Virtual Fostering Change Program (VFCP) for PAC Teams

Kristin Cooney
November 2011
A perfect partnership

Proven PAC practices: clinical and technical work

combined with

Proven practices for change: effective introduction & scale up
Virtual Fostering Change Program for PAC

- Interactive internet-based program
- Practice-based learning
  - Website & printed materials
  - Face-to-face team meetings
  - Individual & team work
- Facilitated by two RH/PAC experts
- Used in conjunction with Global PAC Resource Package
- January 26, 2009 to March 19, 2010
Principles for Fostering Change

- Change must matter to those making the change
- Credible, committed internal Change Agent is critical
- Support for Change Agent is key
- Support for change at all levels is fundamental
- Clarity on purpose, benefits, and results of change is essential
- Motivation throughout the process
- Clear roles and responsibilities
- **Start where you can and start now**
**VFCP PAC Objectives**

- **Provide TA virtually to teams to further develop and define, then implement action plans started during the Senegal PAC conference in October 2008**

- **Meet teams’ objectives in improving the PAC services in their countries:**
  - Strengthening postabortion family planning as an integral component of PAC service delivery
  - Decentralization of PAC services from tertiary care facilities to health centers and health posts
  - Community involvement for improving PAC services
VFCP Objectives

- Introduce and scale up a select best practice or set of practices
- Improve health outcomes in their settings
- Build skills in leading and managing change
- Strengthen individual leadership and management skills
- Improve teamwork
VFCP PAC Teams

- **Burkina Faso**
  - Ministry of Health, Department of Family Planning

- **Guinea**
  - Jhpiego

- **Rwanda**
  - Capacity Project

- **Senegal**
  - CEFOREP and Ministry of Health

- **Togo**
  - Ministry of Health, Division of Family Health
Phases of Fostering Change in the VFCP PAC

- **Part I:** Select and adapt a proven best practice & create an action plan to introduce that practice in 1-4 sites in their country

- **Part II:** Implement action plan over 4 months

- **Part III:** Create a plan to scale up the selected best practice

- **Part IV:** Implement scale up action plan at conclusion of program
Phases of Fostering Change in the VFCP PAC

- **Part III: Create a plan to scale up the selected best practice**
  - Organized into 2 online modules delivered over 6 weeks
  - Use the Nine Steps for Scaling Up to develop action plans to take successful best practices to scale

- **Part IV: Implement scale up action plan at conclusion of program**
VFCP PAC Implementation

Teams developed action plans with facilitator feedback in Part I (January to May 2009)
  - Teams focused on integrating PAC and FP services at one to four health sites in their country

Teams worked to implement their action plans in Part II (November 2009 to March 2010)
  - Teams awarded USAID funding for implementation
  - Received support from VFCP PAC facilitators & partner CAs in their country
    • Burkina Faso and Togo: EngenderHealth
    • Guinea: Jhpiego
    • Senegal: VFCP PAC facilitators; this team didn’t receive additional funding as sufficient funding had already been provided by USAID
    • Rwanda: team from Capacity, which ended in Rwanda in September 2009
VFCP PAC Post-Program Support

Face-to-face capacity building in Togo

- April 2010: 4 teams from MOH Family Health Division and 3 health facilities attended workshop on change management & leadership development to integrate PAC & FP services
- Same participants had recently completed a 3 week technical training on providing PAC and FP services conducted by EngenderHealth
- Completed action plans to address a common measurable result: *By October 15, 2010, 70% of the clients in post-abortum coming to the site will receive quality FP counseling and will accept and receive a contraceptive method before leaving the site."

