Afghanistan Community-Based Postpartum Family Planning Program Description

BACKGROUND

Provision of family planning (FP) services to prevent unintended pregnancies and promote longer birth intervals is an essential intervention to improve maternal and child health. Its importance is highlighted by the fact that 32% of maternal deaths and 10% of childhood deaths could be prevented if FP was used in countries with high total fertility rates[1]. Available evidence suggests that birth-to-pregnancy intervals of 24 months or less are associated with adverse perinatal and neonatal outcomes, poor maternal outcomes, increased risk of prematurity, low birth weight, and neonatal mortality[2345]. Thus, a WHO consultation from 2006 recommends an interval of at least 24 months for spacing after a live birth[6].

Globally, there is substantial unmet need for contraception, particularly within 12 months following delivery. Myriad social, cultural, and economic barriers - such as financial constraints, lack of women's decision-making power over reproductive health, lack of method choices, misconceptions about contraceptives, insecurity, distance to the health facility, and a dearth of services/commodities/staff - can influence the utilization of FP services and contribute to unmet need. Strategies and programs aimed to address unmet need for contraception in the postpartum period can serve to reduce unplanned pregnancies, widen birth intervals, and increase the contraceptive prevalence rate (contraceptive prevalence rate).

The lifetime risk of maternal death in Afghanistan is 1 in 6 and 1 in 9, which translates into an estimated 26,000 women dying every year from pregnancy-related causes[7]. Only 19% of births are attended by a skilled provider[8]. The neonatal mortality rate is 60/1,000 and under-five mortality rate is 257/1,000. Total fertility rate is 6.6 (2008)[9] and CPR is 15.6% (2006)[10]. The national household survey conducted by the Ministry of Public Health (MoPH) in 2006 reported that 33% of currently married women demonstrated knowledge of at least one modern method of contraception. Data on birth-to-birth intervals in Afghanistan is currently unavailable; however, comparing with indicators from a country in the region can serve as a proxy of need for healthy spacing. As such, Pakistan Demographic Health Survey data from 2006/2007 report percentages of 33.7% for birth-to-birth intervals less than 23 months and 33.5% for 24-35 months[11].

PROGRAM RATIONALE

Afghanistan's constellation of poor national health indicators in maternal, child, and reproductive health, the need to bring services closer to the community to expand accessibility, and the evidence demonstrating the benefits of FP on improving maternal and child health outcomes, suggest that the country would benefit from the expansion of community-based FP services. Addressing unmet need in the postpartum period is imperative to improve maternal and child survival.

Therefore, the MoPH, with support from the USAID-funded Health Services Support Project (HSSP) and Tech Serve, has introduced an initiative to revitalize FP in Afghanistan through postpartum family planning (PPFP). Ultimately, this initiative will contribute to the MoPH's efforts to meet the Millennium Development Goals 4 and 5 to reduce maternal and child mortality. This initiative aligns with existing MoPH policies, including the National Reproductive Health Strategy, 2011-2015, which prioritizes birth spacing and FP and commits to increasing efforts in this area of service delivery.

OBJECTIVES

The objectives of the PPFP initiative are as follows:

- To increase CPR;
- To improve met need for pregnancy spacing (at least 24 months between the birth and the next pregnancy);
- To strengthen the capacity of the MoPH staff including community-based health care (CBHC) officers, FP trainers, community health supervisors (CHSs), and community health workers (CHWs).

COMMUNITY-BASED HEALTH CARE APPROACH

The MoPH emphasizes CBHC provision to bring health services closer to the community and meet the needs of the people of Afghanistan. Coupled with the MoPH's efforts to expand and strengthen facility-based services, this emphasis is contributing to the establishment of a continuum of care, bridging services from the health facility to the household. The primary vehicle and first level of health worker of CBHC provision are CHWs. The CHW in Afghanistan serves 100-150 families and is typically selected by the community to serve in this capacity. The CHW is between 20 and 50 years of age, a resident of the community, respected within the area, and serves on a volunteer basis. MoPH policy requires that at least 50% of CHWs trained are female. The CHW is accountable to the local Shura (council) and is regularly supervised by the CHS.

