REVITALIZING AND SCALING UP POSTPARTUM AND POSTABORTION FAMILY PLANNING WITHIN UNIVERSAL HEALTH COVERAGE

Global Convening Report

USAID FROM THE AMERICAN PEOPLE
MOMENTUM A Global Partnership for Health and Resilience
BILL & MELINDA GATES foundation

AUGUST, 2023

MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

MOMENTUM Safe Surgery in Family Planning and Obstetrics is funded by the U.S. Agency for International Development (USAID) as part of the MOMENTUM suite of awards and implemented by EngenderHealth with partners IntraHealth International, Johns Hopkins University Center for Communication Programs, and the London School of Hygiene and Tropical Medicine under USAID cooperative agreement # 7200AA20CA00011. For more about MOMENTUM, visit www.usaidmomentum.org. The contents of this report are the sole responsibility of EngenderHealth and do not necessarily reflect the views of USAID or the United States Government.

@USAID_MOMENTUM @USAIDMOMENTUM USAID MOMENTUM USAID MOMENTUM

Cover photo: R. Shyrock/EngenderHealth.

Suggested Citation:
Mugyenyi, C., Tripathi, V., RamaRao, S. (2023). *Revitalizing and Scaling Up Postpartum and Postabortion Family Planning Within Universal Health Coverage: Global Convening Report*. Washington, DC: USAID MOMENTUM.

CONTENTS

ACKNOWLEDGEMENTS

We thank USAID and the Bill & Melinda Gates Foundation for their generous support for this meeting. We thank the EngenderHealth office in Tanzania for serving as the in-country hosts of this meeting which took place from June 5-7, 2023 in Dar es Salaam.

ABBREVIATIONS

ANC	Antenatal care
CHW	Community health worker
CMS	Commercial medical stores
DRC	Democratic Republic of Congo
FIGO	International Federation of Gynecology and Obstetrics
FP	Family planning
FP2030	Family Planning 2030
HBP	Health benefits packages
HMIS	Health Management Information System
HRH	Human resources for health
LMIC	Low- and middle-income country
mCPR	Modern contraceptive prevalence rate
MEC	Medical eligibility criteria for contraceptive use
MH	Maternal health
PAC	Postabortion care
PAFP	Postabortion family planning
PEACHES	Platform for Enhanced Access to Contraceptives and SRH Supplies
PHC	Primary health care
PPFP	Postpartum family planning
SBCC	Social behavior change communication
SRH	Sexual reproductive health
SRHR	Sexual reproductive health and rights
TFR	Total fertility rate
UHC	Universal health coverage
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The MOMENTUM Safe Surgery in Family Planning and Obstetrics project, led by EngenderHealth, held an action-oriented global expert convening from June 5-7, 2023, in Dar es Salaam, Tanzania entitled "Revitalizing and Scaling Up Postpartum and Postabortion Family Planning within Universal Health Coverage." This convening was co-funded by the United States Agency for International Development (USAID) and the Bill & Melinda Gates Foundation.

This strategic consultation brought together key stakeholders from multilateral and non-governmental agencies, with presenters from (in alphabetical order) the Bill & Melinda Gates Foundation, EngenderHealth, Frontier Health Markets Engage, FP2030, the International Federation of Gynecology and Obstetrics (FIGO), Jhpiego, MOMENTUM Safe Surgery in Family Planning and Obstetrics, Nivi Inc., Palladium, Pathfinder, Population Council, Samasha Foundation, ThinkWell Global, United Nations Population Fund, University of California-Los Angeles, USAID, White Ribbon Alliance Tanzania, World Bank, and the World Health Organization (WHO).

Presentations reviewed case studies of progress and challenges in the scale-up of postpartum and postabortion family planning (PPFP/PAFP); examined how the three pillars of universal health coverage (UHC) (access/coverage, service delivery, and financing, including the ability to protect those who cannot pay) intersect with PPFP/PAFP; and explored key flashpoints in scaleup including task shifting/sharing, private sector engagement, and digital health interventions. Key thematic areas related to financing models, enabling community and health system environments, and data for decision making emerged during the consultation, and participants identified priority actions within these themes. The discussion also highlighted the crucial need for the maternal health (MH) and family planning (FP) communities to truly come together for PPFP/PAFP scaleup to become a reality and fulfill its potential in improving maternal and newborn outcomes.

Participants identified the following priority actions to scale up PPFP/PAFP in the UHC context:

1. Integrate PPFP/PAFP across the health system building blocks, with an emphasis on the stewardship, governance, and leadership elements that enable adequate health financing and workforce.

2. Engage communities to address stigma, bias, social, and gender norms, and to increase clients' motivation to access PPFP/PAFP, including via digital tools.

3. Engage the private sector, support the bundling of services, expand what the private sector can provide, facilitate public-private partnerships, and assure quality.

4. Strengthen health information system coverage indicators for counseling and measurement of PPFP/PAFP for more reliable data from both the public and private sectors.

5. Reallocate financial resources for equitable access, including transition of public resources to focus primarily on the underserved; strengthen subsidized and commercial models for those who are able to pay.

The meeting discussions and resulting action agenda will guide a forthcoming White Paper and Call to Action that will be disseminated by the MOMENTUM Safe Surgery project at key global and technical forums including the XXIV FIGO World Congress. Participants also identified numerous opportunities to bring these priority actions and themes to many other organizational, country-specific, and global platforms to ensure that the robust discussion and commitments made at this consultation lead to substantive follow-up action in support of PPFP/PAFP scaleup. Such dissemination is particularly important as investments in both UHC, and primary health care (PHC) expand, and as the time to meet 2030 commitments becomes shorter.

MEETING OVERVIEW

The MOMENTUM Safe Surgery in Family Planning and Obstetrics project, led by EngenderHealth, held an action-oriented global convening from June 5 -7, 2023, in Dar es Salaam, Tanzania, entitled "Revitalizing and Scaling Up Postpartum and Postabortion Family Planning within Universal Health Coverage," co-funded by the United States Agency for International Development (USAID) and the Bill & Melinda Gates Foundation.

This strategic consultation brought together technical experts, program leaders, policy advocates, and donors within the family planning (FP) and associated communities of practice to collaboratively and practically consider the barriers and enablers to postpartum and postabortion family planning (PPFP[*] and PAFP[†]) availability, uptake, and scale-up in the context of universal health coverage (UHC) and primary health care (PHC) frameworks.

The meeting sought to generate fresh thinking and innovative solutions from the international maternal health (MH) and FP communities that would lead to expanded and improved programming, financing, access, and quality of postpartum and postabortion contraception within UHC. The meeting objectives were to:

- Learn from country case studies of postpartum and postabortion family planning (PPFP/PAFP)
- Uncover, investigate, and understand both barriers and enablers of PPFP/PAFP within UHC
- Identify practical approaches for the integration and scale-up of PPFP/PAFP into UHC
- Recommend policy and programmatic action at country, regional, and global levels for improved coverage with quality PPFP/PAFP

The meeting agenda included interactive presentations and discussions and small group activities to define and refine a responsive action agenda (see Appendix A for full agenda). Through the presentation of country case studies from Democratic Republic of Congo (DRC), Pakistan, and Tanzania, whose experiences showcased both successes and challenges, and the discussion of key health systems bottlenecks and flashpoints (such as human resources, task shifting, regulatory frameworks, and the organization of maternal, newborn, child health services), the expert group debated and identified entry points for integrating PPFP and PAFP within UHC initiatives (coverage, services, and financing). The convening also identified opportunities provided by ongoing efforts to strengthen PHC systems for synergy and amplified impact.

