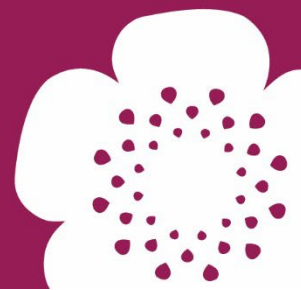


# Postpartum Family Planning (PPFP) in the Democratic Republic of the Congo

Results from a Key Intervention to Increase Counseling, Quality of Care, and Uptake among PPFP Clients



## Background

Postpartum family planning (PPFP) is the prevention of unintended and closely spaced pregnancies during the first 12 months following childbirth (WHO 2013). The postpartum period is an important time for helping women understand and use family planning (FP). Women are more likely to engage with the healthcare system during pregnancy, childbirth, and the year thereafter. Each time a woman seeks care during these times is an opportunity for healthcare workers to integrate FP into their existing counseling and services to better meet the needs of these clients.

In 2013, the World Health Organization (WHO) and its key partners published programmatic strategies for PPFP to support program managers in integrating PPFP into national and local health strategies. These strategies highlighted convenient entry points for PPFP interventions, including antenatal care, labor and delivery services, postnatal care, immunization services, and child health services.



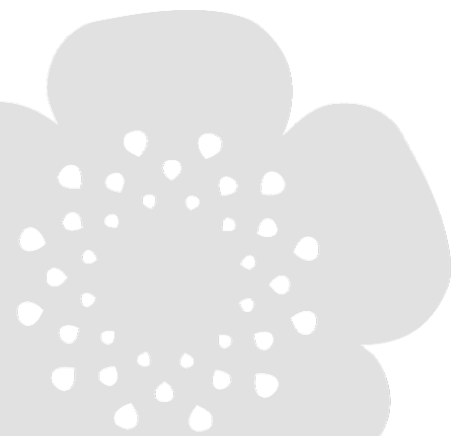
A PPFP client registers for FP counseling at a project-supported clinic

*Photo Credit: EngenderHealth / ExpandFP II*

The Democratic Republic of Congo (DRC) has the third highest fertility rate globally at 6.6 children per woman, as well as a national maternal mortality rate of 846 per 100,000 live births and an adolescent birth rate of 138 per 1,000 teenage mothers. FP can help reduce maternal mortality, but in 2021, the contraceptive prevalence rate in the DRC was only 15.5% (FP2020 2020). The DRC's high rate of unmet need for modern contraception (21%) (UN 2021) is attributed to several factors, including poor integration of FP within the packages of services offered at the health facility level.

At the national level, the Ministry of Health (MOH) is committed to implementing the 2014–2020 Family Planning Strategic Plan, which aims to ensure access to and use of modern FP methods to at least 21 million additional users by 2020 (DRC MOH 2014). In the DRC, 89% of women receive antenatal care from a qualified provider and 82% give birth in a health facility. These high coverage rates for maternal and child health services highlight opportunities for voluntary PPFP counseling and service delivery.

Since 2019, EngenderHealth's ExpandFP II project has worked with the MOH to scale up integration of PPFP. This brief describes how ExpandFP II collaborated with the MOH to integrate PPFP across 15 facilities in Kinshasa to promote access to and voluntary adoption of FP among postpartum clients.



## **Project Strategy**

ExpandFP's PPFp integration strategy had three key components:

1. Ensuring that there is a coordinated effort for PPFp integration among various stakeholders
2. Training and supervising providers to improve their capacity to deliver a wide range of PPFp methods to suit clients' individual preferences
3. Improving PPFp monitoring, so that a client's choice can be recorded and verified at delivery

Together, these strategies sought to increase the number of women receiving PPFp through improved availability and quality of PPFp counseling and service provision.

## **Consultative Meetings**

In 2019, ExpandFP II supported the MOH with the consultative framework meetings “Cadre de Concertation” (the Cadre). These meetings aimed to coordinate PPFp activities and interventions throughout the country. These meetings included representatives from the MOH and other in-country partners and donors. Members of the Cadre also conducted advocacy work to garner commitments from the MOH and other stakeholders to promote and scale up PPFp activities nationwide. Through this consultative framework, ExpandFP II also contributed to aligning, developing, and updating national PPFp policy documents.

## **Provider Training**

ExpandFP II helped the MOH establish a comprehensive, continuous, and sustainable training system for PPFp interventions at all levels of the country's health system. The project provided capacity building to promote maximum retention of provider clinical knowledge, skills, and attitudes—including through short, targeted in-service simulation-based learning activities that were spaced over time and reinforced with structured, ongoing practice sessions at the facility. ExpandFP II and its partners worked together to harmonize their respective FP training approaches to develop an integrated manual for PPFp for use at the facility level.

