

Immediate Postpartum Family Planning

What is the proven high-impact practice in family planning service delivery?

Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility.

Background

Offering modern contraception services as part of care provided during childbirth increases postpartum contraceptive use and is likely to reduce both unintended pregnancies and pregnancies that are too closely spaced.^{1,2} Unintended and closely spaced births are a public health concern as they are associated with increased maternal, newborn, and child morbidity and mortality.³⁻⁵ After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months, based on a consultation convened by the World Health Organization (WHO), in order to reduce the risk of adverse maternal, perinatal, and infant outcomes.⁶ Despite this evidence, 61% of women are not using effective contraception within 24 months postpartum to avoid an unintended pregnancy.⁷



Mothers and their newborn children in the post natal ward at the district hospital in Arrah, Bihar. ©Bill & Melinda Gates Foundation/Ryan Lobo

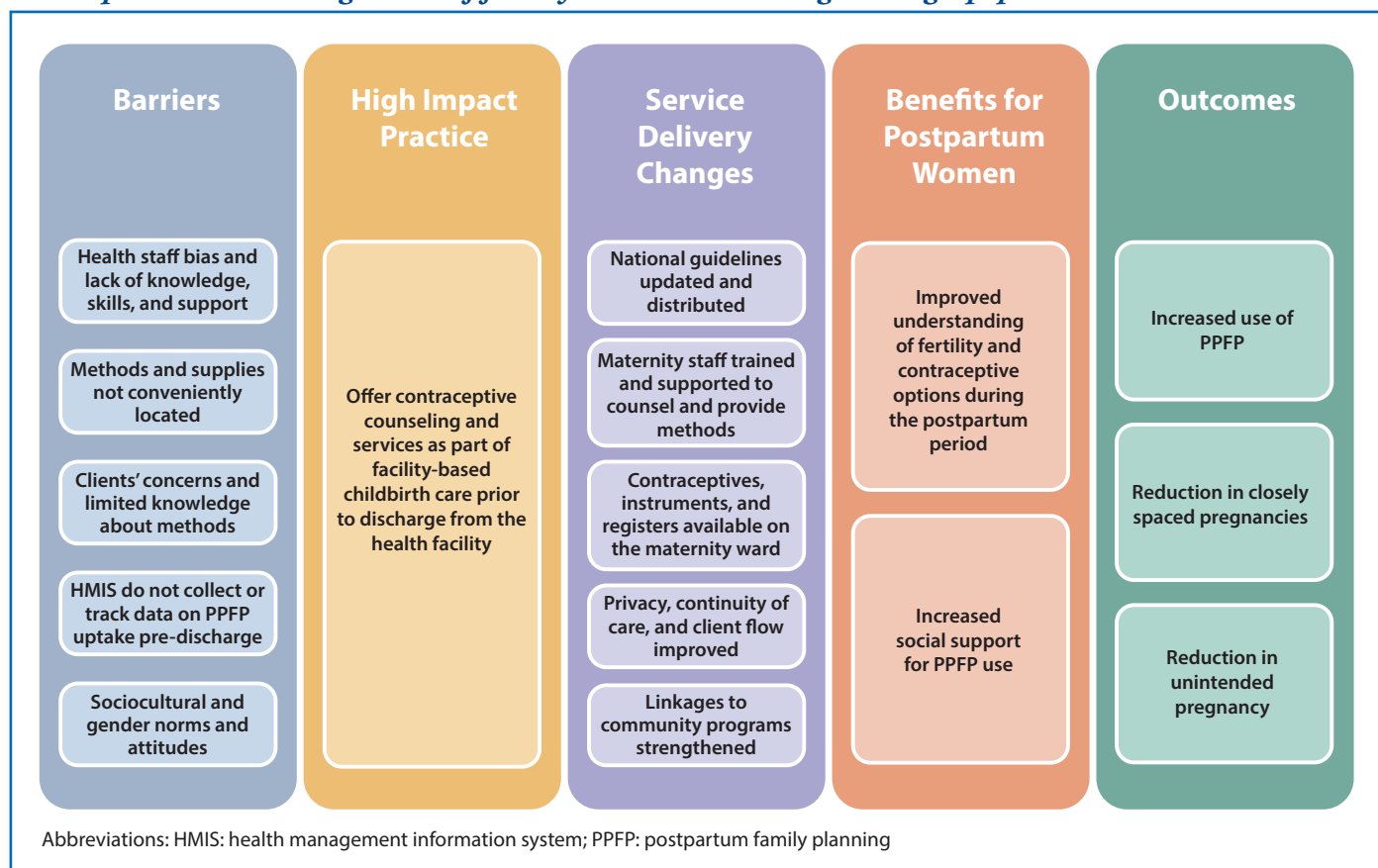
There are many reasons why women do not use effective contraception during the postpartum period, such as sociocultural and gender norms that guide postnatal practices,^{8,9} timing of return to sexual activity,¹⁰ breastfeeding practices and misconceptions of conditions for lactational amenorrhea,^{8,11} and lack of access to contraceptive services (see Figure 1). This High Impact Practices in Family Planning (HIP) brief summarizes the evidence and provides implementation tips for proactively offering family planning as part of care during and immediately after childbirth, often referred to as the immediate postpartum period. (Offering services during the postpartum period is a common approach to addressing gaps in access to services; see, for example, the [Family Planning and Immunization Integration](#) HIP brief.)

