PPIUD Services: Start-Up to Scale-Up
Regional Meeting
Burkina Faso

February 3–5, 2014

Meeting Report

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PSI is a global health organization dedicated to improving the health of people in the developing world by focusing on serious challenges such as lack of access to family planning, HIV/AIDS, barriers to maternal health, and the greatest threats to children under five, including malaria, diarrhea, pneumonia, and malnutrition. PSI's vision under SIFPO is to scale up the delivery of high-quality family planning products and services to address unmet need, working through its network of national member offices in developing countries. For further information, visit http://www.psi.org.

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Acknowledgments

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Acronyms and Abbreviations

ABBEF	Association Burkinabè pour le Bien-Être Familial (Burkinabe Association for Family Well-Being)
ANC	Antenatal care
AGIR-PF	Agir pour la Planification Familiale (Act for Family Planning)
ASF	Association de Santé Familiale
CHU	University Hospital Center
CHW	Community health worker
CMA	Medical Center with Surgical Antenna
DRC	Democratic Republic of Congo
DHS	Demographic and Health Survey
FP	Family planning
IUD	Intrauterine device
LAM	Lactational amenorrhea method
LARC	Long-acting reversible contraceptive/contraception
L&D	Labor and Delivery
MCHIP	Maternal and Child Health Integrated Program
MCH	Maternal and child health
MOH	Ministry of Health
MSI	Marie Stopes International
NGO	Nongovernmental organization
PPFP	Postpartum family planning
PPIUD	Postpartum intrauterine device
PSI	Population Services International
SIFPO	Support for International Family Planning Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WAHO	West African Health Organization
WHO	World Health Organization

Meeting Description

The Maternal and Child Health Integrated Program (MCHIP) and Population Services International's (PSI) Support for International Family Planning Organization (SIFPO) program, with funding from the U.S. Agency for International Development (USAID), convened a regional meeting in West Africa to bring together international and regional experts to advance integration of postpartum intrauterine device (PPIUD) services into maternal health services. The meeting took place in Ouagadougou, Burkina Faso, from February 3 to 5, 2014. A total of 48 participants from 11 countries actively engaged in South-to-South learning, sharing successes and challenges based on their country experiences.

OVERALL MEETING OBJECTIVES

Through South-to-South exchanges, the meeting served to strengthen participants' capacity to accelerate the integration of postpartum family planning (PPFP), including the PPIUD, into maternal health services. The meeting entailed:

- Presentations and discussion on the global evidence for PPFP and PPIUD specifically
- An interactive forum to share successes and discuss challenges to implementing quality PPIUD services, from initiation to scale-up
- An opportunity for participants to visit PPIUD sites in Burkina Faso and interview providers about their experiences
- The launch of the French version of the World Health Organization (WHO) Programming Strategies for Postpartum Family Planning
- Analysis by country of the status of PPIUD introduction or scale-up
- A tutorial on PPIUD insertion, with small-group demonstrations/practice on PPIUD insertion on models and an introduction to PSI's dedicated PPIUD inserter
- Country experiences with and focused strategy discussions on the following elements of a PPIUD program:
    - Site selection and whole site orientation,
    - Advocacy and stakeholder engagement,
    - Counseling, informed consent, and demand generation,
    - Health information systems and monitoring, and
    - Continuity of care.
    - An opportunity to draft short-term actions by country team

See Annex 1 for the meeting agenda.

PARTICIPANT PROFILE

The 48 meeting participants represented 11 countries: Burkina Faso, Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo (DRC), Guinea, Haiti, Madagascar, Mali, Mauritania, Niger, and Togo. The state of PPIUD implementation in these countries ranges widely, from countries where the intrauterine device (IUD) has just been introduced and PPIUD services are not yet available, to those with relatively large, multi-year programs. Among the countries represented, the furthest along a pathway to scale and with the most facilities offering services throughout its territory was Guinea.

Participants included staff from Ministries of Health (MOHs), professional associations, health facilities, United Nations Population Fund (UNFPA), WHO, the West African Health Organization (WAHO), IMA World Health, the Customary and Religious Union of Burkina Faso, EngenderHealth, Futures Group, Marie Stopes International (MSI), Jhpiego, MCHIP, including partner staff from Save the Children, the Ivorian Social Marketing Agency, and PSI and its affiliates. The participants spanned a variety of profiles: policymakers and champions, maternal health care providers, program managers working in maternal health, and global agencies and donors.

Meeting facilitators came from a diverse array of countries, including Burkina Faso, Rwanda, Switzerland, and the United States. Facilitators included staff from USAID, PSI, Jhpiego, MCHIP, and WHO.

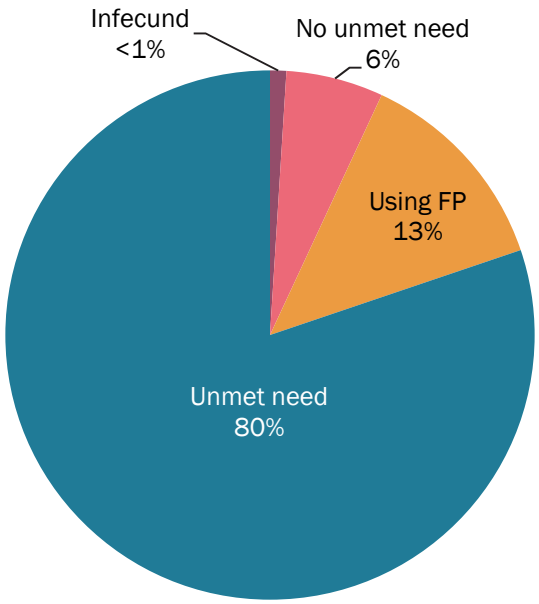
See Annex 2 for a detailed list of participants and facilitators.

Background

Provision of PPFP improves infant and child survival. If the preceding birth interval is less than 18 months, mortality risks are increased two-fold compared to intervals of three years.[1] Use of family planning (FP) is an effective strategy to reduce maternal mortality. Studies have shown that if the unmet need for contraception were met, there would be a 29% reduction in maternal mortality in low-resource countries.[2]

Data from 27 developing countries showed that women are interested in preventing another pregnancy within the first year postpartum, yet more than 63% do not use FP.[3] A recent study in Senegal that looked at women's access to FP information at the time of childbirth prior to discharge from the health facility found that women who received information were more likely to be using FP than those who did not. Additionally, during the exit interviews, a majority of women who did not receive FP information reported that they would have wanted to receive this information.[4]

Figure 1. Unmet PPFP Need (prospective approach), Burkina Faso 2010 DHS



Using Burkina Faso as an example, Figure 1 shows the proportion of unmet FP need among women during the first year postpartum. In the re-analysis of 2010 Demographic and Health Survey (DHS) data (n=5,986), women were asked prospectively "Would you like to postpone your next birth two or more years or have no more children?" Eighty-one percent of women responded that they wanted to delay or limit childbearing but were not using contraception.[5]

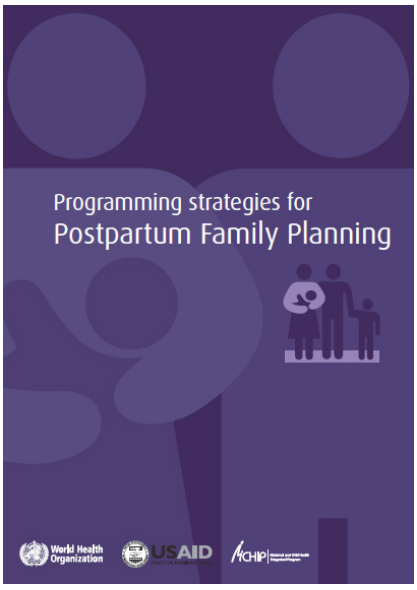
[1] Fotso JC, Cleland J, Mberu C. 2013. Birth spacing and child mortality: An analysis of prospective data from the Nairobi Urban Health and Demographic Surveillance System. *J Biosoc Sci* 45: 779–798.
[2] Ahmed S, Li Q, Liu, L, Tsui, A. 2012. Maternal deaths averted by contraceptive use: An analysis of 172 countries. *The Lancet* 380 (9837): 111–125.
[3] Ross JA, Winfrey WL. 2001. Contraceptive use, intention to use and unmet need during the extended postpartum period. *Int Fam Plan Perspect* 27(1): 20–27.
[4] Speizer IS, Fotso JC, Okigbo C, Faye CM, Seck C. 2013, Influence of integrated services on postpartum family planning use: A cross-sectional survey from urban Senegal. *BMC Public Health* 13:752. http://www.biomedcentral.com/1471-2458/13/752
[5] MCHIP re-analysis, Burkina Faso 2010 DHS, September 2013.

Postpartum IUD insertion (PPIUD), the insertion of an IUD within 48 hours following childbirth, can help address this gap. After women have been counseled on PPFP and accept PPIUDs as their chosen method, the three opportunities for insertion are: intracesarean, postplacental, and immediate postpartum. Intracesarean IUDs are placed during a cesarean section just prior to suturing up the uterus. Postplacental IUDs are inserted within 10 minutes of the delivery of the placenta. And immediate postpartum IUDs are placed after the first 10 minutes but within the first 48 hours following childbirth. These are sometimes referred to "morning after" insertions.

