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Increasing Uptake of Postpartum Family Planning Services in Mozambique

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Abstract

Mozambique's pregnancy-related mortality ratio is one of the highest in Southern Africa at 443 deaths per 100,000 live births and a total fertility rate of 5.4 children per woman.[1] Family planning (FP) can prevent up to 32% of maternal deaths and 10% of child deaths globally.[2] Yet health systems challenges, traditional beliefs, misconceptions, poor access to services, challenging policy environments, and low funding commitments have hindered FP uptake. In Mozambique, unmet need for FP is high: 23% of all women who want to space or limit pregnancy lack access to modern contraception.[3] To improve FP access, Pathfinder International implemented the USAID Integrated Family Planning Program (IFPP, 2016-2021) in partnership with N'weti, Abt Associates, and Population Services International (PSI). This technical brief documents IFPP's implementation of a strategy to improve the quality of, and demand for, postpartum family planning (PPFP) services in supported districts and shares lessons and recommendations for replication, adaptation, and scale-up of the project's PPFP approach.

The USAID Integrated Family Planning Program (IFPP, 2016-2021)

The National Health System provides almost 95% of health care in Mozambique but reaches less than 60%[4] of the population. In 2012, Mozambique made a Family Planning 2020 commitment to provide community-level FP services, strengthen health facilities to offer universal access to FP information and services, and increase the modern contraceptive prevalence rate (mCPR) from 11.3% in 2011 to 34% by 2020. Prior to project start, 96% of modern method users in Mozambique relied on short-acting methods.[5] IFPP aimed to increase Mozambique's mCPR by generating new FP users, diversifying the method mix based on quality comprehensive counseling and service provision, and strengthening family planning and reproductive health (FP/RH) systems.

IFPP covered two provinces—Nampula (mCPR 22%) and Sofala (mCPR 14%)[5]—and implemented activities in all 36 districts within these provinces, covering an estimated population in 2019 of 8,018,168.[6] In partnership with the Provincial Health Directorate (DPS) and District Health Welfare and Women Directorate (SDSMAS), IFPP supported 411 peripheral health facilities in these provinces to increase access to quality FP/RH services by expanding access to long-acting reversible contraceptives (LARCs), strategically integrating FP with other services—for example, HIV testing and treatment, nutrition, and immunization—and improving the quality and youth-friendliness of contraceptive services.

Reaching Postpartum Women with Voluntary Family Planning

IFPP aimed to reach women with high unmet need, including postpartum women. Significant geographic, sociocultural, and systemic barriers[7] limit uptake of contraception among postpartum women in Mozambique. The World Health Organization recommends that women receive information on FP and healthy timing and spacing of pregnancies during antenatal care, at delivery, and during postpartum and well-baby care, including immunization visits.[8] Facility-based delivery is an ideal time to reach families with FP information and voluntary services, but successful implementation requires organized services, up-to-date policies and practices, and mobilization of resources.[9] To help eliminate missed opportunities to reach postpartum women, IFPP strove to broaden the method mix in PPFP services to include LARCs and permanent methods. This brief documents IFPP's implementation of a multi-pronged strategy to improve the demand, quality, and method mix of PPFP services in the project area.

Implementation

IFPP began implementation in late 2016, initially focusing its PPFP activities on health facilities with high delivery coverage (>80 deliveries per month) and later expanded to facilities with fewer deliveries. IFPP's strategic, data-driven approach to PPFP programming involved the following strategies:

Advocacy

Before the project began implementation, IFPP staff approached province, district, facility, and maternity-ward heads, as well as the directors of services at the main hospitals, to explain the rationale for the project and demonstrate the need to reach postpartum clients in their wards. Many postpartum women did not want to get pregnant again right away. Failing to meet their FP needs was a missed opportunity. As PPFP was a new approach for the maternal and child health (MCH) nurses, it was important for IFPP to clearly communicate the rationale and the importance of reaching postpartum women and improving their indicators. As a result, the nurses ultimately saw the potential of PPFP to increase the impact of their work in reducing maternal and child

1. "MOZAMBIQUE COUNTRY QUICKSTATS." DEMOGRAPHIC AND HEALTH SURVEYS. ACCESSED FEBRUARY 23, 2021. HTTPS://DHSPROGRAM.COM/COUNTRIES/COUNTRY-MAIN.CFM?CTRY_ID=61.
2. CLELAND, JOHN, STAN BERNSTEIN, ALEX EZEH, ANIBAL FAUNDES, ANNA GLASIER, AND JOLENE INNIS. "FAMILY PLANNING: THE UNFINISHED AGENDA." THE LANCET 368, NO. 9549 (NOVEMBER 2006): 1810–27. HTTPS://DOI.ORG/10.1016/S0140-6736(06)69480-4.
3. "MOZAMBIQUE: COMMITMENT MAKER SINCE 2012." FAMILY PLANNING 2020. ACCESSED JANUARY 13, 2021. HTTP://WWW.FAMILYPLANNING2020.ORG/MOZAMBIQUE.