Continued technical assistance through partner CAs

- Provided with additional funds obligated by USAID
- TA continued with teams from Burkina Faso, Togo, and Guinea
VFCP PAC Results: Togo

- Training of staff on PAC and FP counseling provided at all 4 selected health centers and educational talks with women started
- Clinical PAC services starting being offered at 3 of centers in May 2010
- A room dedicated to PAC services and PAC equipment and supplies received at 3 of the centers
- One center also commissioned 8 radio public service announcements to educate the community
- From May to October 2010, the 3 sites offering PAC services received and treated 81 women
  - 100% received counseling on FP methods
  - 59% (48 women) accepted an FP method
Involved change agents to carry out activities in three regions: Ratoma, Minière, and Matam

Contraceptives are now regularly supplied and available in the three regions
- Contraceptives available in the PAC units in Ratoma and Matam

Counseling in the delivery room for family planning and healthy timing and spacing of pregnancies

Continued to work to procure equipment as well as sterilization tools and work lamps with the USAID funding received
Conducted monitoring visits at 2 hospitals and 1 health clinic to evaluate the integration of PAC and FP services

Concluded that the Hôpital Gitwe had successfully integrated PAC and FP services, which proved that PAC services can be successful in Rwanda

– Hospital Director attended Senegal conference, understood importance and context, so easily implemented

Conducted training on providing PAC services & integrating PAC & FP services for 13 staff in the maternity ward at Hôpital Ruli

– For all service providers and any available doctors

– Included training on data collection tools, method of pregnancy evacuation, and next steps to implement and improve the integration of PAC and FP services
Global Exchange Network for Reproductive Health: An online resource for PAC

- Library page within the GEN website highlighting key resources for PAC
- Free access to over 2,500 reproductive health/family planning health professionals
- Available in English, Spanish, and French

Post Abortion Care (PAC)

Postabortion Care Global Resources Guide

The PAC Global Resources Guide is a compilation of basic instruments intended for policymakers and program planners who are designing or revising their current postabortion care program. Organizations that provide assistance to PAC programs worldwide may also benefit from this package. More than 600 documents were reviewed for the global PAC Resource package. Each section of the package has undergone extensive international review and field testing.

www.postabortioncare.org

USAID Postabortion Care Resources

USAID funds postabortion care (PAC) programs that comprehensively address women's needs through three critical elements: emergency treatment for complications of spontaneous or induced abortion; postabortion family planning counseling and services to prevent future unintended pregnancies; STI and HIV counseling and or testing for HIV as resources permit; and community empowerment through community awareness and mobilization.


Key resources:

Who Uses PAC Services?

Executive Summary of What Works: A Policy and Program Guide to the Evidence on Postabortion Care
Saving lives and improving the health of the world’s poorest and most vulnerable people by closing the gap between knowledge and action in public health.
Lessons from Senegal: Decentralizing Postabortion Family Planning

Dr. Fatou Ndiaye
Health Workforce and PI Advisor
Senegal Health Services Improvement Project
Senegal
Key Country Statistics

- Total population: **12,500,000**
- Population under 20 years old: **53.4%**
- Urban population: **41.5%**
- Women of reproductive age: **48.9%**
- Maternal Mortality per 100,000 live births: **401**
- Unmet need for contraception: **32%**
# Total Fertility and Contraceptive Prevalence Rates by Year

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<thead>
<tr>
<th>Year</th>
<th>Total Fertility Rate</th>
<th>Contraceptive Prevalence Rate</th>
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<tbody>
<tr>
<td>1978</td>
<td>7.2</td>
<td>0.6%</td>
</tr>
<tr>
<td>2006</td>
<td>5.3</td>
<td>10.3%</td>
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<tr>
<td>2010</td>
<td>5</td>
<td>12.6%</td>
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Problem of Unsafe Abortion in Senegal

- Unsafe abortion lead to 65,000 to 70,000 cases of maternal mortality per year globally.
- 99% of cases of maternal mortality caused by unsafe abortion take place in developing countries (WHO, 2008).
- Studies have estimated that 3.6% of maternal deaths in Senegal are linked to unsafe abortion (DHS IV, 2005).
PAC Decentralization in Senegal

Operations Research and PAC Introduction
- PAC services offered in Hospitals
- PAC expanded to Health Centers & Health Posts
- PAC extended to community level Health Huts