PROGRAM DESCRIPTION

To increase the utilization of contraception during the postpartum period, this initiative positions the lactational amenorrhea method (LAM) as a gateway method to other modern contraceptive methods during the first six months following delivery. LAM is a modern, short term contraceptive method for postpartum women, and is more than 98% effective when three criteria are met[12]. The initiative also focuses on promotion of healthy spacing of pregnancy in order to improve maternal and newborn health outcomes.

The four-pronged approach of the PPFP initiative includes: 1) advocacy to create an enabling environment for PPFP services; 2) capacity building to equip health workers (CHWs, CHSs and facility-based providers) with knowledge and skills to deliver the intervention package; 3) supportive supervision; and 4) monitoring.

1. Advocacy

Advocacy is conducted at all levels - from the national level to the community - to create an enabling environment and mobilize stakeholders to support PPFP. Orientation on key PPFP messages is provided to MoPH health officials, governors and district governors, CHWs, health facility providers, community and religious leaders, health shura, and Family Health Action Groups. Targeting various groups for orientation and mobilization ensures that influential individuals, who often have decision-making power regarding women's access to FP services, are exposed to key messages. Orientation focuses on the promotion of LAM and exclusive breastfeeding, the benefits of birth-to-pregnancy intervals of at least 24 months, risks of closely spaced births, and the return to fertility.

Rationale for including LAM within PPFP counseling:

- More than 98% effective as a contraceptive method
- Can be started immediately postpartum
- Child survival benefits from its promotion of exclusive breastfeeding for the first six months
- Reaches a sub-group of women who have not previously used modern contraception and can serve as an "entry point" for facilitating use of other modern methods
- Provides health benefits to the mother
- Consistent with cultural and religious practices

Reference: ACCESS-FP. The Lactational Amenorrhea Method (LAM: A Postpartum Contraceptive Choice for Women Who Breastfeed. Baltimore: Jhpiego, 2010.

Community members in Faryab review PPFP IEC materials

A PPFP advocacy meeting with the Governor of Baghlan

2. Strengthening Health Worker Capacity

Training

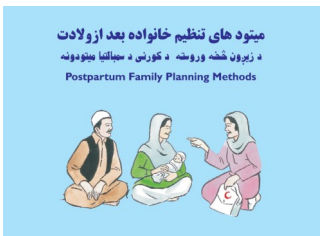
This initiative engages CHWs to visit women during pregnancy and postpartum periods and provide interpersonal counseling and communication about PPFP. While focused at the community level, facility-level health providers and MoPH officials at various levels of the health system require training to develop the appropriate knowledge and skills to support the initiative. To equip CHWs with the knowledge and skills to deliver these services, HSSP developed a CHW training of trainers' (TOT) package for PPFP. At the outset, an eight-day PPFP TOT and a four-day effective teaching skills (ETS) course were conducted at the central level for a core group of CBHC master trainers and MoPH FP officers. Moreover, a two-day PPFP orientation workshop was conducted for managers and MCH officers of NGOs contracted by the MoPH to deliver the Basic Package of Health Services (BPHS), MoPH Reproductive Health Officers, Tech Serve Provincial Health Advisors and HSSP Provincial Coordinators. After undergoing this training and orientation, participants were equipped with the knowledge and skills necessary to design, plan, implement and supervise PPFP trainings. The pool of trainers subsequently cascaded the training to CHWs at the provincial, district and village levels.

Delivery of the Intervention Package

At the community level, trained CHWs identify pregnant women and women who have delivered in the last 12 months through community mapping. In accordance with the responsibilities outlined in MoPH CHW Training Manual (2005), CHWs make household visits to women during pregnancy and postpartum periods to provide counseling on essential maternal and newborn care. After receiving training on PPFP, the CHW incorporates PPFP messages into the household counseling visits.

