Maternal Health Initiative & Savana Signatures

Final Report – Contraceptive Counselling Project

June - December 2023

Executive Summary

- In this project, the Maternal Health Initiative (MHI) and Savana Signatures worked together to implement a programme aiming to increase contraceptive knowledge and uptake. This program focused on training nurses and midwives on delivering an adjusted model of contraceptive counselling integrated into routine postpartum appointments.
- This was a pilot project in which we aimed to compare the value of one-to-one family planning counselling during routine postnatal care sessions (PNC) against the value of short messaging and family planning referral integrated into child welfare clinic sessions (CWC)
- Data from the project suggests that while there were small increases in knowledge and intention to use, reported use of contraceptives declined between baseline and endline surveying. We believe issues with the wording and timing of surveying may be responsible for this reported decline in contraceptive uptake.
- Implementation quality was sufficient to suggest that these programs were not as impactful as hoped. While we are continuing to investigate why these projects may have failed to achieve the desired impact, we conclude that neither project is worth further implementation or scaling at this time.

Overview

Context

A 2021 Ministry of Health Report indicated that the Savannah Region has the lowest family planning uptake in Ghana, with an acceptor rate of just 21%. Meanwhile, over recent years in the Northern Region, there has been a declining family planning acceptor rate (2018: 31.4%; 2020: 28.2%; 2022: 25.5%), leaving it short of the National target of 40%, and behind other nearby regions (e.g. North East was 35% in 2022). One potential barrier to higher rates of family planning is insufficiently good quality counselling, with women not being adequately informed about potential side effects (Rominski et al, 2017), and low levels of shared decision-making (Advani et al, 2023).

MHI's aims and general approach

MHI is aiming to increase the use of family planning by providing high-quality training to frontline staff involved in providing Post-Natal Care (PNC) and delivering Child Welfare Clinics (CWCs). Our training focused on testing two targeted intervention packages aimed at maximising the quality of information women receive around family planning. As part of the training, providers were given materials and guidance on a system they could take back to their facilities and use when engaging with clients.

Program Design

Introduction

This project aimed to test the value of individual PNC family planning counselling with the value of incorporating family planning counselling into CWC immunisation. As such, two separate training sessions were run, one focused on PNC and the other on CWC.

For the PNC session, 23 staff attended from 3 facilities in the Savannah Region (Bole, Salaga, and Buipe). For the CWC session, 24 staff attended from 3 facilities in the Northern Region (Tolon, Savelugu, Tamale Central).

Discussions with the Northern and Savannah Regional Health Directorates were held through June and July 2023, resulting in approvals for the project. Programming materials were designed by MHI's team in collaboration with their network of international advisors, with consistent input and collaboration from the Savana Signatures team.

The training facilitator, Madam Hikimatu, leads a session and demonstrates the use of the PNC counselling tool.

Training sessions ran in August 2023 and were facilitated by Sulemana Hikimatu (Senior Health Tutor and Public Health Nurse at Community Health Nurses Training School (CHNTC) -Tamale).

Sessions were delivered via lectures and interactive components, including role-play in pairs. For both sessions, the goal of this training was to improve the quality of information shared by providers of family planning counselling, so women can make informed decisions and go on to have happier and healthier futures.

Training included information on the benefits of family planning, how to respond to common concerns and misconceptions, principles of effective counselling, and management of side effects. Each training then focused on explaining the counselling materials provided to attendees, tailored either to PNC or CWC care. An explanation of the materials for each intervention arm, and their intended use at the facility, is provided below.

Evidence

The two programming strategies outlined below were selected based on an extensive review of the evidence supporting different approaches to increasing contraceptive knowledge and uptake. Both approaches are supported by numerous randomised control trials (RCTs).

