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EDITORIAL

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Strengthening the family planning component of maternal health care: A new call to action to seize the opportunity provided by universal health coverage and primary healthcare frameworks

Postpartum family planning (PPFP) is the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth.[1] Postabortion family planning (PAFP) is the initiation and use of modern contraceptives at the time of postabortion care or before fertility returns after abortion.[2] PPFP and PAFP are recognized as high-impact, evidence-based interventions that can reduce maternal and child mortality and morbidity, respond to unmet need for voluntary contraception, and accelerate progress toward the Sustainable Development Goals.[2,3] However, cross-cutting barriers have limited their scale-up in many low- and middle-income countries, despite increasing recognition of their value and impact. Although there has been progress over time and some notable success, efforts in scaling up PPFP and PAFP have been uneven, as the result of a variety of continuing barriers.[4,5]

Many countries included PPFP and/or PAFP as part of their FP2020 and FP2030 commitments.[6] The improvement over time is evidenced by the vast majority of the FP2030 commitment-making countries currently including both. In the past decade, many country programs progressed in developing policies and guidelines that encourage the strengthening of family planning (FP) provision in the postpartum and postabortion periods. However, barriers remain, including health workforce shortages and siloed program oversight, policy, and financing separating maternal health and FP services. Such barriers limit the translation of country-level commitments into expanded FP coverage within postpartum and postabortion services.

The experience of Tanzania provides a valuable illustration of both progress and persistent obstacles. PPFP and PAFP are priorities in National Costed Implementation Plans.[7,8] The Tanzania program produced comprehensive training guides for providers, and all facilities that provide delivery care are authorized at that point of care to provide PPFP for those who desire it. Recently updated antenatal care, labor, delivery, and postnatal care registers capture PPFP data. New uterotonic guidelines, the introduction of direct facility funding, and policies for free PAFP services in all public health facilities, along with the designation of specific comprehensive postabortion treatment rooms were all aimed at expanding the availability of PAFP in Tanzania. Yet, the translation of these positive changes into uptake of PPFP and PAFP is hampered by critical workforce shortages and other service readiness gaps. Only 40% of health facilities have at least one provider trained in FP, and many facilities lack essential equipment, educational materials, up to date health management information system tools, and sufficient physical space for designated postabortion treatment rooms.[9] Pervasive misinformation and sociocultural norms also reduce demand for PPFP/PAFP services.[10] These barriers are reflected in Tanzanian service delivery data as of 2022. Although there has been dramatic progress in PPFP uptake (37% of all deliveries), there is still a long way to go to fully address unmet need for FP in the postpartum period, relative to women's expressed desires. PAFP uptake reported in Health Management Information Systems has decreased slightly over this same period, from 88% in 2020 to 81% in 2022.[11] It is important to recognize that there is also likely underreporting or non-capture of all postabortion patients.

Tanzania's experience mirrors those of many other low- and middle-income countries. However, there are opportunities for action and progress. Universal Health Coverage (UHC) policies, frameworks, and benefits packages, as well as the renewed attention to primary health care (PHC), offer timely platforms to advance coverage of PPFP and PAFP, along with broader FP and sexual and reproductive health services.[12,13]

Progress on PPFP and PAFP requires specific, targeted steps to take advantage of these opportunities to strengthen the FP component of maternal and postabortion health care. A Call to Action, launched on the United Nations UHC Day, December 12, 2023, and endorsed by a wide range of global public health stakeholders, identifies the key actions that are needed to scale-up access, quality, financing, and adoption of PPFP and PAFP (see Box 1) and address current barriers that limit progress.[14] The Call to Action reflects evidence from research and program learning, as well as the deliberations of an expert consultation convened in Dar es Salaam in 2023.[9]

Taken together, these actions can strengthen three critical domains of the enabling environment required to scale up PPFP and PAFP:

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BOX 1 A Call to Action to scale up PPFP and PPFP in the UHC and PHC contexts

1. Integrate PPFP and PAFP across the six health system building blocks identified by the World Health Organization, with an emphasis on the stewardship, governance, and leadership elements that enable adequate health financing and workforce allocation.
2. Engage communities to address stigma, bias, social, and gender norms, and to understand client motivation and needs for accessing PPFP and PAFP services, including via digital tools.
3. Engage and strengthen 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 voluntary PPFP and PAFP uptake 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 on the underserved; strengthen subsidized and commercial models for those who are able to pay.

- Values and norms, not only among communities but also among providers and policy makers, that uphold full access to PPFP and PAFP
- Quality data that are used for decision making
- Financing models that promote equitable access to services

Focusing on these critical domains will also advance the UHC goals of meeting the contraceptive needs of women and girls without financial hardship. Serving individuals where they are in relation to their life course and desired fertility is both a good strategy and a way to maximize coverage.

