

implementation story:



An Integrated Approach to Increasing Postpartum Long-Acting Reversible Contraception in Northern Nigeria



Trained health care worker assisting a delivery.

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Background and Context

Many women around the world do not get to choose how many babies they have, when to have them, or how to space them. In Northern Nigeria—particularly North West Nigeria—the median age of first marriage is 18 (Nigeria Demographic and Health Survey [NDHS], 2018). In addition, many women are pregnant half a dozen times by the end of their childbearing years. Limited access to information and care to appropriately time and space pregnancies puts women at an increased risk of maternal health complications. Early childbirth is associated with increased risk of complications during pregnancy and childbirth and higher rates of neonatal mortality (NDHS, 2018).

With a population of over 200 million and a maternal mortality ratio of 512 deaths per 100,000 live births, Nigeria is the second largest contributor to the global burden of maternal deaths—58,000 annually (NDHS, 2018). In fact, the unmet need for voluntary family planning among married women of reproductive age is 19 percent and only 3 percent

“CHAI has transformed our knowledge, has made us stand confidently, made us to know we can do it. When CHAI started, I was among those to say: How can a woman who has delivered and in pain be given family planning? Would that work?”

Postpartum family planning service provider



“Sometimes after church on Sundays, the TBA [traditional birth attendant] will call and tell me that there is a woman who has delivered and says she wants to have an IUD [intrauterine device] inserted. I just give my handbag to my children and go straight to the health facility to provide the service.”

Service provider

of postpartum Nigerian women use contraception within six months after delivery (NDHS, 2018). In addition, only 16.6 percent of married women of reproductive age use contraception and just 12 percent use a modern method—a slight increase from five years earlier when the contraceptive

prevalence rate was 15 percent and the modern contraceptive prevalence rate was 10 percent. A major contributor to the low contraceptive prevalence rate in the country is poor access to family planning services, which is more pronounced in rural areas. In 2015, only 5,500 of the country's 29,000 primary health facilities offered voluntary family planning and only about 1,000 offered long-acting reversible contraceptives.

Expanding access to long-acting reversible contraceptives provides women the choice of more options, including more effective methods to reduce unintended pregnancies and associated negative health outcomes. Providing long-acting reversible contraceptives during the postpartum period is an even more effective intervention as it provides women with voluntary family planning when they need it most and when the health benefits are greatest. However, only 3 percent of postpartum Nigerian women use contraception within six months after delivery (Track20, 2016).



Nurse holding insertion materials.

THE HIGH IMPACT PRACTICE

The program used the [Immediate Postpartum Family Planning](#) high impact practice to develop and implement an integrated reproductive, maternal, neonatal, and child health approach to increase access to voluntary postpartum family planning (High-Impact Practices in Family Planning, 2017). Between 2016 and 2019, the Clinton Health Access Initiative Inc. (CHAI) worked with three states in North West Nigeria—Kano, Kaduna, and Katsina—to address the low contraceptive prevalence rate and high unmet need. The project aimed to address several key barriers identified through a baseline assessment, including the shortage of trained health care providers for postpartum family planning, limited availability of family planning commodities and equipment, lack of national data on immediate postpartum family planning, limited client knowledge on methods, and restrictive sociocultural and gender norms.

The integrated approach included:

- Strengthening the quality of service delivery by training and mentoring health workers and focusing on quality of care
- Integrating voluntary postpartum family planning messaging into routine antenatal care counseling to ensure pregnant women were adequately informed during pregnancy and before delivery
- Leveraging community birth attendants through a Champion Traditional Birth Attendant strategy to generate increased community referrals for voluntary postpartum family planning
- Reorganizing the clinic workflow to provide voluntary postpartum family planning information at all points of care for pregnant women including antenatal care, routine immunization, labor and delivery, and postnatal care units.

Nurse counseling mother on family planning options.



Implementation Story

CHAI conducted a baseline assessment among 845 facilities in 30 local government areas across the three states to understand the level of service provision and effectively dispense resources. Working with the state ministries of health, the project developed a tailored and integrated voluntary postpartum family planning scale-up approach to address key supply and demand constraints.

