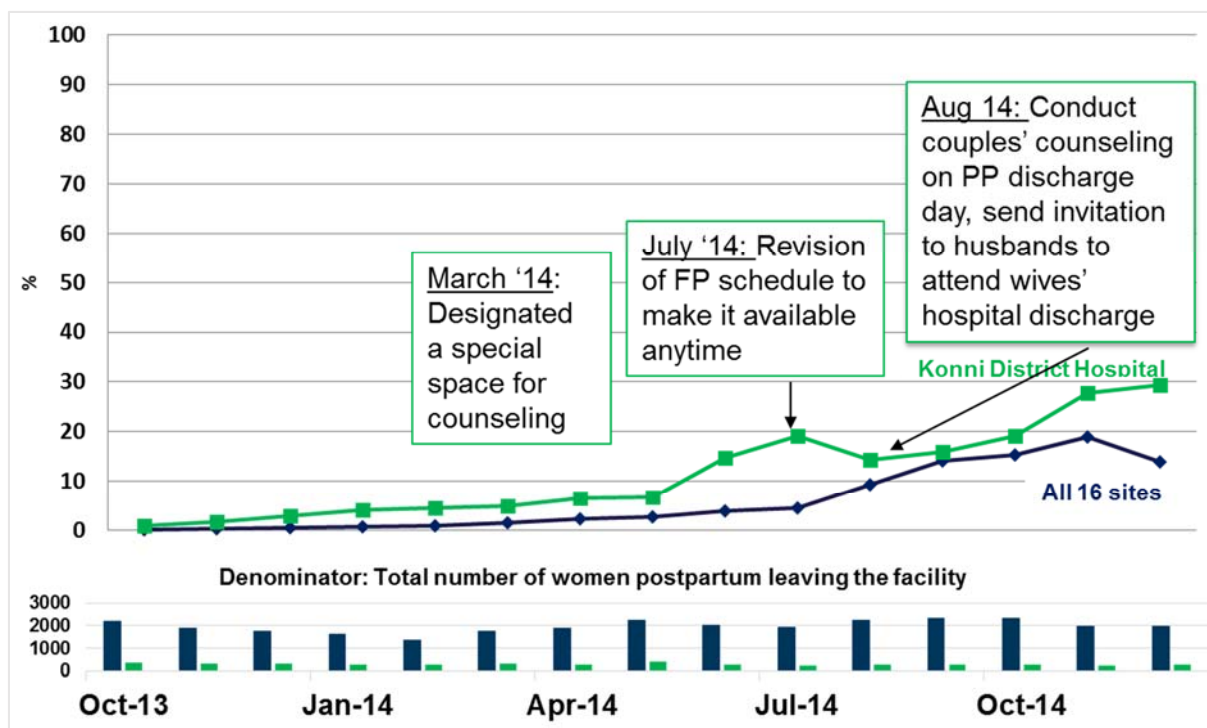
- Reinforcement of essential equipment (requesting and obtaining FP commodities from MOPH)
- Provision of systematic counseling to all postpartum women
- Provision of providers’ refresher training on HTSP
- Documentation of counseling in partogram
- Provision of FP counseling to both mothers and partners before discharge

Figure 2: Number of postpartum women who received FP counseling before exit, chose a modern FP method, and left with their preferred FP method, 16 sites (Oct 2013 – Dec 2014)



Involving husbands in FP issues is a major challenge in Niger because of cultural and traditional barriers. Nevertheless, the Konni District Hospital team tested change ideas and implemented changes resulting in a greater percentage of couples receiving FP counselling before leaving the health care facility than in the other 15 facilities (Figure 3).