PAC Expansion
- Services available in 5 regions
- 523 Providers trained
- PAC register developed
- 323 Service Delivery Points providing PAC

Decentralization Continued
- PAC services offered in Health Centers/Health Posts in 7 regions
- MVA included in essential medicines list

PAC Integration
- National Norms, Policies & Protocols revised to include PAC and disseminated

% of Postabortion Patients Counseled and Accepted FP Before Discharge, 2003-2010

- % received FP counseling
- % received FP method
Decentralization Expanded the Availability of PAC/Family Planning

- Postabortion care services decentralized to all levels of care:
  - 93% of hospitals
  - 99% of health centers
  - 50% of health posts

- Postabortion care services reorganized to create a stronger link between treatment and prevention (FP)

- Postabortion FP data integrated into national health information system
Challenges to Ensuring Access to Postabortion Care and Family Planning

- Socio-cultural and religious beliefs
- Shortage of contraceptive commodities and stock-outs
  - Procurement and distribution of MVA kits
- Insufficient links between PAC and other services
- Lack of practicum in pre-service education
Challenges to Ensuring Access to Postabortion Care and Family Planning in Senegal (cont’d)

- Health worker strikes and data retention
- Maintaining a regular supervision system appropriate for monitoring provision of PAC services and supporting trained providers
- Lack of access to PAC/FP services in rural areas – especially at health hut/health post facility level
Continuing Gaps in PAC/FP Services

- Separate locations for family planning and postabortion care services
- Implementation hindered by poor contraceptive logistics at the health system level
- Contraceptives not available during emergency services
- Poor provider counseling skills and insufficient of supervisory support to overcome service challenges at the provider level
Thank You For Your Attention
Postabortion Family Planning: A strategy for increasing contraceptive use

Eastern Europe and Eurasia Region

Nancy Pendarvis Harris, MPH
Nino Berdzuli, MD, MPH
JSI Research & Training Institute, Inc.
Family Planning in the EE Region 2004

FAMILY PLANNING SITUATION

- Low fertility rates
- High abortion rates
- Low use of modern contraception
- High unmet need for contraception

HEALTH SYSTEM BARRIERS

- Policy barriers (old Soviet health systems & policies)
- Limited access to family planning services and contraceptives
- Distrust of modern contraception
The Total Abortion Rate and the Prevalence of Modern Contraceptive Methods in 18 Countries

Abortions per Woman

Percent of Married Women Using Modern Contraception

Georgia

Azerbaijan

Armenia

Romania

Belarus

Bulgaria

Russia

Moldova

Turkmenistan

U.K.

Kyrgyzstan

Kazakhstan

Hungary

Uzbekistan

U.S.

Westoff, 2005
Unmet Need for Modern Family Planning Methods

Survey estimates for selected countries, various years
Context of Postabortion Family Planning in the Region

- Postabortion family planning counseling and services were limited
- Lack of interest or incentives by medical staff to provide family planning counseling
- Few effective and systematic links between abortion and family planning services
- Lack of referral for family planning counseling and methods
Postabortion Family Planning Counseling and Method Receipt

Survey estimates for selected countries
Overall strategy

Integrated approach aiming at creating FP “safety net”

Rural
Family Doctor
Nurse
Community nurse

Urban
OB/GYN
Family Planning Doctor
Family Doctor
Pediatrician
Midwife
Nurse

GYN
departments/maternity

OB/GYN
Midwife
Hospital staff

FP information
FP counseling
Free contraceptives
Referrals

FP information
FP counseling
Free contraceptives
Referrals

FP information
FP counseling
Free contraceptives
Referrals

FP information
FP counseling
Free contraceptives
Referrals

John Snow, Inc.
A “Three Pillars” Approach to Postabortion Family Planning

**Quality** of postabortion family planning services – clinical practice guidelines, protocols, job aids, training (*services in place*)

**Supplies in place** – contraceptive commodities, IEC materials (*products available*)

**Awareness** of the importance of family planning/post-abortion family planning, e.g. IEC, BCC, mass-media, service marketing (*increased demand*)
Addressing Quality of Postabortion Family Planning Services

Training alone is not enough!

