# Postpartum Family Planning Study Group
# Summary Report
June 5-23, 2017

https://www.globalhealthlearning.org/community/270758

## BACKGROUND

From June 5 to June 23, 2017, the Family Planning Technical Team of the USAID-funded global Maternal and Child Survival Program (MCSP) facilitated a study group on the recently updated *Postpartum Family Planning course* on the Global Health eLearning Center. In collaboration with K4Health, MCSP hosted the online study group to give participants an opportunity to discuss the practical application of the theoretical components described in the course. The study group focused on country experiences in PPFP, different PPFP integration models, use of effective training approaches, and how to effectively capture and monitor PPFP services.

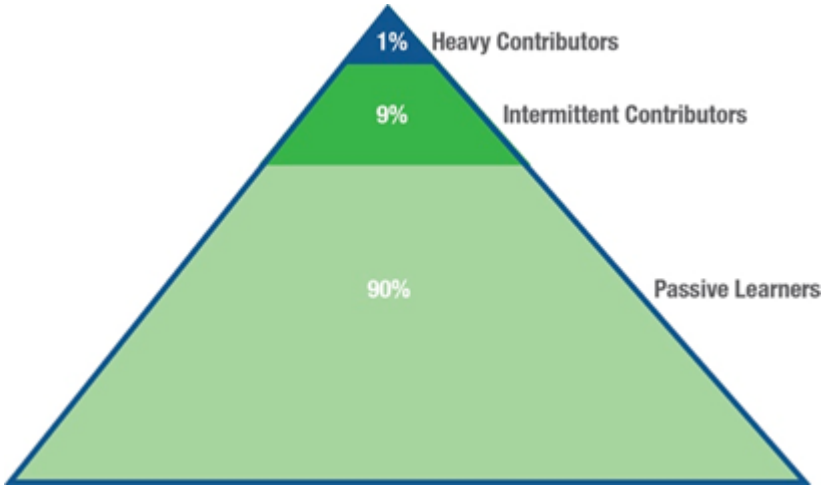
The study group was promoted to anyone who had started or completed the PPFP course and more broadly among FP2020's and K4Health's networks and the Postpartum Family Planning Working Group.

### Discussion statistics

Number of registered participants: 190 *(An additional 17 participants signed up but never created GHeL accounts)*
Number of participants' countries: 43
Number of contributions: 56 by 22 active participants
Number of countries contributing: 12 - Burkina Faso, Cambodia, Cameroon, Congo, Ethiopia, India (2), Kenya (4), Niger, Nigeria (3), Pakistan (2), Uganda (2), and United States (3)

Refer to Appendix A, for a table on country participation, representing all those who registered for the study group.

The participation rate of approximately 12% (22 of the 190 participants) is in line with research from the Nielsen Norman Group that suggests that in most online communities 90% of members are passive learners, while 9% of members contribute a little and 1% of members account for most of the contributions and interactions[1].




## MAIN THEMES

The study group centered around four main topics related to the practical application of implementing PPFP services and programs. They are as follows:

- Overview of opportunity that PPFP can offer for achieving improved mCPR and FP2020 goals
- Operationalizing PPFP, including the use of Alternate Training Approaches and Facility-Based Training
- Capturing PPFP service data and other PPFP measurement successes and challenges
- Using Social and Behavior Change Communication for PPFP

Each topic was accompanied by real world examples and a set of guiding discussion questions that can be found in Appendix B.

## POST-STUDY GROUP SURVEY RESULTS

A post-study group evaluation survey was sent to all 190 participants, of which 26 responded (14% response rate).

### I. Background

| | |
|---|---|
| **No. of surveys completed and countries represented** | **15** Countries represented: Burkina Faso, Cameroon, DRC (2), Egypt (2), Haiti, India, Kenya (3), Malawi, |

[1] [1] Nielsen, J. October 9, 2006. "The 90-9-1 Rule for Participation Inequality in Social Media and Online Communities." Nielsen Norman Group, http://www.nngroup.com/articles/participation-inequality/.

| | |
|---|---|
| | Niger, Nigeria (4), Pakistan (3), Tanzania, Togo, Uganda (2), and US (2) |
| **Top organization types represented** | ● International NGO (58%)<br>● Government/ministry (23%)<br>● National/local NGO (12%) |
| **% who completed the course before the study group** | 27% |
| **% who completed the course while taking part in the study group** | 35% |
| **% who started the course but haven't completed it** | 23% |

## II. Usefulness and use of study group

Overall the post-study group survey findings revealed that participants found the study group useful. Almost all respondents (96%) responded that the study group helped them to better understand postpartum family planning. Other findings are found in the table below.

| | |
|---|---|
| **Top aspects of the study group that were most useful** | ● Opportunity to learn from others (83%)<br>● Provided additional examples from the field (70%)<br>● Provided additional resources and references (65%) |
| **Most useful topics covered in the study group** | ● How to use data to drive quality improvement or program decisions (61%)<br>● Tips and discussion on how to operationalize PPFP in facilities (61%)<br>● Discussion of policy and advocacy issues (50%) |
| **Confidence to apply what they have learned as a result of participating in the study group** | 61% reported more confidence<br>33% reported somewhat more confident |
| **Key insights that participants gained from the discussion** | Opportunities for integration with other services<br>• *Integration of PPFP to other maternal and health services*<br>• *It has assisted me to advocate with program staff to increase service delivery points who will be providing PPFP i.e. PAC room and postnatal wards*<br>• *To help mother in getting early methods of FP*<br>• *We need to intensify Health Education On PPFP from ANC so that mothers can make choices early unlike giving this information just postnatally*<br><br>The importance of policy/advocacy efforts |

| | |
|---|---|
| | • *If implementors and governments put more effort in PPFP we would be able to reach many more women with FP*<br>• *Country specific goals to be decided when making policy for the nation wide.*<br>• *The first thing i realise is that the challenges in policy advocacy, counseling etc are not peculiar to my country only. This helped me realise that am not alone and that there resources to use and skills to learn to make the job easier.*<br><br>Other key takeaways<br>• *How to address myths and misconceptions related to PPFP*<br>• *There are different types of PPFP and each may be applicable to different age group.*<br>• *I liked the sharing on PPFP integration. I also liked the different tools shared to capture data from the 3 countries*<br>• *SBCC strategy to guide programming, identifying opportunities to address common barriers to postpartum contraceptive uptake and continuation, and key considerations for implementation*<br>• *PPFP has an important health benefit for mothers and babies and children* |
| **Top actions that participants reported planning to take as a result of participating in the discussion** | Share information gained from the study group<br>• *i'll share the information with my colleagues*<br>• *Share with field offices the importance of PPFP especially among adolescent mothers*<br>• *To continue teaching others, transfer knowledge to other co workers*<br>• *Share the new knowledge with my colleagues and request for training on PPFP for those lacking knowledge and skills to scale up the sane and competently practice and be able to implement.*<br><br>Train providers<br>• *I am an FP trainer and will organize PPFP integration training for 30 health care providers working in ANC, maternities and labour wards in private health facilities.*<br>• *I am supporting an adolescent program that is dealing with provision of FP to adolescents and I can now be able to provide better guidance to the program staff*<br>• *I will apply my enhanced skills during the next provider review meetings, in community sensitizations and in gathering of childbearing age groups.*<br><br>Improve M&E efforts<br>• *I will work with M&E to monitor the uptake of LARC in the newly introduced service delivery points* |

| | |
|---|---|
| | • *Currently we are implementing an adolescent health project focusing on PPFP and PAFP and we are grappling with data collection tools ensuring we do not loose data along the different service delivery points*<br><br>Revise policy<br>• *Some Policies to be revised.* |
| **% who shared information from the discussion with others** | 61% |

## III. Use patterns

The post-study group survey respondents included 7 respondents who did not post in the study group (39%) as well as those 11 who did (61%). This helps capture the experience of some of the potential "lurkers" (i.e., those who followed along but did not actively contribute) and provides insights as to why they didn't post to the discussion. Reasons survey respondents gave for not posting included: being satisfied with the content and having no questions to ask. Two reported challenges with their device and/or internet connectivity. For example:

- *I was not able to get the channel to send my views because the line was busy but I was able to read contributions from the participants.*
- *I had problem with my system and had to frequently visit…to read other people's posting. Honestly, you guys did great job in every aspect of the course.*

For the individuals who posted, the majority (73%) found that it was easy to post messages.