During the antenatal visit at eight months' gestation, PPFP counseling focuses on promotion of exclusive breastfeeding, the benefits of birth-to-pregnancy spacing of at least 24 months, and the three criteria of LAM. During the postpartum visits at 24-28 hours, one week, and 3-4 months, the CHW reinforces these PPFP messages. Moreover, during the postpartum visit at 3-4 months, the CHW provides counseling on other modern methods of contraception, depending on the mother's method preference and fertility intention for spacing or limiting. Based upon the mother's fertility intentions, the CHW can provide oral contraceptive pills, injection (Depo Medroxy Progesterone Acetate [DMPA]), or condoms. Information, education and communication (IEC) materials highlighting PPFP messages are used by CHWs as a job aid when delivering counseling.

IEC PPFP Materials:



PPFP Counseling Cover

DMPA Injection

LAM Criteria

Administrating DMPA

Messages provided by the CHWs and timing of delivery are summarized in Figure 1.

	Household Counseling Visit				
	Antenatal 8-9 Months Gestation	24-48 Hours Postpartum	Within 7 Days Postpartum	6 weeks Postpartum	3-4 Months Postpartum
Behavior Change Communication Messages					
Benefits of longer birth intervals, risks of shorter birth intervals	X	X	X	X	X
Essential newborn care, including exclusive breastfeeding and BF technique	X	X	X	X	
LAM, promotion of six months' exclusive breastfeeding, appropriate complementary feeding	X	X	X	X	X
Timing of return to fertility, signs indicating return to fertility		X	X	X	X
Transition from LAM to longer term contraceptive methods	X	X	X	X	X
Discussion of contraceptive methods, potential side effects, strategies to minimize side effects			X	X	X
Referral to health facility for contraceptive methods, if needed			X	X	X

Figure 1: PPFP Messages Delivered by CHWs and Timing of Messages

**Table adapted from ACCESS-FP Healthy Fertility Study materials*

3. Supervision

HSSP developed a Quality Assurance (QA) tool on PPFP for CHSs and CHWs to set operational, explicit, and evidenced-based standards for the delivery of services. This tool is used by BPHS-implementing NGO supervisors and managers to systematically identify gaps in the performance of CHWs and CHSs that need to be reduced or eliminated. NGO supervisors, CHWs, and CHSs can analyze the causes of the gaps and identify and implement interventions to close the gaps between actual and evidenced-based (desired) performance. In addition, self-assessments allow health workers to use the tool as a job aid. Improvements and/or compliance with the standards are recognized. The chart below shows the quality of PPFP performance in five provinces. Assessments were conducted by HSSP provincial coordinators and NGO supervisors after training to monitor quality of implementation.

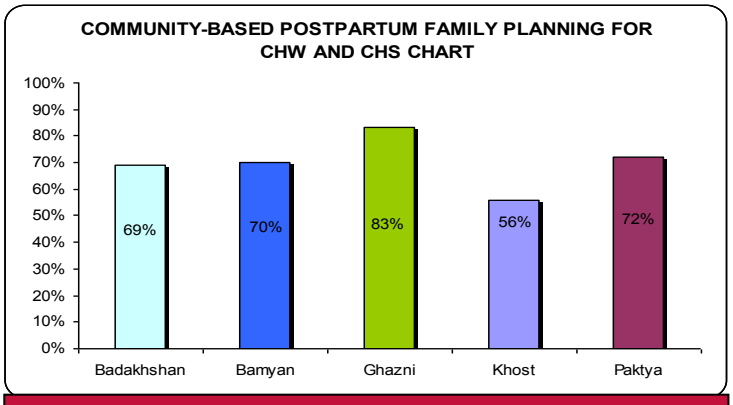


Figure 2: Percentage Achievement to PPFP Performance Standards, by Province

4. Monitoring

PPFP services (including LAM and the transition to other modern methods) were integrated in the BPHS in 2009, and corresponding key indicators will be included in the MoPH national monitoring checklist. The monitoring is conducted according to the MoPH policy on a monthly basis by representatives of the MoPH Grants and Service Contract Management Unit (GCMU). Health facility staff use specific forms to collect data from facilities and households on key indicators, which is reflected in the national health management information system (HMIS) tool. In addition, knowledge of FP methods, CPR, and exclusive breast feeding through 6 months postpartum, are indicators captured in the Afghanistan MoPH GCMU household survey, which is collected every two years.

