

# Planning for Systematic Scale-Up of Immediate Postpartum Family Planning in the Agneby-Tiassa-Mé Health Region of Côte d'Ivoire

**In 2017, the Ministry of Health and Public Hygiene (MSHP) of Côte d'Ivoire initiated the institutionalization of immediate postpartum family planning (IPFP) following promising results of a first ever IPFP intervention implemented at the Treichville University Hospital.**

MSHP took steps to operationalize IPFP by launching an appeal to international donors and technical partners to support Côte d'Ivoire's scale-up of IPFP to all public facilities that provide childbirth services. In response to this request, Pathfinder International initiated the "Immediate Postpartum Family Planning (IPFP)" intervention in the Agneby-Tiassa-Mé (ATM) Health Region in 2017.

In a country with low contraceptive prevalence and strong political will to increase contraception services in the immediate postpartum period, project staff, in collaboration with MSHP, decided to focus on Côte d'Ivoire's health districts of Agboville, Adzopé, and Akoupé. These health districts, which were not traditionally preferred for donor-funded family planning (FP) activities, were selected for their weak FP indicators and lack of specific interventions to strengthen them.<sup>1</sup>

From the onset of the intervention, the Pathfinder-led Evidence to Action (E2A) Project, USAID's global flagship for strengthening FP and reproductive health (RH) service delivery, enhanced implementation by integrating adolescent- and youth-responsive approaches into the immediate postpartum contraception package. Furthermore, E2A also supported planning for the scale-up of the intervention through the application of two ExpandNet's tools: *Beginning With the End in Mind (BWEIM)*<sup>2</sup> and *Nine Steps for Developing a Scaling-Up Strategy*.<sup>3</sup>

This technical brief presents key implementation learnings and highlights the main steps of the scale-up planning process (Table 1).

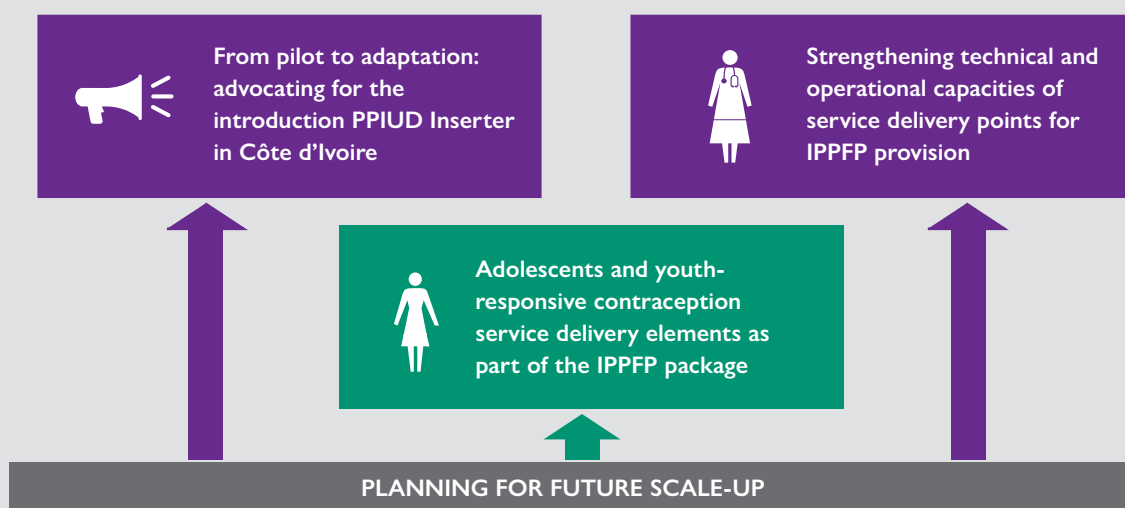


## DESIGNING THE IPFP INTERVENTION

Funded primarily by the Hewlett foundation, the initial phase of the IPFP intervention was implemented from August 2017 to October 2018 by Pathfinder International, E2A, and the MSHP. This project, which aligned with the government's vision to extend FP services to women during the immediate postpartum period, advanced several enhancements to the IPFP high impact practice:<sup>4</sup>