## IV. Suggestions for Improvement and future topics for discussion

The survey included an open-ended section that asked participants for suggestions on how to improve the PPFP study group. Some respondents either shared that they had no suggestions or included positive comments, such as:

- *I wish to appreciate the team for the job well done.*
- *J'apprecie les formations en ligne avec Global Health . J'ai personnellement plus de 20 certificats de formation.*

Those who provide suggestions, included the following:

- *Plan more weeks. Not easy to done office work and course on line*
- *SBCC for adolescents*
- *Please kindly allow participation through various emails for the consultants in the study. This is because the study line was not easy to access. Thank you*
- *There should be concerted efforts in advocacy for IUD. The implants are well received but there are strong resistance to accepting IUD.*

- *I want you to include a topic on compliance in this study group.*
- Can the completion time be extended as I was asked to be away from the office and was in an area where there was no internet; therefore I was not able to complete the course in time
- *We want to delve into the community aspects of increasing access and utilization of PPFP services*
- *Advocacy and policy concerns would also be another good topic*

Additional PPFP-related topics that survey respondents reported interest in discussing in future study groups were:

- How to engage men in PPFP (83%)
- Special needs of pregnant adolescent when it comes to PPFP (61%)
- Tips and discussion on adding PPFP indicators into the HMIS (56%)

For the full report on the post-study group online survey results, see Appendix C.

## FINDINGS FROM DISCUSSION

The study group was successful in four primary areas:

1. **Promoting the sharing of resources and tools to effectively design, implement, and monitor PPFP services**

The main objective of the study group was to provide more examples of practical application of the theoretical concepts outlined in the course. The four study group facilitators all shared a number of resources as well as country-level templates/tools to aid participants in designing, implementing, and monitoring PPFP services. In addition, participants contributed their own experiences as well as a number of attachments to reports and data from their activities. A participant from Pakistan started her contribution by stating *"First of all thank you for sharing such useful information."*

A participant from Burkina Faso shared that *"We are currently working with the Health Promotion Division of the Ministry of Health to develop a demand-generation strategy for PPFP through the development of radio-TV spots, posters, leaflets and jobs aids….Thanks Chelesea. I share with them MCSP PPFP SBCC strategy devolpment tools from Jhpiego and materials developed by PSI of which I have contributed while working with PSI."*

The importance of advocacy was noted from the beginning of the study group and not just awareness raising of the importance of PPFP with government officials but throughout all levels of the health system, including among the community. A participant from Ethiopia shared *"The policy is supporting but the demand creation is still minimal and country wide logistic shortage is critical challenge."* Another participant from Northern Nigeria commiserated, *"Mobilisation and direct community sensitization is what is needed to accelarate acceptance."* In response, the study group facilitator that led the discussion around social and behavior change communication (SBCC) shared a number of SBCC resources

for participants working at the community level to use to design, implement, and monitoring SBCC for PPFP. These included:

- *Guide for Planning and Implementing SBCC for PPFP*
- SBCC for PPFP Online Course
- Make Me a Change Agent curriculum
- Urban Youth Adolescent SRH SBCC Implementation Kit developed by HC3
- Among other resources and country-level examples

We also heard from a participant in Kenya who shared how

> *women believe that by breastfeeding for two years they are practicing a form a PPFP that will prevent pregnancy. This they gather by counseling they receive on LAM from TBAs who tell them that as long as they are breastfeeding they will not become pregnant….There is a therefore a lot of misinformation about LAM and PPFP because facility deliveries within the area are below the below the 25% mark and their primary source of information is other women within their age group or TBAs who are not very well informed.*

The same participant shared a potential solution to this issue: *"In my opinion therefore if we could get more information on differences between how women view PPFP and what they actually understand it to be; there would therefore be better chances of ensuring that the women have the right information and use it to access PPFP."* In addition, it was noted that SBCC is key to reaching the influential members of communities, like TBAs!

Other advocacy-related resources were shared by the facilitators, including an interesting analyses of DHS data conducted by AvenirHealth, looking at month-by-month uptake of PPFP which has been recently used in Rwanda to convince policymakers as to the benefits of PPFP as well as where there are gaps. And, from a service delivery perspective of integration of PPFP with others services, a number of country examples along with service statistics were shared from India, Indonesia, and Madagascar, to name a few.

2. **Sharing solutions to overcome challenges to designing, implementing, and monitoring PPFP services**

In addition to sharing resources and tools, we witnessed participants sharing personal experiences as well as responding to each other's comments related to challenges that they have and are facing, especially as it relates to data and measurement issues. For example, PPFP happens at various points of service delivery, such as labor and delivery, postnatal ward, family planning unit, and others. So, there is a need for staff in all of these departments/units to be trained on not only PPFP counseling and services but also data collection so that all places where PPFP can be and is delivered it is also accurately captured. A participant noted that in Uganda, *"some of the data is not captured and in some instances we still have challenges of the tools inadequacy in capturing PPFP especially PPIUD between 0-48 hours."*

Also, in most countries, health management information systems (HMIS) don't include indicators for PPFP. However, we learned from a participant from Burkina Faso that they are making progress with incorporating PPFP indicators into HMIS there. He shared *"we have worked with the MoH to introducing PFPP indicators in the HMIS. In addition support has been given to MoH to review the data collection tools to take into account the PFPP indicators. The Districts In charge of HMIS have been training on the data collection system developed by the the project team for quality purpose."*

Another issue that a participant raised was the issue of those who deliver at home, who are a critical target group with higher unmet need. She shared that in Kenya, "*Those that may deliver at home are recorded in the postnatal register in the maternity as they bring their children."* Having multiple registers ensures ease of aggregation of the data for the monthly reporting. A participant shared that *"Uganda captures PPFP data in 2 registers mostly; Integrated Maternity Register and FP register. There is usually an improvised register at the PAC units and thereafter at end month, summaries are collated into HMIS forms and later entered into DHIS2."* She acknowledged "*Separate register detailing out the methods and follow ups could also be advantageous because then all records are made and kept in one place."*

**3. Sharing new and novel approaches to promoting, implementing, and tracking PPFP services**

In addition to sharing resources and examples of solutions for addressing some of the challenges encountered, participants shared a number of novel approaches that they are employing.

A participant from Pathfinder International shared how they are using quality improvement as a strategy to increase systematic integration of PPFP counseling and services is a different model than introduction through other approaches (like training and follow up). We also heard from a participant from URC in Uganda *"where are Quality improvement teams set the LDHF approach works well but where the QI teams are non functional the LDHF approach is ineffective. the success of PPFP training is measured by Health care Providers ability of offer PPFP services professional with client centred attitude."*

One of the facilitators shared an interesting study in Egypt by Omar Shabaan that found 4 times better transition from LAM to another method and 5 times fewer pregnancies when providers gave women counseled on LAM and gave a pack of emergency contraceptive pills (ECPs) to take home too, with instructions to use if LAM criteria lapsed and they hadn't used and/or switched to another method yet. This group was then compared to women who only received counseling on LAM.