Figure 3: Comparison of percentage of women discharged who received FP counselling with husband, 16 sites and in Konni District Hospital (Oct 2013 – Dec 2014)

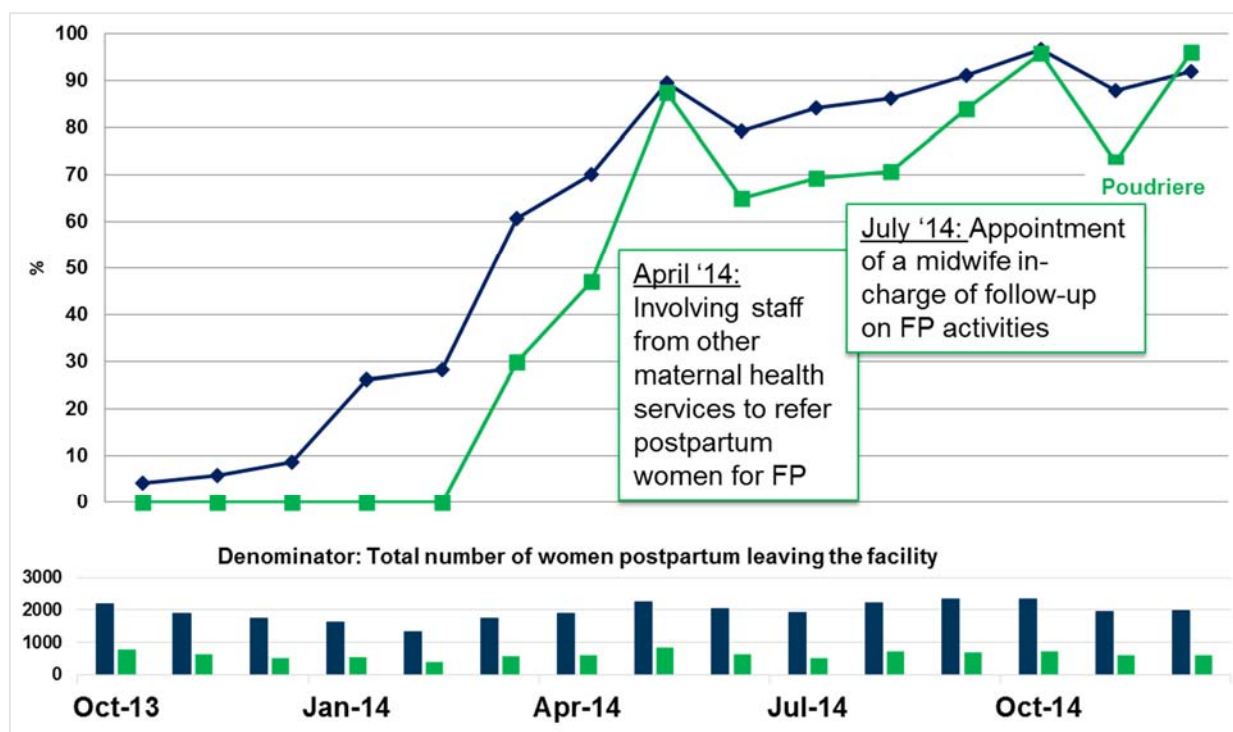


Poudriere Regional Hospital is one of the two main maternity facilities to which many pregnant women from the Niamey and Tillabery regions go. This hospital created a special FP position held by a midwife who also served as a QI team leader several years ago during USAID Health Care Improvement Project predecessor project in Niger. All midwives were part of the QI team.

The QI team in Poudriere made many changes to achieve the FP counselling results shown in **Figure 4**, some of which are as follows:

- Designation of a special space for counseling (Mar 2014)
- Involvement and empowerment of staff from other maternal health services in referring postpartum women for FP (Apr 2014)
- Provision of clear job descriptions to health providers (Apr 2014)
- Rotation of midwives with each taking turns staffing the FP counseling room (Apr 2014)
- Involvement of new delivery room providers in raising awareness and provision of FP services to women (May 2014)
- Revision of the supply chain management system to ensure continuous availability of commodities and thus promote client satisfaction (Jun 2014)
- Prioritization of couples for FP services – that is, in cases where women came with their partners, they were received first even when there were other women waiting to be seen (Jun 2014)
- Appointment of a midwife in-charge of follow-up FP activities (Jul 2014)
- Revision of FP schedule to make it available 24 hours a day instead of mornings only (Jul 2014)
- Daily check of completed charts (Jul 2014)
- Prioritization of FP services at time of discharge for women who received C-sections (Jul 2014)
- Insertion of PP IUD in the delivery and the operating rooms (Jul 2014)

