

Programming strategies for Postpartum Family Planning



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Table of contents

List of acronyms	iv
Acknowledgments	v
Preamble	vi
Method of work	vii
Chapter 1: Postpartum family planning and why it's needed	1
1.1 Postpartum family planning: definition and parameters	1
1.2 Rationale for PPF	2
1.3 The unique family planning needs of postpartum women	3
Chapter 2: General considerations – understanding the landscape for PPF programming	5
2.1 Review of country-level data	5
2.2 Health systems issues	6
2.3 Moving from the general to the specific	10
Chapter 3: Integrating PPF across contact points – setting considerations	13
3.1 Antenatal care	14
3.2 Labour and delivery/pre-discharge	16
3.3 Postnatal care	18
3.4 Infant health and immunization services	20
3.5 Country programme case examples	22
Chapter 4: Monitoring and evaluation	31
References	35
Annex 1: Statement for collective action for postpartum planning	36
Annex 2: Supporting evidence for programme design	38

List of Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
BCC	Behaviour communication change
BCG	Bacille Calmette–Guérin (vaccine)
CHW	Community health worker
CYP	Couple-years protection
DPT	Diphtheria-pertussis-tetanus
EBF	Exclusive breastfeeding
EPI	Expanded Programme on Immunization
FP	Family planning
FP/RH	Family planning/reproductive health
HIV	Human immunodeficiency virus
HMIS	Health management information system
HTSP	Healthy timing and spacing of pregnancy
iCCM	Integrated community case management
IEC	Information, education, communication
IMCI	Integrated management of childhood illnesses
IUD	Intrauterine contraceptive device
LAM	Lactational amenorrhoea method
LARC	Long-acting reversible contraception
MCHIP	Maternal and Child Health Integrated Program
MEC	Medical eligibility criteria
MNCH	Maternal, newborn and child health
MIYCN	Mother, infant and young child nutrition
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
PPFP	Postpartum family planning
PPIUD	Postpartum intrauterine contraceptive device
PPTO	Postpartum tubal occlusion
RCT	Randomized controlled trial
SDP	Service delivery point
SPR	Selected practice recommendations for contraceptive use
STI	Sexually transmitted infection
TO	Tubal occlusion
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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Before a global technical consultation, MCHIP hosted a technical meeting in Washington, DC, on 18 July 2012, to gather input on a draft of the Programming Strategies for Family Planning document. The 22 participants included health-care providers, researchers and programmers representing 13 organizations. Their input was incorporated in the draft, which then served as the basis for deliberations during the WHO Geneva technical consultation. These contributors included: Adrienne Allison, Mengistu Asnane, Lynn Bakamjian, Holly Blanchard, Jeannette Cachan, Elaine Charurat, Carolyn Curtis, Selamawit Desta, Maxine Eber, Leah Elliott, Mary Lyn Gaffield, Justine Kavle, Jan Kumar, Patricia MacDonald, Catharine McKaig, Maureen Norton, Kate Rademacher, Saumya Ramarao, Elizabeth Sasser, Cathy Solter, John Stanback and Daren Trudeau.

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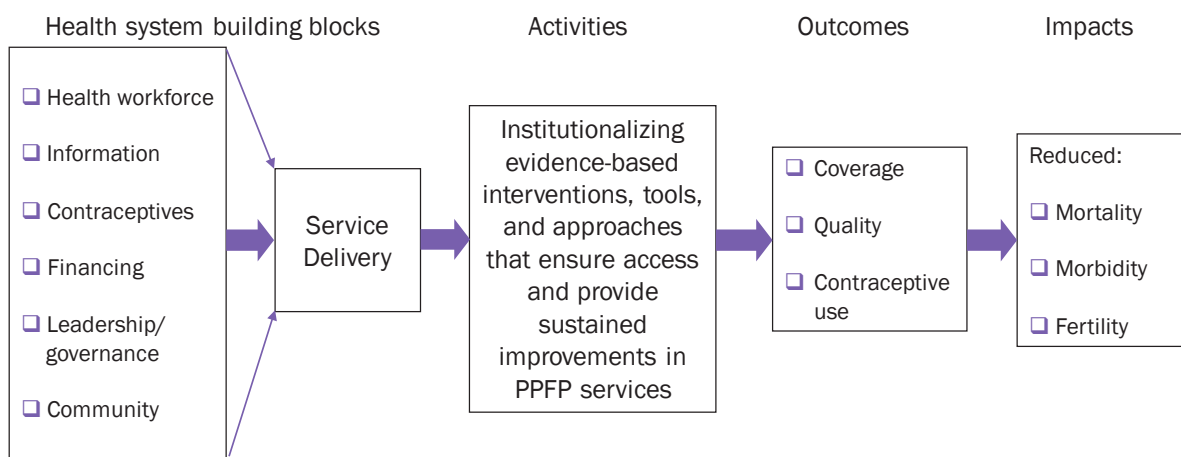
Preamble