Recently, the global community experienced a resurgence of interest in PPIUDs and as a result, programmatic experience has expanded. Globally, more women are delivering in facilities, which provide increased opportunities for PPFP, including PPIUD services. Offering IUDs during the immediate postpartum period provides mothers with an effective, long-acting reversible contraceptive (LARC) method prior to leaving the facility. The insertion technique has improved so that expulsion rates are low. Other advantages of PPIUDs include: 1) the side effects of IUD insertion are masked by the routine process of uterine involution following childbirth; and 2) IUDs have no impact on breastfeeding. Copper IUDs (380 A) can be used for up to 12 years for birth spacing or limiting. Furthermore, most PPIUD users are very satisfied with their method.

While there are countries with a range of experiences, PPIUDs still represent a small proportion of contraceptive service delivery in sub-Saharan Africa, and there is more that needs to be done to make this option available to every woman who delivers in a facility. PSI, MCHIP, and other partners have collaborated with a number of country partners and supported the introduction of services, but only a few countries have taken services to scale. PSI and MCHIP previously held a similar regional meeting in Zambia, held in April 2013 for Anglophone African countries, with the same goal of discussing start-up and scale-up of PPIUD services. A second regional meeting in Africa permitted programmers and policymakers from Francophone countries to learn from those with a solid base of programming and gain insights from each other's experiences, ideas, and strategies to advance their programs.

Programming Strategies for Postpartum FP



WHO used the Francophone regional meeting on PPIUD as an opportunity to launch the French version of the newly developed *Programming Strategies for Postpartum Family Planning*. Dr. Mary Lyn Gaffield from WHO reported that, beginning in 2010, several member states and organizations had requested more information about PPFP through the first year after childbirth. The *Programming Strategies* for PPFP were developed after review of existing guidelines, an extensive literature review, telephone surveys from key players in several countries, technical meetings among multidisciplinary experts in Geneva and Washington, and expert review of the document. During the regional PPIUD meeting, the participants had an opportunity to use the Programming Strategies for PPFP in a case study. One participant expressed that the case study exercise was his preferred activity since it was "an experience that could be applied in our own country."

Site Visits and Demonstration Stations

During the first day of the meeting, participants had the opportunity to visit sites in Ouagadougou that provide PPIUD services: Centre Medical avec Antenne Chirurgicale (CMA) Kossodo, Association Burkinabè pour le Bien-Être Familial [Burkinabe Association for Family Well-Being] (ABBEF), CHU [University Hospital Center] Yalgado, and CMA Sector 30. Participants met with providers and toured the facilities, discussing training, counseling, client flow between antenatal care (ANC) and labor and delivery (L&D), and record keeping. They were also able to view insertion registers and client cards stamped with the woman's method choice. Participants remarked on the importance of good documentation. Retaining clients' contact information facilitates follow-up of clients who do not return. In addition, insertion figures, six-week follow-up data, and records of complications can help maintain quality services and ensure that issues are caught and addressed. In addition, participants viewed champion providers as a key resource to promoting and sustaining a successful PPIUD program.

Participants practice IUD insertion on anatomic models.

IUD insertion demonstration station with anatomic model, PPIUD insertion kit, and clinical skills checklist.

To allow a chance for small-group, in-depth discussions of quality issues around PPIUD insertions, the second day featured PPIUD demonstration stations using anatomic models. Doctors and midwives from MCHIP and PSI oriented participants to PPIUD insertion techniques as detailed in a clinical skills checklist. Interested participants then practiced PPIUD insertion on Mama-U models.

Country Self-Assessment on Scaling-Up PPIUD

As part of MCHIP efforts to document accomplishments in achieving its stated goal of "scaling up high-impact interventions," the program developed a tool to quantify both the maturity of health system competency for making an intervention available at scale and, where possible, a sense of coverage. MCHIP's prior use of this tool was both retrospective and for the present. MCHIP and PSI adapted the tool (Annex 3) for the regional workshop and tested its use as a way to gain consensus among participants from the same country on strengths and areas for improvement for introduction or scale up of PPIUDs in that country.

In summary, this activity was useful in framing the discussion to include a health system perspective, in addition to addressing clinical or facility-level issues. (For more information on results of this activity, see Annex 4.)

Examples of PPIUD Programs Represented

BURKINA FASO

Motivated by the 2011 regional family planning conference in Ouagadougou, Burkina is committed to increasing the country's contraceptive prevalence rate from 15% in 2010 to 25% by 2015.

In March 2013, Jhpiego initiated PPIUD services in five sites as part of its commitment to FP2020, training 50 providers on postpartum family planning counseling and 30 providers on PPIUD service delivery. With funding from UNFPA, Jhpiego has since scaled up PPIUD services to another 10 facilities, with the goal of expanding to an additional 10 facilities in 2014. Challenges experienced include gaps in communication between ANC and labor and delivery, which require further attention.

Burkina PPIUD Insertions and Findings at Follow-up 6 Weeks Post-Insertion

- 280 women received PPIUDs:
  - 57% counseled immediate postpartum; only 20% during ANC
  - CHU Yalgado: 56% of PPIUDs inserted during C-sections
  - Other sites: 88% of PPIUDs inserted in the immediate postpartum period
- 106 women had follow-up at 6 weeks
  - 91% had no problems
  - 2% expulsion rate
  - 1% infection rate

Data as of September 2013.

DEMOCRATIC REPUBLIC OF CONGO

PSI network member, Association de Santé Familiale (ASF), introduced PPIUD services in five public sector clinics in Kinshasa beginning in December 2012. Ten trainers from the National Reproductive Health Program, the Congolese Ob/Gyn society, the Association of Delivery Nurses, and ASF were trained. Services are complemented by education activities conducted by specially trained community mobilizers during prenatal and immediate postpartum care to increase informed demand for the method. A separate training of providers by a partner nongovernmental organization (NGO) at the five pilot sites helped to augment PPIUD service delivery during part of the pilot phase. In 2013, the National Reproductive Health Program integrated PPIUD approaches, including insertion techniques, into training modules for FP providers.

DRC PPIUD Insertions and Findings December 2012-March 2014

- 2,976 women received PPIUDs:
  - 59% of insertions took place in the 48-hour postpartum period
  - 30% were postplacental
  - 11% were intracesarean
- 2,857 women had follow-up at 15 days:
  - 97% had no problems
  - 3% expulsion rate
  - 0% infection rate

Data as of March 2014.

Lessons learned include the importance of national ownership and buy-in from technical staff at the National Program to help institutionalize PPIUD into training for service providers and the need for close collaboration between PPIUD and family planning providers to facilitate client follow-up. Good post-insertion counseling increased the likelihood of women returning for a 15-day follow-up visit. Sensitizing clients during prenatal care and in the postpartum ward increased demand for PPIUD services. Additional sensitization among male partners is needed to overcome issues such as spousal refusal, which prevented some women who elected to have a postpartum IUD from receiving it. In addition, mistrust of PPIUD among a subset of staff in pilot clinics impacted some women's opinions about PPIUD, underlining the importance of whole-site orientation and ongoing sensitization of clinic staff. Regular supportive supervision of PPIUD providers has helped to reinforce skills and maintain positive attitudes about PPIUD.

GUINEA

The majority (78%) of women within the first postpartum year do not want to become pregnant yet only 10% are using FP.[6] The Guinea Ministry of Health's new Health Strategic Plan prioritizes expanding access to and voluntary choice of LARC and permanent methods as central to family planning program efforts.

Before initiating PPIUDs, MCHIP/Guinea had already done considerable work in PPFP. The program chose to train providers working not just in ANC and maternity, but also child health and vaccination, as well as nutrition services. The first experience with PPIUD began with six health facilities in Conakry (which also serve as practicum sites for medical students) and involved training providers and providing supplies and equipment, including supplemental registers for monitoring service delivery. Scale-up of services to the interior of the country followed gradually (see box).

Key to implementation was establishing means of coordination between units of care, such as ANC and labor and delivery, through the use of a PPFP counseling stamp on the client card and regular coordination meetings. Standards for PPIUD service delivery were also integrated with the existing Standards-Based Management and Recognition (SBM-R®) quality improvement program. Regular supportive supervision by project staff further reinforced quality of services. Finally, a pool of trainers was prepared to assist with expansion. Many clients benefiting from this intervention gave positive feedback about the peace of mind they felt for the protection against another pregnancy.

