

Setting up Postpartum Family Planning/ PPIUD Services in Health Facilities Implementation Guide



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Foreword

The postpartum period, while often time overlooked, represents an important time for many women. Not only are they most susceptible to delivery-related complications, needing time to recover from physical and emotional demands of childbirth, but also most at risk for unplanned pregnancies. Because the World Health Organization (WHO) recommends at least 24 months birth-to-pregnancy interval to reduce maternal, perinatal and infant health risks it is of utmost importance that women receive appropriate and timely family planning (FP) services and information during this crucial time.

The steady increase in facility-based births and antenatal visits in a facility over the past decade lends us with more opportunities to provide and link women to quality family planning services. With the gains we have achieved in maternity care services, it is only fitting that we continue to enhance maternity care by integrating FP services in all points of maternity care – from antenatal, immediately after delivery and first year postpartum.

The **Setting Up Postpartum Family Planning and Intrauterine Device Services in Health Facilities Implementation Guideline** provides health facilities, planners and program managers with an informative tips and strategies in setting and integrating up Postpartum Family Planning and Intrauterine Device (PPFP-PPIUD) services in their health facilities. This document outlines the elements involved in designing a PPFP-PPIUD program. It provides a step-by-step guide on initiating, sustaining and maintaining quality PPFP services in a health facility. The content offers strategies that can be applied towards either developing a comprehensive program that addresses a woman’s FP needs through the entire postpartum period, or strengthening the delivery of FP services to women who are postpartum at one or more points of contact within the health system. It is not, however, intended to be prescriptive or serve as definitive “how-to” document. So while users are encouraged draw from this document, more importantly, they are also urged to adapt and apply the concepts and strategies in most suitable to their particular context. The information presented here is culled from actual experiences of planners and health program managers in the field, specifically from the Centers of Excellence for PPFP-PPIUD Services established in the country and from other delivery sites across the globe.

One of the gaps identified in the provision of FP services postpartum is the lack of enabling environment for the integration and adoption of PPFP services in the health system. We are hoping that this document will play a central role in supporting health facilities, planners and program managers who intend to implement, integrate as well strengthen PPFP-PPIUD services in their health facilities. I strongly urge that planners and program managers will utilize this manual in ensuring that more women are receiving quality and integrative FP and reproductive health services. And with this, we can achieve and sustain better maternal health and newborn outcomes.



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Department of Health Secretary

Acknowledgement

This replication manual is a result of close collaboration between the Department of Health and USAID's Flagship Program on Maternal and Child Integrated Program (MCHIP) to create an enabling environment for the implementation and adoption of Postpartum Family Planning in the Philippines. The development of this document testifies to the work done to develop and establish the capacity to integrate Postpartum Family Planning services in Maternal Child Health care programs and services throughout the country during the past two years.

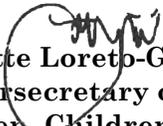
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The Family Health Office composed of Dr. Joyce Ducusin, Dr. Rosalie Paje, Dr. Melissa Sena, and Ms. Onofria de Guzman.

We hope that as more healthcare providers and facilities across the country integrate the postpartum family planning services into their existing Maternal and Child Health programs, we will be able to provide high quality service to more women who need family planning services and eventually achieve our MDG 4 & 5 commitments to reduce maternal and newborn mortality


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Abbreviations

AMSTL	Active Management of Third Stage of Labor
ANC	Antenatal Care
ARMM	Autonomous Region of Muslim Mindanao
BatMC	Batangas Medical Center
BEmONC	Basic Emergency and Obstetric Care
BHS	Barangay Health Station
BTL	Bilateral Tubal Ligation
CHT	Community Health Team
CST	Clinical Skills Training
COE	Centers of Excellence
CPR	Contraceptive Prevalance Rate
CRMC	Cotabato Regional Medical Center
DHS	Demographic and Health Survery
DJMH	Dr. Jose Fabella Memorial Hosputal
DOH	Department of Health
DOHRO	Department of Health Regional Office
DPT	Diphtheria-Pertussis-Tetanus
DR	Delivery room
DRH	Davao regional Hospital
EBF	Exclusive Breastfeeding
EVRMC	Eastern Visayas Regional Medical Center
FP	Family Planning
FP-CBT	Family Panning Competency Based Training
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
ICCM	Integrated Community Case Management
ICV	Informed Consent and Volunteerism
IMCI	Integrated Management of Childhood Illnesses
IUD	Intrauterine Device
LAM	Lactation Amenorrhea Method
LAPM	Long Acting Permanent Method
LARC	Long Acting Reversible Contraceptives
LGU	Local Government Unit
MCHIP	Maternal Child Health Integrated Program
MCH	Maternal Child Health
MDG	Millenium Development Goals
M&E	Monitoring and Evaluation
MEC	Medical Eligibility Criteria
NDHS	National Demographic and Health Survey
NHTS-PR	National Household Targeting System for Poverty Reduction
OPD	Outpatient
OR	Operating Room
PID	Pelvic Inflammatory Disease
PMTCT	Prevention of Mother-to-Child Transmission
PP	Postpartum
PPC	Postpartum Care
PTME	Post-training Monitoring and Evaluation
R1MC	Region 1 Medical Center

RH	Reproductive Health
RHU	Rural Health Unit
SDN	Service Delivery Network
SPMC	Southern Philippines Medical center
SS	Supportive Supervision
SSV	Supportive Supervision Visit
TA	Technical Assistance
TOT	Training of Trainers
UFMR	Under-five Mortality Rate
USAID	United States Agency for International Document
VSMMC	Vicente Sotto Memorial Medical Center
WHO	World Health Organization
WRA	Women of Reproductive Age
YAFS	Young Adult Fertility Survey
ZCMC	Zamboanga City Medical Center

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Chapter 1: Introduction

1.1 RATIONALE AND NEED FOR PFP AND PPIUD

Background

Every year 5,000 mothers in the Philippines die from complications associated with pregnancy and childbirth. Majority of these complications occur during labor, delivery and the postpartum period and are preventable with safe and healthy spacing of pregnancies and birth. The top three causes of maternal mortality in the Philippines are hypertension, postpartum hemorrhage and infections arising from poor birth spacing and various chronic and infectious diseases. While decline of under-five mortality rate (UFMR) and infant mortality as well as increase in antenatal (ANC) visits and skilled birth attendance were reported in the last few years, maternal mortality rates remain high with reported increase from 162 to 221 between 2006 and 2011.

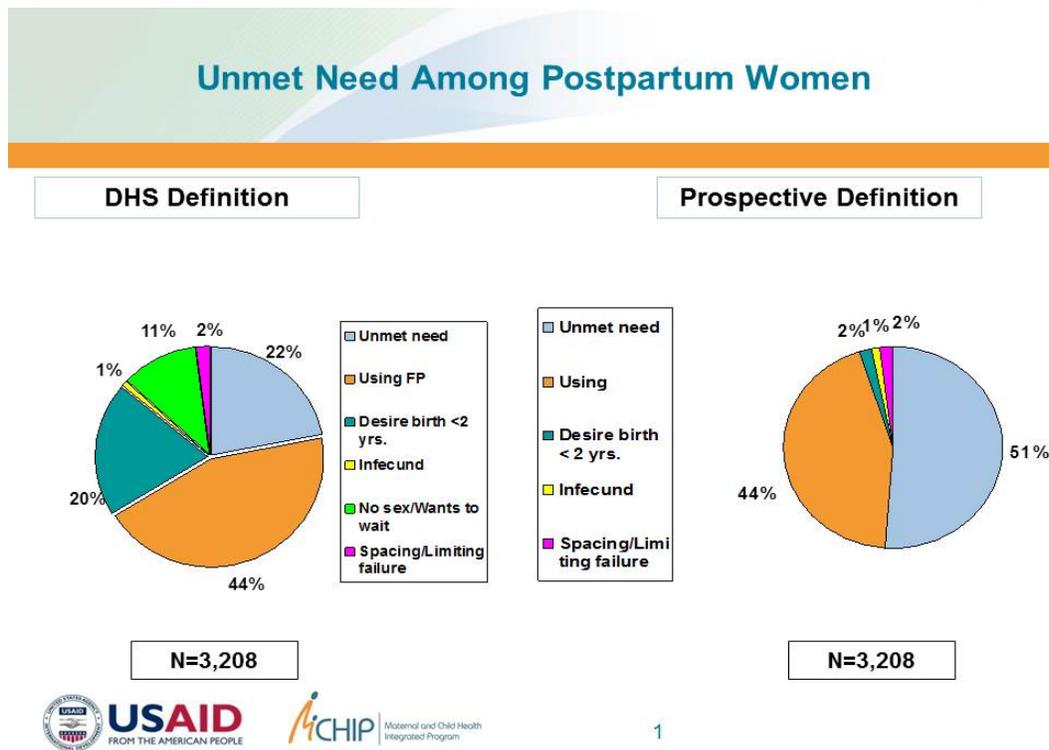
Across the range of maternal child health services, uptake of FP services is still markedly low. Data from National Demographic and Health Survey (NDHS) preliminary report 2013 indicates that the contraceptive prevalence rate (CPR) has increased slightly from 33% in 2003 to 38% in 2013 in comparison to the increase in antenatal visits and skilled birth attendance (SBA). This indicate that with more women accessing formal health care also come multiple opportunities to introduce quality, effective and facility-based FP services. Gaps in delivery of essential maternal health services and challenges in implementation of national health policy remain the major obstacle in improving maternal health outcomes in the country.

FHS estimates that as many as 5.3 million Filipino women of reproductive age (WRA) have unmet need for family planning. According to the NDHS 2008, 22% of postpartum women in the Philippines have an unmet need for FP; significantly higher percentages (51%) of postpartum women have an unmet need according to the prospective definition of unmet need¹ (Figure 1). Women with unmet need, by definition, want to delay their next birth or limit future births. However, they are not using a method of contraception. Global evidence suggests that a birth-to-pregnancy interval of three to five years affords the optimal outcomes for maternal and newborn survival. In the Philippines, although many postpartum women want to delay or limit pregnancies, they are not accessing FP services. This is an unfortunate missed opportunity.

One of the gaps identified is the lack of FP services immediately postpartum, especially Long Acting Permanent Methods (LAPM). With erratic support and access to FP services, there remains a need to improve the integration of FP into existing maternal and child health services, which is a proven practice in maternal health programs.

¹ In this analysis, unmet need is redefined. It is defined prospectively (or *Prospective unmet need*; pie chart on the left) with regard to the woman's next pregnancy, which normally yields in higher rates of unmet need than when it is estimated based on woman's last birth. This definition is based on the question "Would you like your next child within the next 2 years or would you like no more children?". The category "No sex" in the DHS definition of unmet need refers to unmarried women or women who are not living with their spouse who have had sex in the past but not recently had sex. In the prospective definition of unmet need these women are allocated to unmet need categories based on their fertility preferences looking into the future.

Figure 1: Unmet FP need among Postpartum Women, DHS Definition vs. Prospective Definition



The Postpartum Period

The postpartum period is the period beginning immediately after birth of a child continuing until about six weeks. It represents a valuable opportunity for women or couples to learn about and take advantage of family planning services. Similarly, it is also a critical time for healthcare providers to introduce and reinforce the benefits of well and properly timed pregnancies to mothers. To most women living in the developing world, the period of time preceding and immediately following the birth are also the times when the women are most likely to access formal health services through ANC visits, skilled birth attendance and postpartum care.

A study of postpartum women in 27 Demographic and Health Surveys (DHS) for six years shows that 40% of women who intend to use FP method during the first year postpartum are not using any method. Furthermore, although only a small percentage of women (3%-8%) want another child within 2 years of their last birth, 35% have children within this timeframe.²

The postpartum period poses the greatest challenge to many women, especially for those living in the developing world. Despite the high motivation to use FP, they are more unlikely to use one, making them vulnerable to unintended and mistimed pregnancies because of: (1) unpredictability of return to fertility, (2) resumption of sexual activity and (3) limited knowledge on methods that can be offered to postpartum women. In addition to this, many women are beleaguered by competing responsibilities of infant care, domestic chores and lack of financial means leaving them with no opportunity to attend to their own needs. Women are not likely to access services for themselves during the postpartum period; whereas a majority of women receive ANC, and an increasing number are delivered in a facility by skilled birth

² Fowler, Rebecca C. (ed), PPIUD Services Reference Manual, 2010. Jhpiego Corporation

attendants, a much smaller proportion seek postpartum FP services. Encompassing these factors is the lack of integration of FP services into the continuum of care given to pregnant women.

Need for Postpartum Family Planning

“It’s very disheartening to see the same mothers who’ve just given birth six months ago to be back again in the labor room. That is why when a mother accepts PPIUD or any other method we are relieved knowing that she, her baby, and her family are off to a better future and health start.”

- Dr. Lennybeth Latido, Batangas Medical Center

Spacing pregnancies 2 years or more apart could prevent 30% of maternal mortality and 10% of child mortality (Lancet 2012; 380: 147-56). The WHO recommendation for birth to birth spacing of 3 years or birth to pregnancy spacing of 2 years to reduce the adverse effects of short birth spacing such as maternal death, neonatal death, and children becoming stunted and malnourished is a message that finds an ideal platform in PPFPP/PPIUD program integrated into maternal care.

Multiple studies from around the world indicate the link of close pregnancy spacing to adverse maternal, perinatal and infant outcomes. The risks are particularly high for women who become pregnant very soon after a previous pregnancy, miscarriage or abortion. Table 1 presents the risks of adverse health outcomes after short pregnancy intervals.

Table 1. Risks of Adverse Health Outcomes after Very Short Interval Pregnancy (as cited in PPIUD Reference Manual for Providers, 2010)

Increased Risks when Pregnancy Occurs 6 Months after a Live Birth		
Adverse Outcome	Increased Risk	
Induced abortion	650%	
Miscarriage	230%	
Newborn death (<9 months)	170%	
Maternal death	150%	
Preterm birth	70%	
Stillborn	60%	
Low birth weight	60%	
Increased Risks when Pregnancy Occurs Less than 6 months after an Abortion or Miscarriage		
Increased Risk	With 1-2 Month Interval	With 3-5 Month Interval
Low birth weight	170%	140%
Maternal anemia	160%	120%
Preterm birth	80%	40%

To most Filipino women, pregnancy and childbirth may be the only opportunity to avail of formal health services. According to the NDHS 2013, 95% of pregnant women received care SBAs during the antenatal period while 59.8 % of births are being delivered at a health facility. In addition, 84% of women receive at least one postpartum care (PPC) visit during the first week postpartum. These

data indicate there are multiple opportunities to introduce the benefits of safe birth spacing. Yet despite this only a fraction of women receive FP assistance during ANC, prior to discharge and in postpartum visit. An assessment activity conducted by MCHIP in 2012 reports that while service providers claimed that PFP messages were given during ANC, none of the women interviewed in the site reported receiving FP messages during ANC.