- Prior to the intervention, contraceptive services were only offered to postpartum clients during postnatal consultations—six weeks after delivery. The IPFP intervention operationalized the World Health Organization's 2015 recommendations on medical eligibility criteria for immediate postpartum contraceptive use,<sup>5</sup> enabling women to choose from a wide variety of contraceptives after giving birth—including hormonal and non-hormonal, long- and short-acting, and permanent methods.
- To support IPFP access to the IUD, the intervention introduced the long postpartum intrauterine device (PPIUD) inserter. The PPIUD inserter is designed specifically for immediate postpartum use and has the advantage of reaching the uterine fundus for correct IUD placement, which reduces the risk of infection during the insertion process. The copper IUD, preloaded in the inserter, has longer strings to facilitate checking the strings.
- The IPFP was designed to integrate adolescent and youth contraceptive service delivery elements into the overall activities package.<sup>6</sup> These elements included strengthening service providers' capacity in providing adolescent-friendly services, establishing a safe space for providers to discuss their challenges and learnings in providing services to young people, and facilitating desegregated clinical service data collection and analysis to inform decision making.

## IPPPF Intervention Components



Date	Outcome
Aug 2017	Design phase
	<i>Beginning with the End in Mind</i>
	Intro of PPIUD Inserter
	Intro of youth component
	Implementation phase
	<i>Beginning with the End in Mind</i>
	Implementation gaps identified & addressed
	Effective stakeholder involvement
Oct 2018	End of initial phase
	<i>Nine Steps for Developing a Scaling-up Strategy</i>
	Development of scale-up plan

Table 1: Scale-up Planning Timeline and Outcomes

## METHODOLOGIES FOR PLANNING SCALE-UP OF IPPFP<sup>7</sup>

**E2A's approach to planning for systematic scale-up of the Côte d'Ivoire IPPFP innovation used a two-pronged approach.**

### DOCUMENTING THE PROCESS OF IMPLEMENTATION OF IPPFP:

This process involved three key dimensions: (1) reflecting, analyzing, and problem-solving among frontline workers to refine implementation; (2) capacity strengthening of project managers to respond to emerging needs in the field; and (3) ensuring the project's experiences contributed to IPPFP scale-up in the country. Data were collected through project document review, key informant interviews, and direct observation.<sup>8</sup>

**LEVERAGING TWO EXPANDNET TOOLS:** E2A used two ExpandNet tools to analyze the feasibility of the interventions for scale-up in the region. To guide project design and implementation, E2A applied the 12 recommendations from *BWEIM*,<sup>9</sup> while *Nine Steps for Developing a Scaling-Up Strategy*<sup>10</sup> supported stakeholders to identify key adaptations required to take the innovation to scale and other important conditions needed for a sustainable scale-up of IPPFP in Côte d'Ivoire.

## PLANNING FOR SYSTEMATIC SCALE-UP

**To promote and facilitate the implementation and future scale-up of IPPFP in Côte d'Ivoire, E2A made a deliberate effort during the initial phase to bring together individuals and organizations to form the IPPFP Resource Team (RT).**

This team comprised the Ministry of Health (PNSME—National Maternal and Child Health Program, PNSSU—National School and University Health Program, the ATM health region and districts, the project managers (Pathfinder and E2A), other FP partners (Jhpiego, AIBEF), and the SOGOCI (Côte d'Ivoire Society of obstetricians and gynecologists). E2A facilitated the capacity building of the RT on ExpandNet scale-up methodology and supported them in applying two essential ExpandNet tools as part of the scale-up planning process.

*BWEIM* outlined steps implementers must take to design a pilot that maximizes the potential for future scale-up. Applied during the design phase and throughout the process of implementation, it supported the project stakeholders to identify key adaptations (see graph 1 above) and some main challenges. As part of an ongoing process over the life of the initial phase of the innovation, implementers had the opportunity to examine these challenges, enabling project staff and frontline workers to take corrective actions and address gaps during implementation. Such actions include:

### ADAPTATIONS MADE AT THE DESIGN PHASE

To increase access to the services for adolescents and young people, the project included elements of adolescent-friendly services into the overall package of services. These include building capacity of service providers on the provision of youth-responsive services, value clarification and attitude transformation on provision of long-acting methods to adolescents and young women, periodic meetings for service providers to share experiences and challenges in addressing adolescents' and young people's needs, careful clinical data collection to ensure data desegregation by age, and service statistics analysis and interpretation per age group.

## PROGRAMMATIC ADJUSTMENTS INITIATED BY THE HEALTH FACILITIES DURING IMPLEMENTATION

To increase knowledge about postpartum contraception, in addition to reorganizing services to include counseling on immediate postpartum contraception as early as possible during ANC visits, some health facilities also held regular meetings to ensure the availability of contraceptive products in the health centers—especially in the delivery room. Furthermore, they used innovative approaches to dispel myths and rumors. For example, some health facilities invited women to share their experiences on FP use with other pregnant women in the waiting room, with a provider present to respond to questions.