We also learned from a participant in Nigeria how cascading PPFP trainings to all staff and stakeholders has helped them increase acceptance of PPFP as well as effectively track PP and interval insertion.

*In February, HCWs of selected PHCs were trained and PPFP activated. TBAs were brought in to help sensitize the communities and escort an acceptor to the facility if she delivers at home.*

*Last to be introduced were ETS drivers and riders. They were counselled to help transport acceptors both PP and interval to facilities. Now the NGO in collaboration with local transport unions had put in place a volunteer base of drivers who help tranport women in labour, pregnant women and neonatals with complications to the neares facility at a minimal cost. It also provided specialised motorbike ambulances to some hard to reach communities for the same purpose. The drivers and riders were taught how to handle women in labor and or complications. This cascades down to all stakeholders.*

*In Kano Nigeria, PPFP icons integrated into TBA Tally Sheets. Each TBA will tick the number of PPFP acceptors for the month. In addition, ETS drivers and riders also indicate the number of acceptors they take to facilities in their logbook. This way, acceptors who had their babies at home are tracked and added to the total for the month.*

*Outreach teams also integrate the number of PPFP insertions for the month. The facility Focal Mentee includes such numbers n her monthly summary log book.*

4. **Reinvigorating promotion efforts and raising awareness about the PPFP course**
The overall course completions increased by 10%. Before we started promoting the study group, there were 460 successful course completions of the PPFP course. After we promoted the study group and up until a week or so after its completion, we saw an additional 46 learners successfully complete the course.

Course completions numbers - overall

| **Course** | **Course Completion (prior to Study Group - June 4, 3017)** | **Course Completion (during study group and immediately following, Jun 5 - July 5, 2017)** | **Added course completion** |
|---|---|---|---|
| Postpartum Family Planning | 460 | 506 | +46 |

## REFLECTIONS

In reflecting on the experience, the study group facilitators felt well prepared for the three-week learning event given the advanced planning, specifically in producing a detailed schedule and overarching topics. In addition, regular and prompt communication between the facilitators and K4Health helped mitigate any anxiety or issues that arose in using the platform.

The main facilitator remarked that the study group was successful. One of the main facilitators has had experience with online discussion forums hosted on the IBP Knowledge Gateway, and noted that participation is often a challenge and that the level of engagement in the PPFP study group was higher than online discussion forums she has conducted in the past. The K4Health team thought that email notifications had been integrated into the platform specifically for study groups. Unfortunately, this feature did not end up working during the study group and is something that the K4Health team will follow-up to investigate and fix.

Although this study group attracted the most registrants, this interest did not convert to more participation in the discussions. The number of contributions by active participants was more in line with the first two study groups hosted on the Global Health eLearning platform (see table below).

Participation rates of GHeL study groups to date

| Study group | Number of participants | Number of contributions/posts | Participation rate |
|---|---|---|---|
| Gender and Health System Strengthening | 104 | 63 contributions from 22 active participants | 21% |
| GIS Techniques for M&E of HIV/AIDS and Related Programs | 73 | 42 contributions from 17 active participants | 24% |
| mHealth Basics | 177 | 90 contributions from 44 active participants | 25% |
| Improving Health Care Quality | 95 | 93 contributions from 28 active participants | 29% |
| Governance and Health | 105 | 81 contributions from 31 active participants | 30% |
| **Postpartum Family Planning** | **190** | 56 contributions by 22 active participants | **12%** |

**PPFP Study Group Report - Summary and Recommendations**

**Summary of Findings**

- The study group was successful in 4 primary areas:
    - Promoting the sharing of resources and tools to effectively design, implement, and monitor PPFP services
    - Sharing solutions to overcome challenges to designing, implementing, and monitoring PPFP services
    - Sharing new and novel approaches to promoting, implementing, and tracking PPFP services
    - Reinvigorating promotion efforts and raising awareness about the PPFP course
- Evaluation survey revealed positive feedback from active participants and passive observers (lurkers)
- Advanced planning and regular communication helped mitigate issues that arose
- Personal communication to participants helped to encourage those who contributed a post to contribute more to the discussion

**Recommendations/Next Steps**

- For the number of topics discussed (4 main themes), maintain three week timeframe or expand to an additional week
- Possible follow-up with the identified champion participants to document their experience in participating in the online study group
- Consider sending a short survey to those who registered but did not visit the site at all to better understand the reasons for not visiting.

# APPENDIX A: COUNTRY PARTICIPATION

| Country | # of Participants | Country | # of Participants |
|---|---|---|---|
| Afghanistan | 2 | Malawi | 1 |
| Angola | 1 | Malaysia | 1 |
| Bangladesh | 2 | Myanmar | 4 |
| Brazil | 1 | Nepal | 1 |
| Burkina Faso | 2 | Niger | 1 |
| Burundi | 1 | Nigeria | 23 |
| Cambodia | 1 | Other | 1 |
| Cameroon | 1 | Pakistan | 11 |
| Canada | 2 | Rwanda | 6 |
| Congo | 2 | Senegal | 1 |
| Democratic Republic of Congo | 5 | Solomon Islands | 2 |
| Cote d'Ivoire | 1 | Switzerland | 1 |
| Denmark | 1 | Tanzania | 7 |
| Egypt | 1 | Timor-Leste | 2 |
| Ethiopia | 3 | Togo | 1 |
| Ghana | 5 | Uganda | 7 |
| Guatemala | 1 | United Kingdom | 2 |
| Haiti | 1 | United States | 44 |
| India | 15 | US Virgin Islands | 1 |
| Kenya | 15 | Zambia | 3 |
| Liberia | 1 | Zimbabwe | 3 |
| Madagascar | 3 | | |

# APPENDIX B: DISCUSSION TOPICS AND QUESTIONS

## Topic 1: Overview of opportunity that PPFP can offer for achieving improved mCPR and FP2020 goals

### Post 1: Overview of opportunity that PPFP can offer in achieving improved mCPR and FP2020 goals

Welcome to the PPFP study group and thanks for joining us. Before we start, you may want to review the GHeL *Postpartum Family Planning* course, at least for the definitions of terms like postnatal, postpartum, interpregnancy intervals, and fecundity.

As we have passed the mid-point between the London Summit of 2012 and our target year of 2020, we need to accelerate our progress to add 120 million new family planning users. We also know that the global environment is not conducive to increasing resources right now, so we need to work smarter with the resources we have. **Postpartum family planning is one strategy to work smarter and increase use of family planning overall.** For this to work:

- Every woman and girl who is pregnant gets counseled on the benefits to her and to her baby of waiting at least 2 years before conceiving again,
- Effectively integrate services at the time of birth in a facility, or
- Link family planning with other services she will seek for her baby in the postnatal and extended postpartum periods, such as postnatal care, immunization, and other child health services.
- If pregnancy does not go to term, the same approach to integrating services should also be part of any post-abortion care services.

Currently, in most low resource countries, between 40 and 55% of (non-first) births occur after interpregnancy intervals of less than 24 months as data drawn from a sub-sample of women who gave birth within 2 years of the DHS survey shows in this figure (attached).

However, 93% of the same women expressed no desire for a pregnancy within a year, yet less than a third used any form of contraception. In other words, **62% postpartum DHS respondents expressed an unmet need for postpartum family planning (PPFP).** While the majority intend to seek a pregnancy later, about a quarter of all postpartum women want to limit any future births. You can see, however, that PPFP unmet need varies widely by country as depicted in this figure, in part depending on whether women are already seeking family planning within those first two years of birth.