TIMELINE AND COVERAGE

From 2007 to 2009, the PPFP initiative was implemented in 13 provinces of Afghanistan. From 2009 to 2010, the initiative expanded to another 11 provinces in the south/southeast. According to the project design, the program was later introduced to the remaining 10 provinces. Coverage throughout all provinces of the country will be completed by the end of 2011. The map below depicts the three phases of expansion.

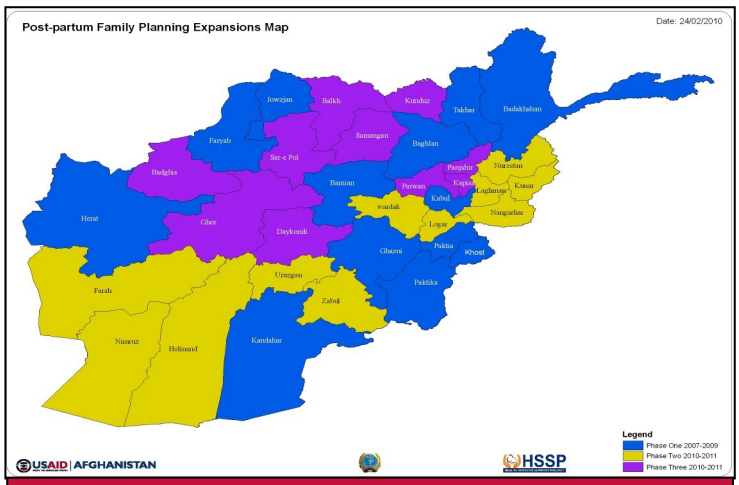


Figure 3: Phased Expansion of the Community-Based PPFP Program

As of the end of July 2011, 11,573 out of the 21,919 total CHWs in the country and 891 out of the 1,023 total CHSs in the country have received PPFP training, which represents 53% and 87% coverage, respectively. Furthermore, 140 MoPH RH Officers, NGO MCH Officers, NGO Managers, HSSP Provincial Coordinators, and Tech Serve Provincial Health Advisors also received the orientation. The 12-day ETS and PPFP TOT was conducted for 245 CHW trainers.

RESULTS TO DATE

Household survey results from the MoPH GCMU from 2009 to 2010 showed that exclusive breastfeeding increased from 38.6% to 42.8%. However, knowledge on the number of modern contraceptive methods decreased from 70.9 %to 62.7 and CPR decreased from 40.3% to 38%. In general, the declines could be explained by factors such as growing insecurity, health facility staff turnover or possible disruption to supervision and monitoring during the transition between the Performance-based Partnership Grants (PPG) and Partnership Contracts for Health Services (PCH).

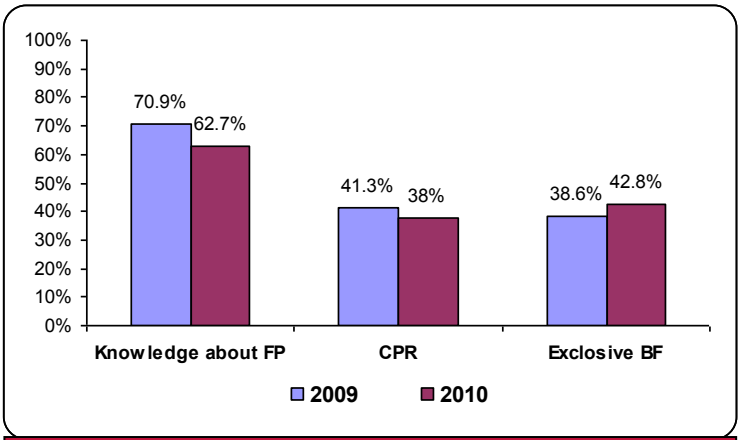


Figure 4: Key Indicators, PCH Household Survey, 2009- 2010

The PCH 2009-2010 household survey revealed some promising increases in other indicators, including delivery with a skilled birth attendant (35.7% to 38.4%), and tetanus toxoid (TT2) (46.2% to 50.2%). These results suggest that providing PPFP services within the maternal and newborn care contacts given by the CHW might be contributing to improved health outcomes for mothers and babies and should be further examined.