Photo: Kendra Hebert

Integrated Family Planning Project, 2019. A mother of 10 was counseled on FP during a mobile brigade in Sofala province and opted for a LARC.

morbidity and mortality. Continuing to meet with health facility managers throughout the project to show them improvement in their indicators, especially regarding PPFP—for example, the number of women referred to the maternity ward by traditional birth attendants, the number of clients who received an FP method after delivery, and the number of IUDs inserted after delivery—helped to ensure their continued commitment to implementation.

Training, supportive supervision, and mentoring

Most providers in the project areas initially lacked confidence in their skills to provide PPFP, especially postpartum IUD (PPIUD). IFPP worked in health facilities, district hospitals, and the central hospital to train MCH nurses in PPFP, beginning in maternity wards. The project first trained IFPP staff and health-facility-based Ministry of Health (MOH) staff who would serve as trainers and mentors. These trainers then delivered cascade theoretical and practicum training to all maternity providers, including clinical and auxiliary staff and antenatal care nurses, in order to shift everyone's mentality about the potential impact of offering FP on health facilities, families, communities, and the country as a whole.

Upon completion of a comprehensive, eight-day training, MCH nurses in maternity wards received immediate follow-up in the forms of supportive supervision and on-the-job mentoring to build their confidence in providing a full range of PPFP methods to their clients. Providers who were identified as reluctant to offer PPFP were engaged in health-provider exchange visits. This training and ongoing skills-building support improved

"I learned that FP can help women plan, space, and have their children at the right time and also avoid having more children than they want."

- General nurse, health center

4. VISSER-VALFREY, M, AND MB UMARJI. "SECTOR BUDGET SUPPORT IN PRACTICE CASE STUDY HEALTH SECTOR IN MOZAMBIQUE." LONDON, UK AND OXFORD, UK: OVERSEAS DEVELOPMENT INSTITUTE AND MOKORO, 2010.
5. "INQUÉRITO DE INDICADORES DE IMUNIZAÇÃO, MALÁRIA E HIV/SIDA EM MOÇAMBIQUE - IMASIDA, 2015." MAPUTO, MOÇAMBIQUE: MINISTÉRIO DA SAÚDE- MISAU, INSTITUTO NACIONAL DE ESTATÍSTICA - INE, AND ICF, 2015.
6. "MOZAMBIQUE." CITY POPULATION. ACCESSED JANUARY 13, 2021. HTTPS://WWW.CITYPOPULATION.DE/EN/MOZAMBIQUE/CITIES/.
7. "BARRIERS TO INSTITUTIONAL DELIVERY AND FAMILY PLANNING: A QUALITATIVE STUDY FROM CABO DELGADO, ZAMBEZIA, AND INHAMBANE PROVINCES, MOZAMBIQUE." PATHFINDER INTERNATIONAL AND DFID, 2013.
8. PROGRAMMING STRATEGIES FOR POSTPARTUM FAMILY PLANNING." GENEVA, SWITZERLAND: WORLD HEALTH ORGANIZATION, 2013.
9. "IMMEDIATE POSTPARTUM FAMILY PLANNING: A KEY COMPONENT OF CHILDBIRTH CARE." WASHINGTON, DC, USA: USAID HIGH IMPACT PRACTICES IN FAMILY PLANNING (HIPS), OCTOBER 2017.

Photo: Kendra Hebert

Ponta Gea Health Facility nurses trained by IFPP.

the delivery of quality PPFP services by increasing provider competency and confidence in counseling and provision of PPFP methods, particularly LARCs. In fact, given the program's success in improving PPFP counseling and service provision, IFPP has worked to expand the pool of health-facility-based MOH mentors in order to provide more frequent mentorship visits. In addition, to ensure successful program implementation and monitoring, evaluation, and learning, IFPP provided registration books, documentation mechanisms, and monthly aggregation tools, as well as program-management support to maternity-ward heads where it had been lacking.