This is not an insignificant issue as between postpartum women makeup between 16 and 36% of all women between 15 and 49 years old (Z. Moore, 2015 -- This article is recommended reading; you can download it from this post). According to the U.N. Population Divisions, there will be over 90 million births in the 69 FP2020 countries in 2017. That is 91,000,000 babies, each of them with a mother needing PPFP… If you add the 92 million in 2018, and again 92 million in 2019, and the 93 million in 2020… that is over 360 million women (or three times the FP2020 target!!!).

This reality calls for a global response! In 2015, delegations from 16 countries met in Chiang Mai, Thailand to learn about PPFP and create action plans for accelerating access to PPFP. Since then, the FP2020 secretariat has taken up PPFP as a key strategy and is keeping up the global #ActionPPFP movement, posting new information and blogs as they become available as well as following up with countries to ensure they include PPFP in their costed implementation plans and report on their progress.

During this 3-week discussion, together we will tackle questions related to how we can address this state of affairs to reduce unmet need for PPFP, sharing how challenges have been addressed in different country contexts as well as successful country experiences with scale-up. Before we share our experiences, we would like to hear from you:

- What have been recent successes that you or your country has had in expanding access to postpartum family planning?
- What are some of the policy or program barriers to implementing PPFP at scale in your country?

**Attachments:**

FAMILY PLANNING USE AND PROSPECTIVE UNMET NEED FOR PP WOMEN IN 21 COUNTRIES

SUPPLEMENTARY READING - ZHUZHI MOORE PAPER ON ANALYSES OF DHS DATA FROM WOMEN WHO HAVE GIVEN BIRTH IN LAST 2 YEARS

## Post 2: Overcoming policy and program barriers reported by country implementers or managers

Thank you to Jane, Josephine, Stephen, and Martin for sharing your experiences at country and global levels and thoughts about PPFP implementation. There are definitely some themes in your comments. You all agree that we need to do more to integrate postpartum family planning with maternal, newborn and child health services. But you also highlighted some challenges. We will have to dig a bit deeper over the next 3 weeks into some of these challenges and potential ideas to overcome them. We welcome all participants' thoughts, experiences, and ideas!

To address the unmet need for family planning in the postpartum period, **we have to address some of the confusion that women, their relatives, and many of the providers who serve them have about the return to fecundity**. Return to fecundity is influenced by breastfeeding practices and differs from woman to woman and across countries. If you like data, this repository includes individual country figures showing the proportion of sexually active postpartum women who are at risk of pregnancy along the continuum of the two years postpartum.

To affect change in these beliefs and ultimately proportions of PPFP uptake, **social and behavioral change approaches implemented at the community level are likely to be most effective**. Chelsea Cooper will be addressing these later in the course.

Beyond increasing awareness about the health and social benefits of longer intervals and factors that influence the return to fecundity at the community level, there are many touch points between women and the health systemduring this stage of the life cycle, that create opportunities **to integrate counseling and PPFP services along the continuum of care**. Reproductive health programs can take advantage of these to proactively counsel women about PPFP, Lactational Amenorrhea Method (LAM) and when to transition from LAM to another method, and with the appropriate training offer a range of methods regardless of whether they are breastfeeding, or not. Women can start using these methods before discharge from maternity or at a later return visit for postnatal care or immunization services. In future posts, Holly Blanchard will share how to operationalize these efforts at the facility level, drawing on her own vast experience, including recent work in Indonesia. Work done by Population Council several decades ago revealed that this type of integration was very cost effective, after the initial investments of organizing integrating services and training maternity providers in clinical postpartum IUD, implant, or sterilization skills.

However, as Josephine pointed out, one of our ongoing challenges is around documentation of PPFP at the point of services, and compilation of indicators to assess and improve program performance. Deborah Sitrin will be sharing what we are learning in this area as part of this discussion.

Last August, a survey went out to the 16 countries that had participated in the June 2015 PPFP Global Meeting in Chiang Mai to capture their current progress and to request information on where the challenges or needs were. The responses are shown in the attached slide. As you can see, none said that updating guidelines remained a challenge after a year (though it may have been a challenge

initially for some). Some of the responses had to do with resource mobilization, some with obtaining the right technical assistance on how to design their program. **Do you agree with these?**

- What data or evidence may be most compelling to influence policy makers or program leaders to invest in PPFP? What other arguments have worked?
- What do you see as the greatest challenges to accelerating access to immediate or extended postpartum family planning in your institution or country?

**Attachments:**

SLIDE ON COUNTRY CHALLENGES WITH PPFP.PDF

# Topic 2: Operationalizing PPFP, including the use of Alternate Training Approaches and Facility-Based Training

## Post 3: Operationalizing PPFP and alternate training approaches (Day 1)

In the previous post, we better understood the postpartum family planning (PPFP) needs, opportunities and benefits of PPFP and Healthy timing and spacing of pregnancies (HTSP). Also the significant unmet need. This post discusses alternative training approaches to increase providers' skills and implement PPFP services. Then, we will also we look at examples in Indonesia for operationalizing and implementing PPFP

To implement PPFP services takes much more than training, but ongoing mentoring, review of the data and looking at trends. For example, helping the facility staff take ownership of their data and use it to improve services has increased mothers who adopt PPFP pre-discharge in Indonesia.

**Critical components of operationalizing PPFP:**

- Effective PPFP services require training and mentoring providers assisting women at the time of birth and in maternity wards/postnatal wards as well as in FP clinics. All skilled birth assistants (SBAs) should be trained to provide PPFP services.
- Reach out to mothers with young infants in immunization and baby wellness clinics.
- Integrate messages about the benefits of exclusive breastfeeding and how to use the Lactational Amenorrhea Method (LAM) as a temporary method of PPFP.
- Improved counseling:
    - We found that using an adapted Balanced Counseling Strategy plus postpartum helped ensure an interactive client-focused counseling method. The providers is forced to listen to the client's response as it will guide the next step in counseling
    - Start with the benefits of healthy timing and spacing of pregnancies
    - Encourage method adoption and documentation during ANC, and ensure communication between ANC service and maternity unit
    - Encourage method adoption prior to discharge after childbirth

Let's look at 'Low dose high frequency" (LDHF) and focus on evidence-based practices that promote learning (Bluestone et al. 2012). This post will draw upon country experiences using this approach and the Jhpiego LDHF briefer.

New evidence identifies better ways to improve and sustain improvements in service delivery. This includes the use of interactive techniques that engage the learner, provide opportunities for simulated practice with constructive feedback, case studies, clinical practice at the health facility, and planning learning opportunities when cases occur outside of the prescribed training period. For the latter to occur, a learner may need to return to the training facility when there is a woman requesting a PPIUD.

**LDHF is a capacity-building approach that promotes maximal retention of clinical knowledge, skills, and attitudes through short, targeted in-service and team-based simulation and learning activities. These sessions are spaced over time and reinforced with additional structured, ongoing quality improvement and practice sessions on the job site.**

The attached chart shows the increase in PPFP counseling and mothers adopting PPFP before discharge after frequent short trainings, follow-up visits, and sharing data with facilities.

**Take Home Messages**

- Facility based training/mentoring that includes simulation on models prior to clinical practice and then clinical practice, resulted in improvement in PPFP services where more mothers adopted PPFP before discharge from the facility.

**Questions**

- In what ways is your PPFP training programs employing some of the mentioned interactive techniques?
- Have you used any LDHF approaches in your facilities/programs? If yes, please share with us approaches, both effective and ineffective ones.
- How is the success of PPFP training measured?

**Attachments:**

PPFPCHART.PNG

## Post 4: Operationalizing PPFP and alternate training approaches (Day 2)

Thank you to Joyce, Nadeem, Stephen, and Sadaf for their contributions related to operationalizing PPFP!