[*] **Postpartum family planning (PPFP)** refers to the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth. (WHO. 2013. Programming strategies for postpartum family planning. https://apps.who.int/iris/bitstream/handle/10665/93680/9789241506496_eng.pdf).

[†] **Postabortion family planning (PAFP)** refers to the initiation and use of modern contraceptive methods at the time of management of abortion or before fertility returns after the abortion. (Motuma, V. S., et al. 2022. Postabortion family planning and associated factors among women attending abortion service in Dire Dawa Town Health Facilities, Eastern Ethiopia. *Frontiers in reproductive health*, *4*, 860514. https://doi.org/10.3389/frph.2022.860514).

Participants at the Revitalizing and Scaling Up PPFP/PAFP in UHC convening, Dar es Salaam. Credit: Sea Cliff Hotel Events Team.

TECHNICAL PRESENTATIONS AND DISCUSSION

Through presentations on, and discussion of crucial topics and country case studies in PPFP/PAFP scale-up, participants shared their perspectives and identified open questions. An aggregated summary of these presentations and key discussion points is provided here.

I. Setting the Stage for PPFP and PAFP within UHC

Despite investments over time and high level political and policy commitment, 218 million women and girls have an unmet need for contraception around the world.[‡] There are approximately 73 million abortions per year; nearly half are unsafe, contributing to 5 to 13 percent of maternal deaths.[§] Close to 287,000 women die in pregnancy or delivery;[**] and there are over two million newborn deaths.[††] Many of these deaths could be prevented with expanded access to and uptake of voluntary FP services, and these statistics all point to a need to revitalize FP efforts globally.

Within the wider FP context, PPFP/PAFP services intersect with maternal and child health care and have significant unrealized potential for integration. Furthermore, the time after delivery, fetal loss, or induced abortion is one where an individual is physically vulnerable, perhaps still in pain, and going through multiple emotions. The delivery of FP services (including counseling, contraceptive provision or referral, and follow-up) needs to be tailored to meet the client's needs in that moment. When women/adolescents are counseled and provided contraception before they

[‡] Sully, E.A. et al. (2020). *Adding it up: Investing in sexual and reproductive health 2019*. New York: Guttmacher Institute. https://www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019. DOI: https://doi.org/10.1363/2020.31593

[§] World Health Organization. (2021). *Abortion*. https://www.who.int/news-room/fact-sheets/detail/abortion

[**] World Health Organization. (2023). *Maternal Mortality*. https://www.who.int/news-room/fact-sheets/detail/maternal-mortaliity

[††] United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME). (2023). *Levels & trends in child mortality: Report 2022 - Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation*. United Nations Children's Fund. https://childmortality.org/wp-content/uploads/2023/01/UN-IGME-Child-Mortality-Report-2022.pdf

leave the facility where they have delivered, they are more likely to adopt it. When they are counseled at different touchpoints during and after pregnancy, such as antenatal care (ANC), delivery and postpartum care, they are more likely to adopt FP. Immunization and well child visits are other options for offering FP counseling and services. Contraceptive needs may also be met outside a public health facility. The private sector is estimated to serve over a third of modern contraceptive services in many low- and middle-income countries (LMIC).[‡‡]

UHC offers the promise of covering all people with the services they need regardless of socioeconomic status, disability, and age. Despite its importance, it is only recently that FP of any kind has been included in UHC and other health benefits packages (HBP). Examples include Ghana which added the provision of IUDs, implants, injectables, and permanent methods within the National Health Insurance Scheme from January 1, 2022. The Linda Mama program in Kenya is a free maternity program implemented by the National Health Insurance Fund that aims to increase utilization of maternity services and remove financial barriers to access.

However, in general, it is difficult to find examples where HBPs include postpartum or postabortion care including PPFP and PAFP, where users are aware of their entitlements, and where services are provided without any additional out of pocket expenditures. The integration of PPFP/PAFP into UHC heavily depends on political, cultural, and social contexts, and is not necessarily guided only by need or technical expertise. Additionally, most African countries have restrictive abortion laws so understanding the country context is essential to determine the best approach to advancing PAFP. The extent to which UHC design and implementation (programs and packages) includes sexual and reproductive health and rights (SRHR) at the country level also strongly affects PPFP/PAFP integration and inclusion in national and sub-national budgets.

These issues spur a number of questions:

- Given the numerous and varied service touchpoints for PPFP and PAFP, can a continuum of care that extends from the health facility to the community and household be offered at scale, across both the private and public sectors?
- Are there insights that we gained from responding to Covid-19 that might offer a new way of thinking or articulating how investments in the health sector and FP can offer returns that will apply across our economies?
- Are the ongoing high-level discussions on pandemic preparedness within UHC a good entry point since it is now recognized and accepted that essential SRH health services were disrupted during the pandemic?
- Given the significant focus currently on PHC strengthening, how can PPFP and PAFP scale-up best fit within this and benefit from stronger PHC platforms?

The deliberations that took place during the convening aimed to shed light on these questions and provide solutions to the integration of PPFP and PAFP within UHC as well as PHC strengthening.

II. Moving from Commitments to Action: An FP2030 Analysis

An FP2030 analysis of 30 country commitments documented that 18 contain both PPFP and PAFP objectives and strategies. However, many of the 18 lack specifics on how aims are to be achieved or measured. Eight country

[‡‡] Weinberger, M., Callahan, S. (2017). *The private sector: Key to achieving Family Planning 2020 Goals*. Sustaining Health Outcomes through the Private Sector Project, Abt Associates. https://shopsplusproject.org/sites/default/files/resources/The%20Private%20Sector-Key%20to%20Achieving%20Family%20Planning%202020%20Goals%20%282%29.pdf

commitments (Benin, DRC, Guinea, Kenya, Madagascar, Mauritania, Senegal, Zimbabwe[§§]) only contain PPFP, and four commitments (Cote d'Ivoire, Namibia, South Sudan, Zimbabwe) do not include either PPFP or PAFP.

Discussion Points:

- *There is a need to focus both on coverage as well as quality of services. Currently there are very few mechanisms to track quality.*
- *Including PPFP and PAFP in country commitments is a first step; however, there needs to be an accountability framework for these commitments.*
- *There is a need to track whether countries are including domestic financing in these commitments for PPFP and PAFP.*

III. MH/FP Integration from the Obstetrics Perspective

While much of the discussion of PPFP focuses on the immediate postpartum period, there is also an opportunity for education, counseling, and service provision during preconception, antepartum, postpartum, postpartum, postabortion, and immunization contacts. FP/MNH integration can enable easier recognition of high-risk individuals and pregnancies and more effective delivery of FP counseling and procedures immediately postabortion and postpartum. However, challenges to realizing these opportunities and benefits include workforce shortages, provider bias, and insufficient collaboration among health workforce cadres. As part of the FIGO commitment to supporting access to comprehensive contraceptive care, the organization is collaborating with FP2030 and improving partnerships with national, regional, and global allies and stakeholders leading the way. The discussion flagged FIGO's role in influencing the quality of preservice training as well as the inclusion of PPFP/PAFP in preservice training, and the role professional organizations can play in cascading technical content and skills to their member organizations. Midwives and nurses are also essential for PPFP/PAFP integration, particularly in LMIC, as women often interact more with these non-obstetrician cadres during routine services and they can play a role in providing counseling to women, their partners, and family members. More investment into midwifery courses – including midwifery-specific preservice courses that focus on those specific skills and scopes of work – will improve the quality of care.