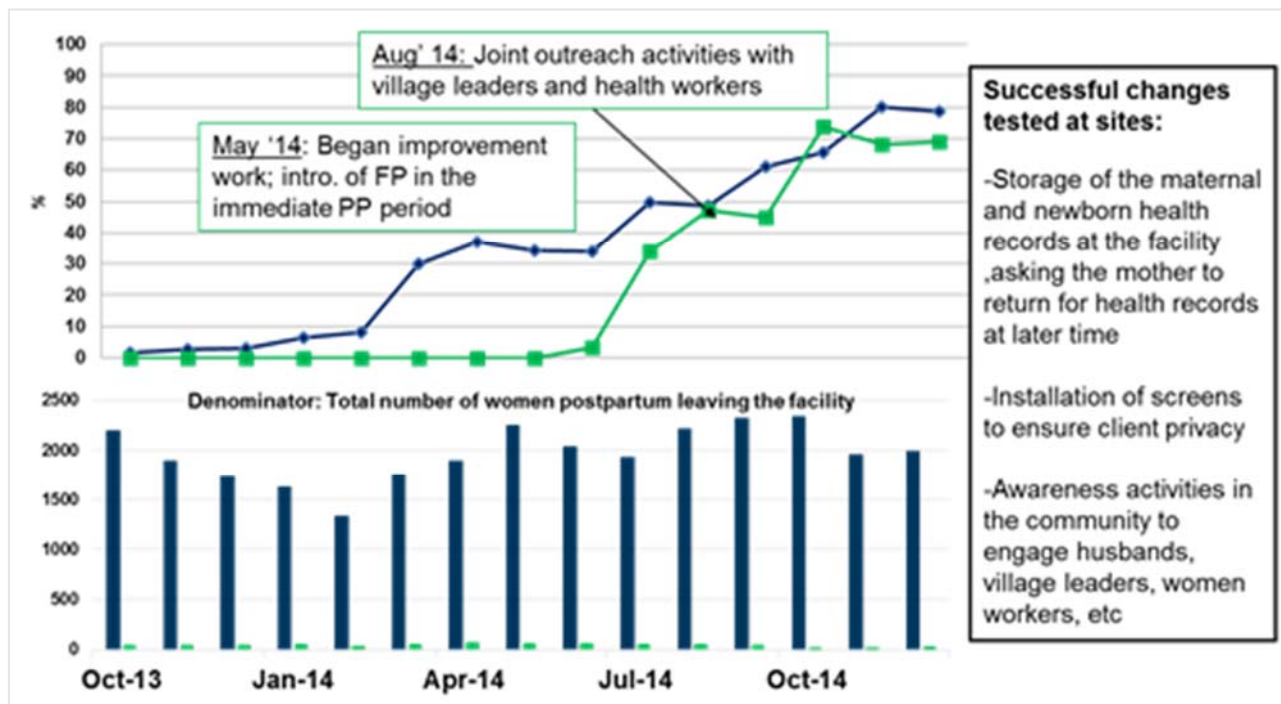
Figure 4: Comparison of percentage of postpartum women who received FP counselling before discharge, 16 sites and Poudriere Regional Hospital in Niamey (Oct 2013 – Dec 2014)



- The midwife in charge in Tsernawa Health Center had some experience in QI from previous work with UR. Tsernawa also had a new medical officer who changed the management, such as addressing provider practices of fraudulent selling of contraceptives (which are normally free-of-charge).

- **Strong and well-targeted messages were necessary to achieve the changes shown in Figure 5, including the following:**
 - Introduction of FP in the immediate postpartum period (May 2014)
 - Installation of screens to ensure client privacy (May 2014)
 - Storage of the maternal and newborn health records at the facility and asking the mother to return to retrieve the records on the 8th day or a day after the newborn's baptism (period after which, per Niger's customs, postpartum women can be seen in public) (Jul 2014)
 - Awareness activities in the community to engage husbands, village leaders, lay women workers, community health committee, and local NGOs (Jul 2014)
 - Joint outreach activities with village leaders and Tsernawa health workers (Aug 2014)

