

# implementation story:



## Transforming Voluntary Family Planning Access and Use in the Postpartum Period: Strengthening Preservice Education of Midwifery and Obstetrics and Gynecology Students in Burkina Faso



Women wait outside of a health facility with their young babies.

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## Background and Context

Closely spaced, repeat pregnancies are a concern not just for Mrs. Balaissa, a mother of five young children, but for many women across Burkina Faso seeking to reduce unintended pregnancy. In a country where women have an average of five children (total fertility rate of 5.4 children per woman), and even more in rural areas where the majority of the population resides (INSD, 2015a), ensuring that women can access voluntarily postpartum family planning (PPFP) immediately after delivery is critical. Jhpiego has long committed to supporting PPFP as a strategy to reduce maternal and newborn morbidity and mortality, by integrating voluntary family planning care within existing health services.

***“In most of the cases in Burkina, after delivery when the new mother goes home, it is not sure she will have access to family planning services before it is too late as she may get an unwanted pregnancy. Having access to immediate postpartum family planning before leaving the maternity reassures us that she has real control of her fertility.”*** Moussa Ouedraogo, midwife, midwifery tutor, and PPFP champion

In 2011 during the Ouagadougou Partnership launch event and in 2012 at the Family Planning Summit in London, the government of Burkina Faso committed to increasing uptake of voluntary family planning (FP) in an effort to reduce maternal and infant mortality. This commitment was materialized by the implementation of the *Family Planning Relaunch Plan* (2013–2015), followed by the *National Family Planning Acceleration Plan* (2017–2020). In 2010 the maternal mortality ratio was 341 deaths



**“I always had pregnancies that surprised me. The arrival of a child is supposed to bring happiness, not insomnia.”**

Mrs. Sana Balaissa, 37, mother of five children and program participant

per 100,000 live births and the infant mortality rate was 65 deaths per 1,000 live births (INSD, 2012).

With a low contraceptive prevalence rate (22.5 percent among women in union) and an unmet contraceptive need of 19 percent (INSD, 2015a), a national budgeted FP acceleration plan was developed to increase contraceptive prevalence from 15 percent in 2010 to 32 percent in 2020 (PNAPF 2017-2020). This ambitious goal required an innovative approach. Burkina Faso has high rates of antenatal care (ANC) (84.8 percent of women having at least one visit) and assisted delivery (86.2 percent) (INSD, 2015b), which provides an opportunity to introduce and scale up PPF. Following the 2012 Family Planning Summit in London, Jhpiego led a pilot project from 2013 to 2015 in collaboration with the Burkina Faso Ministry of Health (MOH) and UNFPA, which offered voluntary PPF and PPF counseling to women in 26 health facilities. The pilot showed promising results and revealed an interest to scale up availability of PPF nationally.

To make PPF care more widely available to women, Burkina Faso needed to expand the number of providers trained in PPF. Through the Sustainable Scale-Up of PPF in Burkina Faso project (2015-2020), Jhpiego transformed provider training by scaling up PPF through preservice education for midwifery and obstetrics and gynecology (OB/GYN) students.

## THE HIGH IMPACT PRACTICE

To increase access to and use of voluntary, high-quality FP, the Sustainable Scale-Up of PPF in Burkina Faso project focused on the [Immediate Postpartum Family Planning](#) (PPFP) high impact practice (High Impact Practices in Family Planning, 2017). When the project began, midwives and OB/GYNs were authorized to offer PPF but were not always trained to do so, leaving women who desired PPF unable to access a method.

The project focused on equipping new midwifery and OB/GYN students—before graduation and eventual deployment—with the knowledge and skills to deliver high-quality PPF care, including postpartum insertion of LARCs. This was an alternative to the traditional approach, in which providers leave their facilities later in their careers for a one- or two-week in-service training—a slow and costly process when scaling up availability.

In addition to strengthening the public preservice system for PPF, the project also strengthened the service delivery environment to integrate immediate PPF into maternal health services and improve LARC access. The project strengthened institutional capacity to train and deploy midwifery and OB/GYN graduates, supported government advocacy to strengthen immediate PPF, and even followed new graduates to their first deployment sites and strengthened PPF skills of existing facility staff.