IV. PPFP and PAFP in UHC: Coverage, Services, and Financing

While most countries have strong national commitments and targets for UHC, reporting is not always linked to a UHC strategy. There are also insufficient strategies and implementation of multisectoral actions to address factors outside the health sector. Gaps in SRHR within UHC are widespread due to insufficient funding, restrictive legal environments, gender inequities, and health system constraints such as poor infrastructure. SRH services are critical components of PHC and 90% of essential UHC services can be delivered through PHC. However, achieving UHC involves making decisions about what services can be provided to whom, and at what cost, including ensuring protection for vulnerable and marginalized populations, including adolescents. It is crucial to influence decisions about which services to include in HBPs for PPFP and PAFP (and for whom) to be part of UHC.

Discussion Points:

- *Why has it been difficult to scale-up, and improve financing and access to PPFP and PAFP within wider UHC reforms?*
- *What are the challenges related to securing political commitment and well-defined strategies?*
- *How do you define who should be covered, how to pay for services, and what services should be covered first?*

[§§] Zimbabwe included immediate postpartum family planning only. This refers to provision of contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility.

V. Flashpoints and Themes in Scale-Up Services

1. MH/FP INTEGRATION OF FINANCING AND PHC

Financing approaches can contribute to the fragmentation of FP programs and PHC systems or, conversely, promote integration. Integration of FP into PHC can optimize scarce resources, increase effectiveness of FP interventions, and promote financial sustainability. The integration of financing must be conceptualized across the three subfunctions of financing: resource mobilization – making the investment case for FP and PHC as well as a combined approach to budget advocacy efforts; pooling – making sure target populations are enrolled in public health insurance schemes and that FP is explicitly included in HBPs; and purchasing – including FP in strategic purchasing arrangements for PHC in the form of capitation, fee-for-service, line-item budgeting, or some combination of these. Financing strongly influences and is influenced by other important health system building blocks, namely delivery and governance. A comprehensive systems approach can help identify activities that can easily be integrated and develop roadmaps for integration. Each pathway is likely to be country-specific and present challenges and opportunities that need to be identified and tackled via a country-led approach.

Discussion Points:

- *What multisectoral approaches to financing can be considered to support scale-up of PPFP/PAFP?*
- *What financial incentives already exist that can be built on?*
- *How can civil society advocate for domestic financing for FP within UHC and PHC?*
- *How are/can all the sources of "off-budget" support (e.g., development and donor partner assistance) be accounted for in designing financing systems?*

2. IMMEDIATE PPFP AND PAFP

Although global ANC and institutional delivery rates have increased, there has not been a corresponding level of improvement in immediate PPFP/PAFP services. Some countries have policy frameworks that inhibit young women and adolescents from accessing FP services (such as requirements for consent from parents, spouses/partners, or guardians). At service delivery points, PPFP counseling needs to be incorporated into ANC services to enable women/adolescents to fully explore their intentions and to make informed decisions about contraception well before delivery. PHC facilities need to be adequately stocked to provide FP as part of postabortion and postpartum care. However, private pharmacy outlets are usually the first point of contact by clients seeking some SRHR services, including medical abortion, and therefore essential to scaling up PAFP services. For PPFP, as most countries have robust routine immunization and community outreach programs, these visits can be used to integrate PPFP information, counseling, services, and/or referrals. Male involvement (as clients in addition to as partners) and social and behavior change communication (SBCC) interventions are required at the community level to increase awareness, and to address negative beliefs and norms around FP.

Discussion Points:

- *There are missed opportunities for immediate PPFP for women who deliver in private facilities, the majority of which are faith-based organizations that may not support FP.*
- *We need to integrate immediate PPFP/PAFP across all contact points (ANC, labor/delivery and pre-discharge, postnatal care, infant health, and immunization services).*
- *A health system approach that includes multidisciplinary and multilevel approaches may be the most effective for increasing PPFP/PAFP, including immediately after delivery and/or as part of PAC.*

3. HUMAN RESOURCES AND TASK SHIFTING

Health workforce challenges may be the greatest obstacles to improving PPFP/PAFP coverage. Most countries have adapted the WHO guidelines on human resources for health (HRH) and task shifting to their contexts. Enabling nurses and midwives to provide PPFP/PAFP (including IUD and implants) broadened the FP method mix in Nigeria and Senegal; and training and supportive supervision of community health workers (CHWs) increased access to short-acting contraception (oral and injectable) in Madagascar and Burkina Faso. However, to expand comprehensive FP services, task shifting may need to consider actors beyond the traditional cadres of health care providers. As private sector pharmacies and Accredited Drug Dispensing Outlets are often the first point of contact for many clients, governments can leverage these to equip providers with the skills and tools needed to deliver a range of FP services including PAFP (especially in those cases where medical abortion drugs are accessed from these outlets). Additionally, community and religious leaders, teachers and school staff, male partners, family members, and satisfied clients all have a role to play in shifting community norms and perceptions around PPFP/PAFP care-seeking behavior. PPFP/PAFP integration and scale-up recognizes that the inclusion of relevant modules in pre-service training is necessary even as scale up of in-service training and supportive supervision are being implemented.

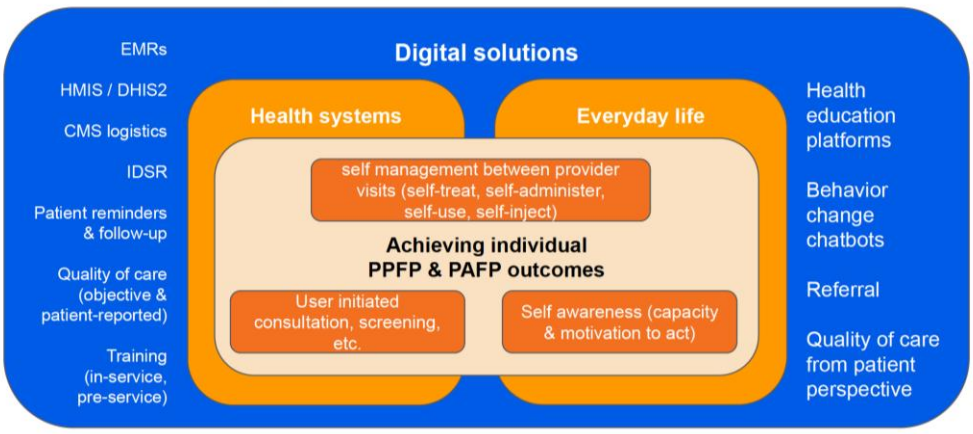
Discussion Points:

- *Can task shifting be sustained by domestic resources instead of being a donor-funded initiative?*
- *What policies and incentives are needed for the private sector to provide PPFP/PAFP?*

4. ROLE OF DIGITAL TOOLS

Digital tools can enable the provision of FP information, services, and commodities, and support universal access to a high-quality package of care without excessive health expenditure. Figure 1 provides a model for understanding these potential impacts. Digital tools can be used on the supply side to improve resource deployment, monitoring, management, capacity strengthening, and quality assurance. On the demand side, they can be used to improve patient and consumer engagement, counseling, screening, referrals, adherence, and provide feedback on quality of care. Patient-/consumer-focused tools such as the private mobile chatbot developed by Nivi enables users based in India, Kenya, South Africa, and Nigeria to make decisions about their reproductive health using behavioral science. While digital tools can provide users with clear, easy to understand information about contraceptive options, we are still learning about how to fully realize the potential of digital tools to achieve wide coverage. Challenges remain around access to these tools and willingness to engage with them.