## PROGRAMMATIC ADJUSTMENTS IMPLEMENTED BY THE PROJECT TEAM

In order to reduce provider bias and prejudice, project staff, in collaboration with facility managers, made deliberate efforts to provide one-on-one value clarification talks with providers during supervisory visits. In addition, the project team introduced a mentorship approach for newly posted providers. To increase access to services for adolescents and young people in facilities where services are not provided to them for free, stakeholders recognized the need to engage in advocating for free family planning services for all adolescents and youth, regardless of where the service is provided.

Nine Steps to Develop a Scale-Up Strategy was used at the end of the initial phase of the project to guide key stakeholders—project managers, frontline workers, MOH, other NGOs, and the Côte d'Ivoire Society of obstetricians and gynecologists—in conducting the initial phase review and applying the step-by-step guidance for developing the IPPFP scale-up strategy, which describes the expansion of the innovation to ten additional health facilities in the same health region.<sup>11</sup>

## KEY SUCCESSSES IMPLEMENTING THE HIGH-IMPACT PRACTICE

**Notable changes took place throughout implementation, including improved quality of services and development of providers' skills.**

**INCREASED AVAILABILITY OF SERVICES:** Providers reported that services were reorganized holistically, through the creation of functional linkages between the maternity ward and FP unit—such as the availability of contraceptive methods in delivery rooms and the extension of services beyond official working hours, including weekends and public holidays, at all hours. The objective was to enable postpartum women in need of FP to receive care by removing the barrier of unavailability of FP and provide integrated IPPFP services.

One provider describes the experience of reorganizing FP services: “In the past, all women who came for contraception went directly to the PMI [Mother and Child Protection Unit]. So, if the PMI closes, or if it's a holiday, women did not have the opportunity to use contraception. But when we came back (from training), we organized the service so that at any time, whether in the morning or even at night, these women could receive their contraceptives. Inputs were also provided for

the maternity ward. We also trained a few nurses. So, we no longer have that problem. When the PMI is not working, women can still benefit from the services. It works well.”

## IMPROVED PROVIDER COMPETENCE AND

**CONFIDENCE:** The intervention fostered professional and personal growth among providers. On a professional level, providers reported increased technical capacity to offer FP services, such as FP counseling and IUD insertion. On a personal level, some providers revealed that they developed self-confidence and self-esteem.

A nurse narrates her experience in providing FP services: “When you know you've done something good for a woman, that you can help her, when you get home, you are satisfied.”

## INCREASED ABILITY FOR POSITIVE INTERACTION

**WITH ADOLESCENT AND YOUTH:** Providers reported that the intervention led to behavioral changes related to their communication with young clients. They developed a counseling approach that featured messages focused on awareness of a young client's aspirations and the difficulty of reconciling a child's upbringing with their desires to finish their own schooling.

One young provider narrates: “I was ashamed to realize that I was doing more harm to my younger sisters by making them feel guilty instead of taking advantage of their situation to give them the necessary information that will perhaps create a change in their lives, but today, I myself have changed, I see things differently.”

## IMPROVED ATTITUDES TOWARD LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARCS):

Practitioners reported that some clients' reactions to the IUD demonstrated an improvement in the quality of counseling and the availability of a full range of contraceptives, including implants and IUDs.

One practitioner, a gynecologist, said: “For the few cases of postpartum IUDs that I have had to insert [...] it was a real craze among these young people. Because really, they had to face many unwanted pregnancies, so as soon as the opportunity [to provide IPPFP] was presented to them, they accepted. So, we performed the procedure right away before we left. [...] Some people say that the pill makes them fat, so they feel a little bit uncomfortable. And then they're offered a method where they don't have to make any particular effort; [...] It reassures them right away.”

## PROVIDERS PERCEIVED IPPFP TO BE A MAJOR ASSET IN REDUCING THE NUMBER OF UNWANTED

**PREGNANCIES:** Provider ability to offer a method before hospital discharge represents a significant change. Many specifically mentioned the IUD.

One gynecologist explained this change: “The change we see is the chance we have to offer a contraceptive right away, before the patient leaves the hospital. Because there are a lot of cases that come back after a year with pregnancies when they are already multiparous. And in general, when you talk to these women: ‘yes, I wanted to come [to the clinic for FP] and then I got pregnant before [being able to].’ So, when faced with these cases, generally speaking, yes, we are a little reassured to have a method that we can use right away when they agree [clients] to avoid these arguments.”