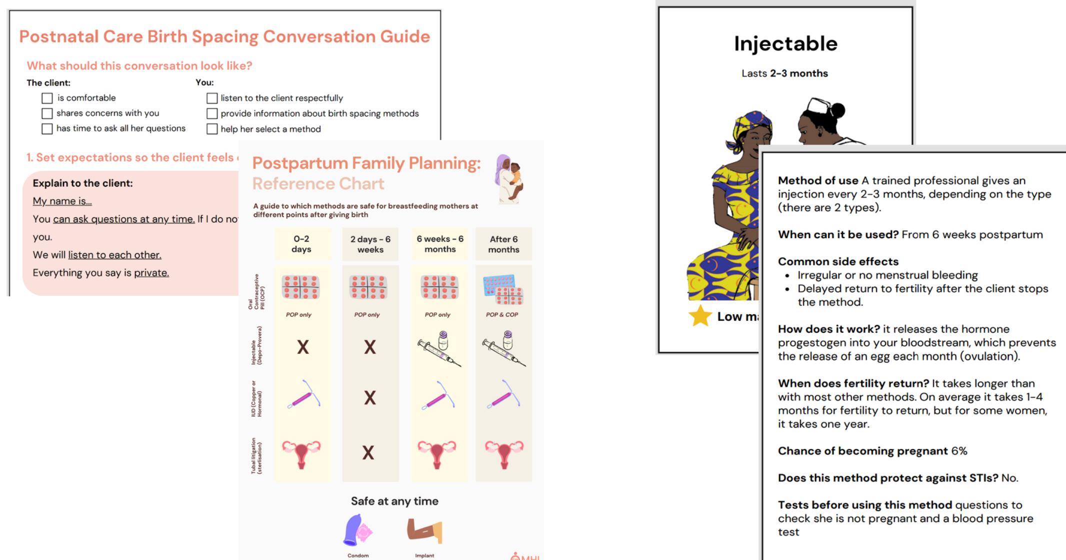
A study by Asah-Opoku et al (2023) in Accra concluded that one-to-one counselling as part of routine postnatal care sessions (PNC) was associated with a significantly greater uptake of contraception during the postpartum period compared to counselling between one provider and a group of clients. Further evidence for the effectiveness of integrating family planning into early postpartum care is presented in this High Impact Practices report.

Meanwhile, Dulli et al (2016) found that incorporating family planning services into routine child welfare clinic sessions as part of immunisation provision resulted in significantly increased postpartum contraceptive use. Positive outcomes have also been reported in Egypt (Ahmed et al, 2013), Malawi (Cooper et al, 2020), and Liberia (Cooper et al 2015).

Intervention Arm 1: Postnatal Care (PNC)

Providers at the PNC session were given a counselling guide, method cards, and a method information booklet. The focus of this intervention is to increase the frequency with which family planning counselling is included in 1:1 counselling sessions.

To guide healthcare workers through a streamlined process of counselling, we provided them with a counselling guide specifically targeted at the postnatal period. This includes guidance on the safety of different methods at different stages after birth. Method cards were also provided to healthcare workers to ensure that counselling was interactive and client-centred. Finally, each training attendee was given a method information booklet with an extensive explanation of family planning methods as a reference material for further learning and reinforcing the knowledge that they gained.



Samples of the conversation guide, method information booklet, and methods cards

Intervention Arm 2: Child Welfare Clinics (CWC)

At the CWC session, providers were given a group talk flipchart, 1:1 'pregnancy risk' cards, and referral cards for directing people to the Family Planning Unit. The intervention is designed to consist of two key components:

Group talk

Providers offer a group talk on family planning to women waiting for their child to be immunised following the flipchart. This group talk emphasises the range of methods available to clients, how to safely take methods and manage their side effects, and the benefits of receiving family planning counselling while at the facility.

1:1 interaction

While healthcare workers are providing any immunisations to the client's child, they are encouraged to engage clients in a very short 1:1 family planning counselling using the 'pregnancy risk card'.

For clients interested in taking up a family planning method, the provider offers them a referral card to encourage them to visit the Family Planning Unit and highlight to the health workers at the unit that the client has already received some family planning counselling.