WHO recommends that women receive information on family planning and the health and social benefits of birth spacing during antenatal care, immediately after birth, and during postpartum and well-baby care, including immunization and growth monitoring.¹² Each visit to a health professional offers a unique opportunity to screen for, counsel, and offer family planning services. Yet each opportunity requires deliberate attention to organize services, update policies and provider practices, and mobilize resources for successful implementation. Facility-based childbirth services offers an ideal platform to reach women and their partners with family planning information and services, provided women's right to make a full and informed choice are respected.

Immediate postpartum family planning (PPFP) is one of several proven HIPs identified by a technical advisory group of international experts. A proven practice has sufficient evidence to recommend widespread implementation as part of a comprehensive family planning strategy, provided that there is monitoring of coverage, quality, and cost as well as implementation research to strengthen impact.¹³ For more information about other HIPs, see <http://www.fphighimpactpractices.org/overview>.

Figure 1. Offering Family Planning Counseling and Services at the Same Time and Location as Facility-Based Childbirth Care: Theory of Change

Assumption: There are high levels of facility-based births among the target population.



It is recommended that programs implementing postpartum family planning include the following indicators:

- Number/percent of women who delivered in a facility and received counseling on family planning prior to discharge (disaggregated by age group, <20 years vs. ≥20 years).
See [MEASURE Evaluation FP/RH Indicators Database](#).
- Number/percent of women who deliver in a facility and initiate or leave with a modern contraceptive method prior to discharge (disaggregated by type of method and age group, <20 years vs. ≥20 years).
See [MEASURE Evaluation FP/RH Indicators Database](#).

Why is this practice important?

Providing family planning counseling as part of childbirth care raises awareness of the importance of birth spacing and postpartum contraceptive options. Women and their partners often have limited understanding about contraceptive options, return to fertility, and risks of a closely spaced or unintended pregnancy soon after childbirth.^{8,9,11,14} Providers, women, and their support networks cite concerns about contraceptive side effects, especially related to effects of hormonal contraceptives on breast milk and the child's health as reasons to avoid contraception during the postpartum period.^{7,15} In settings where women seek care well before active labor or in communities where women are able to recuperate in a facility after birth, family planning counseling can be incorporated into care around the preparation for childbirth and/or immediately thereafter; these approaches are considered acceptable to both providers and clients. Providing information at this time can improve knowledge and attitudes regarding the use of postpartum contraception.¹⁶⁻¹⁹

An increasing number of women and their partners can be reached through facility-based childbirth services. Globally, 4 of 5 births take place with the assistance of a skilled birth attendant, and increasingly these births are taking place in health facilities.²⁰ For example, in Bangladesh, deliveries in health facilities increased from 17% to 37% between 2007 and 2014. During a similar time frame, facility deliveries increased from 39% to 72% in Burkina Faso and from 43% to 64% in Kenya.²¹ As countries continue to strengthen facility-based childbirth care, this will be an increasingly important platform to reach women and their partners with family planning services.