Figure 1: Agency in PPFP and PAFP



Modified from: Narasimhan M, Allotey P, Hardon A. "Self-care interventions to advance health and wellbeing: A conceptual framework to inform normative guidance." BMJ.

Discussion Points:

- *Do we need quality assurance mechanisms or guidelines to ensure that information contained and shared with consumers through digital solutions is safe and correct?*
- *How can digital tools be adapted for use by persons living with disability and those with low literacy levels?*

5. COMMUNITY-BASED AND SELF-CARE APPROACHES

There are numerous ways in which PPFP/PAFP care can be brought closer to clients by midwives and CHWs who have an in-depth understanding of the contexts within which FP decisions are made. Service providers that are close to the community can identify barriers to FP uptake faster than facility-based service providers and develop workable solutions to these barriers. Task shifting some FP provision tasks to midwives and CHWs will enable scale-up of PPFP/PAFP, as will scaling up of self-care approaches. The role of male partners in contraceptive decision making is also crucial, for example their inclusion in discussions and counseling with health providers, with their partners' consent. Small changes to the processes in examination/counseling rooms to include male partners have been seen to make differences in community perception and norms. It is also essential to meet clients where they are and initiate FP discussions in wider settings at the community level such as women's economic empowerment programs or sessions.

Discussion Points:

- *Investments in health literacy as well as digital tools will improve self-care.*
- *Many barriers to self-care are driven by physicians. How can providers be converted into allies?*
- *Physician attitudes should not be overlooked when task shifting FP provision to midwives and CHWs.*

6. PRIVATE SECTOR AND TOTAL MARKET APPROACH

A total market approach is important to PPFP/PAFP integration, as equitably meeting the diverse needs of various population segments requires coordination across the public and private sectors. The private sector goes beyond commercial suppliers, pharmacies, drug outlets, and private facilities. Provider associations and networks, professional networks, and youth associations are also a vital part of the private sector that can influence access and uptake. Private sector inclusion in PPFP/PAFP scale up should happen at various points. The private sector needs to be involved in planning program activities and participate in key technical working groups, including for task shifting policy development. Training, supportive supervision, and capacity strengthening activities should be implemented in a way that enables participation of private sector providers. Private sector providers also have a role to play in community-level service provision, which goes beyond CHWs to include dispensers in Accredited Drug Dispensing Outlets and community pharmacies. Close collaboration with the private sector is required to ensure that contraceptives are available in diverse private sector outlets and that SBCC campaigns also include the private sector. The lack of data from the private sector in many health systems means that decisions made, and strategies employed, are likely not reflecting the diverse needs and preferences of different population groups. Market and willingness to pay analyses will go a long way in providing insight on the segments of the population that the public and private sectors should focus on, respectively.

Discussion Points:

- *Segmentation of the population to identify which groups can and prefer to access FP services in the private sector will enable governments to focus public resources where they are most needed.*
- *Training staff in the private sector may require different approaches than those used in the public sector such as more self-learning and online resources.*

7. SUPPLY CHAINS

Reliable supply chains are required to maintain the availability of contraceptive commodities within the private sector, including pharmacies and drug stores. The Platform for Enhanced Access to Contraceptives and SRH Supplies (PEACHES) implemented by Commercial Medical Stores (CMS) Uganda is one successful approach to supply the private sector, as the National Medical Stores are focused on the public sector. Private sector supply chains are a complex network of importers, wholesalers, distributors, sub-distributors, and retail outlets. It can be difficult to get details on what is being purchased at what time, which often results in stock-outs, high markups, poor geographical reach, and less choice. PEACHES aims to improve distribution efficiency, increase affordability and accessibility of commercial SRH commodities. This is done by consolidating orders and procuring SRH commodities from importers then directly distributing them to retail outlets at a wholesale price. CMS also has a call center and inventory management system to ensure efficiency. The consolidated distribution of SRH commodities has created increased demand and availability of SRH commodities in the commercial sector. Preliminary results indicate that retail outlets prefer SRH commodities to be delivered to their doorstep at a wholesale price and importers benefit from a corresponding increase in sales of their products. CMS distributes a mix of both for-profit and cost recovery commodities.

Discussion Points:

- *How can data from the private sector be combined with public data so that we can better understand population use of SRH commodities within countries?*
- *How can we strengthen supply chains to ensure that SRH commodities intended for free distribution do not end up for sale in the private sector?*

VI. Programming Strategies for PPFP and PAFP: Similarities and Differences

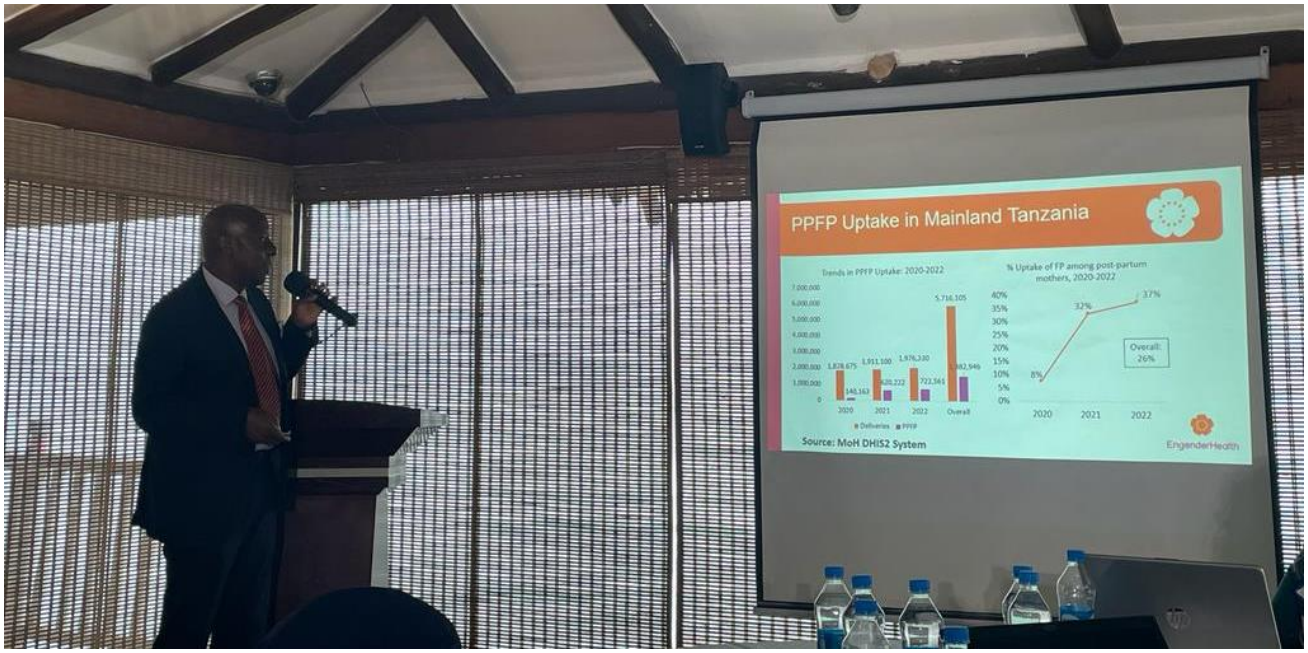
Rita Kabra of WHO presented an overview of the similarities and differences in PPFP and PAFP programing strategies. An effective health system with skilled workers and commodities is a prerequisite for both, and PPFP and PAFP equally require counseling and information provision that honor the principles of voluntarism and informed choice. But, while contraceptive choices during PPFP are affected by postpartum physiological changes and the mother's breastfeeding status, as noted in the MEC guidelines,[***] there are fewer restrictions in the case of PAFP. PPFP can be supported by multiple opportunities for counseling, whereas PAFP counseling is more time-bound. Restrictive abortion policies, self-administered medication abortion, and emergency situations all make it more difficult to deliver PAFP. PAFP is also affected by community perspectives and norms that affect both the client and the health service provider.