Building the capacity of health care providers to deliver evidence-based care is one important piece of quality improvement (QI), but it is an on-going process.

In Indonesia where Jhpiego is developing capacity of PPFP in 44 facilities in nine districts, we noticed that interactive training coupled with clinical practice is a good beginning, but on-going review of the monthly service data, review of PPFP performance standards, peer practice on anatomic models (Mama-U and implant arm) and BCS+PPFP job aids, helped to increase the percentage of mothers who adopted PPFP prior to discharge.

Although in the attached chart from yesterday's posting, it appears that a decline occurred in April 2017 among PPFP acceptors. On careful evaluation, the 14% drop was due to lack of documentation of LAM counseling in the medical records (see attachment.) **LAM is an effective yet temporary PPFP**. What is key about LAM use is that the mother has been counseled on the 3 criterion of LAM, and accepts that if anyone of the three no longer applies, then she can no longer count on LAM for PPFP. In the Indonesia project. Due to the high rate of LAM adoption, we wanted to ensure that there is evidence of quality LAM counseling in the mother's medical record before the project staff could report that this mother was a LAM user. Other words, it was not enough that facility staff reported the mother was planning to breast feed and was using LAM. All methods depend on quality counseling, but LAM is particularly true since there is misunderstanding about breastfeeding and LAM. During the month of April, we initiated this careful documentation to verify LAM counseling. Perhaps mothers were counseled, yet documentation is lacking.

**Take Home Messages**

- The collection of service statistics, analysis, and review of trends are highly motivating to staff and District Health Office.
- Using the data for decision making helps facility staff take ownership of their services.

**Discussion questions:**

- Is there a QI team in your facilities that could support systematic documentation and review PPFP data?
- How can it include the quality of PPFP services using indicators such as percentage of postpartum mothers counseled pre-discharge/total number of deliveries percentage who adopted PPFP pre-discharge by method?

**Attachments:**

PPFP_DATA_FROM_INDONESIA.PNG

PPFPCHART.PNG

# Topic 3: Capturing PPFP service data and other PPFP measurement successes and challenges

## Post 5: Monitoring PPFP -- Capturing pre-discharge PPFP

Building off of some of the discussion about indicators that was brought up as part of the operationalizing PPFP discussion, we will now focus on routine monitoring of PPFP the rest of this week.

The Family Planning Register rarely captures if a woman is postpartum when she receives family planning. As a result, PPFP is not reported in health management information systems, making it difficult to track how many women get family planning during this time of high need.

As discussed in previous posts, PPFP can be provided to women immediately after birth. PPFP can also be provided to mothers in the postnatal and extended postpartum periods, and integrated into postnatal care, immunization, or other child health services. Tracking use of PPFP is complex!

Let's first focus on what's least complex to measure - the number of women who receive family planning before discharge after giving birth in a facility. Let's look at three examples of how this information is captured. These approaches are used in facilities where the USAID-funded Maternal and Child Survival Program supports PPFP implementation:

Rwanda: Using the Delivery Register

To capture pre-discharge PPFP, a column is manually added (by hand) to the Delivery Register margin. No need to re-print registers during the pilot phase! Using codes, the provider documents:

- If PPFP counseling done (Y) and outcome (Y/method code, Y/Declined, Yes/Plan). Column is blank if no counseling done.
- Method for women choosing to adopt PPFP before discharge (MJ=jadelle, P=pills, etc)

Kenya: Using the Family Planning Register

In the FP Register, timing of FP initiation is recorded in the "Remarks" column using codes:

- 1=Immediate Postpartum (<48 hrs)
- 2=Postpartum (2day-6wk)
- 3=Extended Postpartum (6wk-1yr)
- 4=>1yr since birth or No previous birth
- 5=Post-abortion (<48 hrs)

Copies of the FP Register are kept in Labor & Delivery and Postnatal Wards to capture PPFP at these points of service. Data are aggregated using all copies of the FP Register in the facility for monthly reporting.

Nigeria: Using a separate register

Two separate registers are used: 1) PPFP Daily Register to record woman receiving PPFP and details of IUD insertion and 2) PPFP Follow-up Register to record type of follow-up (phone or at facility), timing, and findings/complications. The PPFP Daily Register; PPFP Follow-up Register are kept in Labor & Delivery.

**Questions for discussion:**

- What do you think are advantages and disadvantages to each method described for capturing pre-discharge PPFP?
- How do other countries/programs capture PPFP uptake? What lessons can you share?
- PPFP is not reported in the HMIS, even in these countries where PPFP is documented at facilities. What would it take to convince the HMIS department in your country to add PPFP to the list of indicators? Do you think it should be a priority to advocate for adding PPFP into HMIS, **or** is tracking PPFP at facility level sufficient?

**Attachments:**

RWANDA DELIVERY REGISTER_PPFP MARGIN.JPG

KENYA FP REGISTER_REMARKS COLUMN_TIMING.PDF

REVISED PPFP DAILY REGISTER_NIGERIABO-DIPO.DOCX

REVISED PPFP FOLLOW-UP REGISTER_NIGERIABO-DIPO.DOCX

## Post 6: Other opportunities to collect PPFP uptake

Thank you to all those who have contributed thus far to our discussion on monitoring PPFP! It was great hearing from Jane, Rosemary, Josephine, and Martin.

During our last post, we discussed measuring the number of women who receive family planning before discharge after giving birth in a facility. However, some women will not start a method immediately after birth, or may choose to use lactational amenorrhea (LAM) and will need to switch to another method once LAM is no longer effective. Plus, we can't forget about women who give birth at home, and later come to a facility for care.

To reduce missed opportunities, some countries take advantage of other reasons women visit facilities after a birth – postnatal care, child immunization, etc. – to counsel women on the benefits of birth spacing and offer family planning. Let's look at a couple examples, and the data collected.

Liberia

After a successful demonstration in 2012, the MOH decided to expand FP-Immunization service integration to health facilities in 3 counties, with support from MCSP. Vaccinators provide brief information on FP at the end of each immunization visit, and offer women a referral for same-day, co-located family planning services. If women decline same-day referral, they are given a brochure on the benefits of FP with an attached referral card in case they decide to return for services on a different day. Referrals are in both directions - women who come directly for FP services are also screened for need for immunization services for their child, and providers give a referral card to vaccination when appropriate.

At implementing facilities, FP referral acceptance is noted in the margin of the immunization (EPI) ledger next to the child's name, and recorded on the daily vaccination tally sheet. Referral completion is noted in the comments section of the FP ledger (EPI in). In addition, referrals from FP to immunization services are also tracked in the comments (EPI out). These notations allow for calculating:

- % of mothers receiving child immunization that accepted (and completed) referral for FP

- % of mothers receiving child immunization that started using FP the same day
- % new contraceptive users referred from immunization

The project also tracks FP outcomes (new contraceptive users) and immunization outcomes (Penta 1 and 3 doses administered and immunization dropout). Tracking immunization outcomes provides an opportunity to ensure that immunization is not negatively affected, and hopefully benefits from service integration.

Mozambique

The Mozambique MOH recently adopted systematic screening for FP. All women who come to the facility for any reason are asked about their FP use. Women needing a 'refill' of pills, injectables, or condoms receive the refill at the same point of service, and don't need to be referred to the FP unit. New users or women interested in switching to a different method are referred to the FP unit using a referral card.