Postpartum women in the Philippines represent an underserved segment of WRA needing FP. They continue to be overlooked in the current health system, the 2008 NDHS report short birth interval of less than 24 months particularly among women aged below 20.³ This indicates the continuing unmet need among WRA most especially among very young women. Reaching out to this segment of the population is instrumental in achieving our MDG 4 and 5 goals.

About PFP and PPIUD

Postpartum family planning (PFP) in the extended postpartum period is the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth. The rationale behind this is that not only are pregnancies during this period hold the greatest risk for mother and baby but that the first 12 months after childbirth also present the greatest opportunities to introduce FP to mother in terms of number of contacts with health care services.

For more than 30 years, women throughout the world have been using the IUD as their primary method of contraception. It is, in fact, the more commonly used reversible method among married women of reproductive age worldwide. According to recent estimates, almost one in five (153 million) married contraceptive users is currently using the intrauterine contraceptive device (IUD)⁴.

The (IUD) is a small, flexible frame made of plastic in the shape of a “T” which is inserted into the uterine cavity by a trained service provider. Almost all types of IUDs have one or two monofilament (single-strand) strings that extend, through the cervix, from the uterus into the vagina. It is a highly effective, long-acting, reversible family planning method that is safe for use by most postpartum women—including those who are breastfeeding. It is also relatively inexpensive and convenient and has a very low rate of complications. In the Philippines, only the Copper T 380A is available. Copper T 380A act by preventing fertilization. Copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tube and fertilizing the egg. These actions are largely local with no measurable increase in the woman’s serum copper level. And because there are no effects on the quantity or quality of breast milk, copper-bearing IUDs can be used immediately after delivery regardless of whether the woman is breastfeeding.

Postpartum insertion of an IUD (PPIUD) within 10 minutes or up to 48 hours after birth has been shown to be safe, effective and convenient for women—like the regular or “interval” IUD (*Interval* refers to IUDs inserted at any time between pregnancies, at or after 4 weeks postpartum, or completely unrelated to pregnancy). Diligence studies have also shown that PPIUD have the highest rates of continuation among other FP methods.

Inserting the IUD in the immediate postpartum period (postplacental, intracesarean) saves time for both the woman and provider—because the procedure is conducted in the same setting

³ Natividad, Josefina. Teenage Pregnancy in the Philippines: Trends, Correlates and Data Sources. Journal of ASEAN Endocrine Societies Vol. 28 No. 1 May 2013.

⁴ Fowler, Rebecca C. (ed), PPIUD Services Reference Manual, 2010. Jhpiego Corporation

and involves only a few minutes of additional time. It is during this period that a woman is most motivated to take an FP method. Although inserting the IUD in the early postpartum period (first 48 hours) does require a separate procedure, it does not require an additional visit—which increases the likelihood that the woman will have it done. Providing PFP services at the birth facility also helps to relieve overcrowded outpatient facilities, allowing more women to be served. Furthermore, for many women who rarely access health care services, the insertion of an IUD immediately postpartum presents a unique opportunity for them to initiate a long-acting and reversible method of family planning. The popularity of the PPIUD in countries as diverse as China, Mexico and Egypt supports the feasibility and acceptability of this approach.⁵

Timing of PPIUD Insertion

PPIUD insertion refers only to those IUDs placed during the immediate or early postpartum period (within 10 minutes or up to 48 hours after birth). IUDs inserted during the immediate postpartum period (i.e. postplacental and intracesarean) have the highest rates of retention, but the IUD can be safely inserted at any time during the early postpartum period, that is, within the first 48 hours after the birth. The three types of PPIUD insertion are:

Postplacental: Within 10 minutes of placental expulsion and after active management of the third stage of labor (AMTSL) in a vaginal birth, the IUD is inserted with an instrument or manually before the woman leaves the delivery room.

Intracesarean: Immediately following the removal of the placenta during a cesarean section, the IUD is inserted manually before closure of the uterine incision.

Early postpartum: Not immediately following the delivery/removal of the placenta but within 2 days/48 hours of the birth (preferably within 24 hours, such as on the morning of postpartum Day 1), the IUD is inserted with an instrument. .

The global initiative to increase PFP and PPIUD is due to the following reasons:

The evidence for its safety and effectiveness when inserted during the immediate (10 minutes after placental expulsion) and early postpartum periods (within 48 hours) is supported by strong data in the literature.

The evidence-based medical eligibility criteria (MEC) for its specific use has changed and whereas in the past there were 39 WHO MEC category 4 conditions, currently there are only 10 which means that the vast majority of women desiring birth control can safely use IUD.

The success of the PPIUD programs, globally, support the feasibility of implementing this approach

The IUD is repositioned as an attractive alternative to Bilateral Tubal Ligation (BTL) in low-resource settings because IUD can be continuously used for 12 years with minimal cost for the user.

Providing FP in the postpartum period is cost-effective and efficient because it doesn't require significant increases in staff, supervision and infrastructure. This makes PFP-PPIUD a fitting FP program for low-resource settings such as the Philippines. Other advantages of PPIUD include compatibility with breastfeeding⁶, ease of insertion, use of inexpensive instruments ,

⁵ Fowler, Rebecca C. (ed), PPIUD Services Reference Manual, 2010. Jhpiego Corporation

⁶ LAM users are more likely to take on modern FP methods after six months, and therefore are good candidates for IUD inserted postpartum because they don't have to worry about protection from pregnancy once the LAM ceases to take effect.

short time required for insertion, and takes advantage of the client's childbirth in a facility as an opportunity to provide PPFPP-PPIUD. . For many women who rarely contact the health care system, FP provided in the immediate postpartum does not require costly and inconvenient return to the facility and thus expands the opportunities for providing couples with FP.

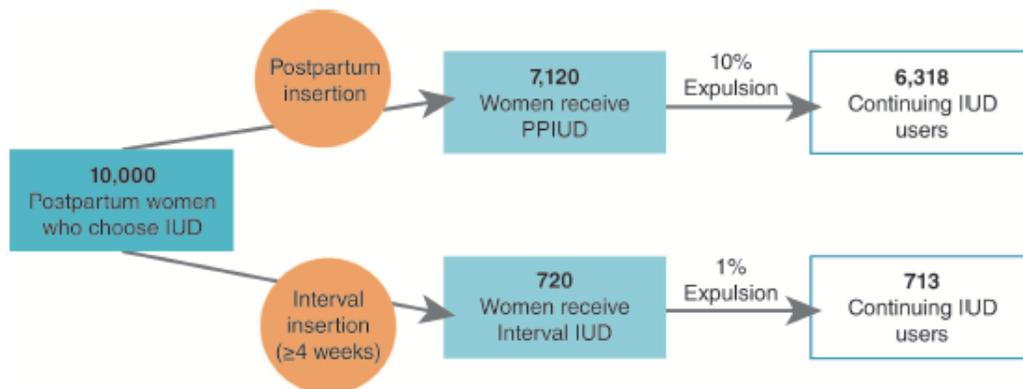
1.2 PUBLIC HEALTH APPROACH TO PPIUD

In a U.S.-based study, women who use the IUD are more satisfied with their choice of contraception than those using other reversible methods (e.g. 99% versus 91% for pill users). Moreover, the advantages of IUD use outweigh the risks for the vast majority of women including adolescents, even in the presence of many conditions previously thought to preclude IUD use, such as HIV/AIDS, history of pelvic inflammatory disease (PID) and history of ectopic pregnancy.

Although the PPIUD expulsion rate may be as high as 10%–15%, the retention rate is more than 85%–90%⁷— which from a public health perspective, is an acceptable rate. And in situations where access to health care is limited or use of postpartum follow-up services is infrequent, this potential for continued use of contraception is an important consideration.

Using data from a 2003 study done in Egypt, it is possible to estimate the magnitude of the difference that can be made by offering immediate postpartum IUD insertion. In the study by Mohamed et al., 71.2% of the women who requested immediate postpartum IUD insertion were able to have one inserted. The diagram below illustrates that women immediately provided with IUD at the facility before going home have a 10-fold greater chance of receiving it than those who were asked to return for a later insertion (>4 weeks). As observed those who were told to return at >4 weeks to the outpatient department for the procedure, only 7.2% ultimately had an IUD inserted. Given that PPIUD is considered by WHO as category 1 or can be used “under any circumstance,” women who request immediate postpartum insertion, once properly counseled and evaluated for its safe provision, should be provided the method at the time of their choosing within 48 hours after delivery and prior to discharge.

Figure 2 Public health approach to PPIUD



1.3 POLICY CONSIDERATIONS

On June 27, 2012, the Department of Health (DOH) issued Administrative Order (AO) 2012-20009 also called the “National Strategy Towards Reducing Unmet Need for Modern Family Planning as a means to Achieving MDGs on Maternal Health,” outlining the government’s commitment and comprehensive approach to close in the gaps in access to modern FP services as a strategic thrust in reducing the maternal mortality and infant mortality rate by 2015. The AO cites major supply and demand factors affecting the high level of unmet need for modern FP

⁷ Fowler, Rebecca C. (ed), PPIUD Services Reference Manual, 2010. Jhpiego Corporation

and distinguishes areas which government-led intervention must address. Among these, the provisions on enhancing service delivery for LAPM and designating DOH regional medical centers as training centers for LAPM including IUD insertion provide a strong basis for implementing the PFP/PPIUD program in health facilities in the Philippines. The delivery of enhanced FP services shall be directed to the beneficiaries identified in the National Household Targeting System for Poverty Reduction (NHTS-PR).

In the Philippines, efforts in collaboration with DOH have been initiated to: (1) create an enabling environment for the delivery of PFP/PPIUD services to women by establishing resources and capacity for service delivery and training in PFP/PPIUD and (2) advocate policy formulation in support of PFP-PPIUD integration in overall maternal health care.

The key to successful implementation and delivery of PFP-PPIUD services is integrating it with existing maternal and child health services in the facilities. This strategy is aligned with the DOH's guideline on implementing FP programs that are integrated, harmonized and synchronized with other public health programs and campaigns. The PPIUD program also complements the department's emphasis on skilled birth attendance in birthing facilities, inclusive of lying-ins and rural health units (RHUs) with birthing units since the timing of insertion is integrated into the continuum of care that birthing mothers receive at the health facilities.

Chapter 2: Planning for a PFP-PPIUD Program in Health Facilities

This chapter outlines the process and detailed steps in planning a PFP-PPIUD program in a facility. It aims to give program managers a glimpse into the preparatory activities involved in setting up PFP and PPIUD services in their facilities including the needed resources.

When planning for PFP-PPIUD program in a health facility, planners must first consider and assess the needs of that particular facility and its immediate community. It is important to consider whether the PFP and PPIUD program is being introduced for the first time or whether a pilot program has previously been introduced in the past and needs reinvigoration or whether it's staff had prior exposure to PFP concepts and technologies. This is useful in drafting the plan and determining what sort of training and administrative support needs to be developed for the facility. If PFP-PPIUD services are being introduced for the first time, time and resources may need to be allocated for orientation, advocacy, training curriculum, and PFP-PPIUD service delivery guidelines or protocols. On the other hand, if PFP-PPIUD services are simply being expanded program managers may choose to use and adopt existing policy, protocols, guidelines, training packages used in other pilot sites.

After this activity, planners should draft an action plan identifying the human, material and financial resources needed to successfully carry out the steps in implementing the program. The action plan indicates the specific tasks that need to be completed, responsible persons, timeline of when the tasks will need to be completed, allocation of resources for specific activities and assistance to be sought from lead agencies providing training and technical assistance for PFP-PPIUD services.

2.1 ASSESSMENT OF LOCAL CAPACITY AND INFRASTRUCTURE OF SITES

Facilities and hospitals planning to implement a PFP-PPIUD program are advised to conduct an initial needs assessment activity to determine what training needs and infrastructures need to be put in place to establish PFP and PPIUD services. Likewise, mapping out the facility's available resources, capacity and network will help planners develop a viable plan of action that is both responsive and specific to their own needs and capacity. A short checklist below (Table 2) can aide planners in assessing their current capacity *vis a vis* their needs. The checklist is organized according to three major components: facility, service delivery and recording and reporting system.

In particular the assessment should consider the following:

Training needs of providers in the facility. Before designing the training activity, planners are recommended to conduct a baseline of the knowledge, attitudes and skills of providers in the facility. With a number of regular trainings in varied areas of maternal and child health care being conducted year round by the DOH, it will be good to determine if providers or any of the staff in the facility have acquired skills, through prior training, in:

- Basic Emergency and Obstetric Care (BEmONC)
- Family Planning Competency-Based Training I & II

- PFPF-PPIUD Clinical Skills Training
- PFPF-PPIUD Training of Trainers

This will help trainers in developing specific modules that will enhance and strengthen acquired skills and knowledge in PFPF and PPIUD.

Current composition of MCH staff. Make an initial assessment of the composition of the facilities of the MCH staff. Who are performing deliveries and providing ANC services? Which providers are available 24 hours, 7 days a week? Are there an adequate number of providers to attend to potential clients? Determining the composition of MCH providers in the facility will help programmers and planners to tailor the learning programs and activities to build capacity for PFPF- PPIUD services.

Existing MCH services. Determine the range of existing MCH services offered at the facility and if these services are offered 24 hours. Is the facility linked to an established Service Delivery Network (SDN)? In doing so, planners may be able to identify already existing services that may be enhanced through the introduction of PFPF and PPIUD services. For instance is the facility offering ANC services? Is FP counseling offered in the facility? Is FP provided during ANC or is it only provided in PNC? If facility is offering labor and delivery services, are they open 24 hours and are there providers available round the clock? If so, plans should be made for adequate number of providers be trained to provide PFPF-PPIUD services 24 hours. Alongside this check if providers are following protocols on infection prevention as this is important in assuring safety and FP continuation of potential clients.

The success of the PFPF-PPIUD program largely depends on the extent of its integration in the MCH services of the facility. It is crucial that services and access to PFPF- PPIUD is integrated in every point of care because PFPF and PPIUD encompass all aspects of care that a mother encounters from pregnancy to delivery

Infrastructure of facility. Surveying the infrastructure of the facility will help the planners assess the extent of physical renovation needed to integrate PFPF-PPIUD services in the facility. Check if there are designated spaces for PFPF counseling, an area to perform early PPIUD insertions, instruments needed to perform PPIUD insertion (refer to Annex __ **PPIUD supplies**), and regular supply of PFPF commodities. Determine if facility has acquired accreditation for Maternity Care Package from Philhealth as this will help in future demand generation for PPIUD services.