Lessons learned from Guinea include the importance of identifying one or more strong PPIUD champions in each facility, especially as there is a need to reorganize service delivery to accommodate the intervention. This requires intra-facility communication and coordination, for example, to ensure that supplies are pre-positioned in labor and delivery. Counseling in both ANC and labor and delivery is very important to stimulate demand for the method. In Guinea, the cost of the IUD is waived if a woman receives the method during her childbirth visit. Furthermore, obtaining a good contact number for telephone follow-up requires specific attention so that women understand that they may receive a call, and can clarify if the number belongs to a relative or friend, and whether that person is aware of her method choice. MCHIP/Guinea has also worked to link PPIUD expansion to strengthening of basic emergency obstetric and newborn care (BEmONC) services, so as to facilitate integration of services. Lastly, a strong focus on capturing data at the service site is essential to monitoring program implementation.

Guinea PPIUD Insertions and Findings April 2011–September 2013

- 293 providers trained in PPFP
- 85 trained in PPIUD (working in 32 sites)
- 44% of women who had facility births received PPFP counseling
- 2,882 (4%) opted for PPIUD
  - 1% opted for PP tubal ligation
  - 90% chose the lactational amenorrhea method (LAM)
- 45% of insertions were in the immediate postpartum period
- 35% were postplacental
- 18% were intracesarean
- 2,421 women had follow-up at 6 weeks
  - 97% had no problems
  - 1.3% expulsion rate
  - 1% infection rate

MALI

PSI/Mali began a PPIUD pilot program in 2011, starting with a training of trainers in Bamako. In total, PSI has trained 25 trainers and 97 providers in Bamako, Kayes, Sikasso, and Segou in both community health centers (*centres de santé communautaires* or CSComs in French) and

[6] ACCESS-FP re-analysis of DHS, 2005.

Referral health centers (*centres de santé de reference* or CSRef) using a training of trainers (TOT) model.

In 2013, MCHIP initiated PPIUD services in four sites in the district of Kita—the referral health center (CSRef) and three community health centers (CSComs)—training 10 participants who developed action plans on incorporating PPIUD services at their sites or with their professional organizations. In 2014, MCHIP expanded PPIUD services to additional regions, conducting training for 30 Ob/Gyns and midwives from Kayes, Bamako, and Sikasso on PPIUD counseling and service delivery. Providers trained included those from facilities in Bamako and in the regions, a representative of the Kayes regional health department, as well as representatives of the Order of Malian Midwives, the Association of Malian Midwives, and the Malian Obstetrical/Gynecological Society.

As in other countries, Ministry of Health ownership has been an important component in scaling up and institutionalizing PPIUD services. In Mali, the Policies, Norms, and Procedures (PNP) are revised every four to five years. The last revision in 2012 integrated guidelines for PPIUD and discussions are under way to incorporate these into pre-service education for midwives.

Photo credit: A. Coulibaly

A new mother who uses PPFP, in the district of Kita, Mali.

Sites are chosen primarily based on caseload of deliveries. Projects included sites from all three levels of the health pyramid, from community health centers to referral hospitals to national hospitals, targeting facilities with high numbers of deliveries. They also sought sites where providers were most motivated to add PPIUD services or had benefited from previous trainings in PPFP, LARC, and infection prevention practices and could readily incorporate PPIUD into their portfolio. Equipment and supplies for the delivery room as well as supplemental registers are provided to the sites.

PSI arranges weekly coaching visits to the health centers to reinforce skills after training and address provider concerns or resistance about the method. Similarly, MCHIP conducts transfer of learning visits six weeks after training to follow up with providers and address any issues with PPIUD service delivery at their facilities. Projects have also focused on establishing systems for monitoring services for program improvement. Health centers send data on the number of PPIUD insertions to referral centers, including a line specifically for PPIUD along with the overall number of IUDs inserted. A supplemental register for PPIUDs provided to the maternity unit includes space to indicate timing of counseling and of insertion (postplacental, postpartum immediate, or during cesarean) as well as any problems or complications. These data are reported monthly to referral centers and the referral centers report quarterly to the national hospitals.

NIGER

Niger was among five countries (along with Benin, Chad, Côte d'Ivoire, and Senegal) participating in a UNFPA-funded regional project to train a team of five providers from one

hospital during a regional course in Guinea. All participants received training in PPFP counseling, and a subset were trained in PPIUD insertion.

Knowledge Exchanges

To engage in South-to-South learning and uncover localized insights and program knowledge for introducing and expanding PPIUD services, participants engaged in a series of knowledge exchanges.[7] The session consisted of five stations, each with a facilitator and a note-taker. At each station, participants assembled in groups of 8 to 10 people, representing a mix of countries and organizations, and they rotated through the stations every 25–30 minutes.

The knowledge exchange sessions were preceded by plenary "igniters," during which representatives from different countries presented briefly on each topic. The facilitators then guided groups through the topics, using a list of prepared questions. Note-takers and facilitators synthesized the results of all five rounds of discussion to share with the participants the next day.

More than half of participants ranked the knowledge exchanges as their favorite session. For example, one participant wrote, *"This session permitted a rich exchange of experience among the participants [who] find themselves at various stages of PPIUD implementation."*

KEY POINTS ON EACH TOPIC

SITE SELECTION AND WHOLE-SITE ORIENTATION

Igniter: Jeanne Tessougue of PSI/Mali recommended selecting pilot sites from all levels of the health pyramid—from community health centers to referral hospitals. PPIUD services work best at sites that provide enough deliveries to allow providers to put PPIUD training to good use. Provider motivation is also critical. PSI/Mali sought out sites with providers whom they knew to be motivated to add PPIUD services and they used coaching to address provider concerns about the method.

Key Points

Site Selection Criteria

A high volume of deliveries is necessary to make PPIUD training worthwhile. Participants agreed that it is not worth introducing PPIUD services in sites that have too few deliveries for providers to keep up their PPIUD skills.

Key Criteria for PPIUD Site Selection:

- High volume of deliveries
- Site offers FP, ANC, and L&D
- Geographic accessibility for clients and trainers
- Providers who are motivated to offer PPIUD

Sites with three key services: FP, ANC, and L&D. The sites with the highest delivery volume are typically national referral hospitals that handle high-risk deliveries, most of which do not offer routine ANC. A key component of PPIUD services is comprehensive FP counseling during ANC. To improve service integration, participants recommended selecting sites that offer ANC and FP services in addition to delivery. Referral hospitals can be included as an exception if they have strong communication with ANC providers at other sites, such that they coordinate referrals of women who have opted for PPIUD during ANC and respect notations on the mothers' ANC cards to that effect.

[7] The methodology for these knowledge exchanges was adapted from Pugh KB. 2011. *Sharing Hidden Know-How: How Managers Solve Thorny Problems with the Knowledge Jam.* Jossey-Bass.

Prioritize sites with geographic accessibility for clients and trainers. Sites should be accessible to trainers to enable frequent post-training follow-up and supervision.

Prioritize sites with motivated providers. Participants shared that many providers are biased against the IUD and will not offer it to clients even if they receive training. During the pilot phase, program managers can rely on their familiarity with individual providers to distinguish sites with personnel who are motivated to provide PPIUD services. Participants recognized that this strategy works only on a small scale, however. They made recommendations for effective whole-site orientations (below) in order to overcome the barrier of provider motivation.

Whole-site orientation

Conduct whole-site orientation at all PPIUD sites. Whole-site orientation introduces the benefits of and strategies for integration of PPIUD services to all facility staff—upper management, providers, support staff, and other potential "gate keepers," including guards. Whole-site orientation is very useful, particularly when the innovation being introduced is subject to myths and taboos, as the IUD is in many of the participating countries. Without whole-site orientations, personnel who do not attend PPIUD training themselves may otherwise assume that they have no role to play in enabling PPIUD service integration and may even talk clients out of choosing the PPIUD because of their misunderstandings about the method.

Participants shared two ideas to reduce the costs of whole-site orientations: combine personnel from several sites to participate in one orientation together and/or take advantage of regular staff meetings to share learning on PPIUD services.

Involve the leadership of PPIUD sites in orienting others. Participants recommended inviting managers in charge of sites to PPIUD training to ensure their buy-in, even if those head doctors and nurses focus their time on management rather than practicing medicine themselves. These head providers should take a leading role in whole-site orientations in order to demonstrate the importance of the PPIUD program to all staff. The support of the top management of a health facility is critical to a PPIUD program's success.

ADVOCACY AND ENGAGING STAKEHOLDERS

Igniter: Dr. Mala Sylla of the Mali MOH discussed advocacy and engaging stakeholders. He emphasized the importance of having the commitment of the MOH and incorporating PPIUDs into national standards. Dr. Mala shared the story of an advocacy activity involving the National Assembly to address women's sexual and reproductive health rights last year. Also, he relayed the process of MCHIP and PSI coordination to support the MOH in producing a national reference document for PPIUD.

Key Points

Share knowledge and harness energy at international conferences

Use support from important regional meetings such as the FP Conference in Ouagadougou 2011. Benin, Burkina Faso, Guinea, Mali, Mauritania, Niger, Senegal, and Togo used the Ouagadougou Conference on FP in 2011 to jump-start their FP programs and develop action plans with key stakeholders present. The governments of these countries were ready to introduce a new method and embraced PPFP (and in some countries, this also included PPIUD).