Women have more contraceptive options during the immediate postpartum period. Based on a consultation convened by WHO, women can safely use contraceptive implants during the immediate postpartum period,²² in addition to many other types of contraceptives (see Box). Therefore, immediately after birth, women may choose from a wide variety of contraceptives including hormonal and non-hormonal, long- and short-acting, and permanent methods.²³

What is the impact?

Offering modern contraception as part of childbirth services increases postpartum contraceptive use. Immediate postpartum family planning is not a new concept. The International Postpartum Program, implemented from 1966 to 1973 in 138 institutions across 21 countries and reaching 3.5 million women, demonstrated the feasibility of providing family planning services in the context of hospital-based obstetric care. In 1971, at the height of implementation, approximately 21% of obstetric patients in participating facilities obtained contraception during the immediate postpartum period, proving that family planning services could be incorporated into obstetric wards quickly and at low cost.²⁴ The program is estimated to have averted 500,000 unwanted pregnancies over its 8 years of implementation.²⁴

Box: Contraceptive Options During the Immediate Postpartum Period

For breastfeeding women:

- Female sterilization
- Male sterilization
- Intrauterine device (IUD)
- Implants
- Progestogen-only pills
- Lactational amenorrhea method (LAM)
- Condoms

For non-breastfeeding women*:

- Female sterilization
- Male sterilization
- IUD
- Implants
- Injectables
- Condoms
- Emergency contraception

* Promote advance provision of Combined Oral Contraceptives while women are in the facility with counseling to begin after 21 days.

Source: WHO Medical Eligibility Criteria for Contraceptive Use (2015).²²

More recent experiences consistently demonstrate the potential impact of this practice. Table 1 summarizes experience from 5 country programs, 3 of which are based on unpublished data. The timeframe examined in all the studies was the immediate postpartum period prior to women leaving the facility. Studies were considered if multiple contraceptive methods were offered. Taken together, old and new, these findings show that if women are provided comprehensive counseling and are proactively offered contraception from a range of choices as part of childbirth care, between 20% and 50% of women will leave the facility with a method. This is consistent with evidence from India, Nepal, and Senegal that found women were significantly more likely to be using modern contraception postpartum if they were offered family planning services at the time of delivery.²⁵⁻²⁷

Table 1. Percentage of Women Giving Birth Leaving the Facility With a Modern Contraceptive Method, Before and After Introduction of Contraceptive Counseling and Services During Childbirth Care

Country	Before	After
Afghanistan ^{28,29}	4% (180/4179)	51% (1700/3362)
Honduras ^{30*}	10% (47/474)	33% (188/571)
Honduras ^{31†}	9% (23/251)	46% (142/308)
Indonesia ³²	9% (307/3373)	41% (1286/3101)
Niger ^{33,34}	0% (7/2193)	31% (686/2213)

* Hospital Escuela, the government-run hospital.

† Hospital Materno-Infantil in Tegucigalpa, the Honduran Social Security System.

How to do it: Tips from implementation experience

Invest in good documentation and monitoring to help ensure voluntarism and informed choice.

Childbirth can be a stressful and challenging time for women. Clear documentation and recordkeeping, along with consistent monitoring, can help programs assess progress while ensuring clients' rights are protected. For example, when counseling is provided during antenatal care, method choice should be indicated on the client's record, whether it be a woman-held card or a facility chart. This documentation facilitates communication across providers who are caring for the same client and ensures continuity of care. The record should emphasize method choice or refusal, rather than whether or not counseling was provided.

Update national service delivery guidelines and clarify the role of service providers. This is particularly critical if existing guidelines reflect delayed start of progestin-only methods, like implants, which are now an option for immediate PPFP use according to WHO's 2015 *Medical Eligibility Criteria for Contraceptive Use* (5th edition).²² Guidelines as well as job descriptions should clearly articulate that all antenatal and maternity care providers have a role in PPFP, and that it is not just the responsibility of a few trained provider(s). The role of community health workers in promoting PPFP can also be specified

Conduct formative assessments to guide social and behavior change strategies. Understanding barriers to PPFP uptake and tailoring programmatic approaches to address those barriers can improve uptake.³⁵ Programs have found that when first starting PPFP services, providers can identify interested clients through counseling during antenatal care services and at birth. As services become established, and programs seek to increase uptake on a sustained basis, demand creation at the community level is needed.³⁶ This is particularly

helpful in contexts where misinformation and resistance to intrauterine devices (IUDs) or long-acting reversible contraceptives (LARCs) is strong in the community in general.³⁶

