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Session 410: Unmet need for family planning among post-partum women and other vulnerable groups (adolescents, refugees, and migrant urban slum dwellers).

Title: Implementation of immediate post-partum family planning in health facilities in Burkina Faso: Status and Challenges ten years later

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Short abstract (150 words)

A decade after the launch of an action plan to improve access to family planning (FP) in the immediate postpartum (IPP) period in Burkina Faso, this study measures the implementation of this proven high-impact practice. Quantitative data from a cross-sectional mixed-methods study are used to describe the provision of IPPFP services, including counseling, availability of contraceptives, equipment, supplies, and skilled personnel (especially for providing LARCs) in 76 health facilities and 144 providers in the Centre and Hauts Bassins regions of Burkina Faso. The institutional challenges of implementing IPPFP in Burkina Faso are also examined using transcripts of key informants' interviews with managing authorities supporting the implementation. The results indicate that nearly all health facilities that offer IPPFP have the necessary methods available on the day of assessment. The primary need appears to be related to complete LARC supplies and equipment and, to a lesser extent, provider training in IUD insertion.

Extended abstract (2-4 pages)

Context

Immediate postpartum family planning (IPPFP) is a high-impact practice in family planning that consists of offering contraceptive counseling and services as a part of facility-based childbirth care prior to discharge from the health facility[i]. It is an evidence-based practice that promotes maternal and child health through adequate birth spacing. Burkina Faso, along with several other West African countries, has adopted IPPFP in budgeted national family planning plans, and it has been at the heart of various operational interventions. Numerous scientific studies have focused on the determinants of family planning uptake in the postpartum period, categorized as socio-cultural and institutional determinants. While socio-cultural factors can pose significant barriers to family planning use, the institutional environment in which it is implemented is just as crucial but seems less well-studied.

Indeed, key recommendations for implementing the IPPFP include ensuring the availability of staff, equipment, supplies, and counseling for women during prenatal visits, as well as investing in "high-level" actions such as national service delivery guidelines, good documentation, and monitoring[ii]. This study aims to measure the availability of IPPFP services in health facilities in the Centre and Hauts-Bassins regions of Burkina Faso, following the government's decision to make these services available to women in all health facilities. Therefore, this study focuses on the availability of these methods. Then, assessing that the institutional environment extends beyond the health facility level, we examine in a second step the quality of IPPFP implementation in Burkina Faso from the perspective of the managing authorities supporting the practice within the country.

Main questions

Two main questions underlie this research: (**i)**-To what extent are counseling services, methods, equipment, and qualified staff available for the provision of IPPFP services in health facilities? (**ii**)-What institutional challenges are emerging in implementing IPPFP interventions in Burkina Faso?

Methodology

Data

The data comes from a cross-sectional assessment conducted between December 2022 and March 2023 in Burkina Faso. This mixed-methods study includes a comprehensive evaluation of health facilities in the Centre and Hauts-Bassins regions and key informant interviews involving program managers from the Ministry of Health and implementing organizations. We aimed to survey all health facilities offering a method to at least one client after delivery and before discharge in the preceding three months. However, due to security issues in some Hauts Bassins districts, we were only able to survey 76 out of the 90 identified facilities. The study collected data on health facilities and the services they offer through face-to-face interviews with health facility in-charges and direct observation. Structured interviews with a brief questionnaire were also conducted face-to-face with one to two eligible health providers. Semi-structured, in-depth interviews were conducted with key informants from one representative of each organization supporting IPPFP services in the region.

Methods

We will descriptively summarize quantitative data on service availability (counseling, methods), and provider readiness (training, knowledge) to provide the service (Q1). A hierarchical clustering of the facilities combined with a multiple correspondence analysis will also be carried out to identify the main profiles of health facilities based on the descriptive variables [results not presented in this abstract] (Q1). The optimal number of clusters will be identified considering both the barplots of inertia showing clustering strength and the relatively "small" size of our sample. A thematic analysis of interview transcripts with 17 program managers in governmental and non-governmental organizations will then be conducted to identify the institutional challenges of implementing the IPPFP in Burkina Faso (Q2).