Involve influential stakeholders

Engage high-level advocates. For example, the First Lady of Burkina Faso is a leading champion for FP. After the Ouagadougou FP conference in 2011, Burkina Faso committed to increase the contraceptive prevalence rate from 15% in 2010 to 25% by 2015. Additionally, the Chief of Maternal Health Services at a teaching hospital in Burkina Faso became convinced of the value of PPIUD services when he saw the data on it. He then shared it with the MOH which accepted the PPIUD data as an evidenced-based practice.

Delineate responsibilities among key stakeholders in the government, civil society, and NGOs. Understand the role they play in FP and mobilizing resources. Use these meetings to revise the FP standards and guidelines (that include PPIUD).

Use PPFP as a strategic platform to advocate for FP. PPIUDs are a form of both long-acting reversible contraception (LARC) and PPFP. In support of clients' voluntary and informed decision-making, PPIUD should be presented as one of a range of FP options for postpartum women.

Get the commitment of political and religious leaders, the commitment of men to support pregnancy spacing, and work through a steering Committee (Minister of Health) and Technical Committee.

Study tours

Organize PPIUD study tours. PSI advocated with the MOH for expanding PPFP method choice with PPIUDs and identified a country, Zambia, which had PPIUD experience. PSI, together with the MOH and other NGOs, identified a champion for PPIUD, who was sent to a successful program in another country to learn about implementation. On his return, he was able to organize a training of trainers on PPIUD. Additionally, a study tour to a successful program was helpful to launch PPIUDs in Burkina Faso. After Burkinabè stakeholders visited a successful program in Guinea, they initiated their services in May 2013.

Logistics

Engage the logistics systems to avoid stock-out of IUDs and other consumable supplies in the delivery room.

Look to global players such as UNFPA, the United Nations Children's Fund (UNICEF), and WHO for help. UNFPA is working with the Burkinabè team to plan an expansion to 20 additional sites.

CLIENT COUNSELING, INFORMED CONSENT, AND DEMAND CREATION

Igniter: Dr. Hanitra Razakanirina of PSI/Madagascar shared details on the PSI experience with launching a new PPIUD program at a referral health center in 2013. In this instance, providers themselves had heard about PPIUD and asked for PSI's assistance in starting up services. PSI began by conducting training for providers and midwives on demand creation and counseling. In addition, they ensured that communication materials addressed all FP methods available at the health center, including PPIUDs. The topic of PPFP was also integrated into parenting and childbirth preparation classes at the center.

Key Points

Counseling and Informed Consent

Train service providers in PPFP as well as PPIUD. Service providers trained with too great a focus on PPIUD may place undue weight on this method. On the opposite end, if service providers do not fully understand the method or harbor misconceptions about efficacy or side effects, they may be less motivated or unable to appropriately counsel clients who wish to use it. Training providers on PPFP and then on postpartum IUD services helps frame PPIUD as one of multiple options postpartum women may choose.

Provide FP counseling at multiple contact points. General FP counseling should be done first, followed by method-specific counseling after the woman has made her initial choice. Several participants suggested offering general FP counseling in a larger group, followed by individual, method-specific counseling between each client and the provider. Offering counseling on all methods appropriate for postpartum women during multiple contact points (during ANC, early labor, in the 48 hours postpartum, and during child health visits) should ensure that women are well-informed of their options.

During PPFP counseling, offer a range of FP methods, show clients the actual device, and strive for privacy. Clients may have difficulty connecting between illustrations of FP options and what the method really entails. A simple poster with FP commodities glued on to it can give them a more tangible idea of the size of an IUD and what other methods look like. Privacy is important for clients to be able to ask questions and make a choice without being influenced by others.

Demand Generation

Integrate FP promotion and counseling at the community level. Community health workers who visit households can conduct FP counseling for pregnant clients and encourage women to visit health facilities to deliver and obtain services. Engagement of religious and community leaders was also cited as a way to promote use of FP, as well as male engagement. In DRC, one project engaged men by organizing an event around a soccer match during which community leaders took time to talk about FP and its importance in improving women's health, which led to an increase in clients accessing services, including women visiting the health facilities with their partners.

Use mass media to reach wider audiences. Radio spots in local languages as well as the national language can promote FP and the benefits of birth spacing. For PPIUDs, one participant mentioned engaging community radios in disseminating the message that women do not need to wait until their child is walking to pick an FP method; they can even start a FP method right after birth. Most participants agreed that radio was preferable to TV spots in that it allowed greater reach.

Satisfied clients can also be champions. Women who have had good experiences at the health facility or with the method often share their opinions through their social networks.

Ensuring Quality at Scale

Establish performance standards and monitor adherence to them. Standards and checklists provide a uniform assessment measure across all levels in the country to monitor performance. Supervision during counseling can check that providers talk about all FP methods, and that side effects and limitations of specific methods are adequately covered. Providers should ask clients questions to make sure they understood. Checklists both remind providers what to cover during counseling and serve as a tool to evaluate the topics discussed.

Conduct operational research, surveys to examine user satisfaction, contraceptive continuation rates. There are links between continuity of care and quality of counseling. After women have received counseling, it is important to examine both whether they received the method they selected and whether they continued to use that method. In Guinea, findings from a one-time activity to ask providers to track women who had PPIUDs found a continuation rate of 93% after one year, suggesting that women who chose the method were highly satisfied and appropriately counseled.

MONITORING & EVALUATION

Igniter: Aissata Tandina from MCHIP/Mali explained how PPIUD data are used across the three levels of the health system in Mali—community health centers, referral centers, and national hospitals. Health centers send data on a quarterly basis to reference centers at the district level, where they get aggregated with the reference center's own data, including a line for IUD insertions. In sites that have introduced PPIUDs, they use a comments area to indicate separately the number of postpartum IUDs, with detail on type of insertion. The referral center is similar; however, it compiles the community health center data with its own data (adding intracesarean IUDs), so that the data are available at the national level. Although not yet approved for use, new health information system tools have been proposed that formally integrate PPIUD. Currently, the supplemental register for PPIUD data is maintained in L&D.

Key Points

Tools

Tools for tracking PPIUDs are needed in ANC, L&D, postpartum, and the FP section. Having data on PPIUD services is critical for understanding the program's evolution and trends at various levels of the health system, sharing results, and obtaining additional buy-in, especially given that PPIUDs are relatively new.

In ANC, depending on the existing register format, one can use the observations/comments column to indicate whether a woman was counseled on PPFP and which method she chose (if she chose a method). Also, a client card can indicate her choice and the client should be instructed to bring the card to the facility for a birth. Many programs have used a stamp system to add to this card.

In L&D, the registers are typically already very dense. Furthermore, PPIUD monitoring requires a number of additional elements to be tracked, such as how many and the percentage of women counseled in this service area and when the counseling took place, how many women accepted and received a PPIUD, when and how many have come back for follow-up, how many experienced expulsions, infections, etc. All these elements cannot simply be added to existing registers; thus, a supplemental PPIUD register was found to be necessary.

Essential Indicators
Several essential indicators were agreed upon at the meeting:

- **Percentage of PPIUD acceptors** from among the total number of women giving birth in the facilities (MOH especially keen for these data)
- **Number and percentage of expulsion or infections**
- **Proportion of health facilities with IUD stock-outs**

Note: The percentage of postplacental insertions can be used to gauge the quality of counseling in ANC and of the level of coordination between units.

Additional Indicators
Additional indicators were agreed upon to examine trends over time:

- **Percentage of women accepting FP in the immediate postpartum**, disaggregated by method (LAM, IUD, female sterilization, vasectomy, condoms, or none)
- **Proportion of acceptors for each method** (with the idea that changes in this proportion may indicate a change in attitudes toward specific methods)

Guinea has further **linked the FP unit to PPFP services**. Whenever a client accepts a method such as the IUD or a tubal ligation, she is counseled to practice exclusive breastfeeding. For a woman who does not opt to leave the birth facility with a method, she is also advised to adhere to lactational amenorrhea method (LAM) criteria until she can start the method of her choice. A FP client card is drawn up for her within the maternity ward, but she is advised to return for future services in the FP unit, where her FP client card will be taken and stored. Ideally, the FP client card will be used to coordinate follow-up, either from the FP unit, or working in collaboration with community health workers who may visit women at home. She may decide to get her chosen FP method in a health center closer to her home, which is fine as long as she continues with a method of FP for the desired duration.

Data

Conduct special studies. These could explore cultural norm issues, such as reasons why women do or do not accept a FP method in the immediate postpartum period, and factors that make the IUD more or less attractive to potential acceptors. Similarly, follow-up studies of acceptors could explore reasons for premature discontinuation of methods including the IUD.

Assess whether local or national information systems have:

- A focal point for collecting, synthesizing, and analyzing data at the facility level;
- Maternal and child health (MCH)/FP supervision tools and processes that include a review of whether services are organized in a manner that favors PPIUD services; and
- Commodities and supports in the L&D area.

Investigate trends. Any abrupt change in trends for PPIUD data would be something that a facility or supervisor should investigate further.

