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# Scaling-up post-pregnancy family planning services: experiences and challenges from Afghanistan

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## WHY WAS CHANGE NEEDED?

In Afghanistan, modern contraceptive prevalence (mCPR) is low among women of reproductive age at 16%,<sup>1</sup> while the unmet need for family planning (FP) is high at 25% among women of reproductive age.<sup>2</sup> The Ministry of Public Health (MoPH) committed to increase the mCPR to 30% and reduce the unmet need to 10%, by 2030.<sup>3</sup> The mCPR at 1 month postpartum is 6%, and at 6 months postpartum is 22%.<sup>1</sup> One in two currently married Afghan women (age 15–49 years) want to either delay their next pregnancy by at least 2 years (24%) or limit child-bearing (26%).<sup>2</sup> This low postpartum family planning (PPFP) uptake and high unmet need indicated the need to promote contraception during the postpartum period to reduce the number of unintended pregnancies and abortions. Spacing pregnancies by over 2 years can reduce maternal and infant mortality by 30% and 10%, respectively.<sup>4</sup>

With 49% of deliveries attended by a skilled provider in an institution, 59% of pregnant women receiving antenatal care, and 80% of children receiving at least one vaccine in their first year,<sup>1</sup> numerous opportunities exist in the country for integration of PPFP counselling and services. Reflecting on this, in 2019 the MoPH Afghanistan, jointly with the WHO, established postpartum/post-abortion family planning (PP/PA FP) ‘corners’ within the delivery rooms of 25 health facilities (HFs) in Kabul and Herat provinces, to provide quality PPFP/PAFP contraceptive services through trained healthcare providers and equipped health facilities under the WHO FP Accelerator project.<sup>5</sup> The purpose of this intervention was to test whether establishing PP/PA FP ‘corners’ in the delivery room would increase the uptake of long-acting reversible contraception.

## HOW DID WE GO ABOUT IMPLEMENTING CHANGE?

In 2018, WHO supported MoPH to update National Family Planning service delivery guidelines (previously updated in 2007) and the related training materials based on: WHO Medical Eligibility Criteria (MEC), fifth edition (2015); Selected Practice Recommendations for Contraceptive Use, third edition (2016); and Decision-Making Tool (DMT) for community health worker and their clients (2012).

In 2019, a baseline assessment of the selected 25 health facilities showed that only 50% of facilities had intrauterine device (IUD) and implant insertion/removal kits, 13% had implants, and 20% had FP counselling tools. The assessment indicated the need for capacity building of the HF managers and healthcare providers on the importance of PP/PA FP services and the need to increase the availability of counselling tools, job aid (MEC wheel) and equipment for IUD and implant insertion/removal.

PP/PA FP ‘corners’ were set up in 15 health facilities (district hospitals, comprehensive health centres, basic health centres) in Kabul and 10 in Herat. The facilities were selected because of higher institutional delivery rates, compared with similar clinics, higher utilisation of FP services, more service providers with basic skills and competence in PPFP counselling, insertion of postpartum IUDs and implants, availability of required equipment for insertion/removal of IUDs and implants, and better access to the infection prevention equipment and supplies.

The PP/PA FP ‘corners’ were equipped with long-acting reversible contraception—IUDs and implants. The HF managers and service providers of the 25 HFs were oriented on the importance and working modality of PP/PA FP

'corners'. Thirty-three service providers from both provinces were trained in IUD/implant safe insertion and removal, and an additional 30 providers received refresher training. All women in the PA/PP period were offered FP counselling and choice of contraceptives using WHO DMT and MEC wheel<sup>6,7</sup> at the PP/PA FP 'corners' from 2020 to date.

Three checklists were developed to monitor and supervise regularly the performance of FP 'corners' to ensure the quality and uptake of PP/PA FP services. These included (1) PP/PA FP services quality improvement checklist, (2) provider post-training follow-up, and (3) monthly self-reporting. Since February 2020, the monitoring and supportive supervision visits were conducted quarterly in both provinces by the project Monitoring and Evaluation focal point, MoPH FP officers, the provincial reproductive health (RH) officer and the implementer non-governmental organisation (NGO) RH officer.

An electronic database for PP/PA FP indicators was developed and utilised from March 2021. It included indicators on the number of normal deliveries/abortions and the number of IUDs and implants inserted after birth/abortion. Monthly data are entered into the database, cleaned, analysed and reported to the Department of Reproductive Maternal Newborn Child and Adolescent Health at MoPH and WHO.

