Statement for Collective Action for Postpartum Family Planning

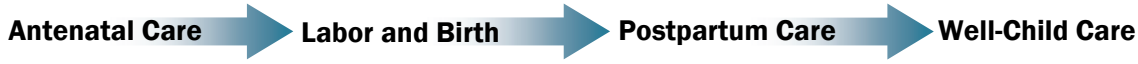
This statement for collective action is for all programs that reach postpartum women during the first year following a birth to integrate PPFP counseling and services into their programs.

Programs should prioritize reaching postpartum women, the group of women with the greatest unmet need for FP, in their strategic and operational plans and budgets, including updating the knowledge and skills of a range of providers, offering integrated PPFP services in facilities and communities, and ensuring that a broad range of contraceptive options are available to women, men and couples.

What Is Postpartum Family Planning?

Postpartum family planning (PPFP) is the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth. Not only do pregnancies during this period hold the greatest risk for mother and baby, the first 12 months after childbirth also present the greatest opportunities in terms of number of contacts with health care services.

Continuum of Health Care Contacts with Opportunities to Offer PPFP



Why Is PPFP Important?

Even though PPFP saves lives, women in the extended postpartum period often do not receive adequate attention or the family planning (FP) services necessary to ensure access to lifesaving contraception during this vulnerable time.

- According to an analysis of Demographic and Health Survey data from 27 countries, 65% of women who are 0–12 months postpartum want to avoid a pregnancy in the next 12 months but are not using contraception.[1]
- FP can avert more than 30% of maternal deaths and 10% of child mortality if couples spaced their pregnancies more than two years apart.[2] Closely spaced pregnancies within the first year postpartum are the riskiest for mother and baby, resulting in increased risks for adverse outcomes such as preterm, low birth weight and small for gestational age. Pregnancy occurring within six months of the last delivery holds a 7.5-fold increased risk for induced abortion and a 1.6-fold increased risk of stillbirth.[3]
- Postpartum women may not realize they are at risk of pregnancy even if they are breastfeeding. A study in Egypt found that 15% of breastfeeding women, who were not using the Lactational Amenorrhea Method of contraception, conceived prior to resumption of menses.[4]

Strategies to Address Unmet Need for PPFP

Raise Awareness of FP Needs of Postpartum Women: Providers, women, their families and communities, as well as policymakers and program managers, are often unaware of the need for PPFP and/or don't know that a woman's fertility can return in the early months after birth and that with timely initiation most contraceptive methods are safe for the breastfeeding mother. In addition, policymakers need compelling arguments to expand their focus beyond antenatal care, labor and delivery care, and child care, to address postpartum care, including PPFP.

Ensure No Missed Opportunities across the Continuum of Care: The continuum of care throughout a woman's pregnancy, childbirth and postpartum provides an array of opportunities to reach her with FP counseling and services. Between 50% and 60% of pregnant women make prenatal visits or have contact with health care providers at or soon after delivery, and additional contacts occur for infant care and other child health services.[5] And when PPFP is introduced in the context of primary care, including comprehensive maternal, newborn and child health (MNCH) services encompassing antenatal, birth, newborn, immunization, nutrition and community health care, it provides more acceptable, timely and effective ways of reaching postpartum women and addressing their FP needs.[6,7]

Organize Services: Efficient organization of services is essential to allow enough time to include FP counseling and decision-making, and to ensure that integrated services, such as birthing units or immunizations sessions, have all the necessary equipment, supplies, contraceptives and trained staff to provide FP, including long-acting and/or permanent methods. Preservice and inservice training of all MCH healthcare providers should ensure that all are skilled in PPFP counseling and services.

Maximize Community-Based Care: A recent review indicated that 50% of all births occur outside of health institutions[8] and of those, 70% receive no postpartum care. As a result, these women have limited opportunities to receive FP information or services. And disadvantaged groups such as adolescents, minorities, and rural women may have even less access. Community health workers can bring information and services to women and men in the communities where they live, rather than requiring them to visit health facilities, which may be distant or otherwise inaccessible. Men may effectively be involved in PPFP in their role in decision-making, in influencing the attitudes of families and communities, and as clients.

Expand the Range of Options: PPFP methods that can be initiated immediately following birth include: 1) the intrauterine device, which can be inserted immediately and up to 48 hours after birth or after four weeks; 2) a tubal ligation, which can be performed up to one week after birth or after six weeks; or 3) a vasectomy, which can be performed for the woman's partner any time during pregnancy or the postpartum period. In fact, vasectomy is a very appropriate and convenient postpartum method because the 12-week period that it takes before the male is infertile coincides with the normal practice of postpartum abstinence. The extended postpartum period provides the only opportunity for a woman to use the Lactational Amenorrhea Method (LAM)[1], which can be effectively used up to six months postpartum while the mother is fully breastfeeding, thus providing important nutrition to the infant. Other methods, including pills, injections, implants and condoms, can be safely used by the breastfeeding or non-breastfeeding mother, although desired time of initiation may vary by method and breastfeeding status.

Potential Program Benefits of Implementing PPFP

The postpartum period, especially the immediate postpartum period, is a time during which couples generally have multiple encounters with the health care system. Providing contraception during this time is cost-effective and efficient because it doesn't require significant increases in staff, supervision or infrastructure.[9] Also, for many women who rarely contact the health care system, FP provided in the immediate postpartum does not require a costly and inconvenient return to the facility, and thus expands the opportunities for reaching couples with FP.

Integrating PPFP into MNCH programs and services contributes to expanded services for women during the first year postpartum and increased use of FP among women and their partners during the first year postpartum, and can result in dramatic reductions of high-risk pregnancies, reduced unmet need for FP, and improvements in the health and survival of mothers and children.

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[1] Ross J and Winfrey W. 2001. Contraceptive use, intention to use and unmet need during the extended postpartum period. *International Family Planning Perspectives.* 27(1): 20–27.
[2] Cleland J et al. 2006. Family planning: The unfinished agenda. *The Lancet.* 368(9549): 1810–1827.
[3] DaVanzo J et al. 2007. Effects of interpregnancy interval and outcome of the preceding pregnancy on pregnancy outcomes in Matlab, Bangladesh. *BJOG.* 114(9): 1079–1087.
[4] Shaaban OM, Glasierr A. 2008. Pregnancy during breastfeeding in rural Egypt. *Contraception.* 77(5):350–354.
[5] Ross and Winfrey op. cit.
[6] Huntington D and Aplogan A. 1994. The integration of family planning and childhood immunization services in Togo. *Studies in Family Planning.* 25(3): 176–183.
[7] Saeed GA et al. 2008. Change in trend of contraceptive uptake—effect of educational leaflets and counseling. *Contraception*. 77(5): 377–381.
[8] Fort A, Kothari M and Abderrahim N. 2006. *Postpartum Care: Levels and Determinants in Developing Countries*. Calverton, Maryland, USA. Macro International, Inc.
[9] Singh S et al. Guttmacher Institute and UNFPA. 2009. *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*. New York. Guttmacher Institute and UNFPA.

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[1]LAM requires 3 criteria: 1) no return of menses, 2) fully or nearly fully breastfeeding, and 3) infant less than 6 months of age.