Consider home visits if targeting PPFP adoption among first-time, young parents. Programs targeting young married women and adolescents have found value in using home visits or community group engagement.³⁷ (See the [HIP brief on Community Group Engagement](#).) Mothers-in-law, co-wives, and other senior women are key influencers of married adolescents. These programs documented the need to carefully test strategies for approaching and counseling young married women, as well as their partners and senior women in the household.³⁸⁻⁴⁰

Offer the broadest range of contraceptive methods possible and make them available prior to maternity discharge. Institutions that demonstrate marked improvements in postpartum contraceptive uptake did so by expanding the method mix and by focusing on method adoption during the pre-discharge period. For example, in Honduras, the range of methods available was expanded from IUDs and female sterilization to include progestin-only oral contraceptives and condoms. The result was a fivefold increase in the percentage of postpartum women leaving the hospital with a method of their choice, from 9.2% in December 1990 to 46% in February 1992.³¹ A study in Egypt found that counseling on and advance provision of emergency contraceptive pills for LAM users in the event of a delay in transitioning from LAM to another method significantly decreased the incidence of unintended pregnancy and increased timely transition to another method.⁴¹

Consider leveraging antenatal care visits to educate clients on contraception. While the effect of including family planning counseling as part of antenatal care on increased PPFP uptake is unclear, doing so allows women to fully explore their intentions and to make an informed decision about contraception before delivery.⁴² Counseling earlier during a pregnancy may be particularly helpful if introducing IUD or sterilization as women often need more time to consider and discuss these options with their partners.

Do not forget men. Male involvement during and after pregnancy can reduce the occurrence of postpartum depression and improve use of maternal health services, such as skilled birth attendance and postnatal care.⁴³ The effect of male involvement in maternity care on postpartum contraceptive use is unclear.⁴³ Yet inequitable gender norms have a powerful effect on women's ability to make and act on decisions about birth spacing and limiting. Providing men and women the opportunity to engage in family planning discussions as part of maternity care—together or separately—can directly address these inequitable norms and create space for joint decision-making for effective use of family planning.

Plan for contraceptive uptake later during the postpartum period. In Rwanda, the PPFP counseling session is an opportunity to make a plan for returning to a facility for postnatal care and immunization and for obtaining a PPFP method at that time. Data from one quarter in 2017 from 10 districts showed that 24% of women adopted a method pre-discharge and an additional 67% left with a plan of when to start. Immunization services tend to reach high coverage and provide a possible platform for linking or integrating family planning services (see related HIP brief on [Family Planning and Immunization Integration](#)).

Ensure adequate staff, equipment, and supplies, and if possible ensure their availability 24 hours a day, 7 days a week. Needs vary considerably from country to country and from facility to facility, depending on the existing clinic space, the extent to which current staff can undertake this additional responsibility, and the availability of equipment and supplies. Ensuring systematic PPFP counseling may entail making PPFP-trained

providers available on call at night or on weekends.^{30,31,44-46} In addition, conducting whole-site orientations helps ensure that even staff who have not been trained or do not possess a clinical background can support PPFP.³⁶ In some cases, even cleaning staff have been found to affect program performance.⁴⁶ Make sure to pre-position supplies and organize client flow through labor, delivery, and postnatal wards to identify appropriate space for counseling. In Niger, when the schedule was revised to offer PPFP services at all times rather than during the morning only, the number of women delivering who left with their method of choice increased from 44% to 55% within one month in one rural district hospital.^{33,34}

Encourage facility leadership and adjust management practices based on facility size. Larger facilities may require more intensive engagement of staff than smaller facilities to achieve similar output. In the International Postpartum Family Planning Program, small facilities with motivated providers demonstrated the highest rate of postpartum contraceptive uptake. Among facilities with fewer than 10,000 patients per year, about 27% of obstetric patients opted for contraception during the immediate postpartum period. Facilities with 10,000 to 20,000 patients, however, averaged 17% postpartum contraceptive uptake, and the largest institutions (with caseloads of 20,000 or more) averaged only 13%.²⁴ These findings are consistent with research in Guatemala that found higher rates of postpartum contraceptive uptake at lower levels of the health system.⁴⁷ Problem-solving strategies, as part of leadership, management, or quality improvement approaches, help staff address barriers as they arise.^{33,34,48}

