

Inside the FP Story Podcast

SEASON 2, EPISODE 5

Innovating to meet clients' needs

[About *Inside the FP Story* Podcast]

From Knowledge SUCCESS and the World Health Organization's IBP Network, this is Season 2 of *Inside the FP Story*—a podcast *with* family planning professionals, *for* family planning professionals.

The international family planning field has generated a *lot* of data, a lot of reports, and a lot of lessons learned. But we don't often have the opportunity to get *behind* that information, to hear directly from the people who implemented a program, or who did the analysis, and so we reinvent the wheel or miss the mark because we don't know what could be *really* critical in a particular context. *Inside the FP Story* is that opportunity.

Each season, we hear directly from program implementers and decision makers from around the world on issues that matter to family planning programs. Through these honest conversations, we learn how we can improve our family planning programs as we work together to build a better future for all.

I'm Sarah Harlan, the Partnerships Team Lead for the Knowledge SUCCESS project. I'm pleased to welcome our narrator, Sakshi Sharma.

[Introduction to the Second Season: Family Planning Implementation Insights]

Narrator

This season on *Inside the FP Story*, we're partnering with the IBP Network to explore issues around implementing family planning programs. This season, we've learned about programs that focus on community engagement and youth—including programs that reach people living in rural and remote areas, programs integrating family planning services with other health areas and settings, and programs that are responsive to the unique needs of adolescents and youth.

This episode, we are changing course a bit, to focus on overall systems and policies. From pre-service training for midwives and obstetrics and gynecology students in Burkina Faso to a fixed day approach for family planning provision in India, we will explore innovations that meet family planning clients' needs and create enabling environments that allow family planning programs to be successful.

[Strengthening Pre Service Education of Midwifery and Obstetrics and Gynecology Students in Burkina Faso]

Earlier this season, we learned about a program that successfully integrates family planning with postpartum care. Postpartum Family Planning—or “PPFP”—is considered to be a high-impact practice in family planning, and is a critical way to ensure that women adopt a family planning method of their choice after giving birth.

In this episode we’ll hear about another PPFP program—this time in Burkina Faso, where Jhpiego worked with multiple partners to strengthen the national pre-service education system for midwifery and obstetrics and gynecology students. Using global standards and guidelines—for example, the WHO Family Planning Handbook and the Medical Eligibility Criteria for contraceptive use—they ensure that providers are appropriately trained in PPFP *before* they complete their education. This program has successfully increased access to postpartum family planning throughout Burkina Faso.

To hear more about this program, we spoke with Yacouba Ouedraogo and Bethany Arnold, both with Jhpiego.

Yacouba Ouedraogo

My name is Yacouba Ouedraogo, and I’m working as a Senior Program Manager for Jhpiego in Burkina Faso.

Bethany Arnold

Hi, my name is Bethany Arnold. I’m a Technical Advisor on the Family Planning and Reproductive Health team at Jhpiego.

Yacouba Ouedraogo

This intervention we had between 2015 and 2020 was to respond to a need to make PPFP services available to women in Burkina Faso. And to do that, it was necessary to increase the number of providers capable of offering these services in the health facilities. So we did a close collaboration with Ministry of Health, first of all, to introduce the PPFP service in the pre-service education, to have provider trained since the pre-service education and when they are deployed at the health facilities we also had to do the mapping of the site where they were deployed and to strengthen the health facilities’ capacities with equipment and support the delivery of health services by the new graduates.

Bethany Arnold

It included also developing and building skills labs at both of those schools and then a few others as the project continued. The project followed the graduates from their midwifery training school or from their medical training school to their first site and supported them both in terms of provision of supplies for postpartum IUD insertion as well as general support for the start of their clinical career.

Narrator

The supplies were provided to the facilities where the graduates were deployed, and followed them if they moved facilities. The first three years, the program followed the graduates to their

sites for supervision visits. In years four and five, they still worked in pre-education and followed graduates, but they added onsite training to expand the number of providers trained—beyond just new graduates.