A Jhpiego-trained midwifery instructor at the ENSP in Ouagadougou trains midwifery students on the insertion of a PPIUD using the Laerdal Mama-U anatomic model in the school skills lab.

PHOTO CREDIT: Jhpiego

A Jhpiego-trained midwife counsels a pregnant client on immediate PPF options during an antenatal care visit.



PHOTO CREDIT: Jhpiego

## Implementation Story

“Before the operationalization of the [PPFP] skills lab, the training focus was only theory: discussing and showing pictures on the key steps of procedures. Now we are more confident that after the skills lab students are ready for clinical practice with clients. We are now doing a real competency-based training!” — Moussa Ouedraogo, midwife, midwifery tutor, and PPFP champion of the project

### AN INNOVATIVE TRAINING MODEL

The project aimed to increase access to and use of voluntary FP by transforming how FP is addressed in the postpartum period, focusing on (1) strengthening the capacity of preservice education institutions to better integrate PPFP; (2) strengthening the provision of high-quality PPFP at the health facility level; and (3) supporting the MOH to update policies, standards, and guidelines to ensure high-quality FP delivery.

The Jhpiego model included integrating PPFP into preservice education by creating strong links between preservice clinical training and quality FP care, specifically:

- Encouraging the MOH to follow evidence-based service delivery innovations
- Using a participatory approach for policy and strategy changes, engaging health stakeholders at all levels in thematic working groups
- Promoting high-quality education and training, including hands-on practice in skills labs, strengthening student and instructor competency (specifically, teachers and instructors were trained in clinical simulation and effective teaching skills), curriculum revision, and expanding and supporting clinical practicum sites
- Strengthening post-training follow-up and implementing a mobile mentorship program. This entailed sending out messages and short quizzes by text message (SMS or short message service) to midwifery graduates to remind them of key messages related to PPFP, including immediate PPFP, interval FP, postabortion care, and infection prevention. Each week, two to three messages and two quiz questions were shared, with themes changing weekly or monthly.
- Promoting the identification and use of PPFP champions—new graduates who showed good performance in PPFP skills. These champions received additional support to train other providers in strengthening their skills in PPFP provision.
- Using a standards-based approach focused on competencies to strengthen the PPFP preservice education system

Initial project efforts focused on engaging the MOH, the Ecole National de Santé Publique (ENSP, National Midwifery School) in Ouagadougou, and the University of Ouagadougou Medical School to strengthen the national preservice curriculum for midwifery and OB/GYN students. The new training aimed to address PPFP through competency-based training, alignment of curriculum and materials to the most recent World Health Organization (WHO) guidelines, and a strong focus on clinical practice through simulation labs and strengthened clinical practicum sites. The WHO fifth edition of the [Medical Eligibility Criteria for Contraceptive Use](#) (WHO, 2015) was used to ensure preservice education training and PPFP counseling followed the criteria and that students understood the safety of each contraceptive method for use in the context of a particular client. The project also gave new graduates and facilities the critical WHO publication, [Family Planning: A Global Handbook for Providers](#) (WHO, 2018).

When midwifery students completed their training and graduated, Jhpiego followed the new midwives to their first deployment sites,



“IN TERMS OF FAMILY PLANNING, IT’S FIRST THE COUNSELING THAT WE NEED TO GIVE TO EVERY WOMAN . . . NOW WE FOCUS ON COUNSELING TO ENABLE THE WOMAN TO MAKE AN INFORMED CHOICE. THE PRACTICE HAS REALLY HELPED US ACQUIRE THE PRACTICAL SKILLS.”

Ibrango Adjara, midwifery student



Madame Bouda Clementine, a trained midwife for 18 years and a midwifery trainer trained by Jhpiego, teaches students at the ENSP Training Center in Ouagadougou

equipping them with immediate PFP materials (e.g., postpartum intrauterine device insertion kits including Kelley forceps). As the project progressed, Jhpiego supported four additional ENSP locations—Bobo-Dioulasso, Koudougou, Tenkodogo, and Fada—to ensure all midwifery students, regardless of location, graduated with competent skills in PFP provision.

In the later years of the project, the focus shifted from supporting only midwifery students and new graduates to providing full-site support, including training for other staff at health facilities where new graduates were deployed so that PFP could continue even as new graduates were reassigned elsewhere.