Tools and Resources

Compendium of WHO Recommendations for Postpartum Family Planning⁴⁹ is a web-based tool that integrates core WHO guidance to guide women through their family planning decision-making during the first year postpartum. Available from: <https://postpartumfp.srhr.org/>

K4Health Postpartum Family Planning (PPFP) Toolkit⁵⁰ provides a comprehensive collection of best practices and evidence-based tools and documents on PPFP. Available from: <https://toolkits.knowledgesuccess.org/toolkits/ppfp>

Programming Strategies for Postpartum Family Planning¹² is a resource for program planners and managers when designing interventions to integrate PPFP into national and subnational strategies. Available from: http://www.who.int/reproductivehealth/publications/family_planning/ppfp_strategies/en/

Service Communication Case Study: Bangladesh: Behavioral Maintenance and Follow-Up⁵¹ is an example of a project that has successfully used social and behavior change communication via mHealth to communicate important information about pregnancy and the first year of a child's life, including PPFP, to expecting and new mothers and their families. <https://sbccimplementationkits.org/service-communication/case-studies/case-study-behavioral-maintenance-and-follow-up-in-bangladesh/>

Suggested citation:

High Impact Practices in Family Planning (HIPs). Immediate postpartum family planning: A key component of childbirth care. Washington, DC: USAID; 2017 Nov. Available from: <https://www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning/>

Acknowledgments: This brief was written by Laura Raney, Anne Pfitzer, Trish McDonald, Erin Mielke, Elaine Charurat, Aachal Devi, and Shawn Malarcher. Critical review and helpful comments were provided by Afeefa Abdur-Rhaman, Ribka Amsalu, Michal Avni, Maggwa Baker, Neeta Bhatnagar, Rosanna Buck, Megan Christofield, Arzum Ciloglu, Kim Cole, Temple Cooley, Chelsea Cooper, Carmela Cordero, Ana Cuzin, Peggy D'Adamo, Ellen Eiseman, Mario Festin, Coley Gray, Karen Hardee, Nuriye Hodoglugil, Caroline Jacoby, Emily Keyes, Joan Kraft, Cate Lane, Samantha Lint, Ricky Lu, Sara Malakoff, Janet Meyers, Pierre Moon, Dani Murphy, Winnie Mwebesa, Maureen Norton, Gael O'Sullivan, Saiqa Panjsheri, Alice Payne Merritt, May Post, Shannon Priyor, Heidi Quinn, Setara Rahman, Elizabeth Sasser, Ritu Schroff, Caitlin Shannon, Willy Shasha, Jim Shelton, John Stanback, Sara Stratton, Caitlin Thistle, Carroll Vasquez, Michelle Weinberger, Jessica Williamson, and Melanie Yahner.

This brief is endorsed by: Abt Associates, CARE, Chemonics International, EngenderHealth, FHI 360, FP2020, Georgetown University/Institute for Reproductive Health, International Planned Parenthood Federation, IntraHealth International, Jhpiego, John Snow, Inc., Johns Hopkins Center for Communication Programs, Management Sciences for Health, Marie Stopes International, Options, Palladium, Pathfinder International, Population Council, Population Reference Bureau, Promundo US, Public Health Institute, Save the Children, U.S. Agency for International Development, United Nations Population Fund, and University Research Co., LLC.

The World Health Organization/Department of Reproductive Health and Research has contributed to the development of the technical content of HIP briefs, which are viewed as summaries of evidence and field experience. It is intended that these briefs be used in conjunction with WHO Family Planning Tools and Guidelines: http://www.who.int/topics/family_planning/en/.

For more information about HIPs, please contact the HIP team at www.fphighimpactpractices.org/contact/.

The HIPs represent a diverse and results-oriented partnership encompassing a wide range of stakeholders and experts. As such, the information in HIP materials does not necessarily reflect the views of each co-sponsor or partner organization.

References

A complete list of references used in the preparation of this brief can be found at:

<https://www.fphighimpactpractices.org/briefs/immediate-postpartumfamily-planning/>