We asked why the program chose to focus on pre-service training, as opposed to in-service, or on-the-job training.

Yacouba Ouedraogo

Every year we have around 1,000 new graduates deployed on the field. Every time we have new graduates, we have to train them again. So the objective was to have the new graduates ready to offer the services. The curriculum we revised with the Ministry of Health is still being implemented and all the new graduates we have now are skilled on PPFP. The main reason is to build the sustainability, starting at pre-service education.

Bethany Arnold

This project was designed with an eye towards sustainability, really from the get-go. Often with in-service training, you train two providers from site A, two providers from site B, two providers from site C and so on. But you're playing catch-up all the time. And so then new graduates come to facilities, and they need to be included. And so the idea was really to start from their foundation.

Narrator

What made this project innovative from previous approaches was the holistic approach—and the inclusion of PPFP within both pre-service and in-service education. The continual support was also a unique and effective approach. The program team worked with the graduates to make sure they had the necessary equipment and support to be able to deliver PPFP services once they started their career.

Part of this support was provided in the form of mobile mentorship. We asked Yacouba to describe this component of the project.

Yacouba Ouedraogo

Mobile mentorship approach was implemented using an online platform to send some SMSes to the providers. So, the providers were oriented during the training—some during the pre-service education training and some during the in-service onsite training—and they were voluntary to provide their phone numbers to be included in the program.

And the program aims to strengthen the knowledge, sending knowledge reinforcement messages, and also sending quizzes to assess knowledge retention by providers. This process helped us to keep connection with the providers when they're on the site.

Narrator

The program also used a champion model. When new graduates are deployed, many of them will work with more experienced providers that did not receive the same training in postpartum

family planning and therefore do not have the same skill set. To address this, the program included on-site training, using new graduate champions to encourage other providers to become trained in PPFP.

Yacouba Ouedraogo

Those people are used to encourage their colleagues, in other sites, and even to bring the health facilities, the previous providers to also join and try to learn with them and to get them engaged for the service delivery. And we did a kind of mentorship to support these motivated champions and help them to work with the others to try to engage, to motivate the other providers to also drive the service delivery.

Narrator

Overall, the program was successful. Not only did the students in the program learn the skills required to deliver high quality PPFP services, and gain the necessary equipment—but the project successfully scaled up nationwide, training over 730 midwifery and 70 OB/GYN students. These students were deployed to more than 270 health facilities across every region of the country.

Yacouba Ouedraogo

It is helpful to have now the PPFP services fully integrated in the pre-service education for the OB/GYN and also for the midwives. So, today this approach is integrated and all the new graduates leave the school and join the field of service delivery skilled for a PPFP service delivery.

Narrator

This program translated into higher uptake of postpartum family planning. For example, IUD uptake was 10% in project sites compared to 4.7% nationwide. Bethany talked about the importance of these results.

Bethany Arnold

This project really has been about the sustainability factors, about making sure that all new midwives and new OB/GYNs trained in the public system in Burkina Faso are trained in PPFP. Those who have worked on not just curriculum development, but national guideline development, it is a very long, difficult process sometimes. And so I think that really getting it integrated into the pre-service training system was a tremendous impact.

Narrator

Often, when innovations start in a country, they are started in just one district or community with the hope of spreading. But this approach went beyond just a few districts—it helped change policies and systems to ensure that postpartum family planning methods are available in *all* regions and *all* districts in Burkina Faso.

Bethany also talked about the impact of the on-site training approach. They added this approach to the pre-service training based on need.

Bethany Arnold

When a new graduate was deployed to their site and they were with their colleagues, then it was training their other colleagues who may have graduated five years before, 10 years before, 30 years before, training them in PPFP methods at the facility to really ensure that as providers eventually moved or were reassigned elsewhere that those services were still available. And the impact with that, the team has really created a standard for training in Burkina Faso, and that other implementing partners are doing so that you're not taking providers outside of their health facility, but training them right in the facilities.