## PPFP NATIONAL SCALE-UP

The project successfully scaled up PFP nationwide, training 732 midwifery and 70 OB/GYN students who were deployed to more than 270 health facilities across all 13 regions of the country. In later project years, the project trained more than 2,000 providers from 380 facilities as part of on-site trainings to increase awareness about FP methods, specifically long-acting and reversible contraceptive methods (LARCs), among postpartum women. Among women delivering in project-supported sites between January 2016 and March 2020, 67 percent (568,452) received FP counseling and 49 percent (280,785) left the facility with a voluntary FP method, helping reduce unmet need. During the same period, 14,191 women received intrauterine devices (IUDs) and 30,871 received implants within 48 hours of delivering in these facilities. The project ensured PFP was consistently available in facilities and “revitalized” the availability and voluntary use of the copper IUD. Overall IUD uptake in project sites was 10 percent, compared with nationwide uptake of 4.7 percent (PMA, 2019).

To ensure PFP data were tracked to inform monitoring and decision making, specific PFP indicators were developed in the Health Management Information Systems (HMIS) and data collection tools were revised and used. Several of the indicators used are also referenced in the Immediate PFP high impact practice brief, including the percentage of women delivering who received PFP counseling, percentage of women who received their chosen method of contraception within 48 hours following delivery, and proportion of those women who chose a LARC (disaggregated by IUD and implant). The project supported the MOH to pilot an electronic data collection system using smartphones in 77 health facilities and the process is still ongoing as efforts continue to build an interoperable system with the District Health Information System 2 (DHIS2) database. This integrated system will strengthen monitoring of progress toward project and government objectives, while also supporting facility-based FP decision making.

## DELAYS AND THE NEED FOR ONGOING SUPPORT

Training at the preservice level presented several significant challenges, including crowded clinical practicum sites that limited opportunities to practice skills and delays in new graduate deployment. Many senior providers assumed there were gaps in clinical training and required that new graduates continued to learn from senior staff before allowing them to provide care. This delayed service initiation, combined with the eventual reassignments of graduates throughout the project, highlighted the need to add on-site FP training (including PFP).

Due to the sheer magnitude of the PFP scale-up, ensuring that new graduates had appropriate supervision to support them in delivering PFP was challenging. Working with district health management teams, district supervisors, and other mentors was useful for establishing supportive supervision and skill maintenance, although it also required orienting these teams on the skills and approaches necessary to ensure PFP delivery.



Two young mothers outside a clinic with their young children.



### **Developing skills labs and strengthening instructor capacity improved the overall teaching quality**

although additional considerations are necessary to ensure high-quality immediate PFP provision. Despite support for skills acquisition as part of preservice education, for example, practicum sites were still crowded with students joining from several private midwifery schools. This issue will require further advocacy with the MOH and engagement with clinical practicum sites and private midwifery facilities.

### **In addition, strengthening preservice education alone was not enough.**

Adding on-site PFP training and engagement with facility managers to ensure PFP availability was also necessary. The long delay (anywhere from a few months to more than a year) between graduation and deployment to facilities was also an issue beyond the project's control and increased the risk of losing skills. Rapid support to maintain or relearn skills was therefore needed. After new graduates were deployed to facilities, regular supervision was critical and required engaging local, district, and regional leaders.