Reporting and recording system. What are the existing reporting and recording practice of the facility? Who maintains the records? How frequent is reporting done? And where are reports submitted? What is the existing recording mechanism for capturing FP counseling and services data? Are there logbooks and reporting forms? See how PFPF-PPIUD tracking may be integrated into the existing mechanism of the facility. Is the facility using the DOH-prescribed FP Form 1 to capture vital information of FP provision for all clients? How are data managed, maintained and retrieved? Is it done manually or electronically?

Tracking progress and documentation of PFP-PPIUD services in the facility is important in improving quality and measuring the impact of the program on maternal and newborn health outcomes. At this early stage of planning, facilities are encouraged to place equal attention to both delivery and monitoring of services since documenting the impact of the program is critical in mobilizing and sustaining the fiscal and administrative support for PFP- PPIUD. A monitoring and reporting system in place provides a wealth of information that will assist in the direction of the program and a rich data source for future research.

Policy and Advocacy. Like any new program, the support of key stakeholders, and opinion leaders is critical in ensuring both the viability and sustainability of PFP-PPIUD services in the facility. Identifying potential “champions” for PFP-PPIUD is an effective way to successfully rollout, promote and sustain the program. A “champion” is a charismatic individual who demonstrates exceptional commitment to push forward a particular cause, practice, program, policy or technology. Public health champions are often identified from key leaders, health care providers or other authority figure with a certain sphere of influence to facilitate change. Planners are advised at this early stage to identify key opinion leaders in the community and assess their reception to PFP. Once convened, these opinion leaders can provide critical support and commitment in implementing the program. Such commitment may be demonstrated either through a hospital order, or even simple memorandum expressing that program will be implemented, supported and strengthened in and by the hospital.

Table 2: PFP-PPIUD Services Capacity Checklist for Health Facilities

	YES	NO	N/A	REMARKS
FACILITY CAPACITY				
Facility licensed by DOH				
Philhealth Accreditation for MCP				
Maternal and child health services				
Funding assistance from LGU				
Funding assistance from DOH				
Funding assistance from other government agencies				
Funding assistance from private agencies or international donor aid				
Linkage with regional DOH offices				
Collaboration and linkages with other organizations in the community				
Private area for counseling in ANC				
Private area for counseling in labor area				
Private area for counseling in PP ward				
Dedicated area in facility to perform Early PPIUD				
Staffed labor and delivery unit				
Separate FP Unit in the facility				
HUMAN RESOURCES				
Providers trained in:				

	YES	NO	N/A	REMARKS
FP-CBT I				
FP-CBT II				
BeMONC				
PPFP-PPIUD Clinical Skills Training				
PPFP-PPIUD Training of Trainors				
Doctor				
Midwives				
Nurses				
Philhealth accredited providers				
Human resource development program/s (i.e. technical updates)				
SERVICE DELIVERY COMPONENT				
Offers services 24 hours				
Adequate number of providers trained in PPFP-PPIUD counseling and clinical skills				
Regular supply of PPIUD and other PPFP commodities				
Access to long-acting reversible or permanent PPFP commodities				
Adequate supplies and instruments needed for PPIUD insertion, BTL, and NSV				
Available IEC materials on PPFP and PPIUD in the facility				
Available PPFP and PPIUD job aids				
Offers ANC services				
Offers PP care services				
Referral to higher level facilities for services not available in facility				
Linkage to a SDN				
Infection prevention practice or protocol				
Solid waste management				
REPORTING and RECORDING				
Existing or established recording system for FP data				
Existing or established reporting mechanism for FP data				
Protocols for recording and reporting FP data				
Staff trained in recording and reporting FP data				
Coordinating with a reporting unit				
POLICY and ADVOCACY				
Receptiveness of administration to implement PPFP-PPIUD services				
Presence of FP-RH Champion/s				

	YES	NO	N/A	REMARKS
City or local ordinances supportive of FP provision				
Hospital policies or orders supportive of FP provision				

2.2 CONSULTATIONS AND ENGAGING STAKEHOLDERS

Consensus Building for PPF/PPPIUD

Building consensus for PPF/PPPIUD services in the community leads to increased commitment for sustaining PPF/PPPIUD in the facility. Not only is there greater chance for acceptability in the community but ownership of the program which also ensures sustainability on a long-term basis with stakeholders better appreciating their roles in the program and its benefits to their community.

One way to establish the need for PPF/PPPIUD services is through a review of local datasets such as demographic and health surveys, facility data, local data and quarterly LGU reports. This allows, managers, planners and implementers to understand the magnitude of need and opportunities for PPF programming. Data points such as unmet need for modern FP, number of deliveries, maternal, newborn and under-five mortality provide useful markers for the status of MNCH and FP in the locality, as well as understanding the context for PPF information and services. They can be used to advocate for integrating FP with MNCH settings and to show what settings and interventions could be prioritized in the design of PPF/PPPIUD program. Planners can make a case for PPF/PPPIUD by citing evidences demonstrating how PPF can improve maternal and newborn outcomes. Likewise, experiences from other PPF/PPPIUD program sites may be used as good examples and inspiration. For instance, planners may look at the number of women discharged from a facility without FP counseling to build a case for missed opportunities in FP services. Leveraging these data also helps in gaining buy-in from opinion leaders and other key stakeholders in the community; emphasizing that the postpartum period is a missed opportunity that can easily be filled. Table 3 presented below shows some key data points and program implications.

Table 3 Illustrative Findings and Potential Programme Interventions. Source: Programming Strategies for Postpartum Family Planning, WHO: 2013.

ILLUSTRATIVE FINDINGS	POTENTIAL PPF PROGRAMME INTERVENTIONS
<ul style="list-style-type: none"> ▪ High unmet need for limiting future pregnancies ▪ High percentage of births in facilities ▪ Health system with infrastructure at district level for IUD and female sterilization services 	<p>Facility-based intrapartum services:</p> <ul style="list-style-type: none"> ▪ Expand counselling and method mix to include Long Acting Reversible Contraceptives (LARCs) and permanent methods ▪ Integrate counselling and services for immediate IUD insertion, tubal occlusion and counselling on EBF within labor and delivery units and in postpartum maternity wards at facilities at the district or sub-district level if appropriate
<ul style="list-style-type: none"> ▪ Low modern contraceptive Prevalence ▪ High use of traditional Methods ▪ Existing network of CHTs who are critical link of facility to the community. CHTs are tasked to navigate the demand for varied health services in the community including primary reproductive 	<p>Community:</p> <ul style="list-style-type: none"> ▪ Train CHWs to integrate community education and individual counselling about HTSP, EBF and LAM with referral for other FP methods as a routine part of care ▪ Promote early PNC visits for home births to provide essential newborn care and EBF/LAM ▪ Focus on LAM as a gateway method to the use of other modern contraceptives ▪ Discuss women’s reproductive intentions for spacing or limiting and provide information on contraceptive methods and where to get them

ILLUSTRATIVE FINDINGS	POTENTIAL PPFP PROGRAMME INTERVENTIONS
<p>health care and FP.</p> <ul style="list-style-type: none"> ▪ Short birth intervals ▪ High percentage home births 	<ul style="list-style-type: none"> ▪ Use community-based integrated MNCH/FP services ▪ Provide IECs for CHTs
<ul style="list-style-type: none"> ▪ Insurance or other finance mechanisms, such as vouchers, exist for basic maternity services and PNC 	<p>Financing:</p> <ul style="list-style-type: none"> ▪ Bundle PPFP with the birthing package to ensure that all contraceptive methods are covered during the extended postpartum period
<ul style="list-style-type: none"> ▪ High breastfeeding rates ▪ Successful routine immunization sessions at health centers 	<p>PNC and infant care:</p> <ul style="list-style-type: none"> ▪ Introduce LAM and counsel on transitioning to other effective contraceptive methods ▪ Add a dedicated FP provider to existing routine immunization programs or link/refer women to the FP unit at the clinic

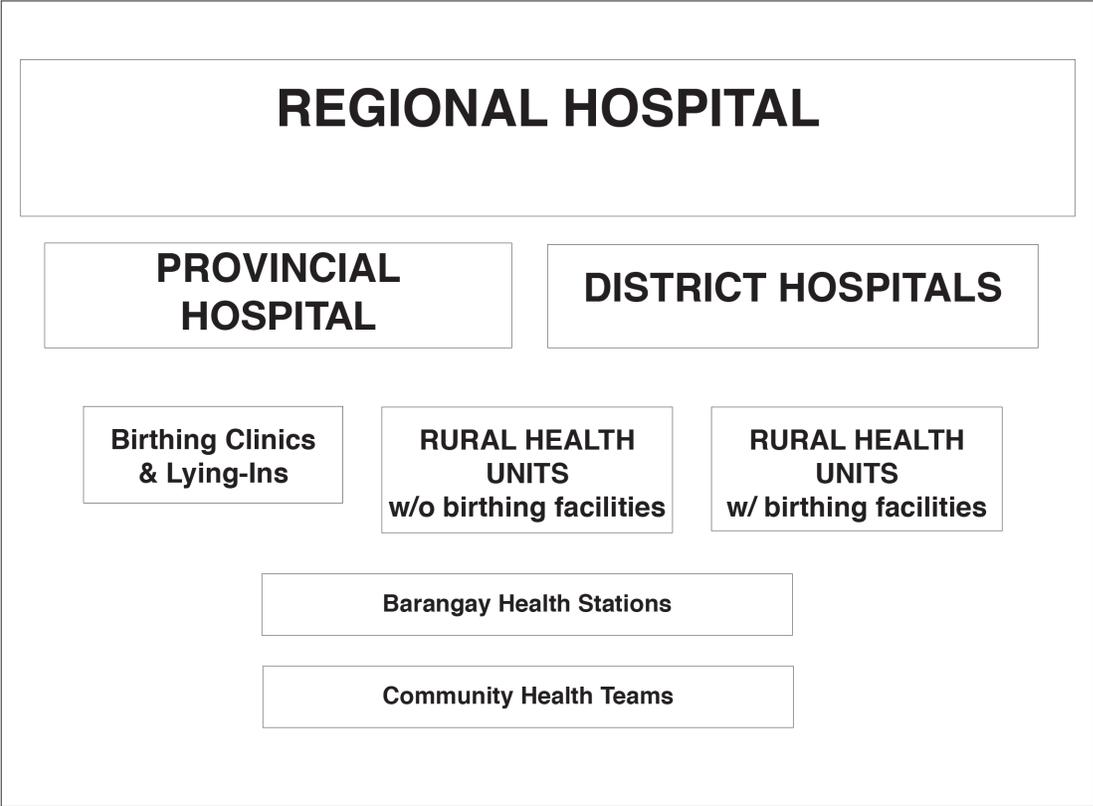
ILLUSTRATIVE FINDINGS	POTENTIAL PPFP PROGRAMME INTERVENTIONS
<ul style="list-style-type: none"> ▪ High rates of staff rotation within and among facilities ▪ Lack of skills and knowledge about PPFP among facility staff, including the provision of LARCs/permanent methods ▪ Facilities lack available and trained staff to provide MNCH and FP services 	<p>Strengthening human resources capacity:</p> <ul style="list-style-type: none"> ▪ Strengthen policies and practices to address staff development and retention to ensure that providers with FP skills are available within ANC, labor and delivery, and PNC ▪ Integrate PPFP-PPIUD in existing trainings currently offered to MCH service providers such as BEMONC training curriculum and EINC. ▪ Introduce or strengthen a comprehensive RH education curriculum that addresses safe motherhood, family planning, and neonatal and child health training issues ▪ Integrate concepts of PPFP within pre-service education and ensure that PPFP and HTSP are well-covered in teaching curricula, practical training and examinations ▪ Dispatch mobile outreach teams to facilities in the short term in order to provide services while building capacity of staff for the long term ▪ Focus on community-based PPFP interventions, including EBF, LAM, pills, injectable and condoms, while addressing health worker and capacity needs at facility level
<ul style="list-style-type: none"> ▪ High HIV prevalence and existence of PMTCT services 	<p>Meeting the needs of women living with HIV:</p> <ul style="list-style-type: none"> ▪ Integrate PPFP with PMTCT services, promotion of EBF and LAM use, as well as appropriate complementary feeding at 6 months, with transition to another effective contraceptive method

While also a good way to gauge the need of the community, consensus-building ensures that service providers, local government including regional and local DOH offices lend their support and ownership to the program. Engaging opinion leaders and stakeholder assists in generating the political and financial commitment needed to provide the human resources, space and supplies necessary for the introduction and/or strengthening of PPFP-PPIUD services including support for training or capacity building and demand generation. This activity should continue until services are well established at the facility.

Create Community Linkages

Creating community linkages is good way of leveraging on already existing service delivery channels for MCH and FP services. The same channels may be utilized by facilities for generating demand and establishing the services. Maximizing on these linkages guarantees that information on PPFP-PPIUD services and access are properly disseminated to target clients, many of whom are probably living far away from the facility. Linkage with the existing service delivery network contributes in generating client demand as well as enhancing and maintaining quality of services and client relations. Global experience has proven that linkage with the service delivery channel may also be utilized to monitor post-insertion clients who fail to return to the facilities for their follow-up visits. Similarly, information giving and counseling may also be channeled through other health units of the network.

Figure 3 Service delivery network diagram



Planners are advised to refer to the MNCHN service delivery network designed by the DOH since these facilities are already offering MCH services on which PPFPP-PPIUD may be integrated and added in view of improving quality and enhancing services. It is easier to introduce PPFPP-PPIUD services in these facilities since the staff may already be familiar with PPFPP but also because it already has more or less stable clients that can easily be tapped to generate demand. Likewise, resources and infrastructure of these service delivery points may be leveraged in the implementation of PPFPP-PPIUD program. In fact, this network may already be operational for other MCH services like referral for labor and delivery services.

