Nigeria PPFP Dedicated Counselor Initiative: Assessment and Key Results

MCSP Implementation Learning Brief

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Background

Maternal and Child Survival Program (MCSP) supports improved maternal, newborn, and child health outcomes by helping to build sustainable capacity and leadership at national, sub-national, and facility levels to improve the quality of antenatal care (ANC), childbirth, and postnatal care and to strengthen essential health system functions that underpin quality care (including commodities, human resources, and information and referral systems). The family planning (FP) component of MCSP in Nigeria focused on increasing FP uptake among postpartum women in Kogi and Ebonyi states by improving access to postpartum family planning (PPFP) across all levels of the health systems. A baseline assessment conducted by MCSP between June and July 2015 showed zero uptake of immediate PPFP in the two project states, due largely to lack of trained PPFP providers. As an innovation to increase uptake of PPFP at the time of birth, MCSP initiated the training of "dedicated counselors" in March 2017 at 36 health facilities across the two states. The head of each facility selected community health extension workers (CHEWs) and nurses/midwives already working in the health facilities to serve as counselors and agreed to dedicate some of their time to PPFP counseling during ANC and immunization sessions. MCSP conducted an assessment in May 2018 to explore the fidelity, feasibility, and scalability of the approach to inform program adjustments and recommendations to the Ministry of Health for future efforts. The assessment included interviews with service providers, client exit interviews, and analysis of routine service data. MCSP received non-human subjects research determination for this assessment.

Box 1: Assessment Questions

- Is PPFP counseling taking place as intended in ANC? How (if at all) is PPFP counseling incorporated within other service areas?
- What are the service providers' and clients' perspectives on quality and feasibility of the PPFP counseling approach?
- What are the success factors, barriers, and opportunities to strengthen provision of effective, high-quality PPFP counseling?
- What are the trends in PPFP uptake?
- How do service providers currently tailor counseling approach depending on their client's age, parity, or marital status?
- What other lessons have counselors learned that merit replication?

Methodology

The assessment was conducted at 10 randomly selected intervention facilities (five per state) and included the following components:

- **Interviews with service providers:** Data collectors interviewed a total of 20 CHEWs and nurse/midwives at intervention health facilities (two per site) using a semi-structured approach (Table 1).

Questions assessed PPFP knowledge, service delivery practices, perspectives on feasibility, and recommendations for further strengthening PPFP counseling and service delivery (Box 1).

- **Exit interviews:** At the same 10 health facilities, data collectors conducted focused exit interviews with four clients (two seeking ANC and two seeking immunization services) to assess their perspectives on services received, comprehension of counseling content, and suggestions for improving services.

- **Routine data:** PPFP routine data was retrieved from an existing data template developed by MCSP, to assess trends in PPFP uptake in the selected health facilities comparing the intervention period to the same period of the previous year.

Key Findings

Table 1: Sample Reached

	Ebonyi	Kogi	Total
Providers			
CHEW	8	7	15
Nurse/Midwives	2	3	5
Total			20
Clients			
ANC	10	13	23
Immunization	10	7	17
Total			40

Provider perspectives

- **Provider practices:** Nineteen of the 20 service providers interviewed indicated that they were able to use the skills they received from the training, including using tools to facilitate counseling, focusing more on one-on-one counseling, counseling on FP during ANC, and focusing more on facilitating client choice.

- Perceived **benefits:** All of the providers who received the training indicated that the overall approach worked well in practice. Perceived benefits included increased awareness about FP among providers, as well as being better able to address concerns about side effects, and increased awareness and uptake of FP by clients.

"I allowed them to make their choice unlike before I led them to method choice."
– CHEW, Kogi

"Since confidential counselling is being done, there is increase in uptake."
– CHEW, Ebonyi

"I have challenge in using one-on-one approach because of limited space within the facility and it takes a longer time to attend to all the patients."
– CHEW, Kogi

- **Perceived challenges:** The main challenges of the approach cited by service providers were increased workload and time commitments, remaining misconceptions and concerns about FP methods hindering FP uptake, and limited space for one-on-one counseling.