Preliminary results

Nearly all facilities (99%) offered FP counseling, as evidenced through responses from the health facility questionnaire, and at least one provider in each facility reports receiving counseling training. Regarding the availability of contraceptive methods (**at least one non-expired method observed or reported available**), 72 out of 76 health facilities had at least one long-acting reversible contraceptive (LARC) method in stock on the day of the assessment, 99% had injectables observed or reported available and 91% had oral contraceptive pills. Emergency contraception was the least frequently available method (25%), as shown in Figure 1, but it is important to note that this method is only recommended for non-breastfeeding women.

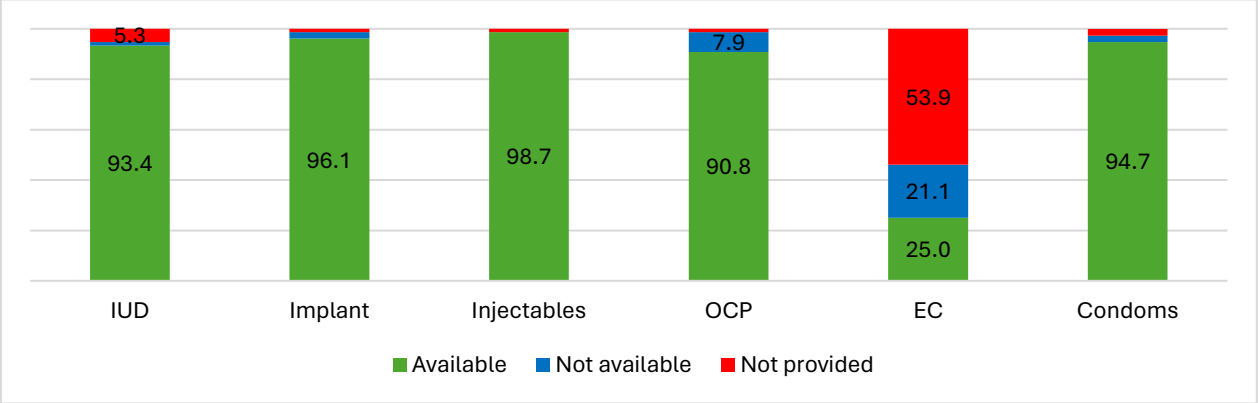

Figure 1: Percentage of health facilities by availability or non-availability of the different methods.
***IUD**: Intrauterine device, **OCP**: Oral Contraceptive Pills, **EC**: Emergency Contraception*
***Note**: Values below 5% are not shown.*

Table 1 focuses on IPPFP methods stock-outs and on supplies, equipment, and staff capacity to provide LARCs. Over the last three months, health facilities have experienced the greatest stock-outs with the oral contraceptive pill and condoms, at 40% and 28% respectively. In contrast, only 5% of facilities reported stock-outs of IUDs. Implant stock-outs were relatively low, with around 15% of facilities experiencing stock-outs in the last 3 months. Additionally, the table indicates that approximately 50% of healthcare facilities were unable to provide contraception to mothers in the past three months due to either unavailability of the method or lack of materials.

Table 1: Distribution of health facilities regarding methods stockouts in the last three months and availability of supplies, equipment, and staff capacity to insert LARCs

	Col %	N
Stockout for IPPFP methods (last three months)		
Intrauterine device (IUD)	5.3	4
Implants	14.5	11
Injectables	11.8	9
Oral Contraceptive Pills	39.5	30
Emergency contraception	18.4	14
Condom	27.6	21
Supplies & Equipment availability for LARC		
Neither	1.3	1
Some available	84.2	64
All Sup. & Equip	14.5	11
At least one provider trained to insert:		
Implants	98.7	75
IUD	88.2	67
At least one provider is confident in inserting:		
Implants	98.7	75
IUD within 48 hours after delivery	88.2	67
Unable to provide a requested method prior to discharge (last three months)		
No	50.0	38
Yes	50.0	38
Total	100.0	76

On the day of the assessment, the supplies and equipment required for LARC insertion were fully available in only 15% of facilities, while 85% had partial availability. In this study, we evaluated the ability of staff to insert a LARC. We considered two measures: the presence of at least one provider who received training in LARC insertion, and the confidence expressed by at least one provider in their ability to provide LARC quickly. Out of the 76 health facilities surveyed, 75 had at least one provider trained in LARC insertion and confident in their ability to offer the service, resulting in a 99% success rate. On the other hand, 88% of health facilities have at least one provider who is trained and confident in IUD insertion.