Samples of the counselling flipchart, pregnancy risk card, and referral cards

Results

Intervention Arm 1: Postnatal Care (PNC)

Summary

Across the three facilities (Salaga; Bole; Buipe) in the Savannah region, there was generally strong implementation of care in line with the training. Changes to care resulted in minor to moderate increases in four out of five knowledge metrics measured. There was an average 2% increase in intention to take up a method of contraception across the facilities, though a 5% decrease in modern contraceptive uptake.

We believe the decrease in uptake is likely due to an unclear wording of the surveying question that led to much higher rates of reported contraceptive use at baseline and endline than regional or national averages. Results may also have been affected by the surveying of clients immediately upon their exit from the facility, along with high rates of reported sexual abstinence.

Quality of Implementation

Prevalence of one-to-one family planning counselling at PNC went from 18% at baseline to 76% at midline to 61% at endline. The reason for the drop between midline and endline is unclear, though the most likely cause is simply the passage of time since the training.

Material use at endline was high, with 75% reporting method card use (dropping from 92% at midline) and 57% reporting seeing the counselling guide (from 62% at midline).

Implementation of the PNC arm of the mini-pilot was the strongest of the arms, with MHI/Savana staff consistently reporting high uptake from providers as well as strong signs that the program was being consistently implemented; for example, at one midline facility visit, MHI staff reported that the materials at the facility were well-used, suggesting consistent use beyond surveying days.

Prevalence of one-to-one counselling measured at each of the three facilities:

	Buipe	Salaga	contr
Baseline	17%	64%	7%
Midline	64%	95%	69%
Endline	38%	78%	81%

In terms of counselling quality, clients at endline surveying reported 70-95% satisfaction across the counselling quality questions. Notably, 27% reported receiving counselling that was not personally tailored to them, indicating room for improvement in providing client-centred care.

Knowledge Change

Knowledge change was not measured at endline to streamline the surveying process for all parties. Baseline to midline results suggest minor to moderate increases across four of the five key areas of knowledge surveyed:

- 10% increase in correct answers regarding the risk of pregnancy, but a 30% increase in responses of "unsure" rather than "no"
- 18% increase in correct answers regarding healthy birth intervals
- 8% increase in correct answers regarding exclusive breastfeeding
- 5% increase in correct answers regarding bleeding side effects
- 9% decrease in correct answers regarding contraceptive effectiveness

Contraceptive Use

The project led to a minor increase in intention to use, but the numbers don't appear to be highly robust. Beyond this, there was a 5% decrease in mCPR at endline (from 22% at baseline to 17% at endline) that we believe was likely due to surveying design issues. As such, we have not broken this out by facility in a table below.

Reported rates of contraceptive uptake at baseline and endline in the surveying are significantly higher than national and regional reported rates, suggesting the question was misinterpreted. Participants were also surveyed immediately after leaving the unit, so there would have been no chance for them to take up a method if the counselling did change their mind unless provided directly at PNC. This was possible for some methods but not all, and only some of the time due to stock issues.

‘Intention to use’, as captured across the three facilities:

	Buipe	Salaga	Bole
Baseline	61.11%	33.33%	90.00%
Midline	76.92%	78.95%	36.36%
Endline	55.00%	42.86%	83.33%
B>E	-6.11%	9.52%	-6.67%

Intervention Arm 2: Child Welfare Clinics (CWC)

Summary

Across the facilities where the child welfare clinic model was tested (Tolon; Savelugu; Tamale Central), there was generally a moderate level of group talk implementation and a mixed level of one-to-one counselling at vaccination.

Knowledge increases were found across four out of five key metrics, with a 12% increase in intention to use a method of contraception. However, we recorded a 13% decrease in modern contraceptive use rate (mCPR). The same reasons around survey wording and timing discussed for the PNC intervention arm apply equally to the CWC intervention. As such, we think that the significant decrease in contraceptive use rate should be interpreted with caution.