- **Sustainability:** Almost all service providers reported that they received supervision or ongoing support on the approach, but intensity of supervision varied across sites. Many respondents indicated that they had trained other facility staff on the approach. The vast majority of providers said PPFP counseling still took place when they were not at the facility. Some counselors focused their dedicated counseling efforts on ANC and/or immunization days (on specific days of the week/month). A majority of respondents said that the register was easy to use.

- **Continuation of the approach:** All of the service providers interviewed thought the approach should be continued and expanded. Specific recommendations for future efforts included training additional staff as dedicated counselors, providing additional communication materials, adding more dedicated space for one-on-one counseling, and focusing more on community and male/husband engagement.

- **Variations in counseling approach by client characteristics:**

  - **Variations by client age**: Thirteen of the 20 providers reported that they adjust their counseling based on the client's age. For adolescents, they reported focusing more on risks of unplanned pregnancy for health/sexually transmitted infections and loss of educational and life opportunities; promoting barrier methods, not offering tubal ligation, and employing a more "gentle" approach. For older clients, they reported focusing more on use of long-acting or permanent methods and health risks/"weak womb."

  - **Variations by client parity**: All but one provider reported adjusting counseling by client parity. For higher parity women, they reported focusing more on long-acting reversible contraceptives and/or permanent methods, whereas for those with only one child, they placed more focus on short acting and lactational amenorrhea methods. For higher parity women, they focused more on limiting births or longer spacing, whereas they promoted 2–3 year spacing for those with only one child. For higher parity women, providers also reported emphasizing the health risks and complications associated with pregnancy, including death.

  - **Variations by client marital status**: Sixteen of the 20 providers indicated they adjusted their counseling based on the client's marital status. Counseling for unmarried clients was reported to focus more on preventing unintended pregnancies and sexually transmitted infections, condom use, and emphasizing that the use of FP can help clients avoid abortions. For married women, they reported focusing more on pregnancy spacing and encouraging their husband's involvement.

> *"She advised me that immediately after I deliver my baby, I can start menstruating again and if my husband comes near to me I will become pregnant. Because of this she … discussed the various family planning methods that are available. Among the methods she discussed with me, I prefer the implant method." – ANC client, Kogi*

Client perspectives

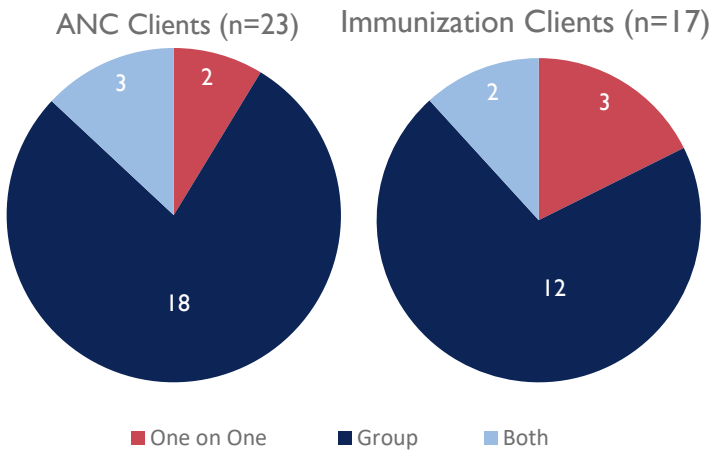
- **Services sought and received:** Of the 40 clients interviewed, 23 said they had planned, even before speaking with the provider, to seek FP information while at the health facility that day. Thirty-six of the 40 clients said that when they were at ANC or immunization services, the provider mentioned something about FP. When asked about the content of the discussion with the provider about FP, clients most frequently mentioned (in order of frequency mentioned): lactational amenorrhea/exclusive breastfeeding, PPFP method options, healthy timing and spacing of pregnancy, timing to start an FP method, and return to fecundity and pregnancy risk.

- **FP information delivery format:** Across the two states, both ANC and immunization clients generally reported that FP information was most often offered in a group format (Figure 1).