Discussion Points:

- *The MEC guidelines need to be revised to reflect broader options for PAFP.*
- *Accreditation of a wider range of SRH commodities manufacturers is necessary to enable their inclusion in public sector procurement.*

[***] WHO. (2015). *Medical eligibility criteria for contraceptive use, fifth edition*. https://www.who.int/publications/i/item/9789241549158.

VII. Country Case Studies



Dr. Moke Magoma presenting the Tanzania case study on day one of the meeting. Credit: V. Tripathi/MOMENTUM Safe Surgery in Family Planning and Obstetrics

TANZANIA

With a population of 59.8 million, 25 percent of whom are women of reproductive age (15-49 years), mainland Tanzania suffers from inadequate health facility coverage (total of 10,107 facilities) and has an HRH gap of 60 percent. While the total fertility rate (TFR) has fallen from 5.6 in 1999 to 4.8 in 2022, the modern contraceptive prevalence rate (mCPR) is only 31 percent amongst currently married women and there is an unmet need for FP of 21 percent amongst married women. The two most popular forms of contraception in mainland Tanzania are implants (45 percent) and injectables (28 percent). Although PPFP uptake has increased 4.6-fold from eight percent in 2020 to 37 percent in 2022, it remains low. In contrast, PAFP uptake fell from 88 percent in 2020 to 74 percent in 2022. While PPFP/PAFP interventions have been prioritized in Tanzania and supported with expanded service availability through decentralization, improved documentation, availability of guidelines and manuals, task shifting, and free PAFP services in facilities, there are still several challenges in the ability to deliver comprehensive PPFP/PAFP services across the country. The HRH gap coupled with inadequate skills among service providers (only 40 percent of health facilities with at least one staff trained in FP), provider bias, poor health facility infrastructure, a lack of essential equipment and health information management system (HMIS) tools, inadequate information, education, and communication materials, and an FP funding gap (even with the introduction of Direct Facility Funding) makes it difficult to provide these services. Pervasive misinformation and sociocultural norms also reduce demand for PPFP/PAFP services. Key opportunities exist to integrate PPFP uptake during ANC, delivery, and postnatal care. Integration of PPFP/PAFP into wider services such as comprehensive HIV counseling and testing and gender-based violence, among others, should be explored. There is also a role for CHWs in awareness creation and referrals.

Discussion Points:

- *As data for medical methods for postabortion care (PAC) is from facilities only, how can Tanzania and other countries begin to track Misoprostol and contraceptives in pharmacies and drug outlets?*
- *How can the private sector be leveraged to increase access to and uptake of PPFP/PAFP?*

PAKISTAN

Pakistan has a population of 234 million, with 49.6 percent of the population being women. In 2018, currently married women in Pakistan had an mCPR of 25 percent, an unmet need for FP of 18 percent and a TFR of 3.6; 30 percent of clients discontinued contraceptive use within 12 months, and 60 percent of all births were spaced less than two years. The health system is decentralized with provincial autonomy and decision-making. Because of this, there is wide variability in service delivery across the country. Adding to the complexity, FP programs are bifurcated, with some aspects falling under the Department of Population Welfare and others under the Department of Health. Coordination between these two departments is fragmented and the placement of FP services makes it a challenge to integrate PPFP/PAFP into UHC. Examples of these challenges include frequent stock out of certain FP commodities, dearth of quality counseling in health facilities, and the low numbers of clients in Population Welfare facilities. Women access FP from the public and private sectors equally. Several strategies to improve access to and uptake of FP have been launched, including setting up National and Provincial FP Task Forces; increasing universal access to FP services; enhancing FP financing; developing legislation to promote FP; increasing FP advocacy and communication; updating curricula; improving commodity security; and involving religious leaders. An example of these strategies in action is the Qadam Ba Qadam (Step by Step) program being implemented by Pathfinder in four provinces. To date, the program has facilitated the institutionalization of PPFP/PAFP services in two provinces and supported all the provinces to adopt evidence based PPFP/PAFP quality assurance frameworks. The project is planning to carry out the costs per service delivered in the public sector for PPFP and PAFP in all the four provinces. The analysis will include a review of services by both the Population Welfare and Health Departments. The Qadam Ba Qadam project has also provided technical support to integrate PPFP/PAFP data into existing DHIS platforms to ensure centralized reporting. This includes the addition of PPFP/PAFP indicators to be reported at community level by CHWs. PPFP/PAFP SBCC approaches are also being coordinated between provincial governments and implementing partners.

Discussion Points:

- *How can we increase and diversify financing, improve funding flows, and increase efficiency in spending when scaled up FP programs cannot be fully funded by government budgets?*
- *What can be done to mitigate changing priorities when provincial governments change?*

THE DEMOCRATIC REPUBLIC OF CONGO

The Democratic Republic of Congo (DRC) has high maternal and neonatal mortality along with low mCPR. There are many missed opportunities for PPFP/PAFP, particularly immediate PPFP, due to challenges including an insufficient number of skilled providers, poor infrastructure, and a lack of commodities and tools (such as job aids). As one-off training has minimal effects on the long-term performance of service providers, continuous on-the-job training is preferable. One response has been Jhpiego's work aiming to improve the coverage of high-impact, integrated day-of-birth, and post-pregnancy interventions (including PPFP) in 16 health facilities in Kinshasa. This project increased the competency of service providers using a low-dose, high-frequency, stepwise, quality improvement, capacity strengthening approach. This involved four to five days of onsite training followed by skills practice over a few weeks, including on PPFP/PAFP counseling and service provision. Adoption of modern contraception steadily increased from less than 10 percent in 2017 to 30 percent for PPFP and 45 percent for PAFP in 2020. Current efforts are focused on local government ownership and collaboration with provisional health departments to strengthen their capacity. The intervention is being scaled-up across four provinces but there are still challenges with funding, low PPFP integration into UHC, and difficulties with Ministry of Health accountability and capacity.

Discussion points:

- *As donor funding for FP declines, what strategies can be used to influence and increase domestic funding for FP programs?*
- *What insights can be gained from successful revitalization of programs like DRC's Emergency Plan for the Revitalization of Routine Immunization (commonly referred to 'the Mashako Plan') launched in 2018 which was funded by the DRC government along with GAVI and other partners?*

VIII. Multilateral and Donor Agency Perspectives on Advancing PPFP and PAFP in UHC

Multilateral and donor agencies recognize the importance of PPFP and PAFP in reducing unmet need and improving maternal health outcomes. At the convening, they shared their perspectives on how they support PPFP and PAFP:

- USAID is advancing voluntary FP, reducing unmet need, and improving health. USAID has invested significantly in PPFP and PAFP; the two High Impact Practices briefs on postabortion FP and immediate postpartum FP are a testament to this prioritization.
- The Bill & Melinda Gates Foundation supports efforts to scale PPFP and PAFP, including addressing the needs of young, first-time parents, and advocates for recognition that PPFP and PAFP are integral components of PHC.
- WHO, as the global normative body in health, has developed programming strategies, conducted research on PPFP and through the Accelerator project, aims to increase access and availability of FP to women and girls.
- UNFPA is actively forming new partnerships and exploring innovative financing approaches, recognizing that integrating PPFP/PAFP into UHC requires taking advantage of every health care contact to offer quality FP information, respectful counseling, and services including a choice of contraceptives. Five key actions UNFPA is supporting include: strengthening health systems; ensuring availability and choice of contraceptive options; inclusive participation of women, adolescents, and youth as agents of change; supporting high-quality and timely data; and shifting the focus from funding to financing.