Strategies to Encourage Communication among Service Providers:

- Conduct whole-site orientations.
- Hold weekly meetings among PPIUD providers to review PPIUD cases.
- Hold quarterly meetings among staff from different services to review data and services.
- Share experiences as a way to improve quality.
- Use supervision to problem-solve and mentor.

CONTINUITY OF CARE

Igniter: Professor Yolande Hyjazi from MCHIP/Guinea stated that to ensure continuity of care for PPFP/PPIUD, all staff should be involved. Additionally, antenatal, L&D, FP, well-baby care, and vaccinators should be included in PPFP counseling. In Guinea, MCHIP trained those who worked in L&D in PPIUD insertion. The FP unit and L&D work collaboratively; after PPIUD insertion, the L&D staff share the name and number of the woman and appointment date. If she does not return for her six-week follow-up visit, the L&D staff call the client and inquire about her PPIUD. If the client has any problems or concerns, she is asked to come to the FP unit. Good communication between ANC and maternity services, even if they are not in the same facility, is key for continuity of care. Using a client card that is recognized by all facilities with information about PPFP is helpful.

Example of PPFP stamp from Guinea.

Key Points

Communication among providers

Seize all opportunities to create links between structures, promote champions to address resistance, and avoid segmentation of staff by unit. It is important to train staff from different shift rotations, including the on-call night staff who do deliveries. Providers should be trained in both counseling and insertion of PPIUDs.

To aid communication between ANC and maternity services, use a PPFP stamp (a rubber stamp that the ANC provider stamps on the client card indicating that she has been counseled on PPFP and the method that she has chosen).

Recognize that ANC and L&D staff need training on counseling, whereas L&D staff need additional training on insertion.

Communication with clients

Orient providers to integrate FP messages into other services. Whole-site orientations stress the importance of everyone being oriented to PPFP so that providers from other services are aware of PPFP. Providers can raise the topic of FP with women when they bring their children in for immunizations, weighing, or nutrition visits.

Use community health workers (CHWs) to provide messages about PPFP. Where PPFP was added to a set of messages for group counseling in local languages and where it routinely happens, there is an increase in PPFP uptake. Orient community leaders to support and echo CHWs who are promoting PPFP.

Meeting with Ministry of Health Representatives

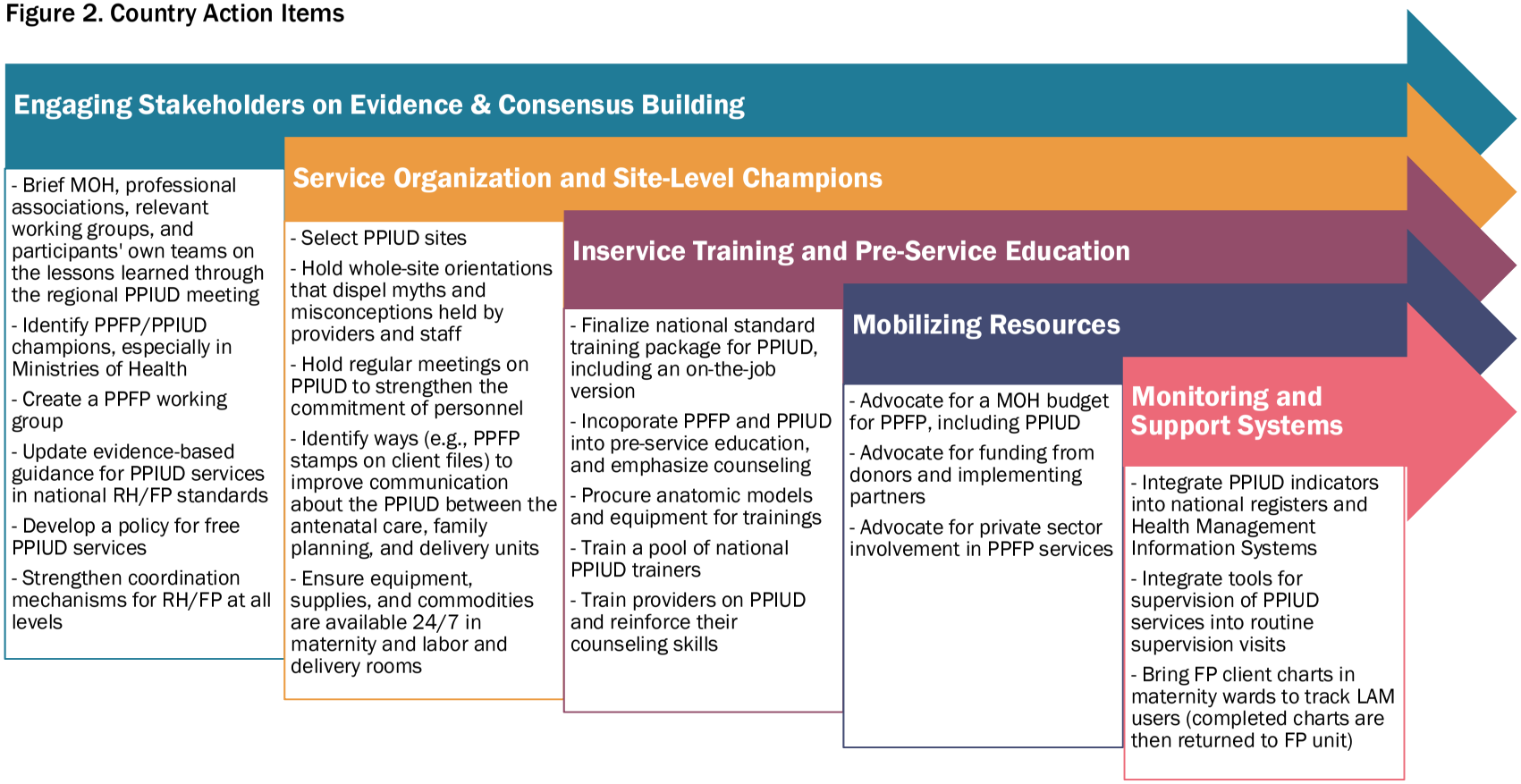
With the help of the WAHO representative, a lunchtime meeting was held on the final day of the workshop with seven of the countries whose MOH were represented. This offered the opportunity to solicit concerns, insights, and ideas from these participants about both challenges and opportunities for integrating PPIUD services into their existing or future operational plans. A common concern was that the timing of the regional meeting came when the current year's operational plans had been developed and approved; thus, the only way to add new activities this year was if donors were willing to provide supplemental funding. But many had good ideas for ways to achieve scale or readiness for scale more rapidly, such as, for example, by offering training and models to pre-service education institution. The short timeline of the regional meeting's action plan horizon limited their ability to make concrete commitments. However, some representatives thought incorporating PPIUDs as part of longer-term FP project planning might be feasible, given a longer horizon, and expressed hope that donors will be receptive to this idea as the need for external resources is generalized in the region. As organizers of the PPIUD meeting, we appreciated the directness of the conversations and offered to continue to advocate with our donors for supporting West African countries, especially in the context of FP2020 and other global initiatives.

Next Steps by Country

During the course of the meeting, participants were divided into country teams that met to exchange ideas and apply lessons learned toward developing a set of action items to undertake in their respective countries **over the next six months**. At the end of this exercise, the teams: 1) drafted a vision of success; 2) shared some fresh ideas they had gained from attending the meeting; 3) outlined constraints to the vision and newly learned strategies to overcome the constraints; and 4) identified areas to be addressed, the required actions, and the responsible individual(s), and developed a timeline.

The following figure is a synthesis of common action items that appeared in several countries' action plans. Each arrow represents a category of action items, which, taken together, lead toward successful program scale-up. Not every country team planned all the next steps listed below; these items can be implemented in whatever order suits each country's context. Time frames are not represented here; but, in general, the plans had ambitious deadlines within six months of the meeting. A common concern across countries was identifying funding to enable these steps.

Figure 2. Country Action Items



Conclusion

Integration of PPIUD into maternal health services offers countries an enormous potential to expand the reach of PPFP programs and offers women a safe, effective, long-lasting, convenient method that they can use to space or limit their pregnancies.

The workshop brought together 48 regional stakeholders from 11 countries representing a continuum of PPIUD programming experiences—from those contemplating the feasibility of piloting PPIUD services, to those embarking upon national scale-up. The variety of programming experiences created a rich environment for cross-country exchanges and learning, combining evidence and support from established programs with fresh perspectives from those just introducing the service. The composition of the country teams included ministry officials and implementing partners, allowing for coordinated planning and integrated activities among key stakeholders following the meeting. The richness of the exchanges and lessons that emerged and the resulting action plans are a testament to years of experience and commitment to making these services a reality for more women in Francophone Africa and Haiti.

