

Readiness assessment of health facilities for providing postpartum family planning services after project-based scale-up activities ended – A study from Pakistan

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Objective: To analyze readiness assessment of health facilities for providing postpartum family planning services after project-based scale-up activities ended.

Methodology: A mixed-method research design was used and using an audit tool, postpartum family planning readiness to perform specific functions was assessed through descriptive analysis and comparisons were made within the facilities. In-depth, interviews were conducted with the service providers in the facilities.

Results: The postpartum family planning readiness was poor owing to budgetary constraints of public health facilities and limited supply of postpartum specific contraceptive methods, resulting in limited utilization of services.

The pilot project may have delivered positive results, the scale-up was limited and the interventions were not sustained once the donor support ended.

Conclusion: Addressing the gaps through regular monitoring, improving supply chains, supervision and refresher training is important to improve readiness specific to postpartum family planning. There is a need for more clear and comprehensive planning for scaling-up pilot projects especially in Pakistan where resource constraints overall affect the sustainability of any donor-supported activities. (Rawal Med J 202;46:982-986).

Keywords: Health facility assessment Scale-up, pilot project, sustainability.

INTRODUCTION

With a 208 million population, Pakistan stands as the world's fifth-most populous country in the world.¹ This population will increase to 227 million by 2025 if the current growth rate of 2.4% remains unchanged. Rapid population growth, stagnant contraceptive prevalence, high unmet need for family planning (17%), 4 million unintended pregnancies and 2.2 million abortions annually present significant challenges for Pakistan.^{2,3} Although there are encouraging signs, such as a more responsive policy environment with demonstrated political and financial commitment but the task that lies ahead is still huge.⁴ Postpartum Family Planning (PPFP), which aims to prevent the high risk of unintended and closely spaced pregnancies during the first year following childbirth, is one of the highest impact interventions to avoid an increased risk of premature birth, low birth weight, fetal and neonatal death, and adverse maternal health outcomes.⁵

Scaling up family planning interventions can "prevent one-third of maternal deaths by allowing women to delay motherhood, avoid unintended pregnancies and subsequent abortions".⁶ In many cases, countries that are trying to reach the major expansion in access to care are also the countries where current health facilities and district management practices are weakest. Examples abound of equipment failure, medicine stock out, fragmented and unreliable information system and un-motivated staff.⁷ A similar situation deals in Pakistan where the public level district health system gives a bleak picture. The Ministry of Health (MoH) in Pakistan has implemented innumerable donor-funded projects, particularly during the last decade but every time a project concludes, concerns about its sustainability are raised.⁸

METHODOLOGY

Data were collected from four district headquarter hospitals (DHQH) which included Mandi

Bahauddin (MB) in which the pilot project was implemented and similar hospitals of Sargodha, Dera Ghazi Khan (DG Khan) and Gujranwala in which the scale-up was done. All four districts were selected from Punjab province where the demand for family planning was highest (54%) and PFP counseling was lowest (10%) as compared to other provinces.²

For this study, we used 1) A Health facility audit tool to assess facility accessibility and readiness to provide care concerning infrastructure, medicines, and supplies/equipment, adapted from instruments previously utilized for health facility assessments carried out in Pakistan which were derived from the Service Assessment and Readiness Assessment tool.⁹ 2) PFP readiness assessment tool adapted from an instrument previously developed through USAID-funded Maternal and Child Health Integrated Program (MCHIP) surveys, which have been implemented in numerous locations globally as well as in Pakistan. 3) In-depth interviews using an open-ended guide to get in-depth information from the health care providers regarding their perspective about the project.

After pilot testing the tools in December 2017, we conducted the facility audit focused on the infrastructure, utilities, furniture, medical equipment, and contraceptives available as well as information on the human resources. This was followed by qualitative data collection. Data collection took place in January to April 2018 in all four districts. Data were collected in the field on paper-based forms.