IX. Identifying and Ranking Priorities to Develop an Action Agenda

Following discussions on the key issues affecting PPFP/PAFP in UHC, convening participants split into four groups to identify priorities for an action agenda responding to the identified challenges and advancing successful approaches. Many priorities were identified (see Appendix C), generating robust discussion on the merits and challenges of each. Following small group discussions, participants voted on the top thematic areas and actions. While recognizing the merits of all proposed actions, the group ultimately selected three priority themes that create an enabling (or disabling) environment, and five actions that comprise an emerging consensus action agenda for strengthening PPFP/PAFP scale, quality, and coverage within UHC frameworks. These are illustrated in Figure 2 and Table 1. The actions in Table 1 have been edited to reflect plenary discussion among participants at the convening's closing session.

Figure 2: Key Thematic Areas for PPFP/PAFP Scale-up

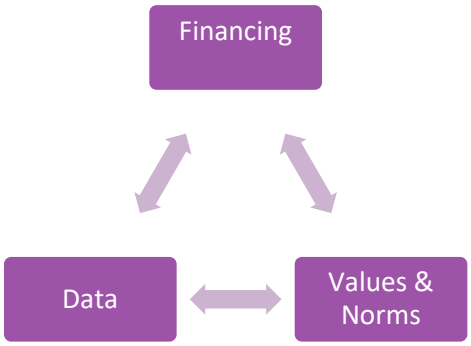


Table 1: Priority Actions to Scale up PPFP/PAFP

1. Integrate PPFP/PAFP across the health system building blocks, with an emphasis on the stewardship, governance, and leadership elements that enable adequate health financing and workforce.
2. Engage communities to address stigma, bias, social and gender norms, and increase client motivation to access PPFP/PAFP, including via digital tools.
3. Engage the private sector, support the bundling of services, expand what the private sector can provide, facilitate public-private partnerships, and assure quality.
4. Strengthen health information system coverage indicators for counseling and measurement of PPFP/PAFP for more reliable data from both the public and private sectors.
5. Reallocate financial resources for equitable access, including transition of public resources to focus primarily on the underserved; strengthen subsidized and commercial models for those who are able to pay.

Participants further discussed key audiences for the first four of these actions, and the barriers and enablers that could affect their implementation. These are summarized in Appendix D.

X. Gaps, Needs, and Next Steps in Dissemination and Advocacy

The convening discussions identified several categories of influential stakeholders who were not sufficiently or at all represented at the convening. These included leaders and donors from the global MH community, those designing and implementing PHC frameworks for health systems investments, and the Global Financing Facility. Participants agreed that sharing the convening discussions and recommendations with these communities of practice and advocating for the enabling changes identified through the discussions, are crucial to move the consensus action agenda forward. In particular, the MH community's buy-in and leadership, and a genuine belief that scaling up PPFP/PAFP will contribute to fewer maternal and newborn deaths, is crucial for PPFP/PAFP integration, from the budget, policy, and point-of-care levels.

Similarly, just as PPFP/PAFP interventions need to be included in UHC HBPs, they must be considered integral services within PHC frameworks, even if some elements of these services (e.g., FP during and after cesarean delivery) may be provided at secondary or other non-primary care facilities.

To further the inclusion of these communities of practice and build greater ownership for the action agenda, participants agreed to disseminate the proceedings and convening recommendations within their organizations and through their communications networks and platforms, as well as upcoming global and regional conferences and other technical forums.

In addition to this proceedings report, the convening will also inform two additional products being developed by the MOMENTUM Safe Surgery in Family Planning and Obstetrics project:

- A White Paper synthesizing the state of the evidence in PPFP/PAFP programming and offering recommendations about how to expand access and coverage of quality PPFP and PAFP services within UHC frameworks.
- A Call to Action distilling the consensus action agenda, serving as an advocacy tool to rally a diverse range of stakeholders—program managers, health care providers, development partners, donors, and advocates—to ensure PPFP/PAFP is included in UHC programming.

The White Paper will be published through the MOMENTUM website and the Call to Action will be released at a side event at the XXIV FIGO World Congress in October 2023.

REFERENCES

Motuma, V. S., et al. (2022). Postabortion family planning and associated factors among women attending abortion service in Dire Dawa Town Health Facilities, Eastern Ethiopia. *Frontiers in reproductive health*, 4, 860514. https://doi.org/10.3389/frph.2022.860514

Sully, E.A. et al. (2020). *Adding it up: Investing in sexual and reproductive health 2019*. New York: Guttmacher Institute. https://www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019. DOI: https://doi.org/10.1363/2020.31593

United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME). (2023). *Levels & trends in child mortality: Report 2022 - Estimates developed by the United Nations Inter-Agency Group for Child Mortality Estimation*. United Nations Children's Fund. https://childmortality.org/wp-content/uploads/2023/01/UN-IGME-Child-Mortality-Report-2022.pdf

Weinberger, M., Callahan, S. (2017). *The private sector: Key to achieving Family Planning 2020 Goals*. Sustaining Health Outcomes through the Private Sector Project, Abt Associates. https://shopsplusproject.org/sites/default/files/resources/The%20Private%20Sector-Key%20to%20Achieving%20Family%20Planning%202020%20Goals%20%282%29.pdf

World Health Organization. (2021). *Abortion*. https://www.who.int/news-room/fact-sheets/detail/abortion

World Health Organization. (2023). *Maternal Mortality*. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

World Health Organization. (2013). *Programming strategies for postpartum family planning*. https://apps.who.int/iris/bitstream/handle/10665/93680/9789241506496_eng.pdf

APPENDIX A – MEETING AGENDA

Time	Session	Speaker(s)
8:30 am	Breakfast and registration	
9:00 am	Participant welcomes	• Moke Magoma, EngenderHealth • Jane Wickstrom, United States Agency for International Development (USAID) • Gwyn Hainsworth, Bill & Melinda Gates Foundation • Vandana Tripathi, MOMENTUM Safe Surgery in Family Planning and Obstetrics/EngenderHealth
9:15 am	Review of meeting objectives, agenda, ground rules, and logistics Participant introductions and icebreaker	• Cleopatra Mugyenyi, Paica Consulting
10:00 am	Setting the stage on PPFP/PAFP within UHC: Why, how, and who?	• Saumya RamaRao, Consultant
10:20 am	Moving from commitments to action: FP2030 analysis	• Margaret Bolaji on behalf of Laura Raney, FP2030
10:45 am	MH/FP integration from the obstetrics perspective	• Aparna Sridhar, International Federation of Gynecology and Obstetrics (FIGO) • Rose Mlay, White Ribbon Alliance
11:10 am	Tea/coffee break	
11:30 am	PPFP/PAFP in UHC: Coverage, services, and financing	• Veloshnee Grover, World Health Organization (presenting virtually) • Ben Light, United Nations Population Fund (UNFPA)
11:45 am	Flashpoints in scale-up: • Flashpoint 1: MH/FP Integration of Financing and PHC • Flashpoint 2: Immediate PPFP/PAFP • Flashpoint 3: Human Resources/Task Shifting	• Eduardo Gonzales, Palladium/Marie Ba, Ouagadougou Partnership • Gathari Ndirangu, Jhpiego/Wilson Liambila, Population Council • Hellen Wilson Lutta, World Bank/Boniface Sebikali, USAID
12:30 pm	Lunch	
1:30 pm	Country case study 1: Tanzania	• Moke Magoma and Anna Temba, EngenderHealth • Farhan Yusuf, Frontier Health Markets Global Technical Assistance