For participants, the next step is to translate these lessons and ideas into action. The meeting provided dedicated time for country delegations to reflect on workshop lessons and prioritize and outline concrete steps to scale up PPIUD in their countries. Some of the priority areas for action that emerged include:

- Creation of national PPIUD working groups
- Identification of PPIUD champions, especially within Ministries of Health
- Adaptation/finalization of standardized training packages, and creation pools of trainers
- Advocacy for donor funding
- Integration of PPIUD indicators into National Registers and Health Management Information Systems

The meeting was a starting point, and early reports suggest that the momentum has continued after participants returned to their home countries. For example, within a month of the meeting, four partner NGOs and the MOH in Mali already had held coordinating meetings and began discussions on coordinating PPIUD activities. Delegates from Madagascar had used new insights to begin additional communication activities to promote the availability of the service, and additional providers had been trained. In Burkina Faso, attendees began monitoring visits and data collection at PPIUD sites to reinforce project activities and provide up-to-date information on services. In addition to helping existing programs adapt lessons from other countries, the meeting was successful in providing delegations from countries without PPIUD services the data and lessons needed to plan for service introduction. In the words of one participant:

The sharing of experiences provided a rich harvest of lessons learned, and very practical guidance. The best testimony we can make about this workshop will be our rapid mobilization for implementation of our action plan.

Meeting organizers are exploring low-cost ways to facilitate continued exchange, including webinars and on-going dialogue with meeting participants.

For further information, please contact Maxine Eber (meber@psi.org) or Anne Pfitzer (anne.pfitzer@jhpiego.org). Copies of all presentations, detailed notes of knowledge exchanges, and action plans, can be obtained from either MCHIP or PSI upon request.

Annex 1: Meeting Agenda

SERVICES DE DIU DANS LE POSTPARTUM : DE L'INTRODUCTION A LA MISE A ECHELLE REUNION REGIONALE, BURKINA FASO, 3-5 FEVRIER 2014	
Aperçu de la réunion	Cette réunion, organisé par le Programme Intégré de Santé Maternelle et Infantile (MCHIP) et le projet d'appui en faveur des organisations internationales de planification familiale (SIFPO), mis en œuvre par Population Services International (PSI)—tous deux financés par l'Agence des États-Unis pour le développement international (USAID)— rassemble des experts régionaux et internationaux pour faire avancer l'intégration du dispositif intra-utérin du postpartum (DIUPP) dans les services de santé maternelle.
Objectifs de la réunion	La réunion renforcera les capacités des participants d'accélérer l'intégration de la planification familiale du postpartum (PFPP)/DIUPP dans les services de santé maternelle à travers : ▪ Des discussions portées sur les domaines du plaidoyer, la mobilisation communautaire, et les diverses stratégies de prestation de services du DIUPP, axées sur l'évidence et guidées par l'analyse des données du programme ▪ Une opportunité pour les participants de visiter les structures sanitaires à Ouagadougou qui offrent les services DIUPP et de pratiquer l'insertion du DIUPP sur les modèles ▪ Le partage des succès et la discussion des défis dans la mise en œuvre des programmes de DIUPP, de l'introduction jusqu'à la mise à échelle ▪ Une opportunité pour rédiger des plans par pays

Agenda

JOUR 1		
Heure	**Session**	
8:30 – 9:00	**Aperçu, objectifs de la réunion, et agenda**	
9:00 – 9:30	**Ouverture**	
9:30 – 10:30	**Préparer le terrain** ▪ Evidence globale pour la PFPP ▪ L'annonce des « Stratégies de programmation pour la planification familiale du post-partum » ▪ DIUPP : À l'intersection de la PF et la santé maternelle	
10:30 – 10:45	**Pause-café**	
10:45 – 11:15	**Présentation :** Stratégies de programmation pour la planification familiale du postpartum	**Visites des structures sanitaires avec services DIUPP**
11:15 – 12:15	**Travaux en groupes** : L'application des stratégies PFPP aux programmes DIUPP	
12:15 – 12:45	**Rapport** des groupes sur l'étude de cas	
12:45 – 13:45	**Déjeuner**	
13:45 – 14:15	**Présentation :** Services de DIUPP au Burkina Faso	
14:15 – 15:00	**Rapport** et discussion des visites de site	
15:00 – 15:15	**Pause-café**	

JOUR 1	
Heure	**Session**
15:15 – 16:15	**Matrice du stade de mise à échelle** ▪ Orientation ▪ Travaux en groupes par pays
16:15 – 16:45	**Discussion plénière :** Thèmes communs vus sur la matrice
16:45 – 17:00	**Résumé du jour 1**

JOUR 2	
Heure	**Session**
8:30 – 8:45	**Photo de groupe** (dehors devant l'hôtel)
8:45 – 9:15	**Vidéo et introduction des techniques d'insertion**
9:15 – 10:30	**Stations de démonstration de DIUPP** (sur modèles anatomiques)
10:30 – 10:45	**Pause-café**
10:45 – 11:30	**Présentation :** Services du DIUPP en Guinée
11:30 – 12:15	**Travaux de groupes :** Quels sont les défis aux programmes de DIUPP ?
12:15 – 13:15	**Déjeuner**
13:15 – 16:30	**Echanges de savoir** Introduction Travaux en groupes : Échanges de savoir sur les considérations programmatiques ▪ Station 1 : Choisir une structure sanitaire et l'orientation du site ▪ Station 2 : Engagement des parties prenantes et le plaidoyer ▪ Station 3 : Le counseling et le consentement éclairé, la génération de la demande ▪ Station 4 : Systèmes d'information sanitaire et le surveillance ▪ Station 5 : Continuité des soins
16:30 – 16:45	**Discussion en plénière des échanges de savoir**
16:45 – 17:00	**Résumé du jour 2**

JOUR 3	
Heure	**Session**
8:30 – 9:00	**Accueil et synthèse des thèmes des échanges de savoir**
9:00 – 10:15	**Travaux en groupes :** Planification des prochaines étapes en équipes de pays
10:15 – 10:30	**Pause-café**
10:30 – 12:00	**Travaux en groupes :** Planification des prochaines étapes
12:00 – 13:00	**Déjeuner**
13:00 – 14:00	**Discussion en plénière :** Prochaines étapes par pays
14:00 – 14:15	**Démonstration :** Autres outils et ressources sur le DIUPP
14:15 – 14:30	**Evaluation de la réunion**
14:30 – 15:00	**Clôture**

Annex 2: Participant List

NAME OF PARTICIPANT	ORGANIZATION
Burkina Faso	
Dr Aïssa BOUWAYE	OOAS/WAHO
Mr Adama COULIBALY	L'Union des Coutumiers et Religieux du Burkina (URCB)
Mme Brigitte THIOMBIANO	Ordre des Sage-Femmes
Céline SOMÉ	MSI/Burkina Faso
Dr Cheick Omar OUEDRAOGO	Ministère de la Santé – Direction de la Sante de la Famille (DSF)
Dr Isabelle BICABA	Ministère de la Santé – Direction de la Sante de la Famille (DSF)
Pr Jean LANKOANDÉ	Hôpital Yalgado
Mme Justine BELEM	Futures Group
Oumarou KABORE	MSI/Burkina Faso
Lea GARANE	Jhpiego – Consultante
Mme Martine OUEDRAOGO	Hôpital Bobo-Dioulasso
Natalie ROOS	OMS/Burkina Faso
Yacouba OUEDRAOGO	Jhpiego/Burkina Faso
Cameroon	
Juliet NSORBIKA	Association Camerounaise pour le Marketing Social (ACMS)
Côte d'Ivoire	
Dr Evelyne-Patrice OBODOU	Agence Ivoirienne de Marketing Social (AIMAS)
Guinea	
Dr Madina RACHID	Ministère de la Santé et de l'Hygiène Publique
Dr Saliou Dian DIALLO	OMS/Guinée
Dr Suzanne AUSTIN	Jhpiego/Guinea
Dr Thierno Sadou DIALLO	Centre Médical de Commune de Matam, Conakry
Pr Yolande HYJAZI	MCHIP/Guinée
Haiti	
Dr Jean Bernard FEVRIER	Ministère de la Santé Publique et de la Population (MSPP)
Dr Natacha ANTOINE	PSI/Haïti
Dr Reynold GRAND PIERRE	Ministère de la Santé Publique et de la Population (MSPP)
Madagascar	
Dr Hanitriniaina RAZAKANIRINA	PSI/Madagascar
Pr Pierana RANDAOHARISON	Ministère de la Santé