Statistical Analysis: The raw data were entered to excel and then necessary checks were put in to ensure minimal data entry errors. Once entered, data cleaning was carried out followed by descriptive analysis. For qualitative data four health care providers from the facilities were interviewed to understand their views about the project they delivered in their respective districts. Thematic content analysis was done using NVIVO software.

RESULTS

Health Facility Readiness Assessment: The readiness of selected health facilities was assessed through two indices of general facility readiness including amenities and family planning readiness.

General Facility Readiness: All the basic amenities were available in all the four facilities. All had an electricity connection backed up by a functional generator. A dedicated mobile was available in all facilities. All the facilities were open for 24/7 and emergency transport vehicle was also available.

Family Planning Facility Readiness: In the facilities trained staff was available to provide family planning services. Two certified trained providers were offering PFP services in the facilities. Counseling for all types of family planning clients was normally referred to these units; this also includes mothers who are coming for antenatal care visits, postpartum clients and regular family planning clients. It was found that separate space along with a private area for counseling was available in all the facilities (Table 1).

Table 1. Client's privacy.

	Pilot	Scale-up		
	MB	Sargodha	Gujranwala	DG Khan
Are FP services provided in a separate room with a door	Yes	Yes	Yes	Yes
Waiting area available	Yes	Yes	Yes	Yes
Private area with seating available	Yes	Yes	No	Yes
Separate space for individual counseling	Yes	Yes	Yes	Yes
Separate toilet available	Yes	Yes	Yes	Yes
Toilet has functioning running water and electricity	Yes	Yes	Yes	Yes

Table 2. Availability of IEC materials and national guidelines.

Materials availability	Pilot	Scale-up		
	MB	Sargodha	Gujranwala	DG Khan
National FP Guidelines	Yes	Yes	Yes	Yes
Brochure for IUD	Yes	Yes	Yes	Yes
Brochure for Pills	Yes	Yes	Yes	Yes
Brochure for Condom	Yes	Yes	Yes	Yes
Brochure for TL	Yes	No	Yes	No
Brochure for Vasectomy	Yes	Yes	Yes	No
Brochure for Postpartum FP methods	Yes	Yes	Yes	Yes
Brochure for Injectable	Yes	Yes	Yes	Yes
A list with all fees and possible exemptions	No	Yes	Yes	No

Table 3. Equipment availability for FP services across the four districts.

Equipment	Pilot	Scale-up		
	MB	Sargodha	Gujranwala	DG Khan
Hand washing stations	Yes	Yes	Yes	Yes
Disinfectants	Yes	Yes	Yes	Yes
Boiler / Autoclave	Yes	Yes	Yes	Yes
Plastic bucket with a lid for chlorine solution	Yes	Yes	Yes	Yes
A puncture-resistant container for sharps disposal	Yes	Yes	Yes	Yes
Bucket for soiled pads and swabs	Yes	Yes	Yes	Yes
Spare IUD insertion/removal kits or sterile packages or metal containers	Yes	Yes	Yes	Yes

Table 4. Availability and functional instruments across the four districts.

Instruments	Pilot	Scale-up		
	MB	Sargodha	Gujranwala	DG Khan
Flashlight	Yes	Yes	Yes	Yes
Working lamp	Yes	Yes	Yes	Yes
Scale	Yes	Yes	Yes	Yes
Blood pressure gauge	Yes	Yes	Yes	Yes
Thermometer	Yes	Yes	Yes	Yes
Stethoscope	Yes	Yes	Yes	Yes
Scissors	Yes	Yes	Yes	Yes
Sterile needles and syringes	Yes	Yes	Yes	Yes
Specula	Yes	Yes	Yes	Yes
Tenacula	No	Yes	Yes	No
Uterine sound	Yes	Yes	Yes	Yes
Alligator forceps	Yes	Yes	Yes	Yes
Sponge holding forceps	Yes	Yes	Yes	Yes
Artery forceps	Yes	Yes	Yes	Yes
Dressing forceps	Yes	Yes	Yes	Yes
Tissue forceps	Yes	Yes	Yes	Yes