2:15 pm	Country case study 2: Pakistan	• Ayesha Rashid, Pathfinder • Shabana Haider, ThinkWell Global
3:00 pm	Tea/coffee break	
3:15 pm	Country case study 3: DRC	• Virgile Kikaya, Jhpiego • Jean Lambert Chalachala, EngenderHealth
4:00 pm	Preview of Day 2	• Cleopatra Mugyenyi
6:00 pm	**Reception**	

TUESDAY, JUNE 6, 2023

Time	Session	Speaker(s)
8:30 am	Breakfast	
9:00 am	Review of themes and discussion from Day 1	• Margaret Bolaji
9:10 am	Themes in scale-up: • Role of digital tools • Community-based/Self-care approaches • Private sector/Total Market Approach • Supply chains	• Ben Bellows, Nivi • Rose Mlay, White Ribbon Alliance • Farhan Yusuf, Frontier Health Markets • Moses Muwonge, Samasha Foundation
10:00 am	Programming strategies for PPFP and PAFP: Similarities and differences	• Rita Kabra, World Health Organization
10:30 am	Directions for small group activity: Moving from commitment to action	• Vandana Tripathi
10:45 am	Tea/coffee break	
11:00 am	Small group discussions	• Small groups
12:15 pm	Lunch	
1:15 pm	Report-back from small group discussions	• Small group rapporteurs
2:00 pm	Identifying and ranking priority actions to develop a draft consensus agenda	• Vandana Tripathi

2:45 pm	Tea break	
3:00 pm	Small groups: What does it take to achieve this agenda? Barriers and enablers at the country, regional, and global level	• Small groups
4:00 pm	Report-back on small-group discussions	• Small group rapporteurs
4:45 pm	Preview of Day 3	• Cleopatra Mugyenyi

WEDNESDAY, JUNE 7, 2023

Time	Session	Speaker(s)
8:30 am	Breakfast	
9:00 am	Review of Day 2	• Saumya RamaRao
9:10 am	Getting creative – Refresher exercise	• Cleopatra Mugyenyi
9:40 am	Connecting the dots: UNFPA's perspective on advancing PPFP/PAFP in UHC	• Ben Light, on behalf of Julitta Onabanjo, UNFPA
9:50 am	Making this real: The human element in MH/FP care	• Grace Lusiola, Consultant
10:30 am	A priority action agenda for dissemination and advocacy	• Vandana Tripathi
11:00 am	Next Steps: • White Paper and Call to Action • Opportunities for continued engagement • 2023 calendar of PPFP/PAFP forums • Brainstorming additional dissemination and advocacy opportunities	• Saumya RamaRao • Vandana Tripathi • Cleopatra Mugyenyi
11:45 am	Appreciation and close	• Erin Mielke, USAID • Gwyn Hainsworth
12:00 pm	Lunch	

APPENDIX B – PRESENTER LIST

Name	Organization
Ben Bellows	Nivi, Inc.
Margaret Bolaji	FP2030
Jean Lambert Chalachala	MOMENTUM Safe Surgery in Family Planning and Obstetrics / EngenderHealth
Gathari Ndriangu Gichuhi	Jhpiego
Eduardo González-Pier	Palladium
Veloshnee Govender*	World Health Organization
Shabana Haider	ThinkWell Global
Gwyn Hainsworth	Bill & Melinda Gates Foundation
Rita Kabra	World Health Organization
Virgile Kikaya	Jhpiego
Wilson Liambila	Population Council
Ben Light	United Nations Population Fund
Hellen Wilson Lutta	World Bank
Grace Lusiola	Consultant
Moke Magoma	EngenderHealth
Erin Mielke	U.S. Agency for International Development
Rose Mlay	White Ribbon Alliance Tanzania
Cleopatra Mugyenyi	Paica Consulting
Moses Muwange	Samasha Foundation
Julitta Onabanjo*	United Nations Population Fund
Saumya RamaRao	Consultant
Laura Raney*	FP2030
Ayesha Rasheed	Pathfinder
Boniface Sebikali	U.S. Agency for International Development
Aparna Sridhar	University of California-Los Angeles and International Federation of Gynecology and Obstetrics (FIGO)
Anna Temba	EngenderHealth
Vandana Tripathi	MOMENTUM Safe Surgery in Family Planning and Obstetrics / EngenderHealth
Jane Wickstrom	U.S. Agency for International Development
Farhan Yusuf	Frontier Health Markets Engage

*Presented virtually or provided presentation remarks via a colleague

APPENDIX C – ADDITIONAL PRIORITY ACTIONS TO SUPPORT PPFP/PAFP SCALE-UP

Many priority actions were suggested, including:

- Increasing domestic financing for commodity security.
- Country-led development of national/subnational roadmaps for domestic funding of PPFP/PAFP.
- Reallocation of resources for equitable access including the transition to public resources focusing primarily on underserved populations and strengthening subsidized and commercial models.
- Supporting sustainable financing or direct resource mobilization by strengthening advocacy tools and models that encourage policy and decision makers to allocate more funding to FP.
- Sustainable financing for FP and integration of PPFP/PAFP in insurance, HBP, or essential service packages.
- Integration of PPFP across the health system building blocks (stewardship, governance, leadership, workforce, financing, integration, budget, information, community, sharing, counseling, and advocacy).
- Improving service readiness by training enough competent providers, ensuring commodity security, and building adequate infrastructure to deliver services.
- Engage communities to address stigma, social and cultural norms, and increase client motivation to access FP, including with digital tools.
- Strengthen advocacy and capacity-building approaches that apply rights-based principles.
- Strengthen social accountability and social behavior change activities.
- Review and update service delivery models to integrate PPFP/PAFP into MH points of care in all possible situations (such as in humanitarian emergencies, during complicated procedures, etc.)
- Improve tracking of PAC/PAFP in public and private sectors including tracking of client access points.
- Include PPFP/PAFP indicators in HMIS.
- Strengthen data information systems coverage indicators for counseling and measurement of PPFP/PAFP provision for more reliable statistics in the public and private sectors.
- Improve coordination between the public and private sectors in several areas including sharing information and data.
- Mainstream PPFP/PAFP into the private sector.
- Engage with the private sector through public-private partnerships to bundle services, improve quality assurance, and expand what services that the private sector can provide to clients.
- Strengthen HRH for PPFP/PAFP by increasing their numbers, increasing task shifting and sharing, and improving pre- and in-service training.
- Task shifting non-health tasks (such as paperwork) to non-health providers such as CHWs and administrators.