The diagram above (Figure 4) illustrates the various levels of PPFPP-PPIUD services across the facilities in the service delivery network. Ideally, the PPFPP-PPIUD service offered at each facility should match the type of resources, capacity and mandate that the facility has. Under this diagram, the first level of service delivery occurs at the household or community level. At the barangay level, Community Health Team (CHT) led by the midwife provide both navigation and basic service delivery functions such as provide information on PPFPP-PPIUD, including where and how clients may access the services. The team usually led by the midwife, may be composed of Barangay Health Workers (BHWs) and other volunteer workers including barangay officials and representatives from people’s organizations or non-government organizations. Meanwhile, PPFPP-PPIUD services, replenishment of PPFPP commodities and PPIUD follow-up are offered at the RHU, district, provincial and regional level facilities.

Chapter 3: Setting up a PFPF-PPIUD Program in Health Facilities

“In the beginning we didn’t have a designated private counseling area available for ANC clients. After PFPF-PPIUD training, we put up a cubicle for consultation where all ANC clients can get counseling before receiving treatment. Since putting it up we’ve had more acceptors because now mothers have an opportunity and space to think things over and weigh the benefits of PFPF on their health and their families.”

~Dr. Jun Bacugan, Region 1 Medical Center, Dagupan City

3.1 BUILDING CAPACITY FOR PFPF-PPIUD SERVICES

Developing Human Resources

A facility should select a team of providers composed of a doctor, nurse, and midwife for training. At a minimum, the PFPF-PPIUD learners should be providers who have a background and are currently working as MCH service providers in the facility. Additionally learners should have undergone FP-CBT I & II and are familiar with interval IUD insertion and removal services. It is also advisable to train highly motivated providers⁸ who themselves are advocates for FP since they will be effective in echoing their acquired skills to other interested staff in the facility.

Competency is developed through practice and mastery keeping in mind adult learning principles. Training should translate to actual practice and reinforced by placing and maintaining trained providers in the ANC clinic, labor and delivery room, and postpartum ward. After training, providers should have continuous opportunities to practice so that they will not lose their skills. Further develop competency of trained providers through mentoring and supportive supervision.

Trained providers from teaching facilities may cascade PFPF-PPIUD skills as a strategy to build a pool of trained staff. PFPF-PPIUD champions skilled in adult learning methods can be used as coaches to effectively train others. Eventually, PFPF-PPIUD training should be included in pre-service or residency education so that all providers who perform essential MCH services are well informed. Additionally, on the job training through mentors in the facility will help establish services and maintain the quality of services in the facility.

3.2 ESTABLISHING A PFPF-PPIUD SERVICE SITE

Establishing a PFPF-PPIUD site can be challenging, especially for facilities contending with limited capacity and resources. Fortunately, global experience on PFPF-PPIUD can provide future PFPF-PPIUD sites with useful lessons in initiating services at their facility. Key to the success in setting up PFPF-PPIUD services in a facility is securing the support of national health agency through regional and local health offices. In the Philippines, the commitment of the DOH to assist and support PFPF-PPIUD implementation is outlined in the national undertaking to reduce the unmet need for modern FP methods. Health facilities planning to establish PFPF-PPIUD services are advised to leverage support from the local government and regional DOH office to ensure that they receive the support necessary to implement and sustain

⁸ Providers with differing views on FP, however should still be engaged since what’s important is that they are willing to update their knowledge and acquire the skills and attitudes essential for delivery of PFPF-PPIUD services.

PPFP-PPIUD services. They are also encouraged to seek technical assistance from international and local stakeholders working in the locality.

As mentioned in the previous chapter, facilities planning to implement a PPFP-PPIUD program are advised to map out the need and opportunities for PPFP-PPIUD prior to establishing or designing the sort of PPFP program to be introduced in the facility. This includes reviewing existing assets, identifying stakeholders and potential partners, available donor support, and evaluating the facility's physical and managerial capacity to implement and sustain the program.

Facilities already providing maternal and child health services should be selected as delivery sites. These facilities have the potential to develop and operationalize protocols, policies and systems supportive of provision of PPFP-PPIUD services 24/7. This will not only facilitate the implementation of the services but also ensure that services are sustained after the initiation phase. Essential criteria for site selection are:

Staffed labor and delivery unit

Adequate infrastructure for service delivery

Trained provider to the level of competency in PPFP-PPIUD

Availability of staff (fewer shortages relative to other sites): FP counselors and providers

Receptive facility managers and administrative support

Regular and adequate supply of IUD and other PPFP commodities, including equipment, instruments and other supplies needed to deliver PPFP-PPIUD services (see Annex 1)

3.3 INTEGRATION OF PPFP-PPIUD IN EXISTING MCH SERVICES

PPFP-PPIUD should not be considered a 'vertical' program, but rather an integrated part of existing MCH and FP efforts. Successful PPFP interventions require holistic and evidence-based strategies that contribute to strengthening the existing health system and improving quality of health care services received by the people. As mentioned, integrating PPFP-PPIUD services into established MCH services also facilitates acceptability of the program both among providers and potential clients in the hospital since it is seen as an integral part of the continuum of care provided to pregnant mothers. The program should reach women at one or more specified contacts with the health system for information and services: (1) ANC, (2) labor and delivery and (3) postpartum care. Experience from existing PPFP programs in the Philippines and other countries demonstrate how an integrative approach drives the demand for services since the months before and after childbirth present the greatest number of contact that women have with the healthcare system.

This section outlines approaches on how to design and integrate PPFP-PPIUD in the three specified contact points. A range of strategies and illustrative examples are enumerated in this section to illustrate the kinds of activities and program interventions that can be taken to integrate PPFP within the various continuum of care offered to women in the facility.

Table 3 Continuum of Points of Contact for PPF

CONTINUUM OF POINTS OF CONTACT FOR PPF				
→ → → →				
STAGE	Pregnancy	Labour and delivery, Pre-discharge (0–48 hours)	Postnatal, including prevention of mother-to-child transmission of HIV (PMTCT) (48 hours–6 weeks)	Infant care (4–6 weeks through 12 months)
SERVICE DELIVERY	Facility-based antenatal care (ANC) Community-based pregnancy screening	Facility-based or home-based with skilled birth attendant	Facility or household visits: <ul style="list-style-type: none"> • If birth at home, within 24 hours of birth • If birth in facility, prior to discharge • Day 3 (48-72 hours) • Between days 7-14 after birth • 6 weeks 	Facility, home visit, or community-based: <ul style="list-style-type: none"> • Immunizations (diphtheria-pertussis-tetanus [DPT] or Pentavalent 1, 2, 3; measles, rotavirus; boosters; etc.) • Well child visits • Nutrition/growth monitoring • Event days (e.g. vitamin A) • Illness visits (e.g. Integrated Community Case Management/Integrated Management of Childhood Illnesses [ICCM/IMCI]) • PMTCT/antiretroviral care and treatment

Antenatal Care

ANC refers to the health services that a woman receives to monitor the health and progress of her pregnancy and her wellbeing during her pregnancy. ANC provides an opportunity to encourage deliveries with a skilled birth attendant and to advise and counsel on the importance of FP methods, including those that can be provided at the time of a birth (WHO 2006, WHO 2010b). Information and counseling on PPF-PPIUD can be provided to the woman and if the woman chooses this method consent prior to labor can be obtained. For the couple or woman who does not desire future pregnancies, ANC also provides a time when counseling about permanent methods can be offered, and voluntary informed consent can be obtained confirming the understanding that these methods are permanent options. ANC helps support the essential link between health care services that are provided in the community and those provided in the facility. It also provides an opportunity to engage husbands and family members to support healthy pregnancy and postpartum behaviors.

Table 4. Contacts during antenatal care

<i>Illustrative Program Strategies</i>	<i>Illustrative Program Activities</i>	<i>Program Case Examples</i>
<p>Strengthen awareness of and demand for PFP during the ANC period</p>	<ul style="list-style-type: none"> ▪ Integrate PFP information and counseling with ANC services offered at facility and community levels ▪ Provide counseling that includes discussion of a woman's or couples' reproductive aspirations and the range of FP options available, including permanent methods ▪ Assign health workers to routinely provide group education on PFP, HTSP and EBF during ANC sessions ▪ Promote the inclusion of husbands and other family members in ANC education and counseling 	<ul style="list-style-type: none"> ▪ At R1MC, PFP counseling are integrated in the ANC services offered at the outpatient department. Since adopting the PFP program, a designated private counseling area has been put up where clients can receive thorough FP counseling. Clients are encouraged to express their reproductive aspirations and informed about the benefits of HTSP. Integration of PFP counseling during the ANC ensures better decision-making process since the client has ample time to weigh her options and elicit the support of her husband and family members. ▪ Women attending ANC at SPMC's newly renovated OB Outpatient Department Clinic can avail of the daily group lecture on FP provided by their FP staff and are encouraged to consider their FP options while still pregnant. Two dedicated FP counselors have also been assigned in the clinic so that clients attending ANC may approach them for information any time. It helps that a private dedicated room for FP counseling has been constructed to encourage potential clients to seek advise on HTSP. ▪ EVRMC and VSMMC integrated PFP-PPIUD concepts in their Usapang Buntis sessions with mothers. With this they effectively disseminate information on PFP-PPIUD, and as a result generate demand for the services.

Illustrative Program Strategies	Illustrative Program Activities	Program Case Examples
<p>Improve the enabling environment for PFP as a routine part of ANC services</p>	<ul style="list-style-type: none"> ▪ Work to improve the knowledge, attitudes and practices of ANC providers and CHTs to ensure they support the provision of PFP information and services ▪ Integrate PFP with service delivery guidelines. ▪ Activities like contraceptive technology updates is an effective way in piquing interest and generating demand for PFP-PPIUD services. 	<ul style="list-style-type: none"> ▪ The publication and release of the <i>PFP-PPIUD Supplement to the Philippines Clinical Standards Manual on Family Planning</i>, an accompanying supplement to the existing manual on family planning endorsed by the DOH, is critical in creating an enabling environment for integration of PFP not only in ANC, but also in the whole range of MCH services. The supplement provides useful information and knowledge that help service providers in ensuring the quality of FP services to women and families. ▪ To cultivate an enabling environment for PFP in their community, R1MC conducted outreach PFP-PPIUD training and orientation activities to district hospitals, provincial hospitals, RHUs with birthing facilities and private lying-in clinics in the region to disseminate updated knowledge on PFP, develop their competence for service delivery and sensitize health workers to the importance of integrating PFP in ANC. ▪ In March 2012, MCHIP organized a national contraceptive update roadshow in Luzon, Visayas, Mindanao which was attended by over 500 FP service providers and program managers. These one-day knowledge sharing and discussion forums—mounted consecutively over the period of one week in Manila, Cebu and Davao—were eagerly received both by service providers and program managers who generously lent their time,

<i>Illustrative Program Strategies</i>	<i>Illustrative Program Activities</i>	<i>Program Case Examples</i>
		<p>participation and valuable inputs during the sessions. The forums provided a much needed platform for international and local FP experts and advocates to discuss the most urgent FP issues facing the country.</p>

Illustrative Program Strategies	Illustrative Program Activities	Program Case Examples
Strengthen continuity of care linkages and referrals between facility and community and ANC and birthing services	<ul style="list-style-type: none"> ▪ Barangay health centers, and CHTs regularly identify, refer and follow up pregnant women for ANC services and provide/reinforce PFP messages . ▪ Referral linkages developed or strengthened between ANC services and labor and delivery services, whether they are located in the same place or in different facilities/settings ▪ A mechanism is in place, such as the client card, that accurately captures and communicates data about clients' health needs and immediate PFP choices 	<ul style="list-style-type: none"> ▪ Weekly mothers' classes at Barangay Health Centers in Batangas City has contributed to the dissemination of information and services on PFP. This has driven the demand for PFP services in BatMC, with some mothers reportedly deciding to give birth in the facility because of the PFP and PPIUD services available at the facility.

Labor and Delivery

This point of contact involves various points throughout the stay in the facility, including admission, early labor, delivery room, maternity ward, immediate postpartum and pre-discharge. Counseling on the importance of FP method options, including LAM, is recommended during this period (WHO 2006, WHO 2010b). But this should be done only during early labor when the woman is not in pain and still capable of making sound decisions.

For women with limited access to health care in facilities, delivery at a facility affords a unique opportunity to address their fertility intentions and need for contraception: it does not require a return visit that may be prohibitively expensive or inconvenient. If a woman seeks to have PPIUD inserted or BTL immediately after delivery, special care must be taken to ensure that high-quality counseling has been done to verify the woman's choice and ensure that client is medically eligible for the chosen method.

Table 5. Contacts during labor and delivery, including pre-discharge

Illustrative Program Strategies	Illustrative Program Activities	Program Case Examples
Effective linkages and protocols are in place to support FP counseling and referrals of maternity clients for PFP information and services and continuity of care	<ul style="list-style-type: none"> ▪ Strengthen capacity of skilled birth attendants to provide accurate and effective PFP counseling, including LAM and when requested, referrals for PPIUD (within 48 hours) or BTL (within 1 week) ▪ Ensure pre-discharge counseling which should include messages about danger signs for mothers and infants, EBF, LAM, fertility desires for spacing and limiting, and HTSP, return to fertility, return to sexual activity, safe modern methods to use while 	Pre-discharge counseling is a good opportunity to reinforce PFP information and benefits of HTSP both to PFP acceptors and non-acceptors. For PFP acceptors and women who've sought PPIUD, pre-discharge counseling is an opportunity to remind clients of PPIUD post-insertion care, post-operative care for BTL clients, warning signs and schedule of follow-up visits. Providing these messages is critical in encouraging mothers to continue with their chosen

Illustrative Program Strategies	Illustrative Program Activities	Program Case Examples
	<p>breastfeeding, and transition from LAM to a modern method (if she is using this method), as well as when and where to go for follow up visits</p>	<p>method. Anticipating the needs of these women, Davao Regional Hospital developed a simple tool to keep their clients informed and alleviate the anxiety that PFP clients often feel. This tool was a simple modification in the discharge instruction slips that DRH postpartum patients routinely receive upon checking out of the hospital. PFP acceptors would receive additional care instructions, including date and time of follow-up check up, on their discharge slips to keep them abreast with what to expect within the coming six weeks.</p>
<p>High-quality PFP information, counseling and services, including PPIUDs and BTL, are provided at maternity SDPs by competent, confident and committed providers</p>	<ul style="list-style-type: none"> ▪ Conduct competency-based counseling and clinical skills training in in-service settings ▪ Provide health-care workers with job aids, up-to-date service protocols, guidelines, screening checklists and other reference materials (WHO 2012c) ▪ Conduct other educational activities beyond one-on-one counseling to increase informed demand, such as group information sessions in the postpartum ward, videos and posters, ensuring that messages resonate with clients and communities 	<p>In the Philippines, designated training centers conduct competency-based and clinical skills training in in-service settings. At R1MC, ZCMC, CRMC, BatMC, EVRMC and VSMMC in-service training for PFP-PPIUD has generated interest in producing evidence-based information that will reinforce the acceptability, safety and effectiveness of PFP-PPIUD.</p>

Postpartum Care

PNC presents an opportune moment when women should be counseled on birth spacing and FP. WHO recommends that women who have delivered in a health facility should receive PP care for at least 24 hours after birth. Three additional PP care contacts are recommended on day 3, between days 7–14 after birth and 6 weeks after birth (WHO 2013c). It is important to reach women before they are at risk for an unintended pregnancy with information about return of fertility, their options to space or limit future pregnancies, and the benefits to their own and their newborn’s health in doing so.