Instruments	Pilot	Scale-up		
	MB	Sargodha	Gujranwala	DG Khan
Mosquito forceps	Yes	Yes	Yes	Yes
Intestinal forceps	Yes	Yes	Yes	Yes
Babcock forceps	Yes	Yes	Yes	Yes
NSV ringed forceps	No	Yes	Yes	Yes
Scalpels	Yes	Yes	Yes	Yes
Sutures	Yes	Yes	Yes	Yes
Needle holder	Yes	Yes	Yes	Yes
Retractor	Yes	Yes	Yes	Yes
Tubal hook	Yes	Yes	Yes	Yes
Sharp trocars	Yes	Yes	Yes	Yes
Sterilizers	Yes	Yes	Yes	Yes
Iodine	Yes	Yes	Yes	Yes
Xylocaine or	Yes	Yes	Yes	Yes
Antiseptic	Yes	Yes	Yes	Yes
Chlorine solution	Yes	Yes	Yes	Yes
Sterile gloves	Yes	Yes	Yes	Yes
Disposal containers for contaminated waste/supplies	Yes	Yes	Yes	Yes
Sharps containers for used sharps	Yes	Yes	Yes	Yes
Plastic buckets or containers for decontamination	Yes	Yes	Yes	Yes
Clean instrument containers	Yes	Yes	Yes	Yes
Instrument trays	Yes	Yes	Yes	Yes
Swab containers with sterile swabs or sterile	Yes	Yes	Yes	Yes
Examination couch or table	Yes	Yes	Yes	Yes
Examination table capable of Trendelenburg	Yes	Yes	Yes	Yes
Operation theatre	Yes	Yes	Yes	Yes
Recovery room	Yes	Yes	Yes	Yes
Procedure area for IUD, injectables or NORPLANT	Yes	Yes	Yes	Yes

The supply of contraceptive measures and the free of cost services were motivating factors for most of the people who were visiting the facility but to add that continuous supply was only available till active monitoring was being carried out by the Jhpiego team. Availability of IEC materials and national guidelines are shown in Table 2. Equipment availability for FP services across the four districts are shown in Table 3. Availability and functional instruments across the four districts is shown in Table 4.

DISCUSSION

Many policies and programmed interventions have

been implemented by governments and donor agencies to increase uptake of modern contraceptives. Yet low and middle-income countries continue to experience high rates of unmet need, non-use and discontinuation due to several factors, including persistent stock-outs.¹⁰ Many women of reproductive age want to avoid or postpone pregnancy but are not able to use any family planning methods. These women face an unmet need for FP.¹⁰

The traditional approach of waiting to discuss and provide contraception until the 4–8-week postpartum visit may be late.¹¹ Furthermore, to have an effective and efficient, supply chain system a

strong political commitment from governments is needed with the active involvement of all stakeholders, adequate financial and manpower resources, appropriate quality and quantity of supplies and effective logistics management. By working on these elements, more women will have the ability to access appropriate modern contraception.¹²

A study from Congo also indicated that for effective PPF services health organizations need to ensure the availability of competent staff and contraceptive supplies.¹³ The waste associated with piloting unsustainable interventions can be avoided. It may be that affordable interventions produce less remarkable results during the pilot phase, but being able to scale up more modest, affordable interventions will make a larger health impact than will small pilots that yield large health benefits for a short time only.⁴ Once the pilot is scaled, the goal is to sustain the intervention so that benefits proven at a small scale can yield measurable health impact.¹⁵

CONCLUSION

None of the facilities was found to be completely ready for PPF/FP services due to deficient supply. However, for Mandi Bahauddin we can state that it was partially ready as only one type of method was absent while for Sargodha, Gujranwala and DG Khan we can state that although they may be ready generally but for PPF/FP, they are not ready. Deficient supply indicates a missed opportunity for the family planning clients utilizing the services.

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