Figure 5: Comparison of percentage of postpartum women who left with their preferred FP method, 16 sites and Tsernawa Health Center (Oct 2013 – Dec 2014)



Gains made during the project demonstrated a valuable impact on PFP in the targeted facilities

During the baseline assessment, a pregnant woman with three children, all close in age, who resides in close proximity to the health care facility in Niamey, stated how she knew all the health providers in the facility and yet, none ever spoke to her about postpartum family planning. During the intervention, she stated: *“This is the first time I am made aware of PFP.”*

In another case, during the intervention, a doctor described how a woman he saw was complaining of always getting pregnant despite taking the pill regularly. He found that she had been using the pills without following the instructions provided on the box.

The baseline data on PFP was made available for nationwide use as the target sites not only represented rural and urban sites, but also effectively captured regional differences in Niger. After the intervention, a critical number of providers and managers developed capacity for improvement and applied it practically to improve PFP in Niger.



All providers know me here, because if it is not Aissa who is sick, It is Issa or Omar or the three children. And no one ever spoke to me about PFPF except you...

Photo taken during baseline assessment of pregnant woman with her two children being questioned about FP. Photo by Sabou Djibrina, URC.

B. Gender Integration

To facilitate the involvement of male partners and increase couples' FP counseling, ASSIST staff worked with health facilities to revise record-keeping tools. New columns were added to previously created recording guidelines, and new record-keeping documents were created to have a designated space to record data on male involvement. Facilities were sensitized on the importance of engaging male partners. Some facilities took additional action to raise awareness of partner involvement among male partners and community members in order to shift attitudes about PFPF and male involvement. Facilities were made aware that the change idea of prioritizing couples for health services was unacceptable because it unfairly disadvantages single women and women whose partners are unable to come to the clinic. ASSIST staff also identified many cultural and gender norms affecting male partner involvement and hindering uptake and utilization of PFPF and FP among women and couples so that interventions could be designed to improve uptake. Norms included stigma against men who attend health care facilities offering FP services and traditional beliefs such as men should not attend childbirth, couples should be abstinent for 40 days postpartum, son preference, and that God will provide for any child conceived. (See **Appendix VI** for further discussion of gender issues identified.)

IV. CONCLUSION

ASSIST helped improve the integration of FP counseling and services into routine postpartum services in 16 facilities (2 hospitals and 14 health centers) in one rural Birnin Konni district and two urban Niamey districts in Niger. The intervention promoted client-centered FP services to improve client choice and adherence with chosen FP methods (e.g., pills, IUD, injectable, condoms) to reduce unmet FP need, achieve healthy timing and spacing of pregnancies, and indirectly contribute to reducing maternal and child mortality.

During the intervention, ASSIST-supported sites rapidly improved the integration of FP counseling into routine postpartum care for women, from 9% in December 2013 to 86% in August 2014. The 16 facilities also made gains in increasing the percentage of postpartum women discharged with a modern FP method of choice and in increasing the percentage of couples counseled for FP. However, progress was more gradual for method provision and couple counseling due to system constraints identified in the baseline assessment, including lack of FP commodities and lack of provider skills and motivation. Due to

shift in funding priorities, the intervention ended in March 2015. We could not assess whether results were sustained. There remains important work to be done, and we hope that the MOPH will strengthen these gains and scale up the intervention to other districts and regions.

V. LESSONS LEARNED AND RECOMMENDATIONS

Many lessons were learned from the intervention. Despite its obvious impact on the national FP program, when the intervention started, PPFp was not part of the national policy or strategy. Both the national and facility levels agreed this had been a missed opportunity for a long time. Because of cultural taboos, conversations about women's health were limited to healthcare provided during pregnancy, post pregnancy, and child health promotion or care. PPFp provides an excellent opportunity for couples counseling. When counseling reaches out to both interests of the couple, cultural barriers can be challenged, and new behaviors are adopted to benefit health and wellness.

The results have shown that through small improvement changes one can obtain significant results in PPFp. In Niger, the environment is very receptive to PPFp: essential FP inputs are in place, providers are aware of this opportunity, Interactions between providers-clients are strengthened and couples are counselled on benefits of birth spacing at this period. The results show that through more improvement changes, one can obtain significant results.