A separate register for recording FP referrals and methods distributed is kept in each unit at the facility. Aggregated data from each unit are reported at the end of the month, allowing them to track indicators such as:

- # continuing FP users seen at each unit (by method)
- # new FP users referred from each unit
- # women switching FP method referred from each unit

**Questions for discussion:**

- Are there different examples of integrating FP with other services that you would like to share? What data are tracked?
- In the examples above, the number of *postpartum* women receiving FP is not tracked, though many of the women benefiting from integration will be postpartum or extended postpartum (have a child <12 months old.) Do you think it is necessary (and feasible) to track how many women are postpartum in the FP register/ledger?
- There has been concern that giving information on family planning to women coming for other services could negatively affect those services. For example, women coming to facilities for child vaccination may not want to hear about family planning and therefore be discouraged from bringing children for vaccination. What evidence do you think is necessary to determine integration of FP with other services is a double win (has a positive effect on both services)?

# Topic 4: Using Social and Behavior Change Communication for PPFP

## Post 7: Why SBCC for PPFP?

To date, we have discussed the benefits of PPFP, training approaches for increasing providers' knowledge and skills, and most recently M&E strategies for capturing postpartum family planning (PPFP) uptake. This week we will focus on the social and behavioral aspects of PPFP programming.

*A service provider counsels a postpartum woman on her contraceptive options. A mother support group provides support for breastfeeding and discusses the importance of timely contraceptive uptake after childbirth. A CHW conducts a household visit and encourages a pregnant woman and her husband to discuss their reproductive intentions and future family planning use. A satisfied family planning user champions PPFP use in her community.*

All of these are examples of using social and behavior change communication (SBCC) for PPFP. SBCC describes the "use of communication strategies—mass media, community-level activities, and interpersonal communication—to influence individual and collective behaviors that affect health." SBCC approaches include communication that takes place in the community as well as between providers and clients at the health facility. Research shows that theory-driven, interactive communication that follows a proven design and implementation process can increase knowledge, shift

attitudes and norms, and produce changes in a wide range of behaviors. The field of SBCC recognizes that behavior and social norms are driven by factors at multiple socioecological levels, including at the individual level, household and interpersonal relationships, community, health system and structures, and broader policy environment.

**Why is social and behavior change communication especially important for PPFP?** It can help to:

- improve client knowledge and perceptions of PPFP;
- increase the practice of recommended PPFP behaviors and use of services;
- improve health worker knowledge, perceptions, and service delivery practices; and
- increase community support, cultivating an "enabling environment" for PPFP

It is important when designing SBCC for PPFP programming to specify the particular behaviors that the program seeks to address. In the *Guide for Planning and Implementing SBCC for PPFP*, we have identified **seven principal PPFP behaviors** at the center of PPFP programming *(see Figure)*. In a given context, some behaviors may require more emphasis than others.

In the design of SBCC activities for PPFP, use of formative assessment techniques is critical for shaping and filling gaps in our understanding of the circumstances of a specific population, allowing programming to be tailored to most effectively meet their needs. This means taking the time to understand:

- current PPFP practices,
- WHY some people may not be using PPFP (what are the barriers),
- why other people ARE using PPFP (facilitators),
- what are the perspectives and preferences of postpartum women/couples and services providers, and
- what are the prevailing community norms about PPFP.

MCSP and predecessor projects have used standard formative assessment approaches like focus group discussions and in-depth interviews, as well as *Trials of Improved Practices (TIPs)* and *Barrier Analysis*.

Yemen

The TIPs approach involved a series of three visits including an exploratory visit, a counseling visit, and a follow-up visit, during which time participants select and try the practices the program intends to promote over a two-week period, to get real-time information on the challenges and observed benefits of the practices as they were being tried.

We learned from the TIPs study that, following tailored counseling, women were very willing to go to the health facility for postpartum family planning. However, health systems issues, including lack of female staff, prevented women from obtaining a contraceptive method. We also learned that husbands were willing to discuss family planning and reproductive intentions with their spouses, and that men and women were willing to champion family planning with friends and families in their communities.

This information provided valuable insights to inform the design of a counseling package and recommendations for future programming. For more information on SBCC for PPFP, see the SBCC for PPFP Online Course.

**Questions for discussion:**

- Have you used formative assessment to inform the design of SBCC activities for PPFP?
- What formative assessment techniques did you use?
- What were some unexpected or surprising findings that emerged?
- What are the main barriers to the seven principal behaviors that you have identified in your program setting?
- How have you used formative assessment findings to inform programming?

During the next post, we will discuss considerations for designing and implementing SBCC for PPFP. We look forward to your contributions over the coming days!

**Attachments:**

 PPFPBEHAVIORS.PNG

## Post 8: SBCC for PPFP: Program Strategies and Implementation Considerations

Thank you to those who have participated thus far in our discussion on social and behavior change communication (SBCC) for postpartum family planning (PPFP)! It was great hearing about the experience using formative research for PPFP programming in Nigeria.

Today, we will focus on developing an SBCC strategy to guide programming, identifying opportunities to address common barriers to postpartum contraceptive uptake and continuation, and key considerations for implementation.

Developing an SBCC strategy helps to ensure that program activities align with formative research findings, meet the needs of specific target audiences, draw from social and behavioral theory, and have measurable indicators of success. HC3's implementation kits have resources for developing an SBCC strategy as well as an overview of key SBCC theories to consider.

As discussed previously, it is important to develop a good **understanding of barriers and facilitators for PPFP use and continuation** among target populations to inform the design of approaches included in the SBCC strategy.

- In **Liberia**, for example, we found stigma around return to sexual activity and postpartum contraceptive use before the baby walks or while the mother is still breastfeeding, which prevented women from accepting a contraceptive method.
- In **Bangladesh**, we learned that many women in program sites believed they were not at risk of pregnancy until menses resumed. Many women also had husbands working abroad, and believed they were not at risk of pregnancy and did not use contraception, even though husbands returned home sporadically for visits.
- In **Yemen**, a formative study revealed that women believed they were protected from pregnancy as long as they were breastfeeding, regardless of breastfeeding frequency or duration.

When we think about SBCC for PPFP, and the complex determinants of behavior, we must remember that it takes more than "disseminating messages" to facilitate behavior change. Specific **SBCC approaches designed to address these types of barriers** include:

- In **Bangladesh**, incorporation of a narrative story with structured discussion questions within home visits and community discussion sessions ("Asma's Story"). The story described one woman's experience becoming pregnant in spite of believing she was not at risk, and prompted people to reflect on their own views and experiences.
- In **Liberia**, development of user-friendly, pre-tested job aids to guide vaccinators in speaking with postpartum women about the availability of same-day family planning services while they are bringing their child for vaccinations.
- In **Egypt**, introduction of "scenario" cards in antenatal and postpartum group sessions, presenting short case scenarios and guided questions to assess comprehension.

Tips for Implementation Success

Consider factors that may influence the success of your activities, such as:

- *Availability of Contraceptive Supply to meet increased demand*
- *Availability of quality PPFP services*
- *Consistent supportive supervision*
- *Involvement of SBCC expertise in program design and implementation*

- *Facilitating strong stakeholder support, including through national and subnational teams responsible for health promotion / health communication*
- *Process evaluations to identify any concerns or areas where adjustments to the approach are needed*

**Questions for discussion:**

- What types of SBCC activities have you used within your PPFP programming?
- Did you have a strategy in place to guide programming? How did you draw from SBCC theory, or a "theory of change"?
- What were some of the successes, challenges, and lessons learned you have observed from your experiences implementing SBCC activities for PPFP?