Community-based interventions are critical during the vulnerable period when women return home from a facility-based birth. Women with PPIUD are followed up to monitor complications such as infection and expulsion. Those who did not accept any PFP method are sought out by the CHTs and counseled on the benefits of healthy timing and spacing. PFP options should be

discussed and provided if requested. Women should also be counseled on safe sex, including use of condoms.

For women living with HIV, PFPF can be integrated with routine PP care services if these exist within the PMTCT program. It is also important program that activities are cascaded to other SDPs in the service delivery network.

3.4 IMPLEMENTING PFPF-PPIUD IN THE FACILITY

PFPF-PPIUD service at a facility needs to be monitored, assessed and corrected (when necessary) to ensure smooth operation and quality of services. Adopting a new program is not easy in any setting especially in health facilities or hospitals inundated with competing responsibilities and programs. As expected, health workers used to doing things a certain way become resistant to change. Incorporating a new service within the workplace is similar to learning and practicing a new behavior that needs to be experienced before it can be fully accepted and fully implemented. Below, are the steps in implementing PFPF-PPIUD services in health facilities:

Immediately initiate service upon return from training. Right after training, convene core staff to echo newly acquired skills and secure the support and commitment of hospital administration or management to initiate PFPF-PPIUD services at the facility. Securing their support at this early stage is optimal in the smooth initiation of PFPF-PPIUD services in the facility. This will also facilitate the integration of PFPF-PPIUD services in the MCH continuum of care.

Create awareness by organizing whole-site orientation for all facility staff – upper management, providers, support staff, and other “gate keepers.” More advanced information on PFPF-PPIUD should be furnished to the service providers. While time-consuming, whole-site orientation needs to be tailored to different types of workers in the facilities and offered at multiple times to engage staff working at different hours.

Whole-site orientation generates demand and also facilitates sustainability by way of:

- making staff aware of their role in filling the unmet need in the community
- motivating staff (instilling pride in adopting a new practice)
- allowing staff to learn new information/skills
- addressing staff myths and misconceptions (about PFPF-PPIUD)
- enabling all MCH staff to engage in education and counseling around PFPF and PPIUD
- enabling other staff working in the facility to be orientated on PFPF-PPIUD concepts so they can also be credible sources of PFPF-PPIUD information of patients coming in the facility.

Whole-site orientation should cover basic topics of PFPF-PPIUD, while more advance information should be designed for FP service providers. The orientation should include:

- discussion on unmet need for modern FP
- WHO messages on healthy spacing and timing of pregnancies
- What is PPIUD

- When in postpartum can an IUD be inserted (postplacental, intracesarian, immediate postpartum/within 48 hours)
- Who will provide the service (or where in the facility can clients get more information)

Provide adequate number of instruments and assure availability of PFPF supplies. Make sure that there is enough supply of broad range of PFPF methods including instruments and training models so that services can immediately commence after the providers' training. If supplies and personnel are inadequate provisions must be made to ensure that these supplies can be acquired at the soonest possible time.

Organize services. Efficient organization of services is essential to ensure that enough time is allotted to include FP counseling and decision making in the current MCH services. Services should be integrated throughout the continuum of pregnant woman's care and be made available at ANC unit, labor and delivery, operating and postpartum ward 24 hours. An institutionalized protocol should be formulated covering this integration. Ensure that providers and counselors are adhering to infection prevention protocols and ICV principles, and appreciate their importance in PFPF-PPIUD services.

Establish a reporting and recording system. Encourage providers to diligently document the delivery of PFPF-PPIUD service using FP Form 1 and PPIUD logbook. Impress on them the importance of tracking progress and documenting evidences and best practices for replication.

Schedule and arrange supportive supervision sessions to monitor the PFPF-PPIUD program using performance indicator checklist.

Maximize community-based care: community health centers and workers can help bring information on services to communities that are not as easily accessible to the hospitals. Likewise, follow-up visits for PFPF-PPIUD clients can be cascaded to rural health units (RHUs) and barangay health stations (BHS), to reach women who live far away from the hospital facilities. CHTs can also be mobilized to disseminate information and benefits of PFPF at the community level. Experience from our sites demonstrates the important role of CHTs in demand generation for PFPF among mothers.

Linkage with community-based social services such the Family Development Sessions organized under the Conditional Cash Transfer Program and similar poverty reduction programs. This linkage should incorporate the benefits of healthy spacing and timing of pregnancy. Likewise information on the broad range of FP choices during the postpartum period, including where to access these services must also be disseminated.

During the implementation of the PFPF-PPIUD program, managers and supervisors need to be aware of these steps and use performance standards checklist (see Chapter 4) to keep track of the progress.

Boxed Story

Initiating PFPF-PPIUD services at Batangas Medical Center

Batangas Medical Center (BatMC) is a regional teaching and training hospital located 106 kilometers, southwest of Manila. Situated in the provincial capital in Batangas City, BatMC mainly caters to families living in province of Batangas and other provinces in the Southern Luzon region, namely Cavite, Laguna, Quezon and Rizal. It also extends its service to patients living as far as Mindoro and Masbate.

Located in a province with growing economic and social opportunities, BatMC occupies an important role in ensuring access to quality healthcare of its immediate and outlying communities. Identified by DOH as a regional technical/training resource for maternal and newborn health programs among them BEMONC, BTL and EINC, BatMC proves clearly as a suitable place to initiate PPF-PPIUD services. Hence, it comes as no surprise that the PPF-PPIUD program has easily found a place in the care already offered by BatMC to its community because it is complementary to other existing programs they are currently in place in the hospital. During the last two years, it demonstrated interest, capacity and commitment towards an integrative maternal health care program.

The success of the implementation and full integration of PPF-PPIUD program in MCH services in BatMC is a result of the facility's tenacious leadership – lending full support to the program– and timely introduction of services in the facility.

Motivated by the new knowledge and skills they gained in the first round of Clinical Skills Training for PPF-PPIUD, BatMC OB-Gyn resident Dr. Lennybeth Latido and FP coordinator Nurse “Bing” Teodora Rayos wasted no time in initiating services at their facility. “After completing our clinical skills training in Manila last August 2012 we immediately sought the assistance of our OB-GYN Department Chair, Dr. Angelita Villena to secure our Chief of Hospital's approval to offer PPIUD services on our patients,” shares Dr. Latido and Nurse “Bing” Rhodora Teodoro.

Dr. Latido adds that this was key in establishing a favorable environment for PPF-PPIUD services in the facility, “the support of our chairman Dr. Villena and hospital chief was instrumental in implementing program in the hospital. Without it we would have probably had hard time establishing it here.” In no time, Dr. Latido began to perform IUD insertion to her postpartum patients acceptors while Nurse Bing offered PPF counseling to ANC patients, imparting the benefits of properly and healthy spaced and timed pregnancies. In order to accommodate early postpartum insertions, an insertion room was set up in the FP clinic.

Dr. Latido and Nurse Bing established a good momentum for the services, generating interest among hospital staff while at the same time developing their competency in PPF-PPIUD. Their effort paved the way for an enhanced maternal care program that is encompassing of the different life stages of a woman. Within a few weeks they managed to institute a regular schedule for the services and develop steady demand among its clientele.

As demand for services grew, so did the need for more providers. Prompting Dr. Latido to transfer her knowledge to other resident OB-GYNs of BatMC two months after initiating services at the facility. Other OB-GYN residents were then oriented with the concept of PPF-PPIUD and insertion techniques through lecture, and one-on-one demonstrations. And while some of her colleagues hesitated in the beginning she eventually won them over with constant encouragement and practice. Supportive supervision from MCHIP's Dr. Bernabe Marinqudue including the Philippine Gynecological Society's recommendation on PPIUD in the 2012 Clinical Practice Guidelines helped build the confidence of the providers and allay their fears about the procedure. With more providers who can counsel and insert PPIUD, BatMC was able to offer PPF-PPIUD services 24/7 in due time.

“It's very disheartening to see the same mothers who've just given birth a year ago to be back in the labor room again to deliver another child. That is why when a mother accepts PPIUD or any other PPF method we are relieved, knowing that she, her baby and her family are off to a better and healthy start, “ shares Dr. Latido. With PPF-PPIUD services in their facility, women have better

options and access to FP services that will help them achieve their reproductive aspirations. Nurse Bing adds that since they started offering PPIUD their patients displayed more confidence with the birthing process and displayed increasing awareness of FP.

BatMC has been identified as one of the most promising Centers of Excellence candidates. MCHIP has worked for the past two years to help staff integrate PPF services into their existing essential maternal and child health program. The facility's success is attributed to the intense commitment of the medical center's providers and leadership to adopt and implement PPF/PPIUD services in their facility. Key to the demand for PPF services at BatMC are the availability of round-the-clock services, effective counseling from pregnancy through the postpartum period, and positive "word of mouth" stories spread by mothers in the community.

Generating Demand for PPF and PPIUD Services

There are two main strokes in generating demand for PPF and PPIUD service: one is generating it within the facility and second is generating demand in the community. Generating demand for PPF and PPIUD in the community is an effective way of promoting facility-based births, reducing unmet need in modern FP and improving maternal and newborn outcomes. As already mentioned in the previous chapter, engaging the LGUs, RHOs, and RHUs in the community is an effective way to mobilize financial, logistic, technical and moral support needed to create and maintain demand for PPF and PPIUD services. Likewise, linking up with the existing service delivery network helps maintain the quality of services and track follow-up of clients.

Generating demand for PPF and PPIUD services in the facility may be done through:

- tenacious one-on-one counseling
- group counseling
- mothers' classes
- ensuring that services are available 24/7
- regular sensitization and awareness activities
- linkage and coordination with service delivery network, i.e. lower-level facilities like RHUs and BHS that regularly hold mothers' classes in the community
- outreach program

Organizing a PPF-PPIUD launching activity in health facility is an effective way in generating demand for PPF services, creating awareness and sensitizing the hospital staff and potential clients on the new services and the accompanying health benefits of a new service. Furthermore PPF-PPIUD sensitization can be reinforced during ANC visits, group lectures such as regularly scheduled mothers' classes, outreach programs, and posting of IEC materials around the hospital particularly in the OB outpatient clinics, labor and delivery area and postpartum ward. If resources are available, it is also suggested that PPF-PPIUD orientation be included in the in-service training of doctors, nurses and midwives.

BOXED STORY

Cotabato Regional Medical Center maximizes resources while creating demand for PPF in a launch ceremony celebrating pregnancy

Integrating postpartum family planning and postpartum IUD services in the continuum of care given to pregnant mothers is a good way to ensure that demand for these services are sustained throughout the implementation period. Maintaining demand for PPFPP-PPIUD services is important in developing competency of the providers and therefore increasing the capacity of the facility to deliver quality FP services to mothers and women in the community. Introducing a new service is always a challenge, healthcare providers who are used to existing hospital policies will need to develop new skills and assimilate into a new job environment. With this in view, it is crucial for facilities initiating PPFPP-PPIUD services to relay to its providers that PPFPP-PPIUD encompasses the whole maternal health care package and should not be viewed as separate component of care.

Cognizant of the challenge of introducing PPFPP-PPIUD services in the facility, the Cotabato Regional and Medical Center in collaboration with the DOHRO XI dovetailed the launch of its PPFPP-PPIUD services in the facility with its yearly celebration of Women's Month last March. Dubbed under the theme of "*Kalinga ni Nanay, Karugtog ang Buhay*," the event was called *Buntis Day* (Pregnant Day), which brings into focus the need to promote healthy bodies and wellbeing among pregnant mothers. The event presented the integral link of antenatal, intrapartum, infant and newborn care with the postpartum period.

The postpartum period is ordinarily missed as an opportunity to introduce health interventions that can improve maternal and infant outcomes. While an important period for newly delivered mothers to recover strength and develop physical and emotional wellbeing that will prepare them for the demanding task of motherhood, FP during the postpartum period is often times put on hold for varying reasons. Among them poor understanding of the return to fertility, limited access and information on PPFPP methods and services, and competing responsibilities that a newly delivered mother face, including childcare and domestic work. Left with little time to attend to their needs and personal aspirations, FP while important to them becomes the least of things available for them. This was the driving message of *Buntis Day* – to reinforce and disseminate vital information on how mothers can take care of their bodies while also ensuring the future health of their unborn babies. Leveraging on this captive market, CRMC maximized their resources and available channels of communication to launch postpartum family planning and postpartum IUD services at the facility.

Attended by 511 pregnant mothers, the event generated considerable interest in PPFPP and PPIUD. Mothers enthusiastically lined up at PPIUD booth where they perused information on healthy spacing of pregnancies, long-acting FP methods, PPFPP and benefits of PPIUD on improving health outcomes for mother, newborns, infants and children. The booth provided reading materials on FP and PPIUD. Other promotional materials such as post-it pads, bookmarks, baby clothes, even muffins that attendees can munch on were given away, making the event more festive and celebratory.

To further illustrate the health benefits of well-timed pregnancies and PPFPP to mothers and infants, a group of CRMC nurses also performed a lively skit communicating PPFPP methods that are available to couples who wish to space pregnancies at least two years apart. Free health services, including complete blood count, blood typing and blood sugar measurements and tetanus toxoid immunizations were also available for the attendees with the first 10 of them receiving free ultrasound. Following the presentation was a short lecture by MCHIP Senior Technical Advisor Dr. Bernabe Marinduque who reiterated the World Health Organization's recommendations on maintaining at least 2 years interval between pregnancies to reduce the risk of adverse maternal, perinatal and infant outcomes. The event was capped by a short forum to accommodate the queries of mothers on PPIUD, particularly on side effects, contraindications and related myths on IUD.

CRMC's Dr. Emilie Flores also gave a lecture on maternal and child nutrition.