It is also vital to involve community leaders on culturally sensitive topics such as birth spacing, sexual education in order to alleviate misunderstanding and create greater tolerance. It is equally important to come up with a routine intervention process. For example, simply educating health workers about missed opportunities on PPFp is very powerful.

Recommendations:

- Integrate PPFp into local and national priority in relevant documents
- Plan the scale-up of PPFp best practices within target districts and regions
- Involve clients, providers, and managers into defining and testing changes to PPFp care processes
- Develop simple and feasible mixed measurement approaches to improve PPFp service delivery. This includes qualitative measures that regularly capture client experience, expectations, and priorities
- Gain greater understanding of gender issues that influence client and provider expectations of PPFp services

Appendix II: Baseline Assessment Results

Observation of health providers (midwives and nurses) in consultation rooms

- **Reception**
 - Criteria for a good welcoming according to facilities' standards were only respected in 61% of cases (54% in private facilities; 62% in public health facilities)
 - Only 6% of providers introduced themselves to their clients, and only 40% respected clients' privacy
- **Counseling**
 - Only 3% of health providers asked clients about birth spacing
 - Only (47%) of Clients expressing interest in using FP methods to health providers, with only 20% during child growth monitoring and 9% during curative care
 - Only 6% of health providers only asked clients about their partners' understanding of FP
 - Only 27% of providers gave their clients information on the benefits of Healthy and Timely Spacing of Pregnancy (HTSP), and 19% on the risk of pregnancy during the return of fertility too soon after delivery
 - Few providers discussed with women compatible or non-compatible methods with regard to breastfeeding (27% for the pill, 21% for injectable, and 10% for other methods)
 - Few providers involved women in choosing their own FP methods (39%) with 22% in Niamey and 52% in Konni; generally, the choice of method is made by the health providers and consists of pills (69%), injectables (25%), IUD (5%) and implants (1%) and 0% for other (exclusive breastfeeding, spermicides, condoms)
 - Among most (94%) providers, the FP method of choice they offered to their clients was appropriate for PP women; however, only 49% respected the WHO eligibility criteria during their consultation with their client
 - 69% of providers gave instructions on using specific FP methods to their clients (42% in Niamey and 77% in Konni)
 - Only 33% of providers discussed the effectiveness of the selected FP method with only their clients (10% in Niamey and 39% in Konni)
 - Only 25% of providers discussed side effects of the FP method with their clients (0% in Niamey)
 - 4% of providers discussed with their client whether their chosen method provides protection against HIV/AIDS and other sexually transmitted infections (0% in Niamey and to 5% in Konni)
 - Less than one-third (32%) of providers advised women on the use of the health center for postnatal care
- **Medical assessment**
 - 97% of providers asked for the identity of their client; however, only 62% of provider took the weight and height of clients
 - A summary of the results of the medical assessment was made only in 6% of cases (16% in Niamey and 3% in Konni)
 - Most (89%) of providers gave their clients contraceptive products (79% in Niamey and 92% in Konni)
 - 94% of providers set up a follow-up appointment with clients, but only 34% are thanked for waiting and listening to the health provider

- **Communication procedures**

- Only 1% of providers adhered to standard communication procedures
- Only 9% of providers provide written guidance to clients (18% in Niamey and 2% in Konni)

Exit interview with FP clients

Services offered

- 47% of clients were advised on FP during their consultation with a provider

FP-related attitudes and knowledge

- 93% of clients said they would have liked to have another child
- 94% of clients reported wanting to have a child after a gap of two or more years, 5% wanted to have a child with less than a two years' gap
- 96% of women knew that it is best to wait two years or more to have a child in order to achieve healthy birth outcomes
- 94% of women knew that there were risks associated for getting pregnant too early (48% maternal complications, 31% of the child deaths)
- 89% of women were aware of at least one modern FP method (97% in Niamey)
- The most known methods were pills (99.6%), injectables (72%), and implants (29%)
- 96% of clients knew where to get contraceptives; however, the places they mentioned are not always appropriate (street vendors, girlfriends)