APPENDIX D – CONSIDERATIONS IN IMPLEMENTING THE PRIORTIY ACTIONS

ACTION	TARGET ACTOR(S)	BARRIERS/THREATS	ENABLERS/ OPPORTUNITIES
Integration of PPFP/PAFP across the health system building blocks, with an emphasis on the stewardship, governance, and leadership elements that enable adequate health financing and workforce.	Multilateral Agencies	• PPFP/PAFP is not widely discussed beyond the FP community. • Fear that discussion of FP/SRH in maternal, newborn, and child health may make it more vulnerable to political threats like FP/SRH.	• Include other players such as MH leadership in these discussions. • PPFP is largely accepted, and policies exist.
	Donors	• Competing priorities and fragmentation of funding. • Inadequate coordination within donor community.	
	Governments and policymakers	• Competing priorities for domestic funding. • Inadequate coordination between Ministries and departments. • Fragmentation of funding within system and programs. • Focus on the public sector without leveraging the private sector. • PPFP/PAFP is not included in FP budgets.	• Political will - FP in Sustainable Development Goals and national commitments is an opportunity for PPFP/PAFP integration.
	Service providers	• Inefficient referral and follow-up. • Shortage of human resources.	• Opportunities for integration with

ACTION	TARGET ACTOR(S)	BARRIERS/THREATS	ENABLERS/ OPPORTUNITIES
		• Overburdened health service providers. • FP and maternal, newborn, and child health are not integrated.	various service delivery points – ANC, immunization, and delivery services. • Increasing numbers of women are delivering in facilities.
Engagement of communities to address stigma, bias, social and gender norms, and increase client motivation to access PPFP/PAFP, including via digital tools.	Governments	• Reluctance to fund this as it is considered the role of civil society. • Linkage of rights issues with LGBTQ+ and/or western values rhetoric.	• PPFP and PAFP fall within rights-based approaches.
	Communities (religious and local leaders, service clients)	• Myths and misconceptions that are fueled by social and cultural norms including religion.	• Existing links with civil society should be leveraged.
	CSOs and NGOs	• Faith-based organizations provide services to large populations and may not want to engage in FP activities (especially PAC).	• Already have networks and platforms that can be tapped.
Private sector engagement, supporting the bundling of services, expanding what the private sector can provide, public-private partnerships, and quality assurance.	Private health providers	• Need to be oriented on PPFP and PAFP data. • Regulatory frameworks that may not enable private sector participation, especially of particular cadres.	• Interest in building capacity and training. • First point of care for considerable population segment. • Sector is active in many areas—healthcare, logistics and supply, insurance amongst others.
Strengthen data information systems, coverage indicators for counseling, and measurement of	Various government ministries (health, planning, finance)	• Lack of data collection tools.	• Digitalization of data collection.

ACTION	TARGET ACTOR(S)	BARRIERS/THREATS	ENABLERS/ OPPORTUNITIES
PPFP/PAFP provision for more reliable statistics in the public and private sectors.	National statistics agencies	• Lack of indicators (exclusion of data points in HMIS). • Lack of integration of maternal/newborn health and FP data sources. • Lack of usage of data by decision makers. • Inertia to use data for practical solutions. • Lack of feedback to data collectors. • Issues with quality and periodicity of data.	• Direct transfer of data from source to national agencies. • Work on data visualization. • Data quality monitoring (data quality assessment).

APPENDIX E – RESOURCES

Akselrod, S. et al. (2023). Getting health back on the highest political agenda—the UN High-level Meetings on health in 2023. *Lancet Glob Health*, 11(6), E819-E820. doi: 10.1016/S2214-109X(23)00166-3. Epub ahead of print.

Appleford, G, RamaRao, S, Bellows, B. (2020). The inclusion of sexual and reproductive health services within universal health care through intentional design. *Sexual and Reproductive Health Matters*, 28(2), 1799589. doi: 10.1080/26410397.2020.1799589=

Chakraborty, N.M. et al. (2019). Association between the quality of contraceptive counseling and method continuation: Findings from a prospective cohort study in social franchise clinics in Pakistan and Uganda. *Global Health: Science and Practice,* 7(1), 87–102. https://doi.org/10.9745/GHSP-D-18-00407

FP2020, Jhpiego. (2015). *Accelerating access to postpartum family planning global meeting*. *Meeting Report 8–11 June 2015 Chiang Mai, Thailand*. https://fp2030.org/sites/default/files/PPFP-Meeting-Report_FINAL.pdf

Gwatkin, D.R., Ergo, A. (2011). Universal health coverage: Friend or foe of health equity? *Lancet,* 377(9784),2160-1. doi: 10.1016/S0140-6736(10)62058-2

High Impact Practices in Family Planning (HIPs). (2022). *Immediate postpartum family planning: A key component of childbirth care*. Washington, DC: HIP Partnership. https://www. fphighimpactpractices.org/briefs/immediate-postpartum- family-planning/

High Impact Practices in Family Planning (HIP). (2019). *Postabortion family planning: A critical component of postabortion care*. Washington, DC: USAID. https://www.fphighimpactpractices.org/briefs/postabortion-family-planning/

Horton, R. (2023). Offline: The world's forgotten children. *Lancet*, 401(10383),1142. doi: 10.1016/S0140-6736(23)00728-6

Huber, D. et al. (2016). Postabortion care: 20 years of strong evidence on emergency treatment, family planning, and other programming components. *Global Health: Science and Practice,* 4(3), 481-94. http://dx.doi.org/10.9745/GHSP-D-16-00052.

Jain, A. et. (2019). Adding a question about method switching to the Method Information Index is a better predictor of contraceptive continuation. *Global Health: Science and Practice,* 7(2), 289–99. https://doi.org/10.9745/GHSP-D-19-00028

Orangi, S. et al. (2021). Examining the implementation of the Linda Mama free maternity program in Kenya. *International Journal of Health Planning and Management*, 36(6), 2277-296. https://doi.org/10.1002/hpm.3298

PAC Connection. N.d. *Postabortion care: Up to date resource materials related to postabortion care*. https://postabortioncare.org/

Pfitzer, A. et al. Opportunities and challenges of delivering postabortion care and postpartum family planning during the COVID-19 pandemic. *Global Health: Science and Practice,* (3), 335-43. https://doi.org/10.9745/GHSP-D-20-00263

Sen, G., Veloshnee, G., El-Gamal, S. (2020). *Universal health coverage, gender equality and social protection: A health systems approach*. *Background paper prepared for the 64th session of the Commission on the Status of Women 2019*. UN Women.

https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/Discussion-paper-Universal-health-coverage-gender-equality-and-social-protection-en.pdf

USAID. n.d. *Preventing child and maternal deaths: A framework for action in a changing world 2023-2030*. https://www.usaid.gov/PreventingChildAndMaternalDeaths/framework

World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). (2018). *A vision for primary health care in the 21st century: Towards universal health coverage and the Sustainable Development Goals*. https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.15

WHO. (2023). *Investing in sexual and reproductive health and rights: Essential elements of universal health coverage*. https://www.who.int/publications/m/item/investing-in-sexual-and-reproductive-health-and-rights-essential-elements-of-universal-health-coverage

WHO. (2016). *New WHO tool helps guide contraception choices following childbirth*. https://www.who.int/news/item/15-01-2016-new-who-tool-helps-guide-contraception-choices-following-childbirth

WHO. (2013). *Programming strategies for postpartum family planning*. https://www.who.int/publications/i/item/9789241506496

WHO. (2020). *Universal health coverage for sexual and reproductive health: Evidence brief.* https://www.who.int/publications/i/item/WHO-SRH-20.1

Yahner, M., Sebany, M. (2023, March 8). Can first-time parent approaches be both impactful and scalable? Findings in Bangladesh and Tanzania show promise (blog). *Save the Children, HNN*. https://www.healthynewbornnetwork.org/blog/can-first-time-parent-approaches-be-both-impactful-and-scalable-findings-in-bangladesh-and-tanzania-show-promise/#:~:text=Despite%20trade%2Doffs%20for%20scalability,Improved%20modern%20PPFP%20use