Based on HMIS data, the number of visits to health posts for receiving any FP method increased from 1,784,457 visits in 2009 to 1,843,591 visits in 2010. The graph below illustrates number of visits to health posts by FP method. Based on this volume of contraceptive distribution, 55.6 oral contraceptives, 6.375 condoms, and 61injectable methods contributed to 122 couple years of protection (CYP) in 2010.

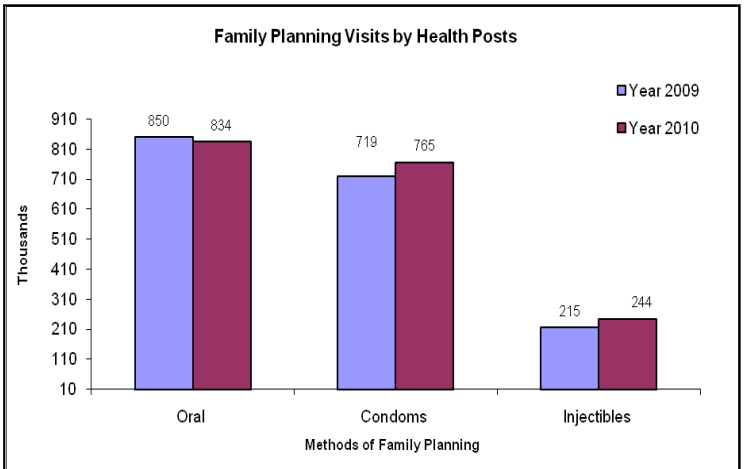


Figure 5: Number of Visits to Health Posts, by Contraceptive Method, 2009-2010

ROLES OF PARTNERS

MoPH: The MoPH is responsible for stewardship of the initiative at various levels of the health system, as well as implementation of the package through the community-based health workers. Select responsibilities are as follows:

- Participate in guiding national policy and developing standards
- Provide technical oversight and monitor implementation, in conjunction with HSSP and Tech Serve
- Implement the endorsed package of materials
- Lead national meetings on PPFP for oversight, decision-making, and quality control; these meetings include executive meetings on a monthly basis and steering committee meetings on a quarterly basis

HSSP: HSSP is responsible for providing technical direction to the MoPH on PPFP program development and implementation, particularly with regards to strengthening the capacity of the MoPH and implementing NGOs to provide PPFP services. Select responsibilities are as follows:

- Develop the PPFP CHW TOT package, including IEC materials and Myths and Realities Facts Sheet
- Train a pool of master trainers in PPFP and technically support the cascade of training at the provinical level
- Develop evidence-based standards on PPFP for CHSs and CHWs and train health workers on implementation of the QA methodology
- Design a national database for tracking assessment results on the QA PPFP tool
- Provide technical direction to the MoPH and support effective implementation
- Support and build capacity of the CBHC unit to assume the lead for implementation

TECH-SERVE: Tech Serve is responsible for providing technical direction to the MoPH on PPFP program development and implementation, particularly with regards to monitoring and evaluation. Select responsibilities are as follows:

- Coordinate PPFP action plan development with the MoPH, Provincial Health Advisors, and HSSP
- Train CHSs in 20 provinces in PPFP
- Perform monitoring and evaluation of project activities

LESSONS LEARNED

- LAM is an acceptable method of contraception in a religiously conservative environment: Islam promotes a minimum recovery period of two years after delivery by pointing towards two years of breastfeeding that women can achieve because they are not becoming pregnant through PPFP. Because this linkage with the LAM method, community leaders are promoting the method, as well as the benefits of birth spacing in mosques during Friday prayers. This support by community leaders has increased community and household acceptance of LAM as a modern method.
- Community involvement is integral to increasing demand for FP methods: The community should be enlisted as an active partner in any endeavor to improve health services. Advocacy at the community level through Family Health Action Groups and health shuras ensured that key PPFP messages reached influential members of the community to ensure an enabling environment.