NAME OF PARTICIPANT	ORGANIZATION
Mali	
Dr Abdourahmane SIDIBE	MSI/Mali
Assetou DOUMBIA	MSI/Mali
Aida Aïssatou LO	MCHIP/Mali
Mme Cely DIALLO	PSI/Mali
Mme Fatoumata DOUMBIA	CS-Réf, Kita
Mme Haoua BA	Centre de Santé de la Commune I de Bamako
Mme Aissata TANDINA	MCHIP/Mali
Dr Jeanne TESSOUGUE	PSI/Mali
Dr Mala SYLLA	Hôpital Régional de Sikasso
Dr Mamadou BERTHÉ	Ministère de la Santé et de L'Hygiène Publique (DNS/DSR)
Mme Mariame ONGOÏBA	CS-Réf de la Commune V de Bamako
Mme Rokia TRAORE	PSI/Mali
Mauritania	
Pr Aissata BAL - SALL	Cellule Sectorielle de Coordination pour l'Accélération de l'Atteinte des OMD Santé (CESCA OMDs)
Niger	
Dr Abdou AMADOU	Ministère de la Santé Publique
Dr Ibrahim SOULEY	Ministère de la Santé Publique
Democratic Republic of Congo	
Mme Gaby KASONGO	Association de Santé Familiale (ASF)
Dr Gisele LOWA	IMA World Health
Togo	
Mme Héloïse ADANDOGOU	Ecole Nationale des Sages-Femmes du Togo / ASSAFETO
Mr Guy C. AHIALEGBEDJI	UNFPA
Dr Andre KOALAGA	EngenderHealth / Agir-PF
Dr Kassouta N'TAPI	Division de la Santé Familiale (DSF)
Pr Koffi AKPADZA	Université de Lomé, Faculté des Sciences de la Santé
M Simtokina N'GANI	Division de la Santé Familiale (DSF)
Facilitators/Other Representatives	
Anne PFITZER	MCHIP
Ashley JACKSON	PSI
Beata MUKARUGWIRO	Jhpiego/Rwanda
Blami DAO	Jhpiego
Devon MACKENZIE	MCHIP
Gahan FURLANE	Jhpiego
Holly BLANCHARD	MCHIP

NAME OF PARTICIPANT	ORGANIZATION
Kodjovi "John" AGBODJAVOU	Jhpiego/Togo
Lillian BENJAMIN	USAID
Mary Lyn GAFFIELD	OMS/Genève
Maxine EBER	PSI
Nancy ALI	Jhpiego
Patricia MACDONALD	USAID
Rachel WAXMAN	Jhpiego
Dr Stanislas Paul NEBIE	Jhpiego/Burkina Faso
Tsigué PLEAH	Jhpiego
Willy SHASHA	Jhpiego

Annex 3: Scale-Up Matrix

1. INFORMATION CONTEXTUELLE
INTERVENTION / PAYS: _____
Nom de la personne qui remplit la matrice: _____
DATE: _____

CAPACITE DU SYSTEME DE SANTE (POUR L'INTERVENTION)			QUESTIONS SUR LA CAPACITE DU SYSTEME DE SANTE LIEE A L'INTERVENTION	Aucune capacité (0)	Phase de préparation (1)	Phase (Pilote) d'introduction (2)	Phase d'expansion préliminaire (3)	Phase d'expansion finale (4)	2. EN CONSULTATION AVEC LE MINISTERE DE LA SANTE ET AUTRES, INDIQUER LES SCORES DE MISE A ECHELLE PAR DOMAINE DE CAPACITE DU SYSTEME SANITAIRE (QUESTIONS COL. D)		3. DECRIRE BRIEVEMENT LES ACTIVITES MISES EN OEUVRE POUR ATTEINDRE CETTE CAPACITE	4. QUELS PARTENAIRES ONT MIS EN OEUVRE OU SOUTENUS CES ACTIVITES (DERNIERE COLONNE A GAUCHE)?
				Aucune capacité du système de santé et aucune activité n'a été entreprise dans ce domaine de compétence pour cette intervention.	**Principaux choix des stratégiques** au niveau national et mesures prises pour établir les capacités nécessaire à l'intervention.	**Pilotage du compétence** liée à cette intervention. Des agences externe prend la majorité de la responsabilité pour ce domaine de competence.	**Le Ministère de la santé ou le secteur privé commencent à assumer la capacité** pour cette intervention, en attendant une intégration complète dans les systèmes nationaux ou infranationaux.	**La capacité pour l'intervention est complètement acquise et pleinement intégrée** dans les systèmes nationaux ou infranationaux (publique ou privés).				
				0	1	2	3	4	Base (20xx)	Actuel (20xx)		
1	Gouvernance	Politique	Est-ce que les éléments de politique nécessaires et les procédures pour la pratique ont été mis en place pour soutenir l'intervention?	Aucune démarche n'a été entreprise pour apporter les changements nécessaires à la politique pour l'intervention proposée.	Des discussions sont en cours au sujet des politiques et lignes directrices qui incluent l'intervention.	Des politiques et lignes directrices ont été développées et sont mises à l'essai notamment par ou avec le soutien d'organismes externes.	Les changements de politiques ont été adoptés, les lignes directrices sont en cours de finalisation; la formation est déployée en accord avec les nouvelles directives.	Une majorité ou la totalité des gestionnaires et prestataires concernés reçoivent une formation sur la politique nationale et sur les lignes directrices qui incluent l'intervention.				
		Plannification	L'intervention est-elle inclue dans les plans nationaux ou infranationaux?	Aucune démarche n'a été entreprise pour apporter les changements nécessaires à la planification pour l'intervention proposée.	Des discussions sont en cours pour piloter/tester l'intervention.	L'activité pilote est inclue dans un plan sanitaire infranational.	L'intervention est inclue dans un plan de santé infranational ou elle est mise en oeuvre ou elle apparait dans le plan sanitaire national, mais seulement pour une partie du pays.	L'intervention fait partie du processus national de planification en santé.				
		Coordination	L'intervention apparait-elle régulièrement dans les discussions d'organes nationaux ou infranationaux de coordination?	Aucune démarche n'a été entreprise pour apporter les changements nécessaires au processus de coordination pour l'intervention proposée.	L'intervention a été discutée au moins une fois dans une réunion de coordination entres parties prenantes au niveau national et bailleurs/agences techniques.	Une activité pilote est en cours en collaboration avec parties prenantes au niveau national et on en discute pendant les réunions de coordination.	L'intervention est inclus dans les thèmes de discussion des réunions d'organes de coordination clés.	L'intervention est pleinement integrée dans les organes de coordination nationaux et infranationaux.				
		Leadership	Est-ce qu'il y a des efforts de leadership pour l'intervention (d'abord par des champions, plus tard dans un groupe institutionalisé au sein du Ministère de la santé)?	Seulement les partenaires externes plaident pour cette intervention.	Il y a au moins un champion/point focal pour l'intervention dans le Ministère our secteur privé. Les discussions preliminaires demeurent.	Plaidoyer fait pour le renforcement de compétences, l'amélioration de la qualité, et l'expansion du programme; plaidoyer pour l'intégration dans les programmes de santé existants y compris ceux des partenaires.	Plaidoyer pour des fonds supplémentaires pour appuyer l'intervention au niveau national.	Un personnel d'une section appropriée du Ministère est chargé de soutenir la gestion/gouvernance de l'intervention et s'assure de la mise en oeuvre.				
2	Finance		Le Ministère de la santé ou le secteur privé incluent-ils cette intervention dans leurs processus de budgétisation?	Le financement externe de l'intervention en est au stade de discussions seulement.	Des partenaires externes financent les coûts associés aux activités de pilotage, qui couvrent une petite zone géographique.	Les bailleurs financent la mise a échelle; le Minsitère de la santé ou le secteur privé étudie les couts et fait des projections pour inclure l'intervention dans leur budget.	Le Ministère de la santé ou le secteur privé fincance la majorité des couts associés a l'intervention, mais il(s) continue(nt) de recevoir une assistance externe.	Le gouvernement a prévu l'intervention dans son budget ou le secteur privé l'a intégrée dans son plan d'affaires.				
3	Ressources humaines pour la santé	Formation	Est-ce que l'intervention est comprises dans les curricula de formation de base et en cours d'emploi appropriés?	A part les discussions, aucune formation n'a eu lieu pour l'intervention proposée.	Seule la formation en cours d'emploi se fait; par des agences externes; et dans des zones pilotes ou dans les cas ad hoc.	La formation en cours d'emploi a lieu seulement avec un appui technique externe.	Les formations en cours d'emploi sont exécutées par le MSP ou le secteur privé (avec peut-être un appui technique externe). L'intervention n'est toujours pas inclue dans les curricula de formation de base.	Le Ministère de la santé ou le secteur privé dirigent la formation en cours d'emploi et l'intervention est intégrée dans la formation professionelle de base.				
		Personnel	Les catégories de personnel de santé appropriés sont-ils autorisés et disponibles en nombre suffisant pour mettre en oeuvre l'intervention?	Les catégories appropriées de prestataires de santés ne sont pas reconnus comme autorisés a réaliser l'intervention.	Les discussions sont en cours pour décider du type de personnel de santé qui pourra mettre en oeuvre l'intervention.	Les catégories de prestataires de santé autorisés mettent en oeuvre un phase pilote avec une supervision effectuée par agences externes.	Les descriptions de taches ont été revues (si necessaire). Le MSP et/ou secteur privé fournit une partie mais pas la totalité des ressources humaines nécessaires à l'intervention.	Les prestataires de santé sont autorisés à realiser l'intervention et le font activement dans le cadre de leur champ de pratique habituel. Le nombre de prestataires est suffisant pour répondre aux besoins.				