In addition to the functioning of the services, we are interested in the institutional challenges of implementing the IPPFP such as the availability of provision funds or the existence of procedural documents within the health facilities, as shown in Figure 2. Approximately 90% of health facilities do not have designated funds for the provision of IPPFP methods, supplies and equipement. Additionally, three facility managers appear to be unaware of the existence of a national training curriculum on IPPFP. However, slightly more than 80% of health facilities have an SOP or guideline on the practice of IPPFP.

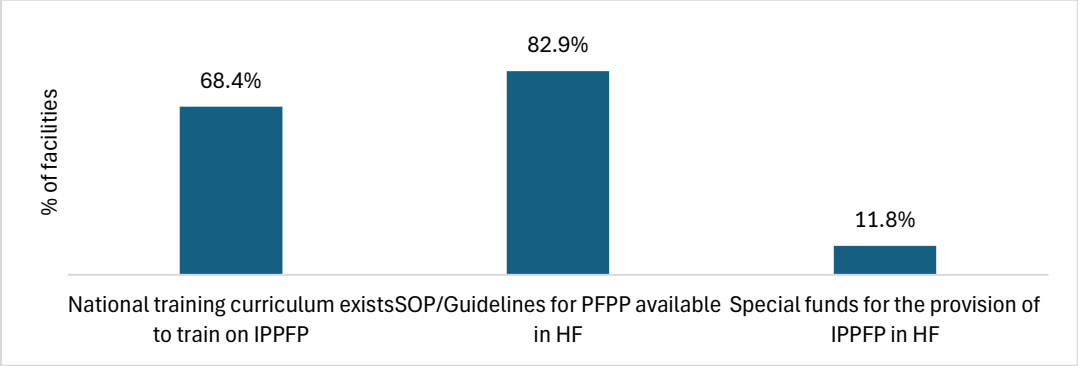

Figure 2: Percentage of facilities whose managers know a national training curriculum and have procedural documents or procurement funds for IPPFP.

Qualitative analyses are being performed to provide further outcomes on the institutional challenges.

Knowledge contribution

This paper presents recent data on providing IPPFP services in health facilities in the Centre and Hauts Bassins regions of Burkina Faso. Most facilities offer family planning counseling services during antenatal care and the immediate postpartum period, according to the results. LARCs, injectables, oral contraceptive pills, and condoms, are also widely available in these facilities. However, due to the cross-sectional nature of the data, we cannot fully determine the regular availability of methods. It was reported that in 50% of these facilities, some women were unable to obtain a method after childbirth.

While they only apply to a minority of health facilities, the results also highlight weaknesses in complete equipment and capacity building for IUD insertion. However, it is essential to question the actual demand for contraceptive methods, specifically the IUD, among post-partum women. Our study only includes health facilities that provide IPPFP services and may receive support from implementing organizations. This limitation of the research excludes health facilities with maternity wards that do not offer IPPFP services to clients. However, the results are still of significant interest and highlight the importance of expanding research beyond the quality-of-service provision at health facilities to include other institutional implementation aspects. Specifically, our findings suggest the need to consider funding availability, institutional commitment, and the sustainability of interventions that support immediate post-partum family planning.

[i] High Impact Practices in Family Planning (HIPs), "Immediate Postpartum Family Planning: A Key Component of Childbirth Care" (HIP Partnership, Washington, DC, May 2022), https://www.fphighimpactpractices.org/briefs/immediate-postpartum-%20family-planning/.
[ii] High Impact Practices in Family Planning (HIPs).