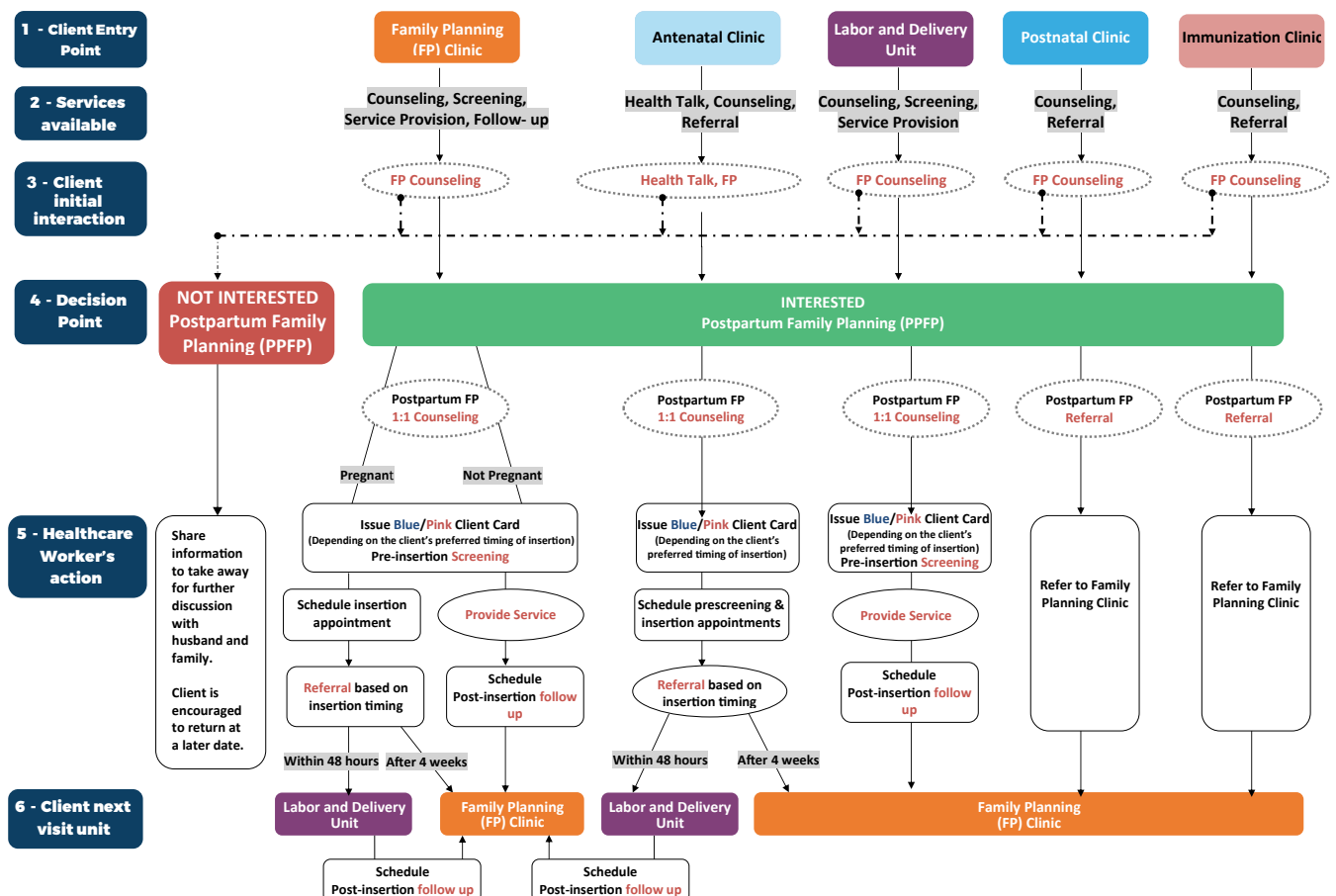
CHAI trained and mentored health care workers in health facilities to provide high-quality voluntary postpartum family planning and provided the appropriate instruments and equipment for service provision. The program adopted training and mentorship model for health workers to improve their knowledge and skills to provide voluntary postpartum family planning. Using the national training curriculum, the intensive five-day didactic training was followed by three months of on-the-job clinical mentoring. Government state trainers in each state conducted the trainings, and CHAI supported the states to identify a pool of (mostly retired) nurses and midwives to serve as clinical mentors and provide on-the-job mentoring. The goal of clinical mentoring was to improve the quality of care at health centers and strengthen the competencies and confidence of trained health workers. Health workers from family planning and labor and delivery units were selected for the comprehensive training and mentoring program, whereas health workers from the antenatal care and routine immunization units were trained solely on voluntary postpartum family planning counseling. The project also donated critical equipment, instruments, and basic consumables to the states, including uterine sound, Kelly's forceps, Cusco's speculum, tenaculum, and tissue forceps to ensure that participating health workers were able to provide appropriate care. CHAI also worked closely with the state ministries of health to ensure timely and consistent distribution of family planning commodities to the facilities to meet service requirements.