> *"One on one is better because a lot of people are shy about agreeing to FP options where other people are present. They prefer to have privacy with the counsellor." – Client, Ebonyi*
>
> *"I prefer group talk. This is because during group talks, you can hear side comments. If what the provider is saying is true, you can hear affirmations from the members of the group. In contrast, if I were to be counselled alone, I may be left to wonder how true the information I am receiving is. I will not have anyone by the side to make side talks." – ANC client, Ebonyi*

When asked how they prefer to receive information on FP, 55% of respondents preferred one-on-one counseling, 33% preferred group education, and 13% indicated they had no preference. Among the clients seeking immunization services, 18% (3/17) received both services from the same provider, 29% (5/17) received both services in the same room but from different providers, and 53% (9/17) received both services in different rooms and from different providers.

Figure 1: FP information delivery format



- **Perceived quality of care:** Clients indicated that they felt very positive about the quality of care for FP services received. Thirty-four of 36 women who received information about FP said the provider explained the information clearly, 35/36 said the provider asked if they had any questions, and all 36 clients said the provider spoke to them in a respectful way.

> *"I have been hearing about family planning but my husband is against it but the information I received from the counsellor made me understand that I have the right to decide when to get pregnant and when to stop."*
> *–ANC client, Ebonyi*

- **Influence on client views:** Twenty-nine of 36 clients who received information about FP said their mind had been changed in some way, including increased understanding about child spacing and that FP is not just for limiting pregnancies, increased understanding about method options, and increased understanding and support to make a choice.

- **Future recommendations:** Clients provided the following recommendations for future efforts: greater engagement on PPFP outside of the health facility, including through community and religious groups and mass media, employing more service providers, offering more one-on-one FP counseling, and focusing more on addressing women's specific concerns about FP.

Service data

Service data from the 10 assessment sites demonstrates substantial improvements in PPFP counseling during ANC, early labor, postnatal care, and immunization visits (Table 2). Dramatic improvements were also seen in PPFP acceptance pre-discharge, when comparing the intervention period to the same period of the previous year. PPFP counseling increased by 44% at ANC, 143% during early labor, 232% at postnatal care, and 267% during routine infant immunization visits. Actual PPFP acceptance at pre-discharge increased by 150%.

Table 2: Service data comparing pre-intervention to intervention period

	April 2016–March 2017 (pre-intervention)	April 2017–March 2018 (intervention period)
# women receiving PPFP counseling at ANC	6,172	8,879
# women receiving PPFP counseling during early labor	1,637	3,975
# women receiving PPFP counseling during postnatal care	1,685	5,598
# women receiving PPFP counseling during routine infant immunization visits	1,116	4,095
# PPFP acceptors (pre-discharge)	3,158	7,883

Program/Policy Implications

Results from this assessment demonstrate the feasibility of the PPFP dedicated counselor approach. In other contexts, the concept of a "dedicated provider" has involved seconding a provider to a health facility, however, in implementation sites in Nigeria, officials envisioned the concept of a dedicated provider as a current provider who is dedicated to or champions counseling or sharing information with non-FP clients. In spite of challenges related to workload and infrastructure constraints, providers saw benefits of the approach and wanted it to continue and be scaled up. Clients appreciated the opportunity to receive PPFP counseling, and reported that it positively influenced their perceptions and practices. The qualitative results align with impressive increases in service statistics for PPFP counseling and uptake. Certainly, there were other program inputs at intervention sites, and this assessment did not compare the intervention facilities to non-intervention sites, but it is likely that this intervention contributed to the improvements as part of a broader mix of service strengthening efforts at program sites. Future recommendations include:

- Engage facility teams to further develop plans for task shifting and sharing such that both group education and one-on-one FP counseling can be provided to clients who desire it.
- Ensure consistent supervision and ongoing support for PPFP counseling and service provision.
- Develop plans for community and male engagement to address PPFP-related norms, concerns, and misconceptions in coordination with facility interventions.
- Explore opportunities to further strengthen linkages between FP and immunization services, as many women bringing their infants for routine immunization services are not using FP.

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Data collectors practice their training using tablet computers. Photo by Chelsea Cooper, MCSP

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