				Aucune capacité (0)	Phase de préparation (1)	Phase (Pilote) d'Introduction (2)	Phase d'expansion préliminaire (3)	Phase d'expansion finale (4)				
Capacité du Système de santé (pour l'intervention)			QUESTIONS SUR LA CAPACITE DU SYSTEME DE SANTE LIEE A L'INTERVENTION	**Aucune capacité du système de santé** et aucune activité n'a été entreprise dans ce domaine de compétence pour cette intervention.	**Principaux choix des stratégiques** au niveau national et mesures prises pour établir les capacités nécessaire à l'intervention.	**Pilotage du compétence** liée à cette intervention. Des agences externe prend la majorité de la résponsabilité pour ce domaine de competence.	**Le Ministère de la santé ou le secteur privé commencent à assumer la capacité** pour cette intervention, en attendant une intégration complète dans les systèmes nationaux ou infranationaux.	**La capacité pour l'intervention est complètement acquise et pleinement intégrée** dans les systèmes nationaux ou infranationaux (publique ou privés).	**2. EN CONSULTATION AVEC MINISTERE ET AUTRES, INDIQUER LES SCORES DE MISE A ECHELLE PAR DOMAINE DE CAPACITE DU SYSTEME SANITAIRE (QUESTIONS COL. D)**		**3. DECRIRE BRIEVEMENT LES ACTIVITES MISES EN OEUVRE POUR ATTEINDRE CETTE CAPACITE**	**4. QUELS PARTENAIRES ONT MIS EN OEUVRE OU SOUTENUS CES ACTIVITES (DERNIERE COLONNE A GAUCHE)?**
				0	1	2	3	4	Base (20xx)	Actuel (20xx)		
4	Prestation des Services	Amélioration de la qualité	**Est-ce que les système d'amélioration de la qualité prennent en compte l'intervention et est-ce qu'ils sont appliqués?**	L'intervention n'est pas prise en compte ni dans les systèmes ni dans les activité d'AQ.	Le système d'AQ est en train d'être modifié pour inclure l'intervention dans le matériel pertinent existant.	Des prestataires d'AT externes forment les cadres de santé dans les zones pilotes en amélioration de la qualité/approches en matière de gestion de la qualité, y compris l'utilisation de la documentation, du suivi, du rapportage et de l'évaluation.	Standardisation de l'approche de l'AQ dans les structures de santé et dans les organismes infranationaux (par exemple, équipes de gestion de la santé de district). Les agences d'AT externes collaborent avec les acteurs locaux pour le mentorat des équipes dans les structures pour mener à bien l'évaluation participative de routine de la qualité des soins; s'assurer de l'adhésion du personnel et le renforcement de l'esprit d'équipe; des procédures d'opération standard pour l'amélioration de la qualité sont développées.	Système d'AQ/GQ institutionnalisé aux niveaux local, régional et national et dirigé par des équipes infranationales du secteur public ou privé.				
		Supervision	**L'intervention est-elle prise en compte dans les activités de supervision régulière?**	Les superviseurs ne prennent pas en compte l'intervention dans leurs activités.	Des révisions aux éléments de système de supervision (par exemple liste de vérification) sont en cours afin d'intégrer l'intervention dans le matériel pertinent existant.	Des prestataires en AT externes forment des gestionnaires dans les sites d'apprentissage sur les techniques de supervision; développer ou réviser les directives de supervsion.	Les prestataires d'assistance technique externes effectuent des visites de supervision conjointes avec leurs homologues gouvernementaux ou du secteur privé; suivent les constats de visites conjointes de supervision ; forment les gestionnaires sur les stratégies de prise de décision et évaluation de l'efficacité des programmes.	Les lignes directrices et les processus de supervision sont institutionnalisés au sein des systèmes gouvernementaux ou du secteur privé; et ces derniers financent et exécutent les visites de supervision de manière autonome dans tous les sites d'intervention.				
		Création de la Demande / Engagement des Communautés	**Est-ce que le Ministère de la santé et/ou le secteur privé s'occupent de susciter la demande pour l'intervention parmi les clients possibles?**	Aucune activité entreprise pour susciter la demande pour l'intervention.	La stratégie et le matérial nécessaire pour bénéficiaires et pour prestataires afin de susciter la demande est en voie de développement.	Les parties prenantes externes font tout le soutien pour l'assimilation de l'intervention auprès des bénéficiaires potentiels.	Le Ministère de la santé et/ou le secteur privé entreprend quelques activités pour susciter la demande pour l'intervention.	Les activités pour suciter la demande sont menées par le Ministère de la santé et/ou le secteur privé et sont integrés avec d'autres programmes. Plaidoyer communautaire pour susciter la demande pour les services.				
5	Logistiques et produits de base		**Est-ce que le Ministère de la santé et/ou le secteur privé achètent et distribuent les produits de base nécessaires dans les quantités suffisantes à travers son système logistique habituel?**	Les produits de base nécessaires à l'intervention ne sont ni inclues dans le système logistique, ni disponibles à travers l'assistance externe.	Discussions en cours avec le MSP et/ou le secteur privé au sujet de l'approvisionnement de produits de base nécessaires pour l'intervention.	Les agents d'AT externes forment les équipes de santé en systèmes de gestion pour l'approvisionement des produits. Les produits primaires destinés aux sites pilotes sont financés par sources externes.	Les produits et consomables sont disponibles dans zones geographiques multiples, mais l'approvisionnement et la logistique sont gérés par des partenaires externes.	L'approvisionnement et la logistique des produits consommables indiqués sont intégrés dans le système du MSP et/ou du secteur privé (prévision, approvisionnement, distribution et contrôle)				
6	SNIS: S&E / utilisation des données		**Les indicateurs/informations appropriées pour l'intervention sont-ils collectés, rapportés et utilisés?**	Aucuns indicateurs convenables ne sont disponibles pour suivre l'intervention dans le système national d'informations de santé publique ou privé.	Discussions en cours sur la nécessité de nouveaux indicateurs et/ou collecte de données et formulaires de rapport.	Une experience pilote ou évaluation préparatoire pour l'intervention a été menée qui a testé des indicateurs, outils et formulaires de rapport.	De nouveaux indicateurs sont utilisés dans certaines mais pas toutes les zones et/ou les indicateurs sont collectés, mais ne sont pas (encore) acheminés à travers la chaine habituelle.	Les indicateurs appropriés pour l'intervention sont dans le SNIS et/ou les systèmes du secteur privé et sont rapportés régulièrement.				
								Score Moyen	0.0	0.0		

5. DONNEES DE COUVERTURE - REMPLIRE LES COLONNES J & K				
Nombre total de districts dans le pays			Couverture Districts à la Base	Couverture Districts à la Fin
Nombre de districts où l'intervention est mise en oeuvre			#DIV/0!	#DIV/0!
Nombre total de structures sanitaires dans le pays			Couv. Structures à la Base	Couv. Structures à la Fin
Nombre de structures sanitaires ou l'intervention est mise en oeuvre			#DIV/0!	#DIV/0!
Population totale du pays			Couv. Population à la Base	Couv. Population à la Fin
Population couverte par l'intervention			#DIV/0!	#DIV/0!

Annex 4: Using the MCHIP Scale-Up Tool; Country Teams' Self-Assessment

Participants received the Scale-Up Matrix (Annex 3) prior to the meeting. Participants from the same country had the opportunity to work together as a country team. Teams went through and assigned a score of 0–4 for each of the dimensions of the tool. These dimensions align with the WHO health system building blocks: *governance, finance, human resources for health, service provision, logistics and commodities, and health information system (monitoring and evaluation and data use).* The tool permits the country teams to evaluate 13 aspects under elements of the WHO health system building blocks. The teams assessed where they thought their country was on a scale from "0" for "no health system competency and no activities for this competency" to a rating of "4" for a mature expansion phase where "the MOH or private sector has fully integrated the competency for the intervention into national and sub national systems." No attempt was made during the workshop to quantify or estimate coverage in terms of population served or number of facilities offering PPIUD services.

Some scores, related to governance and policy, were difficult for some to determine without referring to national documents or sources. As expected, generally the scores of countries that have initiated PPIUD services were higher than those of countries that have yet to begin. Given that the objective was not to establish a baseline, but rather to help guide thinking about dimensions of programming "with the end in mind" of the intervention being available at scale, the facilitators did not question or modify the output of each country.

Governance scores ranged from 0 to 4, with policy and planning achieving maximum scores in a handful of countries. Financing (i.e., the government includes the PPFP/PPIUD in the budgeting process) did not achieve more than a score of 2. Country teams self-assessed the aspect "piloting/testing for the competency related to the intervention" from 1–4. External agencies assume the majority of the financial responsibility for PPIUD programs, so scores ranged from 0 to 1. The two dimensions of "human resources for health" (i.e., inclusion of PPIUDs in in-service and pre-service curricula, and appropriate cadres authorized and available in sufficient numbers to implement PPIUDs) received scores ranging from 0 to 3, as did the "quality improvement" dimension of service provision. "Supervision" and "demand creation" scores ran the gamut from 0 to 4, as did "logistics and commodities" and "health information systems."

PPIUD scale-up scores as assessed by country teams.