Data use

IFPP used an implementation science learning approach, developing a provider behavior-change framework based on the Opportunities, Abilities, and Motivations framework[10] and modified to better account for intrinsic and extrinsic motivations within an organizational context.[11] IFPP's approach to implementation-science learning allowed the team to understand program dynamics at the facility level and to respond to challenges by modifying the implementation approach accordingly.

To generate SDSMAS buy-in and support and to press health-facility and maternity-ward heads to continue to improve, IFPP introduced a PPFP indicator into the key indicators for the FP district profile dashboard. The project convened health facilities with maternity wards for workshops in which they could share successes and challenges and develop action plans for improvement. IFPP staff used data to group high-performing facilities together and to similarly convene lower-performing facilities to determine and document what was working well and what was not and brainstorm ways to adjust accordingly. For example, mentoring helped health facilities address a lack of provider skill in offering certain methods. And when facilities presented challenges like high staff turnover, IFPP helped them mitigate staff shortages by staggering staff holidays and asking district heads to supply additional staff to help fill gaps. These workshops were an important chance to highlight the key roles of maternity-ward and health-facility heads in motivating their staff and removing organizational barriers to PPFP provision.

Barriers and Facilitators to Implementation

Implementation of the PPFP approach was challenged by shortages of tools, supplies, staff, and even electricity. In facilities lacking electricity, a flashlight was needed for nighttime service provision; however, use of a flashlight required two staff, a luxury that many health facilities did not have. In fact, some facilities only had one MCH nurse on duty for a full 24-hour shift; if she was unavailable, service provision was hindered. Frequent staff rotation was another barrier; providers would often be trained and then leave for another health facility or province, necessitating the training and mentoring of new staff. The effort to maintain skilled, quality workforce despite high turnover created a heavy workload. Finally,

10. ÖLANDER, F, AND J THØGERSEN. "UNDERSTANDING CONSUMER BEHAVIOR AS PREREQUISITE FOR ENVIRONMENTAL PROTECTION" 18 (1995): 345–85.
11. "VALLERAND, ROBERT J. "TOWARD A HIERARCHICAL MODEL OF INTRINSIC AND EXTRINSIC MOTIVATION." IN ADVANCES IN EXPERIMENTAL SOCIAL PSYCHOLOGY, 29:271–360. ELSEVIER, 1997. HTTPS://DOI.ORG/10.1016/S0065-2601(08)60019-2.

"What motivates me is the desire to avoid maternal deaths… If a woman does not use family planning, she can get pregnant at any time, and pregnancy and childbirth can create many problems for this lady."

- Nutrition technician, Namina Health Center

some facilities lacked a private space for service provision, and this lack of confidentiality made some clients less likely to accept a method.