The twin event *Buntis Day* and PFPF-PPIUD launch exemplify the effective mobilization of resources to initiate PFPF-PPIUD services in a facility. It demonstrates how existing resources and platforms, in this case CRMC's yearly women's month celebration, can be leveraged to generate interest and demand for PFPF. At the same time, the event also served to motivate CRMC staff to provide quality PFPF and PPIUD services in the facility. The warm reception received from the attendees served as inspiring motivation for CRMC staff to develop and strengthen their PFPF-PPIUD skills.

Also instrumental in strengthening their confidence was the presence of Dr. Helen Yambao who led the opening of the event, as well as the attendance of DOHRO XII Director Dr. Marilyn Convocar who committed an allocation of PhP 500,000 to support the scale up and implementation of PFPF services in the region.

The attendance of ARMM's Secretary of Health Dr. Kadil Jojo Sinolinding was equally inspiring for the both CRMC staff and pregnant mothers present in the event. The attendance of key stakeholders and members of the community at the PFPF-PPIUD launch was critical in securing the necessary support that will ensure that PFPF-PPIUD services are not only initiated but also and most importantly sustainably implemented and owned by the local community.

Chapter 4: Achieving and Ensuring Quality of Care with Supportive Supervision (SS)

“Being a trainer, I should not stop in just teaching. The success of my trainees is also my success, and that is why it is paramount to monitor their progress and offer mentorship as needed.”

~Dr. Marybeth Delos Santos, Medical Specialist, Vicente Sotto Memorial Medical Center,
Cebu City

Training is a continuum of onsite skills acquisition, transfer of learning, and ensuring compliance to standards. And like any new program, PPFPP-PPIUD services will also require continuous monitoring and supervision to ensure that providers feel confident in performing the services and that quality of care is maintained at all times. After training it is important to follow through with the health workers, especially in practicing the newly acquired skills. Health workers tend to lose their skills with time, especially if they are not practicing them regularly or adequately. Although some service providers will take the initiative to maintain and improve their performance, the majority will need additional assistance, which can be provided through supportive supervision. A well-delivered competency-based training is best complemented with supportive supervision.

Supportive Supervision (SS) is defined as a “process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on identification and resolution of problems and helping optimize the allocation of resources and promoting high standards, teamwork and better two-way communication.”⁹ This process promotes a responsive, collaborative, cooperative working environment in contrast to traditional approach to supervision that is based on monitoring, control and often times punitive in nature. Remember that supportive supervision is an ongoing, dynamic and interactive process. Plans for supervision must be made, and ideally, be in place before or soon after training has been completed. Long delays are likely to be associated with a decrease in competency and poor implementation.

For more detailed discussion and step-by-step guide on the conduct of supportive supervision, the “Guidelines for Conducting Post-Training and Supportive Supervision Visits to PPFPP-PPIUD Facilities may be consulted. Key tools for supportive supervision can be found in the appendices. The “*SS Checklist for PPFPP-PPIUD Services*” and “*Performance Standards for PPIUD Counseling and Services*” can be used to evaluate provider competence in the important steps of PPFPP and PPIUD counseling and service provision.

4. 1 RATIONALE AND COMPONENTS OF SUPPORTIVE SUPERVISION

Facilities implementing PPFPP-PPIUD services are advised to coordinate with regional training centers and DOH office to establish an SS timetable immediately after the clinical training of providers. Supportive Supervision is important in ensuring the success of the program. Likewise, information gleaned from ongoing data collection and monitoring will guide implementers, managers and providers in improving service delivery and quality of care. Supportive supervision is also crucial in enhancing worker skills and motivation, strengthening management, and fostering a facilitative working environment.

⁹ Marquez L, Kean L. MAQ Paper, No. 4. Bethesda, MD: University Research Co., LLC; 2002. Making supervision supportive and sustainable: new approaches to old problems.

Preferably, the key principles enumerated below should be covered during the supervision. However, since supervision can be challenging, especially in low-resource settings, it is recommended that emphasis are directed towards those that will have greatest impact on the implementation in the facility:

Evaluation of:

- health worker competence in PFP counselling and service provision
- provider competence in PPIUD insertion
- adherence to infection prevention protocols
- adherence to principles of ICV principles

Data-driven: it uses available M&E data to set goals and objectives, monitor performance and implementation of solutions. Identification of problems should be based on these data and solutions should be measured against them.

Results-oriented: Focuses on the results of processes and program outcomes. This also entails provision of feedback and updates to providers, and report to concerned authorities

Quality-focused: Monitors individual and clinic-wide performance against clinical standards and customer expectations and satisfaction.

Provider-focused. Develops and promotes a standardized provider performance

Monitoring and evaluation during SS serve as the mechanism to document, analyze and report SS visits. This will ensure that the SS is data-driven and results-oriented with focus on quality improvement against clinical standards and customer needs, while also developing and improving providers' performance.

The specific objectives of an M&E during the supportive supervision is to:

Determine the status of project implementation at the site against expected outputs/outcomes

Determine issues and problems in project implementation and project data management

Analyze findings, formulate recommendations and/or catch-up plans as necessary together with the project partners at the site

Another important feature of an SS visit is its transparency and the immediate feedback given during the visits. In this case, briefing and de-briefing activities during the SS visits are very vital. All key stakeholders at the project site must be well oriented on the process, tools and objectives of the activity. The participatory and consultative process ensures the accomplishment of the above objectives.

The frequency of the SS visit varies from one facility to another. The frequency of SS visits will mainly depend on the competency of the trainees, especially during the Post-Training Monitoring and Evaluation (PTME). If for example, the trainee would still need to be mentored because he or she has not achieved the level of competency repeat visits are warranted. Ideally, a PFP/PPIUD trainer, who will conduct the initial SS visits, is not only knowledgeable and skilled on PFP/PPIUD but also equipped as a supportive supervisor.

4.2 INITIATING SUPPORTIVE SUPERVISION IN THE FACILITY

Preparatory Phase

The preparatory phase for supportive supervision (SS) should be accomplished during the action planning session of the clinical skills training. During this period both the provider and supervisor should anticipate routine supportive supervision while PFP/PPUID services are being established in their facility.

During this phase:

- Establish routine supportive supervision

- Determine the personnel to be involved. Ideally, each health worker should be assessed while on the job using the pre-designed tools and given feedback in a timely manner

- Develop clear objectives for supportive supervision. These objectives should be based on the needs of the facility.

Implementation Phase

During the implementation phase, the following steps or activities are carried out:

- Supervisory sessions of providers with supportive feedback. The supervisory committee should plan SS sessions periodically—ideally on a monthly basis, and then eventually every three months—to observe how individual staff members perform in the ward, and how PFP-PPUID services are delivered as a whole.

- Review trends in the results (through links with M&E activities) and institute appropriate changes in order to achieve desired goals. The supervisory committee should promote and maintain open dialogue with staff members to review ‘trends’ and discuss particular cases, listen to staff feelings and suggestions, provide feedback, and jointly solve any problems. SS is key to maintaining and improving staff motivation and job satisfaction. If possible, it is also advised that hospital or facility management be involved in the process as this will strengthen the commitment of the decision-makers to the program.

- Carry out updates and remedial measures to improve results.

4.3 CHALLENGES IN SUPPORTIVE SUPERVISION

Maintenance and improvement of quality of service are among the most challenging components of program implementation. Challenges include but are not limited to:

Lack of Motivation. Many health professions do not consider supervision as part of their regular job description. With already too much workload and very little human resources, keeping supervisors motivated to oversee the quality of services by their providers may present as a challenge. Facilities may devise an incentive program to encourage their supervisors to take on ‘additional staff.’ In the future, revision of scope of work may also be pursued to include supportive supervision as part of health workers job scope.

Insufficient skills in supervision can affect the confidence of the supervisor to catalyze improvement of staff skills. Supervisors are advised to use tools such as the *Performance Standards Checklist*, and *PFP Service Provision Checklist* during the conduct of SS. In

addition, facility supervisors and program managers may seek technical assistance to build their confidence and skills as supervisors.

A suggested response to these challenges is to view SS as a skills enhancement program, monitoring mechanism of PPFPP/PPIUD and provision of technical assistance (TA) to facilities or project partners in implementing PPFPP/PPIUD. Results and findings from the SS will be used to evaluate the quality of performance against standards during the implementation period.

BOXED STORY

Developing competency through supportive supervision

“Being a trainer, I should not stop in just teaching. The success of my trainees is also my success, and that is why it is paramount to monitor their progress. I will not be satisfied in simply training these facilities but more than that I would like to see them succeed in their facilities,” says Dr. Marybeth De Los Santos, a medical specialist at the OB-GYN Department of the Vicente Sotto Memorial Medical Center (VSMCC) in Cebu City. Dr. Delos Santos belongs to the first batch of master trainers mentored under MCHIP’s program to establish the capacity for service delivery and training for PPFPP-PPIUD adoption and scale up in the Philippines.

Developing master trainers proficient and qualified to provide PPFPP/PPIUD training and mentorship to service providers has been an important factor in the adoption of PPFPP-PPIUD services in the country. With nine sites distributed in Luzon, Visayas and Mindanao regions, MCHIP’s approach was to cultivate at least two master trainers to ensure that PPFPP-PPIUD capacities may be rolled up systematically. Having more trainers mean more opportunities and channels to disseminate PPFPP-PPIUD information, knowledge, skills and most importantly, services to women needing it. During the last 2 years, MCHIP has observed a growing demand for PPFPP-PPIUD training with more hospitals and providers learning about the benefits of PPFPP to women and families served by their facilities. Dr. Delos Santos reports, “before PPIUD the only long-acting method we could offer our patients was BTL. It is common for mothers who’ve delivered via C-section and low parity to choose BTL because of the fear of an unplanned pregnancy; so while they’re not ready to stop fertility they still choose a permanent method over the danger of an unplanned pregnancy. Now we have better option to give them.”

Since completing the clinical skills training in August 2012 conducted by MCHIP, Dr. Delos Santos has been at the helm of building capacity of service providers in the Visayas region. Lending her experience, newly acquired technical knowledge and skills to equally motivated providers who share her passion and desire to make PPFPP services accessible in their community. Seeing the benefits of the program to mothers and families served by their facility, Dr. Delos Santos together with her colleague Dr. Cherry Pangilinan immediately initiated PPFPP-PPIUD services in their facility soon after returning from their training.

“The first step was to build and develop our competency on PPFPP-PPIUD. That entailed applying our newly acquired knowledge, skills and attitude learned during the training in our setting. Soon after this, we started to feel confident enough to transfer those skills and knowledge to the residents of the hospital,” recalls Dr. Delos Santos as she narrated her PPFPP-PPIUD journey. In no time, Dr. Delos Santos grew from trained provider to PPFPP-PPIUD champion, and was soon tapped to become a master trainer for PPFPP-PPIUD in the Visayas region. She was then invited to attend the first batch of Training of Trainers for PPFPP-PPIUD in June 2013. After completing Jhpiego’s ModCal for training skills and didactics last September 2013 in Cebu City, Dr. Delos Santos certified as master trainer for PPFPP-PPIUD.

Dr. Delos Santos attributes her journey and success of PFP-PPIUD adoption at VSMMC to the relentless monitoring of the MCHIP team, supportive mentorship and supervision of Dr. Bernabe Marinduque, linkage with DOHROs and USAID bilateral health project VisayasHealth. “I think one thing that made this program successful is the regular monitoring of our monthly accomplishments. Dr. Marinduque was with us from the start until we reached master trainer level; he molded us to become a very good trainer just like him.” As expected there were some challenges along the way, but the supportive supervisions visits conducted at VSMMC and constant communication helped them encompass the initial bumps they experienced, “At first we were struggling with submitting reports but eventually it became part of our routine. With the help of VisayasHealth, we integrated PFP-PPIUD counseling in the Usapang Buntis series and in no time generated more demand for the services.”

VSMMC is a general, tertiary medical center and training facility operated and maintained under the Philippine government’s Department of Health with an authorized bed capacity of 800 and implementing bed capacity of 600 beds. As regional medical center it caters to the communities living in provinces of Cebu, Bohol, Negros Oriental and Siquijor. Established in 1913, VSMMC has always endeavored to bring affordable, quality and responsive health care to the increasing number of people seeking care in their facility. As designated training center for BeMONC and EINC, adding PFP-PPIUD in their programs only strengthens their commitment to integrative maternal and child health.

Chapter 5: Monitoring and Evaluation of PPF-PPIUD Services

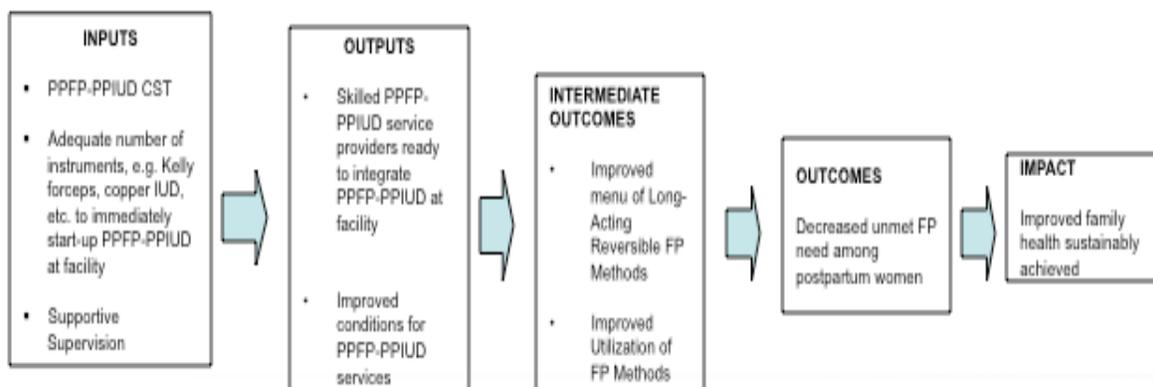
5.1 RATIONALE FOR MONITORING AND EVALUATION OF PPF-PPIUD SERVICES

Monitoring and evaluation (M&E) are key components of any well-managed health program. M&E provides information on how the program is functioning and impacts on the target beneficiary. Likewise, data from M&E helps program managers institute changes or corrections when needed.

Tracking of program activities and progress through regular, ongoing measurements is important in assessing the impact of the program and maintaining and improving services being introduced in the facility. Specifically, M&E:

- Provides data on program progress and effectiveness.
- Improves program management, quality and decision-making.
- Allows accountability to stakeholders, including funders.
- Provides data to plan future resource needs.
- Provides data useful for policymaking and advocacy.