Adoption of a FP method by women

- 54% of women chose a method on their first visit (31% in Niamey and 74% in Konni)
- For lactating mothers, health providers advised to use FP methods 40 days after delivery
- Those who had not chosen a method were either already using contraception (52%), planned to decide later (17%), said that FP is not offered by the health provider (15%), wanted to first wait for their husband's opinion (6%), or refused using contraception (2%)
- The benefits of FP were known by 90% of women (85% in Niamey and 92% in Konni)
- 37% of women stated that they were aware of the side effects of their chosen method; however, their knowledge was vague
- More than 80% of women expressed the need for much more thorough information on FP

Quality environment

FP services offered

- 100% of health facilities reported providing FP services
- FP services were provided during growth monitoring (57%), antenatal care (43%), in immediate postpartum care (32%), in curative consultation (32%), and in six-week post-natal visit (29%)
- Services were not available 24/7 in certain health facilities

Supervision and coordination

- 100% of health facilities reported receiving supervisory visits, of which 75% were quarterly
- 96% had received at least one visit by the district management team in the last six months
- 46% of sites organized meetings with providers to discuss FP concerns
- 68% of facilities met the criteria for providing a place for FP (84% in Niamey and 52% in Konni)

- 57% of the sites had a space for FP

Availability of essential FP materials and equipment

- FP equipment and materials were available in 62% of facilities
- Consumables were available in 71% of facilities
- Contraceptive commodities were available in 61% of health care facilities (72% in Niamey and 50% in Konni)
- 79% of health care facilities stored their FP commodities in a standard fashion
- 68% of sites experienced stock-out of essential materials and equipment (36% in Niamey and 86% in Konni)
- The most frequent causes of stock-out were lack of central supplies (53%), quantity received is less than ordered (35%), delay (12%), and underestimation (12%)
- 77% of health care facilities recorded FP data, making documentation available
- 36% of staff were trained in contraception (28% in Niamey and 44% Konni)
- 25% of health care workers were trained in FP logistics management (11% in Niamey and 41% Konni)

Appendix III: Monitoring Plan – QI Team Level

Indicators	Data	Sources	Frequency	Responsible for data collection
1. % of women in immediate postpartum who were counselled on modern FP methods before discharge	N = Number of women who gave birth at the facility and who received PFP counselling before discharge D = Number of women who gave birth at the facility during the given period	Patient charts Counseling registers Partograms	Monthly	QI team
2. % of women in immediate postpartum who were counselled and have accepted a modern FP method	N : Number of women in the postpartum counselled and who accept a modern FP method D : Number of women who gave birth at the facility during the given period	Charts counseling registers FP session forms Partograms Postpartum registers Postpartum consultation forms	Monthly	QI team
3. % of women in immediate postpartum who were counselled and discharged with a provision on modern FP method of their choice	N : Number of women in the postpartum counselled and discharged with a provision of modern FP methods of their choice D : Number of women in the postpartum counselled on modern FP methods	Patient charts Counseling registers FP session forms Partograms Postpartum registers Postpartum consultation forms	Monthly	QI team
4. % of couples counselled on modern FP methods before discharge	N : Number of couples counselled on modern FP methods before discharge D : Number of women who gave birth at the facility	Patient charts Counseling registers FP session forms IEC/behavior change communication session forms Partograms	Monthly	QI team