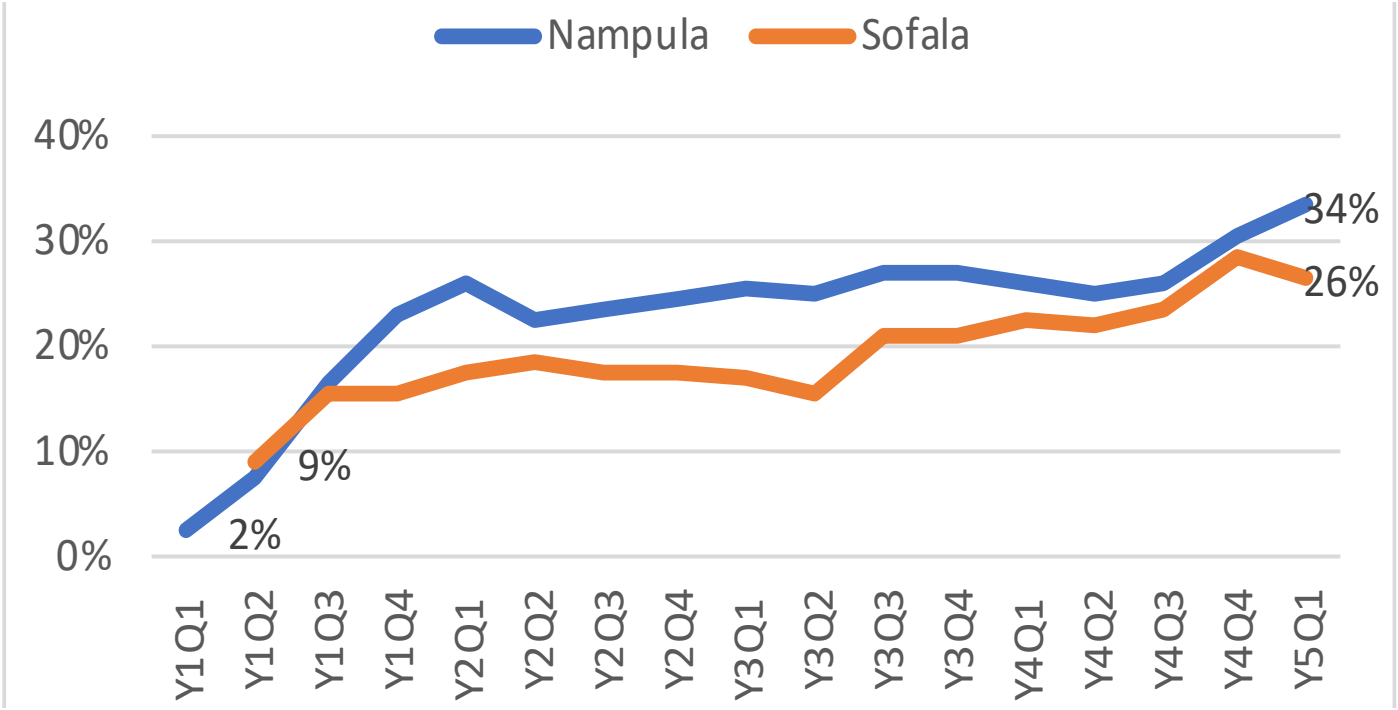
Despite these challenges, several factors facilitated successful implementation of the PPFP approach. Buy-in from DPS, heads of provinces and districts, and the MCH nurses themselves resulted in a strong, motivated workforce of health-care providers who valued and cared about providing quality PPFP services. Training that blended practical skills-building and theoretical knowledge laid a strong foundation for providers. Offering training at providers' own health facilities allowed them to practice and strengthen new skills in their typical working environment. Finally, mentors—Pathfinder staff, and district staff who will facilitate continuation of activities beyond the end of the project—supported the providers in strengthening their abilities and confidence in PPFP provision.

Performance

After one mentoring visit, 100 more providers met standards for PPIUD provision than after training alone. This means that approximately 1 in 10 providers would not have achieved clinical competence after training alone but did so with post-training mentorship. Most providers (95%) mentored in PPIUD provision achieved clinical competence as indicated by the checklists completed at the end of each mentorship visit.

In turn, while the impact of IFPP's PPFP approach varied by province and facility, the overall share of women in both provinces who took up a method after delivering at project -supported facilities increased dramatically, by 32 percentage points in Nampula and 17 percentage points in Sofala, over the span of the project (Figure 1).

FIGURE 1. Percent of women who accepted a PPFP method after delivering a baby at project-supported facilities, by province



Across the project area, there was a notable increase in the proportion of PPFP clients who chose PPIUD (Figure 2). The proportion of postpartum women who received a PPIUD doubled from the first (Y1) to last year (Y5) of implementation, rising from 4.3% to 8.3%.

Lessons Learned and Recommendations

Adapt capacity strengthening activities to respond to the realities of health facilities and providers.

While IFPP's provider training initially lasted for eight days, this proved burdensome for health facilities, so training duration was reduced to five days. Training providers on counseling helped them generate demand for the FP methods they were being trained to provide. Still, some providers worked at facilities that were in remote locations, had low demand, or lacked a maternity ward, and therefore did not offer certain techniques and methods. Because these providers had no opportunity to practice at their own facilities, IFPP facilitated visits to higher-level facilities so that providers could gain experience with these techniques and methods. A peer-training approach allowed providers to learn from others working within the same specialty areas.

Engage PPFP providers in post-training mentorship to facilitate quality provision of LARCs and other methods to new mothers.

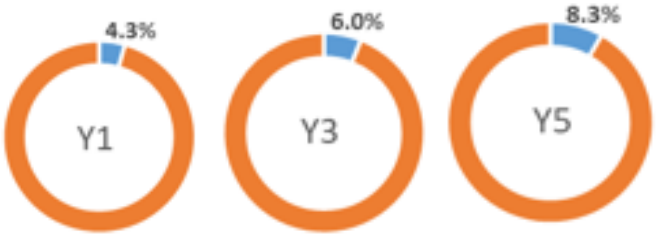
IFPP expected that providers would be more willing to offer PPFP, and particularly PPIUD, after training, mentoring, and management support. However, the growth in provider confidence exceeded expectations. This success highlights the importance of following training with not only supportive supervision but also mentorship. While training and supportive supervision are important to improve quality of services and ensure adherence to proper protocols within a health facility, mentorship provides ongoing on-the-job skills-building opportunities for providers through regular contact, assessment of abilities, reflection, and constructive feedback. Mentorship is relatively inexpensive and easy to implement, and when done well, it is a powerful facilitator of improvement in provider skills and abilities. Read about IFPP's approach to mentorship in Pathfinder's technical brief, *Implementation of a Clinical Mentorship Program in Mozambique*.