- **Evidence-based medicine (EBM) approach** – Clinically-Appraised Topics (CATs) as a tool for addressing provider questions and concerns about specific clinical topics

- **Clinical practice guidelines** – removing barriers for postabortion family planning services (e.g. on immediate postabortion IUD insertion)

- **Reorganization of postabortion family planning services** – facility protocols, counseling by midwives/nurses
Addressing Awareness and Demand: marketing postabortion family planning services

“Ask the doctor about FP methods”
“Did you ask the doctor about FP methods”

“You can get pregnant as early as 7 days after an abortion!”

“Contraception – Your Modern Choice”
Georgia: Healthy Women in Georgia & SUSTAIN Projects (2008-2010)

Result 1: Improved access to postabortion family planning services
- Postabortion family planning services scaled from 12 to 30 maternity hospitals and women consultation centers
- Over 1000 providers trained in postabortion family planning

Result 2: Increased postabortion family planning counseling
- Postabortion family planning counseling increased from 38.6% to 86.5%

Result 3: Increased postabortion contraception acceptance
- Immediate postabortion IUD placements increased from 0.2% to 4.7%
- Oral contraceptives initial acceptance rate increased from 7% to 34%
Changes in Fertility, Abortion Rate and Contraceptive Prevalence between 1999-2010

Source: Georgia RHS 2010
Ukraine: Together for Health Project (2007-2011)

Result 1: Improved access to postabortion family planning services

• Postabortion family planning implemented in 15 regions
• Over 2,500 providers trained in postabortion family planning


Result 1: Improved access to postabortion family planning services

• Postabortion family planning implemented in 114 facilities, in 16 regions

Result 2: Increased postabortion family planning counseling and modern methods use

• Postabortion family planning counseling increased from 83.4% to 95.9%
• Percent of postabortion clients who are planning to start using modern contraceptive method increased from 66.5% to 86%
Best Practices Facilitating the Success of Postabortion Family Planning

- Improving family planning regulatory framework and policies
- Including evidence-based clinical practice guidelines, norms, tools and training in in-service and pre-service medical education
- Horizontalizing and integrating family planning services broadly into MCH and PHC services
- Increasing access to modern contraceptive methods for disadvantage population by providing free contraceptives
- Increasing demand for family planning services and contraceptives
- The changes in the trend of modern contraception use – the high number of users is contributing in spreading information against myths and to an easier adoption of modern contraception
Thank you!
Expanding Access to Family Planning:
Community Mobilization for Postabortion Care in Kenya

Lynn M. Van Lith
JHU-CCP

Managing Partner: EngenderHealth; Associated Partners: FHI 360; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council
Background: 2009–2012

- Builds on work from ACQUIRE—2005
  - In Nakuru district
  - New FP visits doubled (2,034 to 4,362)
  - Return FP visits increased 61%
- Political violence led to premature ending of activities
- Recommendation to revitalize activities and conduct rigorous evaluation
- Rift Valley Province: Nakuru and Naivasha
- RESPOND partners:
  - EngenderHealth
  - JHU·CCP
  - Population Council
**Goal**: Increase communities’ **awareness** and **use** of postabortion care (PAC) and related services to reduce maternal mortality and morbidity.

1. Increase **community knowledge** of the danger signs of abortion-related complications, locations of services, and family planning (FP)–related information and services
2. **Capacity building** to address PAC and FP needs
3. Encourage **involvement of most marginalized** in community action
4. Mobilize communities to prevent and treat incomplete abortion
5. Strengthen **service delivery points** providing PAC and FP
Intervention Design

- Ministry of Health (MOH) Community Strategy with district health management teams (DHMTs)
  - Community health extension workers (CHEWs) and community health workers (CHWs) as primary links—sustainable structures
- Facilitate Community Action Cycle for PAC
  - Train CHEWs/CHWs
  - Support CHEWs/CHWs to conduct community mobilization sessions
  - Focus on the three delays—support groups to develop and implement action plans
  - Mentoring and support to build capacity of CHEWs/CHWs
- Train providers in *comprehensive* PAC services
- Build provider-community partnerships
What is the Community Action Cycle?