Quality of Implementation

There was a moderate level of group talk implementation and a mixed level of 1:1 counselling at vaccination.

At Tamale Central, a group talk was observed at midline but not at endline, while 1:1 counselling at vaccination only occurred at endline, where it was present for about half of the clients. The program champion was non-responsive until after midline when she began engaging with the program.

Tolon had persistent issues with vaccine stock that affected implementation. The group talk occurred at both midline and endline, but there was no one-to-one counselling at CWC on two separate endline visits due to a lack of vaccine stock.

Savelugu had a group talk at midline but not at endline. At midline, mixed one-to-one implementation was observed at one visit and none at another visit that occurred on a very busy day. At endline, strong one-to-one implementation at vaccination was observed.

The consistent challenges with integrating family planning guidance at vaccination appeared to stem from resource constraints by providers at the busy vaccination sessions. Additionally, conversations with providers and clients suggested that many were unconvinced of the value of including family planning guidance at that touchpoint.

Prevalence of a Family Planning Group Talk:

	Tamale Central	Tolon	Savelugu
Baseline	7%	20%	7%
Midline	47%	100%	100%
Endline	13%	84%	39%

Prevalence of family planning counselling at vaccination on the day of surveying:

Composite takes based on client data, observations by Savana, and observations by MHI staff

	Tamale Central	Tolon	Savelugu
Baseline	None	None	None
Midline	None	None	Mixed
Endline	Mixed	N/A (no vax)	High

Knowledge Change

Knowledge change was not measured at endline to focus on additional investigation of implementation quality and behaviour change. Baseline to midline results suggest

moderate increases across most of the areas surveyed. This indicates that the group talk is an effective way of increasing client knowledge.

- 20% increase in correct answers regarding risk of pregnancy, along with a 44% decrease in wrong answers (the difference shifted to “unsure”)
- 10% increase in correct answers regarding healthy birth intervals
- 24% increase in correct answers regarding exclusive breastfeeding
- 11% increase in correct answers regarding bleeding side effects
- 18% decrease in correct answers regarding contraceptive effectiveness
    - At endline, 96% of women incorrectly stated that modern forms of contraceptives are always perfectly effective, suggesting that providers may be disseminating incorrect information in this regard

Contraceptive Use

Overall, there was a notable increase in intention to use but a 13% decrease in mCPR. The discrepancy between these outcomes that should be correlated suggests that the data was undermined by surveying issues, as discussed earlier in the report.

The intention to use results appear to have little relationship with the extent of implementation. For example, at midline at Tamale Central, only half received a group talk and there was no one-to-one family planning counselling at vaccination. However, the intention to use here is the highest of any facility. Meanwhile, Savelugu does not show a significant shift despite having the most thorough implementation of one-to-one counselling. However, it is worth noting that it also had the highest baseline rate of intention to use.

Intention to Use

	Tamale Central	Tolon	Savelugu
Baseline	44.44%	41.18%	69.23%
Midline	83.33%	68.75%	75.00%
Endline	60.00%	57.89%	72.22%
B>E	15.56%	16.72%	2.99%

Conclusions

Overall, it appears the projects were fairly unsuccessful in achieving their goals. While knowledge increases were measured across both intervention arms, contraceptive uptake declined in both cases.

We believe that the cause of this decrease in contraceptive use is likely to be due to surveying issues coupled with unexpectedly high levels of postpartum abstinence. We are finalising some further data analysis and background research to help determine the appropriate conclusions from this data.

However, these results do not suggest that the project should be scaled up given there is no robust evidence of a strong positive benefit from the work. We are mindful of the time pressures on the Ghana Health Service and its staff. Given this, we do not feel that further implementation of changes to care that may increase the workload of frontline staff is justified without clear evidence of their value.

We will continue to investigate the reasons why this project did not work as well as anticipated, or as successfully as in randomised controlled trials from other places.

We welcome any further engagement with these results, this project, or the Maternal Health Initiative's mission in general. Please do not hesitate to reach out through the contact details below.

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