# APPENDIX C: EVALUATION SURVEY RESULTS

**1. In which country do you work?**

| Fill in the blank | Response Count |
|---|---|
| Burkina Faso | 1 |
| Cameroon | 1 |
| DRC (2) | 2 |
| Egypt (2) | 2 |
| Haiti | 1 |
| India | 1 |
| Kenya (3) | 3 |
| Malawi | 1 |
| Niger | 1 |
| Nigeria (4) | 4 |
| Pakistan (3) | 3 |
| Tanzania | 1 |
| Togo | 1 |
| Uganda (2) | 2 |
| US (2) | 2 |
| ***answered question*** | **26** |
| ***skipped question*** | **0** |

**2. Please describe the type of organization in which you work.**

| Answer Options | Response Percent | Response Count |
|---|---|---|
| University/research institution | 0.0% | 0 |
| International NGO (e.g. Save the Children) | 58.0% | 15 |
| National/local NGO | 12.0% | 3 |
| Civil society organization (CSO) | 0.0% | 0 |
| Government/ministry | 23.0% | 6 |
| Hospital | 0.0% | 0 |
| Consultancy firm | 4.0% | 1 |
| Self-employed | 0.0% | 0 |
| Bi-lateral/Multilateral organizations (e.g. UN, WHO, or other donor agency) | 0.0% | 0 |
| Private commercial sector | 0.0% | 0 |
| News media | 0.0% | 0 |
| Other (please specify) | 1.0% | 1 |
| ***answered question*** | | **26** |
| ***skipped question*** | | **0** |

Other Response:

- Coordinates reproductive health

**3. Did you complete the Postpartum Family Planning course on Global**

**Health eLearning Center:**

| Answer Choices | Responses | |
|---|---|---|
| Yes, before the study group began. | 27% | 7 |
| Yes, while I took part in the study group. | 35% | 9 |
| No, I started the course and plan to complete it. | 19% | 5 |
| No, I started the course but don't plan to complete it. | 4% | 1 |
| No, I have not started the course. | 15% | 4 |
| | **Answered** | **26** |
| | **Skipped** | **0** |

**4. From the online course, which sessions/topics in the course did you find most useful?**

| | |
|---|---|
| **Answered** | **11** |
| **Skipped** | **15** |

| Respondents | Responses |
|---|---|
| 1 | Service Delivery: Integration and Linkage Knowledge Check |
| 2 | Session 4 |
| 3 | All the topics were helpful |
| 4 | Service Delivery: Integration and Linkage |
| 5 | all sessions were useful to me |
| 6 | Other opportunities to collect PPFP uptake |
| 7 | SBCC is the most useful topic in my own opinion |
| 8 | I think all the topics were important |
| 9 | SBCC in PPFP |
| 10 | Toutes les parties de ce cours m'ont ete d'une importance capaitale dans le sens qu'elles m'aident a apprehender l'importance du postpartum family planning. |
| 11 | 1. Using formative assessment to inform the design of SBCC activities for PPFP<br><br>2.The main barriers to the seven principal behaviors identified in program setting<br><br>3. The different examples of integrating FP with other services and what data are tracked |

**5. Which topics do you feel like you would like more training on?**

| | |
|---|---|
| **Answered** | **10** |
| **Skipped** | **16** |

| Respondents | Responses |
|---|---|
| 1 | Integration with Maternal, Newborn, and Child Health and Family Planning Services |
| 2 | Topic 5 |
| 3 | Data on PPFP and how to collect it |
| 4 | Integration with Maternal, Newborn, and Child Health and Family Planning Services |
| 5 | none |
| 6 | Strategies to improve the counselling services for the developing countries |
| 7 | I'd like more skills to engage and convince women to accept PPFP |

| | |
|---|---|
| 8 | PPFP compliance |
| 9 | Toutes les parties<br>1. Track how many women are postpartum in the FP register/ledger<br><br>2. How to have a strategy in place to guide programming and How to draw fSBCC theory, or a “theory of change”<br><br>3. The successes, challenges, and lessons learned observed from my experiences implementing SBCC activities for PPFP<br><br>4. How to include the quality of PPFP services using indicators such as percentage of postpartum mothers counseled pre-discharge/total number of deliveries percentage |
| 10 | who adopted PPFP pre-discharge by method |

**6. Did participating in the study group help you to better understand postpartum family planning?**

| Answer Choices | Responses | |
|---|---|---|
| Yes | 96% | 22 |
| No | 4% | 1 |
| | **Answered** | **23** |
| | **Skipped** | **3** |

**7. What specifically did you find useful about participating in the study group? Select all that relate to your experience.**

| Answer Choices | Responses | |
|---|---|---|
| It clarified concepts in the course. | 39% | 9 |
| It provided me with additional examples from the field. | 70% | 16 |
| It provided me with additional resources and references. | 65% | 15 |
| It provided me with an opportunity to ask questions. | 35% | 8 |
| It provided me with an opportunity to learn from others dealing with similar issues. | 83% | 19 |
| Other (please specify) | 9% | 2 |
| | **Answered** | **23** |
| | **Skipped** | **3** |

Other Responses:

- It was very interactive
- i liked the experience sharing on monitoring and data capture

**8. What specific PPFP-related contents did you find most useful: (Select up to three.)**

| Answer Choices | Responses | |
|---|---|---|
| Global overview and survey data from 21 countries | 17% | 3 |
| Discussion of policy and advocacy issues | 50% | 9 |
| Tips and discussion on how to operationalize PPFP in facilities | 61% | 11 |

| | | |
|---|---|---|
| Understanding common misunderstanding or misperceptions about return to fecundity and postpartum family planning | 44% | 8 |
| How to use data to drive quality improvement or program decisions | 61% | 11 |
| How to capture PPFP data at the point of service | 33% | 6 |
| Issues related to integration of PPFP with other health services/contacts (e.g. ANC, maternity, PNC, immunization, nutrition etc) | 44% | 8 |
| SBCC for PPFP: importance, key practices, and use of formative research | 39% | 7 |
| SBCC strategy development and implementation considerations | 28% | 5 |
| Other (please specify) | | 1 |
| **Answered** | | **18** |
| **Skipped** | | **8** |

Other response:

- Discussion of policy and advocacy issues. There are so many challenges in acceptance.

**9. To what extent do you feel that the discussion helped you to apply what you learned?**

| Answer Choices | Responses | |
|---|---|---|
| I definitely feel more confident to apply what I have learned | 61% | 11 |
| I feel somewhat confident to apply what I have learned | 33% | 6 |
| I do not feel confident to apply what I have learned | 6% | 1 |
| I did not learn anything new | 0% | 0 |
| **Answered** | | **18** |
| **Skipped** | | **8** |

**10. What has been a key insight you gained from this discussion – something that helped you think of PPFP in a new way? Please describe that insight.**

| | |
|---|---|
| **Answered** | **14** |
| **Skipped** | **12** |

| Respondents | Responses |
|---|---|
| 1 | the integration with other services |
| 2 | If implementors and governments put more effort in PPFP we would be able to reach many more women with FP |
| 3 | I t has assisted me to advocate with program staff to increase service delivery points who will be providing PPFP i.e. PAC room and postnatal wards |
| 4 | To help mother in getting early methods of FP |
| 5 | We need to intensify Health Education On PPFP from ANC so that mothers can make choices early unlike giving this information Postnatal |
| 6 | Country specific goals to be decided when making policy for the nation wide. |

| | |
|---|---|
| 7 | The first thing i realise is that the challenges in policy advocacy, counseling etc are not peculiar to my country only. This helped me realise that am not alone and that there resources to use and skills to learn to make the job easier. |
| 8 | How to address myths and misconceptions related to PPFP |
| 9 | Integration of PPFP to other maternal and health services |
| 10 | There are different types of PPFP and each may be applicable to different age group. |
| 11 | L'experience des collegues m'a aide a me recadrer |
| 12 | I liked the sharing on PPFP integration. I also liked the different tools shared to capture data from the 3 countries |
| 13 | SBCC strategy to guide programming, identifying opportunities to address common barriers to postpartum contraceptive uptake and continuation, and key considerations for implementation |
| 14 | PPFP has an important health benefit for mothers and babies and children |