1. Organize the community for action
2. Explore the health issue and identify priorities
3. Plan together
4. Act together
5. Evaluate together
6. Prepare to scale up
Evaluation

- Quasi-experimental design
  - Control group for comparison; matched pair of three units each
  - Unit = approx. 5,000 people or five villages with two CHEWs & 50 CHWs
  - Pre-post measurements in both arms to measure change over time

- Baseline: June 2010
- Endline: January 2012

- Quantitative and qualitative measures
  - Community survey of 593 women aged 18–49
    - Exposure to PAC community mobilization
    - Sources of care: maternal and child health (MCH), PAC FP
    - Perceptions of quality of care
    - Use of MCH, PAC, and FP services
  - Inventory and interviews with providers
  - Exit interviews with PAC clients, if possible
  - Monitoring data on client loads for PAC and FP services
  - Focus group discussions, in-depth interviews: CHWs, CHEWs, leaders

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<th>Intervention</th>
<th>Control</th>
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<tr>
<td>Karunga</td>
<td>Eburu</td>
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<tr>
<td>Kiambogo</td>
<td>Maraigushu</td>
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<tr>
<td>Longonot</td>
<td>Moi Ndabi</td>
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Women (ever been pregnant) (N=558)

11% experienced bleeding (N=61)

Sought care

24/37 (Intervention)
19/24 (Control)

Sought care outside community (1–2 hours)

16/24 (Intervention)
8/19 (Control)

Did not seek care

13/37 (Intervention)
5/24 (Control)

Most did not think bleeding was serious enough to seek care

Type of services sought

36/43 (Government) 7/43 (Private)
Summary of Baseline Results

1. PAC services were not offered at any of the 11 health facilities.
2. PAC services are needed and are in demand.
3. Knowledge of FP was high; actual use was significantly lower.
4. Women identify and use government facilities—primary place where FP info is obtained.
5. Just over one-half report discussing FP w/partners, that partners approve, and use FP.
6. There is significant unmet need for FP:
   - A large percentage of women are not using, yet report desire to space or limit births
     - 76% (Intervention, n=182)
     - 80% (Control, n=92)
7. Exposure to community interventions is low.
Special Family Planning Issues

- Providers witness repeat abortions

- FP not offered in same room as PAC

- High numbers of young clients:
  - Cost a barrier to FP
  - Stigma in providing youth with FP and PAC services
### Action Plans: Problems Identified

1. Delay in recognizing the dangers of bleeding in pregnancy
   - Myths about FP
   - Lack of partner support
   - Poor spousal communication

2. Delay in deciding on and seeking care
   - Long distance to facility (*3–5 hour walk*)
   - Wild animals
   - Security concerns
   - Self-medication
   - Religious opposition to FP/PAC
   - Little use of health facilities; home delivery
   - Poor infrastructure (*roads and phones*)

3. Delay in resolving the health problem
   - Lack of trained personnel
   - Lack of equipment & supplies for MVA
   - Poor provider attitudes
   - Unfavorable facility operating hours
Conclusions

Best practices/processes/tools

- Country-led by DHMT, using MOH Community Strategy and structure
- Community engagement is key to success
- Building skills and capacity = taking action for their health
- Work with local social community networks
- Community empowerment must be combined with quality service improvements
- Link facilities with communities to increase use of health services throughout pregnancy

Challenges

- CHEWS/CHWs/community groups have other responsibilities
- Wide geographic coverage
- Lack of incentives; equipment and supplies
- Stigma surrounding abortion
- Sufficient time is needed
Managing Partner: EngenderHealth; Associated Partners: FHI 360; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council