LESSONS LEARNED (Continue…)

- Expanding access to services at the community level is important for increasing utilization: Results indicate increases in contraceptive utilization at the health posts, where services are provided by CHWs. Community-based services appears to be a feasible method for expanding access to contraceptive methods and therefore, advancing efforts to reduce maternal mortality.

SNAPSHOT

The valuable contribution of a community midwife

CHW Marofa holding a flipchart containing pictorial messages

In the village of Kakara, in the Qarabagh District of Afghanistan, a community health worker is welcomed into a house, where she will provide life-saving educational messages for a mother and her eight-day-old baby. Seven years ago, health services in this area were virtually non-existent and maternal and newborn deaths were commonplace. Today in Kakara, Marofa Sohila is working to improve the health of women and babies in her community—one family at a time.

During this visit to Pari's home, Marofa continues the education she began while visiting the mother before she gave birth—with no complications—at the district hospital. The goal is to persuade the 37-year-old Pari to do what she hasn't done before—plan her next pregnancy.

In Afghanistan, expanding access to and use of contraceptives is imperative to saving mothers's lives.

After 23 years of conflict, the country's health system had been nearly destroyed and health indicators for women and children were abysmal. Today, one Afghan woman dies every 30 minutes from pregnancy-related causes, such as bleeding, obstructed labor or infection; however, 78 percent of these deaths are largely preventable. There are proven approaches to reducing maternal deaths, including increasing access to family planning with related reproductive health services, skilled attendance during pregnancy and childbirth, emergency obstetric care and immediate post-delivery care. Women and their children are the primary beneficiaries.

The Health Services Support Project, which is funded by the U.S. Agency for International Development, is working with the Ministry of Public Health in Afghanistan and the Tech Serve Project to revitalize and expand community-based postpartum family planning services. At the outset, the ACCESS-FP program provided technical assistance to develop national training and educational materials. Through this program, 8,500 community health workers in 13 provinces have received the training and materials needed to bring this vital information to women in remote villages.

Only 16 percent of Afghan women between the ages of 15 and 49 use modern methods of contraception, and a woman will give birth to an average of seven children.

In Kakara, the newest addition to Pari's family, daughter Safo, is her fourth child. Pari's other three children are ages seven, four and three.

Active and respected in the community, Marofa, the community health worker, is warmly greeted on her second visit to Pari's home since the new baby arrived. In some areas of Afghanistan, the culturally accepted practice of *purdah* would prevent Pari from leaving the house for 40 days after birth. That's why home visits are so important; they provide a vital link between the health facility and the mother.

Pari listens attentively as Marofa begins the counseling session by displaying a flipchart with pictorial messages. Many villagers in Afghanistan, like Pari, are non-literate, and the flipchart illustrations convey the critical messages that should improve health outcomes for Pari and her baby girl.

Pari's mother-in-law and sister-in-law sit beside her, studying the pictures as Marofa points to them and explains the importance of timing and spacing of births for the health of the mother and children.

Marofa explains that use of the lactational amenorrhea method (LAM) can prevent pregnancy if the baby is less than six months old, the mother is exclusively breastfeeding and her menstrual cycle has not returned. Pari is familiar with the criteria for using LAM because Marofa had talked to her about this method in one of her previous visits. Pari confides that she is using LAM and will continue to use it so that "she can be healthy and [her] baby will be healthy."

The mother-in-law silently nods her head when Marofa reminds the women that the Koran says that babies should be exclusively breastfed and children should be spaced two years apart. The mother-in-law is influential within the household; ultimately, her support will determine whether Pari will move ahead with another method for birth spacing after she is no longer eligible for LAM.

The community health worker is careful to include the mother-in-law and Pari's other support persons in the counseling sessions so that the female members of the household are I nformed about the health benefits of birth spacing. Over the next six months, Marofa will make several other visits to the home to continue counseling and provide Pari with family planning options, if she chooses.

The community health worker's visits aren't for mother alone. Children are a blessing to Afghan families and the community. By providing community-based education about the advantages of healthy timing and spacing of births, Marofa is ensuring a healthier future for Pari and her children.

As she holds the new baby in her arms, Marofa smiles.

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