Appendix IV: Change Package for the Facility (QI Team) Level

Intervention Area	Change Concepts	Change Ideas
PPFP counseling	Establish a provider greeting system and build client confidence in the service	<ul style="list-style-type: none"> Identify a clean place that ensures privacy for the FP counseling Introduction to the client Exchanging greetings with the client Offer a seat Keep the door closed Ensure that your voice cannot be heard outside
	Develop a mechanism to ensure that essential PPFP information is given to each client by the provider	<ul style="list-style-type: none"> Develop a provider counseling checklist of essential items to offer during the session Essential PPFP norms standards by each provider; Use FP IEC (picture box) support at every counseling session Evaluate every counseling session through the check list
	Set up a mechanism to measure the effectiveness of counseling	<ul style="list-style-type: none"> Social workers in each site periodically administer a questionnaire to clients on their understanding of messages and their perceptions of FP Analyze results in the team Make corrections to weaknesses identified Closely monitor the rate of FP acceptors
Completion of medical record	Establish a medical record for every client according to norms	<ul style="list-style-type: none"> Follow rules of the MOPH FP clinical profile (each item must be completed if indicated) Use WHO eligibility criteria before prescribing a FP method Inform client of the medical record's results
Input management	Set up a mechanism to guarantee the availability of contraceptives	<ul style="list-style-type: none"> Put health provider in charge of the management of contraceptives and weekly report to QI team Keep proper stock cards Conduct regular and periodic inventory check Monitor minimum stock levels previously set for each product Place timely orders according to national standards Indicate the availability of contraceptives in weekly QI team meetings Immediately contact the other QI team for help in case of stock-out of certain products in national or regional supply
	Adopt a contraceptives' storage system according to norms	<ul style="list-style-type: none"> Identify a space that meets the following criteria: Clean, airy, moisture-free, and secure Store products away from sunlight Store products away from extreme heat Do not store the product on the floor Sort products according to expiry dates (first-come-first-out) Separate expired from unexpired products Ask the health provider in charge of the management of contraceptives and the monitoring of storage conditions to report to the QI team every week
Internal management	Establish an internal system	<ul style="list-style-type: none"> Use daily staff meetings to discuss the management of deliveries in general and particularly immediate PPFP

Intervention Area	Change Concepts	Change Ideas
of staff knowledge on PFP	for updating knowledge	<ul style="list-style-type: none"> • Daily review of FP cards filled with immediate feedback on any shortcomings • Orient all new staff on PFP norms prior to their involvement in the provision of services • Display checklists in locations visible to service providers • Disseminate to all new staff essential norms in PFP through memos and staff meetings
	Set up an internal evaluation and staff skill-building mechanism	<ul style="list-style-type: none"> • Conduct internal supervision of providers by the head of FP activities • Develop a PFP observation checklist • Organize direct observation sessions with feedback for improvements • Organize periodic demonstration meetings on long-term contraceptive methods (IUDs, implants)
Involving husbands	Set up an internal mechanism that motivates husbands to visit the center	<ul style="list-style-type: none"> • Provider respectfully and privately greets husbands who attend FP services with their wives • Leverage advice on the health of the mother and newborn to talk to the husband on FP • Submit invitations to husbands with the wife's agreement, depending on the context • Congratulate husbands for their presence
	Create PFP husband support groups	<ul style="list-style-type: none"> • Use male community volunteers • Identify husband "role-models" in the community • Integrate these "role-model" husbands as members or resources in the QI team

Appendix V: Change Package for the Management Level

Changes	Activities
Capacity building of service providers on the intervention package	<ul style="list-style-type: none"> • Define and adopt the intervention package • Develop/adopt training tools • Train/orient trainers on the intervention package • Train/guide providers on the intervention package • Organize the post-training evaluation
Organizational services Improvement for the supply of package	<ul style="list-style-type: none"> • Define a list of minimum essential materials and equipment for the supply of the intervention package • Fill in the gaps in essential materials and equipment according to norms and sites' needs • Conduct advocacy with district management team to ensure the availability of key materials and equipment • Assist providers in the proper management of FP materials and equipment and proper storage of contraceptives according to norms • Help providers improve their work environment (greeting, ensuring privacy, input management, distribution of tasks, proper filing, etc.) • Equip health facilities with checklists
Strengthening FP counseling quality in health facilities	<ul style="list-style-type: none"> • Orient providers on PFP content and counseling techniques • Provide the health facility FP counseling support as needed • Encourage providers to the systematic use of counselling job aids • Assist the health facility teams to reorganize IEC sessions on FP • Assist in the documentation of counseling activities
Support the improvement process	<ul style="list-style-type: none"> • Develop the change package • Set up the QI teams in sites • Build capacity of trainers/supervisors in coaching techniques • Organize coaching visits • Organize training sessions between QI teams • Regularly monitor indicators' performance according to the monitoring plan • Document best practices • Disseminate best practices

Appendix VI: Gender Issues Identified in Niger PFP Program

Background

In Niger, a baseline assessment for the PFP project was conducted in September 2013, which prompted the team to identify whether challenges and barriers contributing to men and women's difficulty or inability to access FP services existed within the program.