An M&E system is designed to track and document progress of PPF-PPIUD implementation in a facility. The corresponding M&E framework below outlines the link between and among the PPF inputs like training, PPIUD instruments and supportive supervision to the expected outputs and outcomes. In particular, it illustrates the desired results of setting-up a PPF-PPIUD at a facility:



Planners and facilities setting up PPF-PPIUD services are advised to identify performance indicators based on what objectives they want to achieve. When selecting indicators, the following criteria must also be considered:

- Validity:** Indicator measures what it purports to measure.
- Reliability:** Indicator can be measured consistently.

Timeliness: Indicator is current, available at a useful frequency and timely enough to influence management decision-making.

Precision: Indicator has a sufficient level of detail to permit management decision making

Integrity: Collection of indicator have safeguards to minimize the risk of transcription error or data manipulation,

Performance indicators for PPFPP-PPIUD are used to measure the improvement of FP services at the facility – the availability of FP choice and service providers at the facility. The acceptors for this particular service should be consistently recorded or captured at a prescribed logbook. The level of details of data collected warrants decisions pertaining cases of expulsion, for example, during follow-up visits. The recording of the number of acceptors also gives a trend of FP method use that is useful for planning purposes especially methods that may need commodities or skilled providers, like PPIUD.

5.2. SETTING UP A RECORDING AND REPORTING MECHANISM

While time consuming and sometimes costly, facilities are strongly encouraged to set up a simple M&E plan that is both suitable and achievable based on their available resources. An M&E system is after all meant to enhance delivery of services and should therefore be as straightforward and streamlined as possible. Ideally, recording for PPFPP-PPIUD services should be integrated in the information management system that the hospital already has in place to avoid the additional burden and confusion of using multiple registers. If none is in place, M&E tools may also be integrated in the supportive supervision tools (see Chapter 4.)

When setting up an M&E system, it is important to keep in mind that the mechanism for tracking PPFPP-PPIUD services is established throughout the continuum of care that pregnant women are receiving, from antenatal period, through labor and delivery and postpartum period. If possible little modifications in existing forms be done to encourage consistent, diligent and proper recording of providers. Recording of FP-related services should be consistently done during the following service points:

ANC. After counseling, provider should make notation in client's FP Form 1 whether client accepted family planning or not. They should also tick the preferred PPFPP method that mother chooses to have after birth.

Early labor. Still using FP Form 1, make notation if client has opted to use PPFPP and what method she has chosen to take. Provider may also make prominent notation on the top of the patients' medical record to ensure that other providers are informed of her decision.

Postpartum. If client has not yet been counseled, counsel client in PPFPP method and make appropriate notations in her FP Form 1. If client has already been counseled and chosen to use PPIUD, make sure that client has undergone initial and secondary screening for PPIUD. After the insertion of the IUD, the provider should make several notations in client's medical records, FP form 1, delivery or PPIUD insertion logbook/register. Documentation at this period is critical in tracking for any future problems or complications that the client may experience since the logbook/register may be consulted to identify factors that could have predicted or caused the problem.

In line with the integrating PPFPP/PPIUD with existing FP and MNCHN program requirement, facilities are advised to use or adapt prescribed reporting forms/tools, e.g. FP Form 1 to PPFPP-

PPIUD by making additional notations on the form. In addition, the globally tested consolidation logbooks for PPIUD insertions and follow-ups may also be introduced and may be modified accordingly for a monthly consolidation of all FP including PFP-PPIUD data of the facility.

5.3. PFP-PPIUD DATA STORAGE, ANALYSIS AND UTILIZATION

While recording and reporting are vital elements in the management of PFP-PPIUD data, equally important are the storage, analysis and utilization of these data sets.

Maintaining good quality records is critical to sustaining a successful PFP-PPIUD program because client selection criteria and insertion technique are directly related to expulsion rate and, thus, potentially, to overall program success. If it appears that a larger than expected number of clients is returning with partially or completely expelled IUDs, it is helpful to be able to review notations recorded at the time of insertion (e.g., findings from screenings, difficulties faced by the provider). Likewise, follow-up notations can also provide critical insights into both successful and problematic insertions. Either way, recordkeeping allows program managers and supervisors to assess provider insertion and client assessment practices and to determine whether changes are needed.

Data Storage

Ideally, the consolidation of PFP-PPIUD records/ register data is stored or filed together with other FP data. In the hospital sites with designated FP Clinics, the same clinic is designated as the record-keeper of all FP and PFP-PPIUD data – at all data points: OPD/ANC, Ward, Delivery Room (DR) and Operating Room (OR). However, in other facilities with no dedicated FP clinic and where FP is either integrated to ANC service at the OPD or OB, FP data for OPD shall be maintained and kept under the custody of the OPD head counselor or head nurse at the OPD. The DR/OR data shall go to the main records section after discharge of the patient.

The regional tertiary or DOH-retained hospitals may have a regional staff detailed to the hospitals as FP coordinator or coordinator of a DOH program at the facility. This person will automatically become the keeper of FP data at the facility.

Record keeping of FP data at the birthing facilities attached to a hospital will follow the existing protocol of the hospital. However, if the birthing facility is independent from other facility, then the DOH-prescribed Target Client List, Monthly/Quarterly and Annual consolidation forms, FP form 1 will be used as capture and consolidation tools. As mentioned in the earlier section, the PFP-PPIUD logbooks may be modified to adapt to the needs of the concerned facility.

Data Analysis and Utilization

For easier retrieval, consolidation, analysis and quality check/assurance, electronic filing is recommended. If electronic record keeping is not possible then facilities are advised to revert to manual consolidation of data. This however may pose challenges when retrieving and checking for data quality like duplication of entry.

The most common analysis is looking at the trend of FP method preference. Clarifying the story behind the results may lead to planning for a better performance or replication of good practice. Likewise these data sets may be used for projecting procurement of commodities and supplies.

5.4 Integrating PPFP into the Data Management System of the Facility

In lieu of the ISO accreditation of tertiary facilities with PPFP services, the integration of PPFP-PPIUD into the hospital/ health information management system of the facility is a step towards institutionalizing FP program, as well as other MNCHN services into the existing services of the facility, e.g. pharmacy, admissions, records, etc.

Below are some helpful tips in setting up a simple FP data management system for PPFP-PPIUD data:

Identify person-in-charge of data recording and reporting

Organize an orientation activity to orient and train staff on the recording and reporting tools to be used, including detailed steps on how to fill out the forms. Use this training activity as an opportunity to impart on providers the importance of recording data and data quality. The following tools, previously tested in PPFP-PPIUD sites in the Philippines can be used to track PPFP-PPIUD services in the facilities, and may actually be modified accordingly to accommodate all FP methods:

Integrate PPFP-PPIUD recording tool in existing registers already used by service providers. Ensure that PPFP and PPIUD services are immediately recorded after the client has received service whether in ANC, labor and delivery, and postpartum period. Doing so not only allows providers to develop diligent recording habits but also ensures that all aspects of the service, critical to program success, are well-documented and can be easily tracked.

Establish data collation schedule for monthly and quarterly reporting. Identify a person responsible for collating the data on a monthly or quarterly basis. Ideally, this person should be the FP coordinator. Otherwise, the person in charge of record keeping could be designated as keeper of data. Data should be organized according to the established recording and reporting mechanism.

Lastly, as much as possible, electronically file FP data for easier tracking, retrieval, data quality check and link up with other services of the facility.

A Simple Tool to Track PPFP and PPIUD Services at Region 1 Medical Center

“We use these improvised smiley stickers to keep track of the counseling services provided to our clients which they have either received during their antenatal visits or at pre-delivery,” shares Dr. Casimiro ‘Jun’ Bacugan, head of the Region 1 Medical Center’s (R1MC) Family Planning Unit in Dagupan City. Running on a lean staff of 2 dedicated FP counselors, Dr. Casimiro adds, “The ‘stickers’ allowed us to save up on time and maximize our limited personnel.”

After every counseling session, the FP counselors are instructed to stick a ‘smiley’ on the upper right corner of the patient’s medical record once they have expressed their desire to use an FP method. The smiley tracks the counseling services given to patients. Upon seeing the sticker, the provider will simply proceed in giving the appropriate care. Additionally, PPIUD acceptors during antenatal and pre-delivery care also sign a consent form that is attached to their record and also noted on their birthing plans. This mechanism has been effective in ensuring that there is no duplication of services. Moreover it also guarantees that clients are satisfactorily provided with care they need which is especially critical for postpartum clients who’ve previously accepted a PPFP method during ANC or pre-delivery care.

Initially conceptualized as a means to improve demand for PFP and PPIUD services at R1MC, the tool has become an important mechanism to keep the PFP services synchronized at all points of care. It keeps providers stationed at the OB unit abreast with FP services received during ANC and/or pre-delivery. "At that moment, there were only two of us trained to counsel for PFP, Nurse Rowena Abulencia and myself. We didn't want that to be an obstacle in reaching out to as many mothers as possible so we came up with this idea. A smiley sticker is placed on the patient's record to indicate if she has accepted an FP method. Once we see the sticker on the patient's record, we just reinforce her decision and then proceed to counseling the next patient that way we can provide counseling to more mothers during one shift."

Good quality counseling is critical, not only in generating demand for services, but also in ensuring good continuation rates among PFP-PPIUD users. More so for PPIUD, given the many misconceptions and myths surrounding its use and efficacy. Counseling is the opportunity to clarify these misconceptions and reinforce the benefits of long acting reversible FP methods to potential users and new acceptors. Timely and diligent PFP counseling at all points of care in R1MC has increased uptake of PFP method among women delivering at the facility.

But other than, this tool improving the demand for PFP and PPIUD services, the tool demonstrates an effective, systematic and low cost way of tracking PFP services in the facility. It also facilitates an integrative approach to delivering FP services that is synchronized with the existing MCH service delivery structure of the facility. Monitoring services is critical in documenting progress and mobilizing support and resources for the sustainable implementation of the program in the facility.

Chapter 6: Available PFP-PPIUD Resources

This section enumerates a number of resources that planners may consult in scaling-up PFP and PPIUD services in their facilities and respective communities. The resources enlisted in this section while not exhaustive hopes to provide planners with useful materials that can aide in planning, conducting, designing and implementing PFP-PPIUD program.

PPIUD Services Reference Manual for Providers and Learner’s Handbook (Jhpiego, 2010. Jhpiego: Maryland, USA)

These learning materials offer information, knowledge and tips that help prepare MNCH providers, health educators and counselors, to deliver high-quality PPIUD services to their clients, as part of a comprehensive PFP program. The Reference Manual and Learner’s Handbook are invaluable resources that aid learners in acquiring competency in delivering PFP and PPIUD services which may used to train providers.

PFP-PPIUD Supplement to Clinical Standards Manual (Philippines, Department of Health. 2013. DOH: Manila)

The PFP-PPIUD Supplement to the Philippines Clinical Standards Manual on Family Planning is a supplemental guideline designed to augment the current edition of the Philippine Clinical Standards Manual on Family Planning. It contains updated information on different family planning methods that can be used in the postpartum period including timing of initiation, attributes, risks and benefits.

Department of Health Administrative Order (A.O.) 2012-2009 or “National Strategy Towards Reducing Unmet Need for Modern Family Planning as a Means to Achieving MDGS on Maternal Health”

This AO outlines the government’s commitment and comprehensive approach to fill in the gaps in access to modern FP services as a strategic thrust in reducing the maternal mortality and infant mortality rate by 2015. Facilities and program managers planning on initiating PFP-PPIUD scale up in their communities may use this to leverage support from local government, healthcare providers and other key stakeholders in the community. This document is also useful in breaking perceived cultural barriers on family planning as this demonstrates the national commitment to make modern FP methods available to the mothers who need it the most.

Supportive Supervision Guidelines

This supportive supervision guideline complies major steps and components in conducting, planning and implementing supportive supervision for PFP-PPIUD services. It provides supervisors with key tools that help supervisors maximize the outcome of supportive supervision for PFP-PPIUD.

Advocacy Toolkit Package for PFP And PPIUD

The advocacy toolkit package is provides program managers, PFP implementers and other FP stakeholders with advocacy materials that will help encourage the scale up of PFP-PPIUD program in their communities. Intended for the use of multiple audiences, the materials present the evidence-based data on PPIUD and other LARCS, effective and integrated PFP programming strategies. The contents of the toolkit include: (a) on overview of Philippines health system, its policies in FP, country-specific need and opportunity for PFP; (b) a brief for

academic audiences addressing the technical concerns regarding the safety and efficacy of PPIUDs and other LARCS; (c) brief for health providers responding to the training and program implementation concerns including PPFPP integration opportunities; and (c) brief for local health officials describing the logistical and budgetary aspects of the scale up including the impact of PPFPP program on municipal and provincial health outcomes.

Documenting 20 Years of Experience in PPIUD services at Dr. Jose Fabella Memorial Hospital

This documentation study presents lessons learned by DJFMH in PPIUD implementation can provide facilities planning to scale up PPFPP-PPIUD services with valuable insights and best practices that have helped Fabella in mainstreaming PPFPP services in their hospital.

Programming Strategies for Postpartum Family Planning

The “Programming strategies for postpartum family planning” is an invaluable resource for program planners, managers and facilities intending to scale up PPFPP-PPIUD services in their communities. It presents program case examples, and suggested activities that can aide programmers in designing interventions to integrate PPFPP into existing national and subnational strategies in their respective settings.

PPFP-PPIUD Job Aids

These job aids will include posters on counseling messages during ANC, early labor and postpartum period. Posters on available range of PPFPP options, flip chart on critical steps for PPIUD insertion and patient reminder cards.