## CHALLENGES IMPLEMENTING THE INNOVATION UNDER ROUTINE CONDITIONS

Despite positive changes reported by front line workers, the documentation pointed out persistent challenges around providers' ability to counsel and provide IPPFP.

**PROVIDER BIAS REGARDING IMMEDIATE POSTPARTUM IUD (PPIUD):** Provider bias in service provision poses a major barrier to providing FP services. Throughout the intervention, not all providers accepted the PPIUD as a safe, reliable method of contraception for clients. However, this attitude was less prevalent among trained providers.

One nontrained provider shares her view: *"Personally, I'm still wondering about certain methods [...] I mean the postpartum IUD. I don't know, but I'm a little bit uncomfortable with that [...] Anyway, we'll see [...]"*

Another provider shares comments from some of his colleagues: *"There's this fear among us that the IUD cooper might make sexual intercourse uncomfortable, that's it. There is also the thought that the IUD is reserved for women who no longer want to have children, that's it. So, for young girls, it's not worth, no, no, no [...]"*

**MISSING COMMUNITY COMPONENT IN THE IPPFP INTERVENTION:** According to the respondents, one of the greatest weaknesses of the intervention was the absence of a strong community component to support providers' efforts in providing IPPFP services. They expressed that the intervention would benefit from diversification, including the introduction of social and behavioral change activities within communities—particularly for reaching adolescents, parents of adolescents, and men to raise awareness of the benefits of IPPFP and help reduce socio-cultural barriers.

*"...So you have to go down into the community, that's what's missing from this thing [ project], the problems are in the communities, you see. If that's settled, the work here will be easier."*

## KEY LEARNINGS FROM PLANNING FOR IPPFP SCALE-UP

Côte d'Ivoire's experience in providing immediate postpartum contraception services at a lower level of the health system—as opposed to a University Hospital (as in the Treichville experience), confirmed the need for careful adaptation of any High Impact Practice to the context of local environments—to ensure feasibility and sustainability of scale-up.

Deliberate efforts made by various stakeholders—including frontline workers, the MOH, and the scale-up resource team—in planning for scale-up of the intervention enabled them to identify the scope and pace of scale-up within the health system, as well as the need for diversification—namely, integration of a community component into the next phase of the project. This shows the importance of applying strategic thinking for the successful scale-up of pilot interventions.

Beside the geographical expansion envisioned by the scale-up plan developed by stakeholders at the end of the initial phase, further actions to improve institutionalization of the IPPFP in Côte d'Ivoire were considered. These included the need for the harmonization of data collection tools at facility level, the integration of IPPFP indicators as part of the national health information system, the availability of the PPIUD Inserter as part of the national pharmacy warehouse. This highlights the two key dimensions of a sustainable scale-up—horizontal and vertical scale-up. For more information on the project's recommended next steps for scale-up, see the full report at <https://www.e2aproject.org/fr/publications/cdi-scale-report>.

Implementation of the scale-up plan is currently ongoing, with additional funding from the Hewlett Foundation. Key institutional achievements include: (1) the codification of the PPIUD Inserter by the National Pharmacy (NPSP/Nouvelle Pharmacie de la Santé Publique), making the device part of the country's essential drugs list and available countrywide; (2) integration of IPPFP data into routine data collection tools at facility level; and (3) integration of an indicator related to the immediate postpartum period into the FP national report—number of women who received a contraception method during the immediate postpartum period.

### SOURCES

(1) Adon, K.P. (2014), "Failure to use contraceptive products among women in two health districts in Côte d'Ivoire." African Population Studies Vol. 28, No. 3, 2014; (2) WHO; ExpandNet, *Beginning with the end in mind: Planning pilot projects and other programmatic research for successful scaling up*, 2011; (3) WHO; ExpandNet, *Nine steps for developing a scaling up strategy*, 2011; (4) Family Planning High Impact Practices, "Immediate Postpartum Family Planning: A key component of childbirth care"; (5) WHO, *Medical Eligibility Criteria for Contraceptive Use*. 5th ed, 2015; (6) Innovation defined here as per ExpandNet scale-up methodology; (7) WHO; ExpandNet, *BWEIM*, 2011; (8) See report for full methodology; (9) WHO; ExpandNet, *BWEIM*, 2011; (10) WHO; ExpandNet, *9 Steps*, 2011; (11) For more detail about the scale-up plan, please see full report.