"BEFORE, EVERY 10 MONTHS MY WIVES WOULD GIVE BIRTH, BUT NOW MY WIVES HAVEN'T GIVEN BIRTH IN TWO YEARS. UNLIKE THE REST OF MY CHILDREN, THESE LAST TWO HAVE NEVER BEEN SICK. MY FRIENDS ASK ME HOW IT IS THAT MY WIVES HAVEN'T GIVEN BIRTH IN A WHILE. I TOLD THEM TO SEEK HELP FROM GOD AND STILL GO TO THE HOSPITAL"

Husband of two beneficiaries, Katsina

Figure 1. Client Workflow



The project also worked with health facilities to reorganize clinic workflows to reduce missed opportunities and improve linkages between different touchpoints (e.g., antenatal care, routine immunization, postnatal care, and labor and delivery units). At each unit, health workers provided postpartum family planning counseling information and referred women for family planning services. As shown in Figure 1, clients were able to access voluntary family planning and postpartum family planning via the linked units.

Before delivery, postpartum family planning messaging and counseling were integrated into antenatal care counseling to ensure all pregnant women learned about voluntary family planning options available after birth—[informed by the World Health Organization Medical Eligibility Criteria Wheel for Contraceptive Use](#) (WHO, 2015). To support systems strengthening and the quality of voluntary postpartum family planning, CHAI also implemented a quality improvement plan adapted from the World Health Organization standards for quality of care in health facilities. In alignment with these standards, CHAI's strategy included client exit interviews to assess perceptions of care, which were used to share feedback with health workers on a frequent basis.

One of the trained traditional birth attendants, Hauwa Muhammad from the Kudu local government area said, ***“I am full of gratitude to CHAI for recognizing and building my capacity right from the MNH [maternal and newborn health] program through the PPFP [postpartum family planning] program. Over time, I have become more confident in carrying out tasks such as referrals for ANC [antenatal care], deliveries at the health facilities, and referrals for PPFP insertions. The community now regards me with high respect and people rush to seek guidance on activities that require the attention of an HCW [health care worker]. TBAs [traditional birth attendants] in my community are now respected by men unlike before the takeoff of the PPFP program where we were detested by some people.”***

Due to low rates of institutional deliveries in the coverage areas—Kano (13 percent), Kaduna (32 percent), and Katsina (9 percent)—CHAI implemented a demand-generation strategy that leveraged traditional birth attendants, male influencers, and traditional leaders (NDHS, 2013). These groups were sensitized on the benefit of healthy timing and spacing of pregnancies through town hall and compound meetings, which were promoted to community members at places of worship and Islamiyah schools. At the beginning of the project, postpartum intrauterine device uptake and client demand were low because of the stigma of promiscuity in women, discomfort around the clinical procedure, and family opposition. These barriers were addressed through sensitization activities.

CHAI also trained traditional birth attendants to counsel and refer pregnant and immediate postpartum women to health facilities and equipped them with a counseling handbook in the local language. To address transportation barriers, the program improved referral networks through the use of existing voluntary



community motorbike ambulances to enable access to voluntary postpartum family planning at no cost to the client. The communities provided support for the maintenance and fueling of the motorbike ambulances and demonstrated strong ownership of the vehicles.

During program implementation, 374 facilities—100 percent of which are now additional access points for voluntary postpartum family planning—received equipment and instruments following the training and mentoring of 2,850 health workers. In total, 1,953 traditional and religious leaders, 1,800 Islamiyah students and out-of-school youths, and 1,200 members of Muslim and Christian religious groups in the 30 local government areas were reached with messaging on healthy timing and spacing of pregnancy, voluntary postpartum family planning, and reproductive health. Additionally, CHAI engaged 2,862 traditional birth attendants to increase acceptance of postpartum family planning in their communities and promote uptake through focal traditional birth attendant identification to engage pregnant women close to their due date and provide information on healthy birth, timing, and spacing.