## recommendations

- 01 Ensure close engagement with the ministry of health.** The MOH was crucial for curriculum updates, strengthening teaching and clinical practice, supporting deployment, and safeguarding PFP availability.
- 02 Deploy a multipronged training approach.** Until immediate PFP is fully institutionalized, a multipronged preservice and in-service approach is necessary. This should include supportive supervision and site-based training so that facility staff can respond to demand and offer PFP, even after new graduates are reassigned elsewhere. Equipment provision to all facilities was essential.
- 03 Ensure strong client-centered and balanced counseling.** Immediate PFP provision relies on ensuring pregnant women are counseled on and voluntarily choose a postpartum contraceptive method before arriving at the facility to give birth. This approach is in line with the HIP recommendation to leverage every ANC contact to support contraceptive counseling. A mid-project evaluation found that after deployment, only 34 percent of midwifery graduates involved in the project demonstrated competence in counseling, which needed to be addressed. Future projects should place a strong emphasis on balanced counseling during all ANC visits, facility delivery, and postpartum points of contact, to enable a woman to make the best contraceptive choice for herself.
- 04 Include robust monitoring throughout the process.** It is essential to ensure that PFP data is captured at the local level to feed up to the national level through the HMIS with consistent indicators to measure PFP uptake. Regular use of this data at all levels will also help identify any potential problems in supply chain, provision, or uptake of PFP. The implementation of an electronic collection mechanism via smartphones in health facilities could be one of the solutions to strengthen the collection system by improving the promptness of data transmission.
- 05 Ensure a strong and supportive supervision system.** As with any capacity-strengthening project, but especially when following new graduates, a strong supportive supervision system is essential to further develop skills and engage with facility managers to support PFP delivery. This may include training existing providers in facilities where new graduates are deployed, through on-site training and orientation.

## REFERENCES

- High-Impact Practices in Family Planning (HIPs). (2017). Immediate Postpartum Family Planning: A key component of childbirth care. USAID. <https://www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning/>
- Institut National de la Statistique et de la Démographie (INSD)/Burkina Faso. (2015a). Enquête Multisectorielle Continue (EMC): Santé Générale et Santé de la Reproduction. Ouagadougou: INSD. [http://www.indsd.bf/n/contenu/enquetes\\_recensements/Enq\\_EMCSante\\_generale\\_et\\_Sante\\_de\\_la\\_r%e9production.pdf](http://www.indsd.bf/n/contenu/enquetes_recensements/Enq_EMCSante_generale_et_Sante_de_la_r%e9production.pdf)
- Institut National de la Statistique et de la Démographie (INSD)/Burkina Faso. (2015b). Annuaire Statistique 2015. Ouagadougou: MOH. [http://www.indsd.bf/n/contenu/pub\\_periodiques/annuaire\\_stat/Annuaire\\_stat\\_nationaux\\_BF/Annuaire\\_stat\\_2015.pdf](http://www.indsd.bf/n/contenu/pub_periodiques/annuaire_stat/Annuaire_stat_nationaux_BF/Annuaire_stat_2015.pdf)
- Institut National de la Statistique et de la Démographie (INSD)/Burkina Faso and ICF International. (2012). Burkina Faso Enquête Démographique et de Santé et à Indicateurs Multiples (EDSBF-MICS IV) 2010. Calverton, Maryland: INSD/Burkina Faso and ICF International. <http://dhsprogram.com/pubs/pdf/FR256/FR256.pdf>
- Institut Supérieur des Sciences de la Population, Université Joseph Ki-Zerbo, Ouagadougou, Burkina Faso, and The Bill & Melinda Gates Institute for Population and Reproductive Health at The Johns Hopkins Bloomberg School of Public Health. *Performance Monitoring and Accountability 2020 (PMA2020) Survey Round 6, PMA2019/Burkina Faso-R6 Family Planning Brief*. 2019. Ouagadougou, Burkina Faso and Baltimore, Maryland, USA. : [https://www.pmadata.org/sites/default/files/data\\_product\\_results/PMA2020-Burkina-R6-FP-Brief-EN.pdf](https://www.pmadata.org/sites/default/files/data_product_results/PMA2020-Burkina-R6-FP-Brief-EN.pdf)
- Ministere de la sante, Burkina Faso, Plan National d'Accélération de la Planification Familiale (PNAPF, 2017-2020), citant EMDS-2015. <http://www.familyplanning2020.org/sites/default/files/Burkina-Faso-CIP-2017.pdf>
- World Health Organization (WHO). (2018). Family Planning: A Global Handbook for Providers. Geneva: WHO. <https://www.who.int/reproductivehealth/publications/fp-global-handbook/en/>
- World Health Organization (WHO). (2015). Medical Eligibility Criteria for Contraceptive Use. Fifth ed. Geneva: WHO. [https://www.who.int/reproductivehealth/publications/family\\_planning/Ex-Summ-MEC-5/en/](https://www.who.int/reproductivehealth/publications/family_planning/Ex-Summ-MEC-5/en/)