A supportive environment, including strong leadership and management and adequate medical supplies and equipment, is essential to quality PPFP provision.

IFPP used an implementation science learning approach to develop strong leadership and management within health

Photo: Kendra Hebert

FIGURE 2. Percent of women who accepted PPIUD after delivering a baby at project-supported facilities, by year



facilities and maternity wards. In a survey of providers, most reported strong skills, technical confidence, and high intrinsic motivation but perceived gaps in institutional support at the health facility level. They also included gaps in support—for example, constructive feedback on performance and on-the-job training and technical assistance. IFPP engaged maternity ward heads, and health facility managers as key change-makers to achieve more consistent, proactive, and sustainable integration of postpartum LARCs in all project sites. Each cadre of change-maker were tasked with specific follow-up with both clients and providers to help ensure that they were providing quality PPFP services.

In addition to strengthening the capacity of health care providers, programs and health systems must create an enabling environment for service provision. When surveyed, providers reported material gaps—for example, in readiness of sterilized insertion kits and availability of PPFP methods—that impeded their ability to offer quality, comprehensive PPFP services. If commodities are not available, FP provision is not possible. Yet contraceptive security is only one of many factors that affect providers' ability to provide quality PPFP services. Medical supplies and equipment, such as proper IUD- and implant-insertion tools, are essential. Mechanisms for biowaste disposal and safety, sterilization, clean water, and light, whether via electricity or flashlights, are also necessary. Finally, the physical environment—for example, privacy within the facility and the availability of beds, can either facilitate or hinder service provision and uptake. IFPP provided medical supplies and materials—such as lamps; bedsheets; curtains and plywood for privacy; and soap, basins, and buckets for cleaning—where shortages in some facilities and maternity

Photo: Kendra Hebert

Traditional birth attendants & nurses who work out of Dondo Centro de Saude de Mutua.

wards would have otherwise resulted in an inability to offer certain contraceptive methods in a setting acceptable to clients. The project also engaged sterilization officers as change-makers, ensuring that all materials and equipment necessary for PPFP provision were sterilized daily.

IFPP also worked to create an enabling environment at community level by increasing support for PPFP among the partners and mothers-in-law of pregnant women. The project did this by demystifying LARCs and highlighting the importance of healthy timing and spacing of pregnancies. IFPP engaged traditional birth attendants as IFPP allies who actively promoted PPFP among families and provided community referrals.

Conclusion

While PPFP is not new in Mozambique, IFPP's approach allowed the expansion of and access to this service in alignment with MOH strategies, and its strong results and achievements are notable. IFPP's approach to strengthening PPFP services is worth replicating, but to do so will require sustained investment and consistent support. Much of the project's success was derived from the design of a strong approach from the beginning.

Data-driven advocacy was critical in gaining the buy-in of local leadership, health-facility management, and the providers themselves. IFPP's initial focus on high-volume health facilities (those that handled more than 80 deliveries per month) yielded quick, high-impact results that allowed these stakeholders to see the value of PPFP and solidified their continued support. Training providers in their own environment gave them hands-on practice of new techniques in their typical workspace. Post-training mentorship and supportive supervision facilitated ongoing on-the-job practice, feedback, and reflection, which continuously strengthened providers' confidence and ability to provide PPFP and particularly PPIUD. Finally, analyzing and using data to identify material-, knowledge-, and human-resource gaps that IFPP could fill helped the project support health facilities and providers in consistently offering quality PPFP services. IFPP's PPFP approach and lessons can be applied to strengthen FP access and uptake among postpartum women and meet contextual challenges as they arise. The MOH should consider investing in the scale up and institutionalization of this approach to strengthening PPFP services in Mozambique as a strategy to increase provision and uptake of voluntary FP, particularly long-acting and permanent methods.

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The USAID Integrating Family Planning Program is a five-year activity implemented by Pathfinder International, N'weti, Abt Associates, and Population Services International (PSI).

Photo Credit, Cover: Integrated Family Planning Project, 2019. A Ponta Gea health facility nurse trained by IFPP counsels a new mother on family planning. (Kendra Herbert)

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