Progress

The ASSIST team in Niger worked to improve the ability of health providers to document the number of women and their male partners who received FP counseling before leaving the health facility. Health workers were instructed to add new columns into previously created records and create new record-keeping documents in order to have a designated space to record data on male involvement. An increased amount of data was collected on male engagement due to the record keeping changes initiated in all health facilities. Facility QI teams were sensitized on the importance of engaging male partners and started taking actions to raise awareness of the value of involvement of male partners. Some engaged in outreach to the community to shift attitudes about PFP and male involvement.

Challenges

Despite increased documentation capacity and understanding of the important role that male involvement plays within FP services, the actual involvement of men was still low. Additionally, the following gender-related issues stood out as obstacles inhibiting effective outreach to male partners, which could, in turn, inhibit female clients' ability to access FP and PFP services as well.

Data collection: The team has observed the use of ineffective tools for data collection on the number of male partners involved in births and counseling sessions, the number of female clients accessing services, and the number of couples participating in individual/joint counseling sessions. There also was a lack of understanding and inadequate training of health care providers on the importance of PFP, FP, and male involvement in both services.

Cultural norms and practices: Cultural norms and harmful traditional practices or beliefs have been documented to greatly affect the uptake and utilization of PFP and FP among women and couples, significantly affecting the rates of male involvement as well. Stigma placed on men who attend health care facilities offering family planning services inhibits male partner engagement. Traditional norms dictate that men should not typically attend child birth with their female partners. A member of the ASSIST team in Niger noted that it can also be difficult for male partners to take time off of work to attend their female partner's delivery. Men may contribute financial support to the female partner and transportation to the health facility, but will then return back to work without engaging in individual or couples counseling on FP.

Postpartum abstinence: Traditionally, many Nigerian men and women are expected to abstain from intimate sexual relations for 40 days after a woman's delivery. Women regard the 40th day of their abstinence as a time-marker that signifies the necessity to visit to the local health facility for the first time after delivery. Adhering exclusively to sexual abstinence during the first 40 days after delivery leaves women vulnerable to unintended pregnancy. The ASSIST team identified that men and women do not always abstain from sex during the traditional 40 days of abstinence, yet also do not change their behavior when it comes to the decision to visit the health facility for FP services only after the first 40 days has passed. Potential stigma attached to breaking the cultural norm of postpartum abstinence was cited as a factor contributing to couples' lack of early, postpartum health facility visits and is an area that the Niger team is working to address.

Religion: Religion is often cited as a major contributor to the lack of FP and PFP uptake, but the team has found that the issue with FP uptake and male engagement lies more with the lack of information and understanding of FP and the weak, inadequate approaches to educating and engaging male partners.

There are, however, a number of important gender-related cultural and religious norms that play an important role in the uptake of FP and in the engagement of men.

Family size: First, FP is often misinterpreted as an intervention to solely limit the number of births a woman has, which goes against cultural traditions that teach the belief that every child conceived is a divine grace from God and therefore spacing pregnancies or utilizing contraception are methods that disrupt God's plan for the size of a couple's family. A Nigerian proverb states: "For every open mouth, God will provide enough grain", meaning that even if a family has 20 children, God will provide enough resources to care for everyone. Religious and culturally based proverbs like this can have a detrimental effect on the uptake of modern family planning services.

Inheritance: Culturally, the issue of inheritance sharing within families that have multiple female partners can have a negative effect on the uptake and utilization of modern family planning methods because inheritance is often unequally distributed between co-wives. The team found that wives may not wish to space pregnancies or use contraception due to their knowledge that if their male partner passes away, the wife with the most children would receive a larger amount of inheritance than the wives with fewer children.

Son preference: Son preference was also noted as a major issue inhibiting the use of modern FP methods because families may continue having children until they conceive a son, even if they have to wait for 10 or more pregnancies in order to have a male child.

Based on these gender-related cultural norms, FP and PFP services may be seen as adultery in the eyes of male partners and the community, inhibiting women's ability to utilize such health services.

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