These joint efforts led to an increased proportion of women receiving antenatal care—from 10,320 clients attending their first antenatal care visit in 2016 to 34,527 clients in 2019. In addition, 146,833 women from 374 target facilities chose and received voluntary postpartum family planning immediately after delivery—58,683 for postpartum intrauterine devices and 88,742 for postpartum implants—helping them to safely space their pregnancies. This represents significant growth in the uptake of voluntary postpartum family planning in target areas where such services at facilities were rarely available at baseline. In fact, by the end of the program, 30 percent of women delivering at program facilities across the three states received immediate voluntary postpartum family planning, and 100 percent of women attending antenatal care visits were counseled on postpartum family planning. Due to the strong community-led demand-generation approach, by the end of the program, more than 25 percent of women who received an immediate voluntary postpartum family planning method were women who delivered at home and were referred to the health facility within 48 hours. For those who delivered at home—up to 80 percent on average—the participation of volunteer drivers made it possible for them to access postpartum family planning immediately following home delivery.



A trained Healthcare Provider, a PPFP Beneficiary and a trained Traditional Birth Attendant



Traditional Birth Attendants (TBAs) during a sensitization meeting.

Community engagement and ownership is crucial in the acceptance and sustainability of interventions.

In addition to government stakeholders, it is essential to involve the community including traditional leaders, village heads, and key community influencers such as traditional birth attendants and male stakeholders. As key beneficiaries of the program, they need to be included in program design and implementation to increase their sense of ownership and obligation, ensure the success and continuity of the intervention, and build trust in the formal health care system.

Mentorship, supervision, and feedback are critical for the provision of quality voluntary postpartum family planning.

The Bespoke mentoring model—where mentor and mentee performance are closely monitored—should be tailored to individual providers to improve the provision of health care by addressing gaps identified in the baseline assessment. The Cluster mentoring approach—for strengthening provider skills and confidence at lower volume sites—was used to identify five to seven primary health centers that had two or more health workers who had been trained but not mentored by CHAI. This created an opportunity to pool health workers to reinforce counseling and insertion skills. To ensure adequate hands-on practice during mentoring, traditional birth attendants mobilized clients to attend identified health facilities on mentoring days. This enabled each health care provider to learn best practices from staff in other facilities and foster healthy competition between facilities to improve counseling skills, insertion and removal skills for implants and intrauterine devices, as well as data use and management, to ensure continuous improvement in the provision of quality voluntary postpartum family planning.

Sequencing supply and demand activities, creating an enabling environment at the facility, and ensuring equipment and commodity availability are important program components.

Understanding the local context and barriers that affect uptake of voluntary postpartum family planning, and tailoring program interventions to address them, can improve uptake. These factors should also guide the sequence for conducting activities and priorities—ensuring programs allow enough time between community awareness, acceptance and interest in postpartum family planning, and ultimately uptake of methods. Finally, for optimal health care provision, facilities with trained health workers need to have the required equipment and instruments for voluntary postpartum family planning service provision.

recommendations

- 01 Advocate to the government** and provide technical assistance to ensure commodity security and to strengthen the supply chain to the last mile through increased data visibility (i.e., commodity forecasting, quantification, procurement, and distribution).
- 02 Identify and fill equipment and instrument gaps** at facilities following service readiness audits.
- 03 Strengthen the capacity of the government** to manage the voluntary postpartum family planning program through structured trainings on monitoring and evaluation and quality data management with state monitoring and evaluation officers and training state logisticians on commodity and logistics management systems.
- 04 Update and modify clinic flow** to integrate voluntary postpartum family planning at all points of care including antenatal care, routine immunization, and postnatal care units.
- 05 Engage and train community influencers, including traditional leaders and male stakeholders**, to create community demand and increase awareness about the benefits of voluntary postpartum family planning—by leveraging existing structures and dissemination points in the community (i.e., traditional birth attendants, ward development committees, and emirate councils.)
- 06 Expand the use of existing referral networks** to include voluntary postpartum family planning support and link clients to health facilities providing postpartum family planning.

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