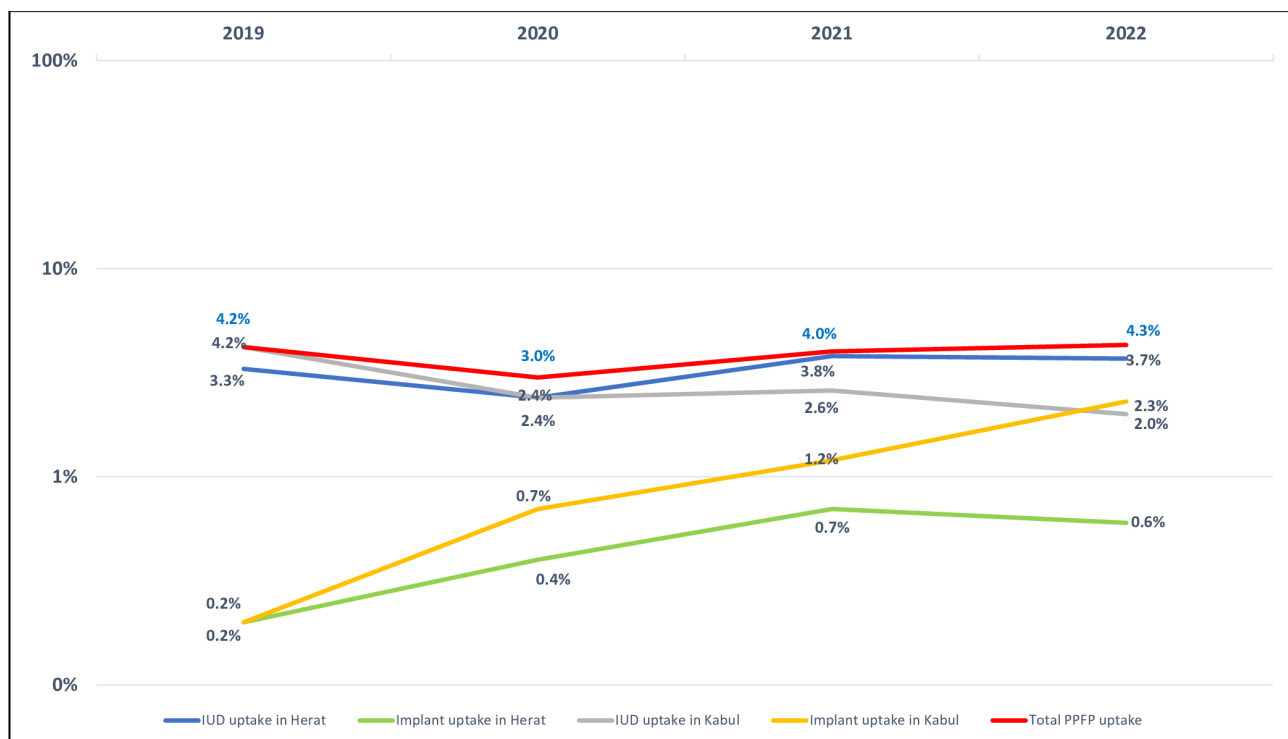
### WHAT WERE THE OUTCOMES OF THE CHANGE IN PRACTICE?

Following the establishment of the PP/PA FP 'corners', the uptake of postpartum implants increased in both

provinces between 2019 to 2022 from 0.2% to 2.3% in Kabul and 0.2% to 0.6% in Herat (online supplemental table 1), and in the post-abortion period, from 15.5% to 22.8% in Kabul and 1.5% to 3.8% in Herat (online supplemental table 2). In Herat, both postpartum (from 3.3% to 3.7%) and post-abortion (from 2.5% to 4%) IUD uptake increased (see figure 1), while in Kabul, a decline was observed in both postpartum and post-abortion IUD uptake, from 4.2% to 2% and 8.1% to 4.1%, respectively (online supplemental table 1 and 2). This reduction in uptake of postpartum/post-abortion IUDs in Kabul could be attributed to a shift in the community preferences from IUD to implant use.

The overall uptake of postpartum contraceptives increased only in Herat province from 3.5% (2019) to 4.2% (2022), while the overall post-abortion contraceptive uptake increased in both Kabul (from 23.6% to 26.9%) and Herat provinces (4.1% to 7.8%) between 2021 and 2022 (online supplemental table 1 and 2).

An external evaluator conducted a mid-term evaluation using mixed methods (desk review, facility observations, key informant interviews and client exit interviews) in June-July 2021 to determine the effectiveness of PP/PA FP 'corners' and the way forward to improve their performance. Findings indicated that 85% of healthcare providers at 25 HFs demonstrated the required knowledge and skills on PP/PA FP services, and 80–90% met the national FP service quality improvement checklist standards. Interrupted supply of equipment, kits and materials needed for PP/PA FP due to the COVID-19 pandemic-related



**Figure 1** Percentage of IUD and Implant uptake from 2019 to 2021 in Kabul and Herat provinces in the postpartum period. IUD, intrauterine device; PPF, postpartum family planning.

restrictions and, in 2021, due to the Taliban taking over the government affected the availability of implants and IUDs in a few health facilities and resulted in PP/PA FP missed opportunities.

A subsequent evaluation of the PP/PA FP ‘corners’ was conducted in August–September 2022. Findings showed that all women in the PA/PP period were offered FP counselling and a choice of contraceptives. It was observed that the PP/PA FP ‘corners’ were marked in all facilities, and all service providers were trained in inserting and removing implants and IUDs. Implants and IUDs were available in 91% of facilities, while the insertion kits were available in all health facilities.

On seeing the success of these ‘corners’, the United Nations Population Fund (UNFPA), in consultation with WHO and MoPH, initiated the scale-up of a similar project in 40 HFs in two additional provinces in Afghanistan.

### WHAT CHALLENGES DID WE FACE?

The key challenges included: (1) 25% staff turnover in the HFs, which resulted in the need to repeat training for new staff; (2) shortage of female staff at HFs—in Afghanistan, the community prefers that only female staff provide FP services to female clients; (3) interruption in the availability of FP commodities due to the COVID-19 pandemic; and (4) escalating unrest and political insecurity from late March 2021, resulting in low performance and reduction of service providers.

### CONCLUSION

Despite the COVID-19 pandemic significantly slowing down the implementation of the PP/PA FP ‘corners’ between March–September 2020, followed by political insecurity and the Taliban taking over the government in Afghanistan during March–September 2021, the mid-term evaluation in 2022 showed that establishing PP/PA FP ‘corners’ in delivery rooms resulted in improved FP counselling and uptake of implants in the immediate postpartum and post-abortion period.

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