## **Supportive Supervision**

ExpandFP II supported the MOH financially and technically to facilitate PPFp supervision. Our approach emphasized mentoring, joint problem-solving, and two-way communication to improve service quality. The project cascaded trained supervision from the national to the peripheral level on a quarterly basis, and from the peripheral level to health facilities. During the supervision visits, certain key aspects of quality assurance underwent review, such as service delivery, stock management, infection prevention, coordination of activities, and data quality. This provided the health system with a coherent view of PPFp interventions so that the MOH and its partners could identify specific issues common at all levels while improving the quality of FP services.

## **Improving PPFp Monitoring**

The integration of PPFp at lower-level health facilities required facilities to have access to standardized monitoring tools to ensure they could routinely collect service delivery data on client adoption of FP methods as well as capture learning around PPFp interventions. The project supported the MOH to revise and adapt the existing data collection forms to include PPFp information. These data collection forms are completed using registers and cards for each client visit at different service delivery sites (FP, antenatal care, childbirth, and postnatal care). The new data collection forms are the first example of PPFp integration in the DRC.

## Results

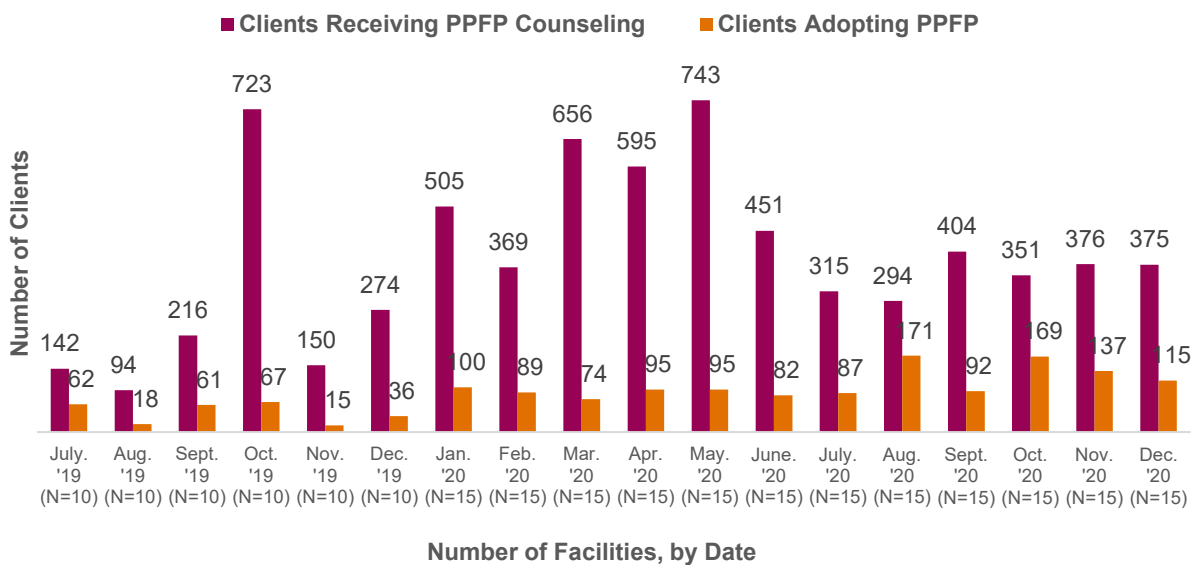
Before the intervention, PPFM uptake prior to discharge was not routinely measured. Between July 2019 and December 2020, 8,115 women delivered at project-supported sites; 88.6% (7,033) of these clients received PPFM counseling and 19.2% (1,565) of those clients adopted a PPFM method before discharge (see Figure 1).

**Figure 1. Clients Delivering, Receiving PPFM Counseling, and Adopting PPFM Methods at Project-Supported Sites (July 2019 to December 2020)**



Furthermore, service data tracking the number of clients who delivered at project-supported facilities, who received PPFM counseling, and who adopted a method between 2019 and 2020 revealed a nearly continuous increase over this period—from 142 clients counseled in July 2019 (44.9% of deliveries) to 375 in December 2020 (73.8% of deliveries) (see Figure 2).

**Figure 2. Trends in PPFM Counseling and PPFM Uptake (July 2019 to December 2020)**



## Summary

Using a comprehensive PPFp scale-up strategy with tailored support to providers, ExpandFP II, in collaboration with the MOH, successfully contributed to a progressive increase in uptake of PPFp over the course of the project. More specifically, our findings suggest that the ExpandFP II project was successful in increasing PPFp uptake, through a combination of service expansion efforts, including training, clinical mentorship, and technical assistance. Our learnings suggest this approach enabled providers to gain an understanding of the need to integrate PPFp messages with other counseling delivered to clients during antenatal care and around childbirth. The project's achievements and lessons learned can and should inform future programs aimed at further increasing uptake of PPFp services.

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