Narrator

We asked Yacouba and Bethany what lessons they learned while implementing this program. Yacouba mentioned the dynamics between the new graduates and some of the existing providers. While the program staff expected that new graduates would be trained and able to immediately start offering postpartum IUDs and postpartum implants and removals at their sites, that wasn't the reality on the ground.

Yacouba Ouedraogo

At the beginning they did not feel very comfortable to work with the new graduates because they were not able to coach them and supervise them as they were supposed to do. So as a result, the new graduates, some of them were not comfortable getting started and moving forward with the activities. So if we, was able to anticipate that kind of attitude and reaction, we could have included another component to address this kind of situation, starting with the in-service component when we were still working with the pre-service education.

Bethany Arnold

That was really the big learning, I think, internally for this project too, is that, as Yacouba said, we needed to anticipate there would be some hesitation from supervisors or more experienced providers who might be apprehensive or not realize that new graduates had these new skills that had just recently been introduced within pre-service clinical training.

This project did a lot of working with students and giving them practice in skills labs. And so they had a lot more time to learn these skills on training mannequins and models than previous graduates who had maybe learned in lecture halls and then were straight at a facility. And so I think there was some misunderstanding, or misjudgment from providers already in facilities as to the skills new graduates were coming in. So that was a big learning and I think it's something we definitely recommend that other people consider in future types of programs, introducing such new skills through pre-service. You really need to make sure that the facilities that will be welcoming these new graduates understand the skills that they come in with and are comfortable having them offer them right away.

Narrator

We asked Yacouba and Bethany what advice they had for others looking to implement similar programs.

Yacouba Ouedraogo

The development of skills lab and capacity building for teachers was a key aspect to improve the overall quality of pre-service education. Not only for PPFP training, but also for other competencies, because the skills lab had many other components for all of the service delivery needed for maternal and child health.

Narrator

Yacouba also recommended integrating postpartum family planning data within health management information systems, so the data can be used to inform decision making.

Bethany added some additional advice for those looking to scale up interventions for system-level change.

Bethany Arnold

If you really want to scale up an intervention, it needs to be a multi-pronged approach. From the start, we thought that, “Okay. Going just through pre-service, that’ll be sufficient. We will have trained providers across the entire country.” Which we did have. But that turned out not to be sufficient, which is why we needed to add the in-service, onsite training approach for other providers who had already graduated years before, who would have otherwise missed the opportunity. When you’re thinking about sustainability, you have to think about equity too, in terms of even, who in facilities is being trained.

The program in Burkina Faso scaled up an innovative approach that strengthened the health system and improved the availability of postpartum family planning. It responded to structural barriers—including the lack of access to trained health providers—that can often prevent women and girls from accessing life-saving contraception. As a result, this project was instrumental in expanding method choice more broadly, improving quality counseling for PPFP, and providing professional development opportunities for the family planning health workforce.

[Fixed-Day Static Approach: Informed Choice and Family Planning for Urban Poor in India]

Now we’ll hear about a program in India that was also designed in response to structural barriers—in this case, lack of access to family planning among poor women in urban areas.

Population Services International India, in collaboration with the national health mission and several local governments, implemented a fixed-day static approach for family planning. This approach makes a wide variety of contraceptive methods available at urban primary health care facilities during specific days and times.

To hear more about this program, we spoke with Deepti Mathur from PSI India.

Deepti Mathur

I'm Deepti Mathur. I work with the Population Services International India and I look after the knowledge management for the Challenge Initiative for healthy cities. And my role is the technical lead for program learning and training.