A wide variety of steps can be taken by stakeholders to advance these actions and strengthen these critical domains. For example, to implement this Call to Action and scale up implementation of evidence-based practices for PPFP and PAFP, the World Health Organization (WHO) has embarked on a Bottle Neck Analysis to assess the factors affecting scale up and sustaining evidence-based, gender-responsive PPFP, task expansion, and social and behavior change communication. The Bottle Neck Analysis approach, under the WHO FP Accelerator Plus project,[15] is based on the notion that specific barriers prevent women and children from being the beneficiaries of essential maternal, newborn, and child health interventions and services. Data from Pakistan, Nigeria, Nepal, Indonesia, Uganda, Ethiopia, Senegal, and Cote d'Ivoire will be reviewed by national stakeholders and decision makers to enable joint reflection on the barriers and constraints they are facing and identification of the best possible, context-specific solutions and strategies to address them in a participatory manner.

Promising strategies are also evident in the literature, including in the most challenging implementation settings. For example, in Afghanistan, establishing PPFP and PAFP corners in health facility delivery rooms in Kabul and Herat provinces strengthened the uptake of long-acting reversible contraceptives during the immediate postpartum and postabortion periods.[16] Systematic reviews have identified commonalities across effective scale-up strategies related to the integration of FP into postpartum and postabortion counseling and service provision and addressing religious and social norms.[17] A forthcoming White Paper will synthesize evidence across research and program learning, to further support implementation of the Call to Action and will be made available via the Call to Action and USAID MOMENTUM websites.[14,18]

A crucial element of making this Call to Action a reality is leadership from the maternal health community, including professional associations, norms-setting institutions, donors, and maternal health experts at the global, regional, and national levels. Together, we need to move beyond the notional framing of “integration of FP and maternal health care,” so that PPFP and PAFP are not seen as add-on services but as essential parts of quality, comprehensive maternal health care. Substantial, sustained action to expand PPFP and PAFP requires their prioritization and supportive action. Concretely, this means recognizing that PPFP and PAFP are proven interventions that contribute to better maternal and newborn health outcomes; engagement to break down the silos in budgets, policies, scopes of work, training, and service delivery points that currently hinder the ability to efficiently provide FP in postpartum and postabortion services; and advocacy for the inclusion of PPFP and PAFP in PHC and UHC benefit and minimum service packages.[19] It has been estimated that a sexual and reproductive health service package comprising pregnancy-related care, management of sexually transmitted infections, essential newborn care, and contraceptive services would cost an estimated US$ 10.60 per person annually.[20] This package would avert the majority of unintended pregnancies, unsafe abortions, and maternal deaths.[21] These gains are the fundamental aims of the maternal health community of practice and support the rights of women and girls to thrive and be full participants in their communities and society.

At the service delivery level, the continuum of preconception, antenatal, delivery, postnatal, newborn, and well-child care creates many opportunities for obstetrician-gynecologists, midwives, and nurses to provide counseling and services beyond the immediate postpartum period. However, workforce shortages, inequitable distribution of providers, provider bias, lack of training, limited scopes of work, limited inter-cadre collaboration, and financial barriers leave these as missed opportunities in many settings. Obstetrician-gynecologists, midwives, and nurses are key voices in calling attention to these constraints and supporting an enabling environment for the delivery of PPFP and PAFP services as core elements of maternal health care.

It is also important to remember that, although they are closely interlinked, interventions that work for PPFP may not necessarily

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work for PAFP. Countries and implementing partners may need tailored interventions depending on where and how services are delivered to ensure that no one is left behind. For example, as self-care approaches for health gain momentum, there will be greater opportunity for girls, women, healthcare providers, and pharmacies to play a role in FP postabortion. PAFP may be provided at the primary-care level, self-managed, and/or delivered through a variety of convenient service delivery outlets such as pharmacies.[22] To ensure that PAFP is supported in these contexts, it will be necessary to pay attention to the values and preferences of users and communities, to ensure an appropriate role for the health system, as well as strong supply chains that reach the last mile, and robust regulatory and policy frameworks that govern health systems.

We urge governments, donors, and implementing partners at the global, regional, and country levels to examine the barriers to PPFP and PAFP in their own policies and programs, and to act now to expand coverage with these high-impact and evidence-based interventions, strengthening the reach, quality, and coverage of PPFP and PAFP. The potential impact is enormous: over 100 000 maternal deaths a year could be prevented with expanded access to and uptake of voluntary FP.[23]

In honor of Dr. Mahmoud Fathalla, the visionary who spearheaded the Safe Motherhood movement, it is time for us to implement proven interventions and make meaningful efforts to reduce morbidity and mortality by seizing the opportunities that UHC and PHC provide to expand the FP component of maternal health care.

AUTHOR CONTRIBUTIONS

VT wrote the first, revised, and final drafts of the paper. SR, RK, LR, AS, AT, and JW reviewed the paper and contributed to the framing, analysis, and recommendations described therein.

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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