Centers of Excellence (COEs) for PPFPP/PPIUD

The COEs provide comprehensive resources for the service delivery and training of PPFPP/PPIUD services. MCHIP defines a COE for PPFPP-PPIUD as a facility that has: (1) the training capacity or team of proficient trainers for PPFPP-PPIUD, (2) established a working relationship with DOHROs to conduct supportive supervision for PPFPP-PPIUD, (3) fulfill all the components for the delivery of quality PPFPP-PPIUD services from counseling, insertion, support, to follow-up care, (4), a staffed labor and delivery unit that allows trainees to get hands-on practical experience, (5) favorable administrative support for PPFPP-PPIUD services, (5) and when feasible the capacity to lobby for policies in support of the delivery of PPFPP-

The nine COEs are:

Luzon

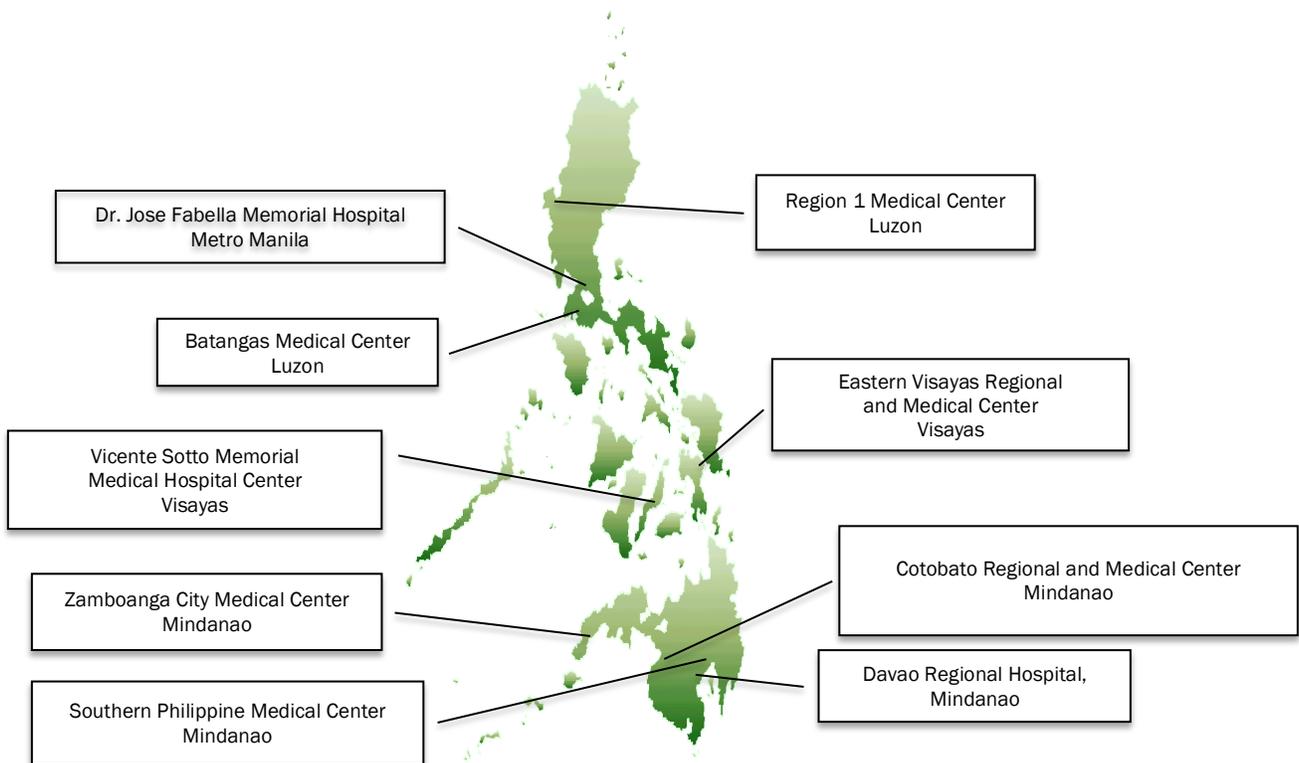
- Region 1 Medical Center in Dagupan, Pangasinan
- Dr. Jose Fabella Memorial Hospital, Metro Manila
- Batangas Medical Center Batangas

Visayas

- Eastern Visayas Regional Medical Center, Tacloban, Leyte
- Vicente Sotto Memorial Hospital, Cebu City

Mindanao

- Cotabato Regional Medical Center, Cotabato City
- Zamboanga City Medical Center, Zamboanga City
- Davao Regional Hospital, Tagum City
- Southern Philippines Medical Center, Davao City



Chapter 7: Setting up a Center of Excellence

As an alternative to conventional capacity building/training programs, MCHIP undertook developing nine COEs across the country mandated to provide comprehensive resources for the delivery and training of PPFPP-PPIUD services on the regional level. Spread out across eight regions from Luzon to Mindanao and identified as key players in the service delivery network for MCH services, COEs function as critical training and service delivery for PPFPP-PPIUD services.

The COEs have been and continue to be instrumental in the adoption and expansion of PPFPP-PPIUD services across the country. Through the COEs, effective competency-based trainings were rolled out to FP providers across the nine project sites and respective catchment areas. Thus, effectively building the capacity for PPFPP-PPIUD services of highly motivated providers in respective hospitals and sites, increasing awareness for benefits of PPFPP while mobilizing support for PPFPP-PPIUD services on the regional and provincial levels.

With the assistance of DOH, nine level 3 and 4 DOH-retained regional facilities were selected to become COEs (see previous chapter). As previously mentioned, these hospitals have established linkage with both DOH central office and DOHRO in their respective regions from whom they receive technical monitoring, support and supervision. The catchment areas of the 9 facilities cover the provinces within the regions where these facilities are providing coverage to a total of 31 provinces and 27 cities and 1 municipality in the National Capital Region.

The steps outlined below are culled out from the MCHIP's experience in developing the nine COE in the country. And are as follows:

1. Undertake CST for PPFPP/PPIUD for service providers. The goals of the clinical skills training are to:
 - develop a core team of subject matter experts in PPFPP/PPIUD;
 - standardize the knowledge, skills, and attitudes of participants in the provision of safe and effective postpartum IUD services;
 - identify and develop champions;
 - prepare participants to start and sustain PPFPP/PPIUD at their workplace;
 - and motivate the learners to develop a competency level that allows them to effectively teach and transfer the skills to other motivated providers

The key areas covered during the training include:

- counseling women/ couples about PPFPP and PPIUD as a contraceptive method;
- screening women to ensure that they do not have any characteristics or conditions that would make IUD an unsuitable option for them;
- inserting the IUD in different postpartum scenarios, while incorporating appropriate infection prevention practices;
- managing side effects and other potential problems associated with the use of IUDs;
- advocating for PPFPP-PPIUD services; and
- facilitating start-up and sustaining PPFPP/PPIUD services at the participants' workplace.

The training course is a competency-based course using various participatory training methodologies, such as illustrated lecture and group discussion, group exercises, role plays, case studies, demonstrations, practice on models, quizzes, and question and answer sessions. MCHIP developed 120 competent clinical skills providers for PFP/PPIUD against the target of 120 through the following trainings.

2. *Set up PFP/PPIUD services.* Immediately upon returning to their facilities the providers were engaged in initiating services at their respective sites with support from MCHIP and their hospital administration and management. Once the providers have attended the clinical skills course, if not certified during the clinical skills course, their first priority is to practice and get certified as a clinical provider. The certification was done during supportive supervision visits from MCHIP.

To set up services, the providers in collaboration with the hospital management will facilitate:

- organize whole site orientation to build awareness for PFP-PPIUD concepts
 - availability of instruments and supplies for PFP;
 - integration of services throughout the continuum of care including adherence to infection prevention protocols;
 - the establishment of a reporting and recording system for PFP/PPIUD;
 - scheduling and arranging supportive supervision sessions to monitor the PFP-PPIUD program using a performance indicator checklist;
 - provide an area for counseling that respects the client's privacy
 - if possible, set up a dedicated area for PPIUD insertion;
 - and if feasible, draft a Memorandum of Agreement for the establishment of PFP-PPIUD services in the facility.
3. *Supportive Supervision visits to the sites.* All sites received supportive supervision visits from MCHIP. The supportive supervision visits focused on evaluation of:
 - health worker competence in PFP counseling and service provision;
 - provider competence in PPIUD insertion;
 - adherence to infection prevention protocols;
 - and adherence to principles of ICV.

During SS visits M&E data are also reviewed to set goals and objectives. This provides an avenue to objectively assess the readiness of the trainees to pass on their newly acquired knowledge and skills to other potential service providers as trainers. Likewise, these visits were utilized to advocate and mobilize support from hospital administration and DOHROs.

All the SS visits have benefited the COE and the program. Two cases in point: Zamboanga began to have an output of PPIUD service only after the first SS was done. Prior to the SS, the two trained service providers did not have the confidence to offer the PPIUD. After the

SS, when providers had a chance to perform insertions on actual clients supervised by the SS team and a department wide orientation was completed, the Zamboanga team started to report significant increases in the number of serviced clients. The boosted confidence of the Zamboanga team was likely facilitated by the extra practicum in the training. The same happened with the EVRMC team.

4. *Training of Trainers.* The Training of Trainers prepares competent clinical trainers to conduct competency based clinical skills courses for service providers of PPFPP/PPIUD. The Training of Trainers for PPFPP/PPIUD was delivered in three phases:

Jhpiego's ModCal for training skills delivered through self-paced computer course;

a four-day group based session;

and, a mentored practicum at one of the hospitals or facilities where the participants are trained to manage a clinical skills training course for service providers. The selected candidates for training of trainers were proficient PPFPP/PPIUD service providers from MCHIP COE and had at least completed the Family Planning Competency Based Training series, a standard comprehensive family planning course for providers in the Philippines.

5. *Supportive Supervision Workshop.* The purpose of the Supportive Supervision workshop is to provide the supervisors guidelines and tools for conducting post-training and on-going supportive supervision visits to PPFPP/PPIUD facilities. The supervisors' workshop was targeted mainly for the RHO personnel to provide them limited clinical and supervisory skills to help them to effectively provide supervision and oversight to the hospitals.

Supportive Supervision guidelines developed by MCHIP were also introduced through this supportive supervision workshop. The guidelines encourage supervisors to observe and assess counseling, infection prevention practices, provider competency and motivation, and record keeping. Guidance on logistical pieces such as timing, personnel responsible, preparation, and organization of the visit is also included. The tools available in the guidelines are as follows:

- Outline, agenda, and schedule for supportive supervision workshop;
- Steps on processing instruments and other items used in PPFPP/PPIUD services;
- Action plan template for strengthening PPFPP/PPIUD services;
- Certification sample;
- Course evaluation sample for supportive supervision;
- Supportive supervision checklist for PPFPP/PPIUD service provision; vii) Supportive supervision tracking sheet; and viii) Supportive Supervision activity checklist.

6. *Assessments.* The PPFPP/PPIUD standard for service provision was introduced to the MCHIP COE during the first clinical service training for PPFPP/PPIUD in Manila. The sites scored themselves based on their performance relative to the standard, which was considered the baseline. A midline assessment was conducted in August 2013 with broad objectives of:

- sharing experiences, learning, challenges and best practices of the different sites;
- validating data and accomplishments;

- linking up sites to the USAID regional projects;
- and identifying the next steps that will ensure the PFP/PPIUD program is sustained for the longer term.

COEs as invaluable resource for implementing and expanding PFP-PPIUD services

The COEs have great potential to be developed as a pivotal channels in scaling-up PFP-PPIUD services. With MCHIP assistance, the COEs have been capacitated as key technical resource in their community and benchmark for facilities planning to provide the PFP-PPIUD services. They become the PFP-PPIUD program experts and master trainers with the capacity to oversee the quality of PFP-PPIUD service provision in their communities.

Likewise, the COEs also serve as platforms for research in PFP-PPIUD and have assumed a catalytic role in the adoption and propagation of the PFP/PPIUD program. Cases in point: Vicente Sotto provides technical supports training in PFP/PPIUD initiated by the DOHROs in Cebu and the same goes for R1MC, BatMC, CRMC, EVRMC, DRH and ZCMC in their respective regions. There is a clamor for training and in fact the idea of replicating the COEs in other DOH retained hospitals is being floated around both in the DOH and the regional projects.

As tertiary facilities, the COEs receive cases that cannot be handled at the lower level facilities. The COEs are the referral facilities for consultation on cases of PFP-PPIUD clients that lower level facilities are unable to provide to. The doctors have more cases at the COEs as well as the clinical training to attend to these cases as compared to the basic training of the providers at the birthing facilities. With this in place, there is also a boost of confidence of the providers at the lower level facilities.

On the other hand, the follow-up visits of PPIUD clients at the COEs may also be downloaded to the lower-level facilities more physically accessible to these clients.

With the leadership of the DOHRO in setting-up the necessary protocols, policies and management systems (e.g. M&E, training/ human resource development, financing, planning, etc.) in place, a service delivery network for PFP-PPIUD services can be enhanced. To illustrate, while the COE has training capacity on PFP-PPIUD they are also providing the same services in their hospitals. If the COEs will act in the capacity as technical resource a set of corresponding policies and guidelines need to be established. The guidelines will specify who, when, where and how the COEs will respond to requests for training, TOT or even technical assistance. This will also guide the planning department of the COEs, as well the requesting agencies, i.e. LGUs for the lower level or devolved facilities.

Meanwhile, DOHRO support plays a very vital role in the adoption and implementation of PFP-PPIUD in other facilities within the region, especially in training more providers. The DOHRO will act in the capacity of the planning, funding and coordinating the training activities as well as monitoring of trained providers. This includes the certification for competency of skilled PFP-PPIUD since the COEs neither have the capacity nor resources to handle PFP-PPIUD region-wide training / scale-up program. This means that scaling up PFP-PPIUD within the COE is still dependent on the capacity and support of the DOHROs.

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Materials	Quantity needed
Blue buckets	2
Green buckets	2
Garbage bins	2
4. Infection prevention materials for demo station (1)	
Drawing of a tap	1
Soap	1
Towel	1
Sterile gloves	1 pair
Chlorine bleach solution (500 ml bottle)	1
Red buckets	1
Blue buckets	1
Green buckets	1
Garbage bins	1
Toothbrush	1
Goggles	1
Plastic apron	1
Surgical caps	1
Mask	1
Shoe cover	1
5. Counseling materials for demo station (1)	
Small tray	1
FP flipchart	1
condoms	1
Depo provera	1
Implants	1
Pills	1
IUD	1
6. Exercise Sheets	Dependent on participants
PPIUD Pretest	
PPIUD Midcourse Test	
PPIUD Course Evaluation	
Exercise Sheets (Exercise 2)	
Exercise Sheets (Exercise 3)	
Exercise Sheets (Exercise 4)	
Clinical Skills Tracking Sheet	
Performance Standards	
7. PPIUD kit	At least 2 per facility
Kidney basin	
Kelly placental forceps	
Ovum forceps	
Sims speculum	
7. Others	
LCD	1
Laptop	2

Materials	Quantity needed
Printer	1
Prizes (chocolates)	
PPIUD video	1
Extension cord	1
Tarp – welcome banner	1
Certificate of participation	Depending on the participants
Flipchart paper	5 rolls
Meta cards	
Name tents	
Masking tape	3
Bond paper	1 ream
Post its	
Markers	20
Notebooks	depending on participants
Ballpens	1 box
Eco Bags	Depending on participants
Trash bags(black, yellow, green)	
MEC Wheels	Depending on participants