Under the Challenge Initiative for healthy cities, which is implemented by Population Services International in India, we adapted an approach of the national health mission, which is done by them in rural areas for permanent methods. We adapted the approach, and we took it to the urban primary health centers, which was never tried before. And we took it for the spacing methods, which has never been tried before. So the high impact intervention that we implemented, increases access and availability of high quality family planning, including long-acting reversible contraceptives for women of reproductive age. It focuses on the needs of young women who reside in slums and this approach ensures the optimal utilization of resources. It ensures the ability of human resources, supplies, method choices on a particular day and time known to the community.

Narrator

This program focuses on the urban poor in India—a population which is increasing by the day, and which often isn't aware of family planning services.

Deepti Mathur

So for a woman who resides in urban pockets, in urban slums, she is first not aware that she has a nearby primary health center, which can provide the services. She did not know that, this can take care of her family planning needs. She doesn't need to go to the bigger hospital, which is about 30-40 kilometers away from her house. So for a woman, this approach means that, one, that the community health worker who visits her household, she is now aware that when she visits the household, she asks the women, she knocks the door, and she asks, "Do you need family planning?" Then she offers complete method choice. She's aware that it is not just the permanent method that you have to offer and go to a bigger hospital. It is the other choices and it is not just pills or condoms. It is the other methods, which includes injectables, IUCDs, or other methods, which are also available at quality as the nearest primary health center. So for a woman, it means that she doesn't have to forgo her day's wages, forgo taking care of her household. She can just visit the nearby primary health center and be assured that on this day she will be given family planning.

Narrator

Deepti talked about the important role of accredited social health activists—abbreviated as ASHAs—in this approach. ASHAs are community health workers instituted by the national Ministry of Health and Family Welfare. This program trains and coaches ASHAs, so they provide high-quality family planning counseling as well as referrals for contraceptive services.

Deepti Mathur

We have the trained provider, we have equipment, we have kits, we have commodities, and we have other things in the environment. However, if the woman who was appointed by the government, which is the community health worker, if she does not know how to find a woman

and how to counsel her, then this approach cannot work. So ASHAs play a central role in this entire approach. Under this TCI project, each ASHA—each equity social activist—was coached once a month for 12 months in person. She was imparted skills on, one, informed choice counseling and referrals.

Narrator

During their in-person trainings, ASHAs were coached on five main areas including informed choice counseling and referrals; creating a list of priority households for family planning, based on records and household visits; using communication materials during counseling; responding to questions about family planning methods; and linking the community to the fixed-day service approach — abbreviated as “FDS.”

One PSI staff member visited 10 households with each ASHA once a month for a year. In 12 months, 6,000 ASHAs were coached across 31 cities in three states of India.

Although this approach was adapted from an existing government program, they encountered resistance when they suggested altering the approach to include more methods, and to provide services in urban primary health centers—abbreviated as “UPHCs.”

Deepti Mathur

This approach came from an approach which was done by the government for permanent methods and for rural areas. So they had a mindset that this FDS means permanent methods. FDS means rural areas.

So, they could not envision that this can cater all methods on that particular day and for that, UPHCs can be enabled and equipped.

Narrator

To address this mindset, the PSI team used evidence. This approach was not just based on anecdotes—the team had actual data that this would work.

Deepti Mathur

So, we showed them the evidence and the chief medical officers were impressed and they asked us to demonstrate it in a few facilities.

Narrator

The PSI team accepted the challenge—in a few select facilities, the team demonstrated the approach. They set their “fixed” day, devised their priority list, and began visiting households to promote and market the program. They coached the ASHAs, secured the contraceptive supplies, and ensured that trained providers were available.

These demonstrations showed the effectiveness of this adapted approach.

Deepti Mathur

And the results of the demonstration was such that it was over between 50 to 90% higher than of those of that particular month. And these results led to a change in mindset of the medical officers first. The medical officers in charge are the heads or the leads of the facilities.

So, they then observed that, the community around wants services, they need services, and then they're coming for services. The need is there. And by demonstrating that, if you fix everything and publicize it in the community, the community takes the services and this works.