**11. Can you share one concrete action that you will take as a result of participating in this discussion?**

**Answered** **15**

**Skipped** **11**

| Respondents | Responses |
|---|---|
| 1 | i'll share the information with my colleagues |
| 2 | Share with field offices the importance of PPFP especially among adolescent mothers |
| 3 | I will work with M&E to monitor the uptake of LARC in the newly introduced service delivery points |
| 4 | To continue teaching others, transfer knowledge to other co workers |
| 5 | Share the new knowledge with my colleagues and request for training on PPFP for those lacking knowledge and skills to scale up the sane and competently practice and be able to implement. |
| 6 | Some Policies to be revised. |
| 7 | Consistency in the face of strong objections. I will be extra diplomatic but consistent with that woman who's on her 11th pregnancy and is still hesitant on accepting a FP method because of some cultural, traditional or other percieved barriers. |
| 8 | SBCC strategy development and implementation considerations |
| 9 | I will focus on informed choice for the PPFP clients |
| 10 | I am an FP trainer and will organize PPFP integration training for 30 health care providers working in ANC, maternities and labour wards in private health facilities. |
| 11 | I am supporting an adolescent program that is dealing with provision of FP to adolescents and I can now be able to provide better guidance to the program staff |
| 12 | Oui |
| 13 | Integration of PPFP in other services; ANC,PNC/IYCC, HIV & TB clinics etc |
| 14 | integrate it in my practice |
| 15 | The idea of PPFP counseling that is not new, but many new aspects have been added based on recent<br><br>research and program experience |

**12. What parts of the discussion were not useful? Please provide suggestions for improvement.**

**Answered** **14**

| | |
|---|---|
| **Skipped** | **12** |

| Respondents | Responses |
|---|---|
| 1 | nothing |
| 2 | All the topics were helpful |
| 3 | None. all the discussion were learning points |
| 4 | None |
| 5 | None. |
| 6 | Every sit was useful I feel personally. |
| 7 | Everything is useful and will become handy sometimes during interactions on PPFP |
| 8 | None. All the discussion was very informative and useful. |
| 9 | None |
| 10 | None |
| 11 | Aucune |
| 12 | i missed the discussion on SBCC |
| 13 | video sessions should be part of discussion |
| 14 | Not applicable |

**13. What other topics related to PPFP would you like to see covered if a similar PPFP discussion forum is organized, for example**

| Answer Choices | Responses | |
|---|---|---|
| Special needs of pregnant adolescent when it comes to PPFP | 61% | 11 |
| Special needs of older, high parity mothers when it comes to PPFP | 39% | 7 |
| How to engage men in PPFP | 83% | 15 |
| Tips and discussion on adding PPFP indicators into the HMIS | 56% | 10 |
| Longitudinal tracking of women over time from pregnancy to extended postpartum | 39% | 7 |
| Other (please specify) | 11% | 2 |
| | **Answered** | **18** |
| | **Skipped** | **8** |

Other Responses:

- PPFP for those with special needs (physically challenged)
- integration of PPFP in other disciplines such as cardiology, oncology, nephrology etc

**14. Did you post any messages in the study group?**

| Answer Choices | Responses | |
|---|---|---|
| Yes | 61% | 11 |
| No | 39% | 7 |
| **Answered** | | **18** |
| **Skipped** | | **8** |

**15. Did you have an easy or difficult time posting messages?**

| Answer Choices | Responses |
|---|---|

| | | |
|---|---|---|
| Easy | 73% | 8 |
| Difficult | 27% | 3 |
| **Answered** | | **11** |
| **Skipped** | | **15** |

**16. What were the reasons that you didn't post a message? Is there anything that could have been done differently to make you feel more willing to post?**

**Answered** **5**

**Skipped** **21**

| Respondents | Responses |
|---|---|
| 1 | just satisfied with the content |
| 2 | no specific reason, i had no question |
| 3 | Nothing<br>I was not able to get the channel to send my views because the line was busy but I was able to read contributions from the participants in the studu |
| 4 | |
| 5 | I had problem with my system and had to frequently visit business to read other people's posting. Honestly you gays did great job in every aspect of the course. |

**17. What was difficult about posting to the study group? How could we make this easier in the future?**

**Answered** **3**

**Skipped** **23**

| Respondents | Responses |
|---|---|
| 1 | For some reason the typing was so difficult and I kept repeating throughout the discussion which was frustrating |
| 2 | I was not always able to navigate to the study group as the link just kept taking me back to the learning site. It would be better to separate link to the study group from the link to the learning site. |
| 3 | I am not sure ...may be it was because of my internet connection... |

**18. Did you share any information from the discussion with others (colleagues, friends, etc.)?**

| Answer Choices | | Responses |
|---|---|---|
| Yes | 61% | 11 |
| No | 39% | 7 |
| **Answered** | | **18** |
| **Skipped** | | **8** |

**19. How do you plan to apply the information that you learned from the discussion?**

**Answered** **15**

**Skipped** **11**

| Respondents | Responses |
|---|---|
| 1 | in next regular staff meeting |
| 2 | During training session and field activities |
| 3 | With this knowledge I will share more with field offices about ensuring that adolescent mothers have access to FP |
| 4 | i will use it to scale up PPFP provision |
| 5 | trough discussion, on job training |
| 6 | To be used in making the programme outlines. |
| 7 | I will apply my enhanced skills during the next provider review meetings, in community sensitizations and in gathering of Child bearing age groups. |
| 8 | Sahre what I have learnet with colleages. |
| 9 | I will share this information with my other colleagues and use it in the ongoing project on FP. |
| 10 | Training providers |
| 11 | For proper data collection on PPFP |
| 12 | Je travaille deja avec les equipes cadres des zones de sante que nous appuyons dans l'accompagnement des prestataires et la mobilisation des communautes dans l'implication sur la planification familiale. |
| 13 | Currently we are implementing an adolescent health project focusing on PPFP and PAFP and we are grappling with data collection tools ensuring we do not loose data along the different service delivery points |
| 14 | I referred my colleagues to complete survey and course as it is very informative and up to date |
| 15 | I plan to use the information to finding ways to reach and support more postpartum women. |

**Please let us know if you have any additional suggestions for future study group discussions.**

| | |
|---|---|
| **Answered** | **14** |
| **Skipped** | **12** |

| Respondents | Responses |
|---|---|
| 1 | thank you so much |
| 2 | Plan more weeks. Not easy to done office work and course on line |
| 3 | SBCC for adolescents |
| 4 | No, i don't have |
| 5 | Please kindly allow participation through various emails for the consultants in the study.This is because the study line was not easy to access.Thank you |
| 6 | More focus on participation from other parts pf the world. |
| 7 | There should be concerted efforts in advocacy fpr IUD. The implants are well received but there are strong resistance to accepting IUD. |
| 8 | I want you to include a topic on compliance in this study group |
| 9 | Yes. See my reactions in item 11.<br><br>I wish to appreciate the team for the job well done. Oboke, Kate. Nigeria |
| 10 | Can the completion time be extended as I was asked to be away from the office and was in an area where there was no internet; therefore I was not able to complete the |

| | |
|---|---|
| | course in time |
| 11 | J'apprecie les formations en ligne  avec Global Health . J'ai personnellement plus de 20 certificats  de formation.<br>We want to delve into the community aspects of increasing access and utilization of PPFP services |
| 12 | Advocacy and policy concerns would also be another good topic<br>do we plan to publish the outcomes of discussion? |
| 13 | If no ...we should consider doing so |
| 14 | Not applicable |