So these medical officers became champions for us. They became advocates for us. This was a game changer actually.

Narrator

Using one fixed day per week for provision of family planning in each community, the program has led to increased uptake in family planning.

Deepti Mathur

So from the demonstrations, we already saw that those particular months, the family planning uptake was higher than was earlier, between 60 to 90%. However, after these demonstrations, we saw that they were scaled up by the city government themselves. From 2% of the facilities where we demonsted, to 100% of the facilities of the city.

Narrator

Scaling up this approach contributed to a 168% increase in annual clients accessing family planning services across the cities in the program—as of March 2020.

We asked Deepti what specifically made the program successful.

Deepti Mathur

Well FDS requires all the pieces to be put together. It will not happen if only one piece is picked up. However, the most critical part is identifying the right clients.

Narrator

She said it is a must that ASHAs have lists—they call them “FP due lists”—which help them prioritize which households to visit to market the program.

We asked Deepti what is one thing she wished she had known before starting implementation of the program. She said looking back, it would have been good to invest more time in analyzing data from the HMIS—or the health management information system—in the areas where they were working. This may have allowed them to look at data on trained providers—and compared this with the actual situation in the clinics, to make sure providers who said they were trained in family planning methods, for example IUD insertions, actually are comfortable providing these methods.

Deepti hopes that others working in family planning learn from the FDS story—as this can help improve access to family planning, even within settings where family planning has not been prioritized.

Deepti Mathur

So one is that everybody should understand the priority of family planning. And FDS is one such approach which can quickly lead to increased uptake. And it only means that you equip the facilities at least for one day in a week.

So if you have a provider, if there is a challenge of providers, ensure that on that particular day, the trained provider is available. That if there is an issue with the supply chain management, ensure that on that one particular day, supplies are there. That ASHAs who anyway are a link between community and the government health services and health teams, that they know how to reach the client. So this is an approach which can change the game entirely and very quickly.

Narrator

Making these improvements to healthcare centers helps improve health systems overall—not just for family planning.

This program showed that FDS can be done in primary healthcare centers in urban areas, and made spacing methods, like IUDs and injectables, more accessible for women in urban centers.

Deepti also shared that these urban centers can offer an opportunity to reach mothers who are bringing their babies for scheduled immunizations. In urban areas in India, there are camps that offer what they call “Urban Health and Nutrition Days”—or UHNDs. Beyond nutrition, these camps provide those communities with immunization and other services also.

Deepti

If family planning is integrated at the UHND, which means, a mother is already there. She has a baby whose taking immunization. She may have future needs for family planning. So an opportunity is there to reach out to the women. Does she need family planning?

Narrator

The programs we featured in this episode showed us how scaling up community-level programs can not only improve family planning access and use, but can strengthen the entire health system. Both programs also responded to structural barriers—particularly poverty—which can prevent women from obtaining reproductive health services.

As this is the first in our two episodes on the enabling environment and strengthening systems for family planning programs, we ended our conversation with Deepti by asking her what an enabling environment means to her, and what it needs to include to be supportive of family planning programs.

Deepti Mathur

There needs to be a shared vision. When we say that family planning needs to be prioritized, this vision needs to be shared by all of the departments. It is not just people who work for the family planning department who must have this. It is people who work for any other dimension, any other area also. That this is a larger goal, which will contribute to their goal also.

[Conclusion]

Narrator

This shared vision—a crucial aspect of family planning programs—will be a key focus of our next episode. Join us next time—for our final episode this season—where we will explore the role of partnerships and advocacy in family planning programs.

These stories are part of a series of 15 stories selected from a global competition hosted by IBP and Knowledge SUCCESS to highlight experiences implementing HIPs and WHO guidelines. If this episode left you hungry for more, we encourage you to read the other stories on the IBP Network website.

[Credits]

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If you have any questions or suggestions for future episodes, feel free to reach out to us at info@knowledgesuccess.org.

Thank you for listening.