Family planning (FP) is an essential component of health care provided during the antenatal period, immediately after delivery and during the first year postpartum (WHO 2009). Postpartum family planning (PPFP) is defined as the prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth.

This Programming strategies for postpartum family planning document was prepared to: 1) support the *Statement for collective action for postpartum family planning* (Annex 1), and 2) be used by programme planners and managers as a resource when designing interventions to integrate PPFP into national and subnational strategies.

PPFP should not be considered a 'vertical' programme, but rather as an integrated part of existing maternal and child health and FP efforts. Successful PPFP interventions require holistic and evidence-based programme strategies that contribute to strengthened health systems and sustained improvements in high-quality services that put people at the centre of health care (Figure 1).

Figure 1. PPFP programme model



The elements involved in designing a PPFP programme or intervention are the focus of this document. It is not, however, intended to be prescriptive or serve as a definitive 'how-to' for programme design and implementation. Users are assumed to have general experience in the design of family planning/reproductive health (FP/RH) programmes; this document provides additional support for PPFP programming. The content offers strategies that can be applied towards either developing a comprehensive programme that addresses a woman's FP needs through the entire postpartum period, or strengthening the delivery of FP services to women who are postpartum at one or more points of contact within the health system. Clinical guidance on FP service delivery is available within WHO's two evidence-based guidelines: the *Medical eligibility for contraceptive use (MEC)* (WHO 2009) and *Selected practice recommendations for contraceptive use (SPR)* (WHO 2008). Additionally, the World Health Organization (WHO) publishes a handbook which providers of family planning services can reference, titled *Family planning: a global handbook for providers* (WHO 2011).

Method of work

This document represents the culmination of a collaborative initiative among the World Health Organization (WHO), United Nations Population Fund (UNFPA), United States Agency for International Development (USAID), and their development partners. Preliminary work to develop this document included convening two stakeholder meetings at WHO to define the scope of work (March and November 2010), and organizing panel sessions during the First Global Symposium for Health Services Research (Montreux, Switzerland) and the Second International Conference on Family Planning (Dakar, Senegal). Discussions during the stakeholder meetings led to prioritizing the focus of the document on programmatic strategies for policy-makers and programme managers. The conference panel sessions offered opportunities to review evidence on the topic and highlight gaps in research at international conferences. Based on input from these forums, a draft document was prepared.

To support the preparation of this document, a synthesis of the literature describing programmatic interventions for PFP was created (Annex 2). Searches of the grey and peer-reviewed literature were performed using PubMed and The Cochrane Library, as well as Google and Bing Internet search engines through July 2012.

In July 2012, a draft version was presented to a multidisciplinary group of United States-based family planning (FP) experts during a technical meeting in Washington, DC. The 22 participants included providers, researchers, and programmers representing 13 organizations. Comments received from these experts were incorporated with the draft and literature synthesis.

WHO convened a technical consultation on 10–12 September 2012. There, experts developed programmatic strategies for policy-makers and programme managers to consider when designing programmes to reduce the unmet need for FP among women after delivery. The 34 experts represented 20 countries and 13 agencies. The multi-disciplinary group comprised experts in international FP, including clinicians, researchers, epidemiologists, programme managers and policy-makers. The background document and a synthesis of literature were provided to the experts prior to the consultation and served as the basis for the group's deliberations during the meeting. Final development was done through a consensus-based process. All participants were asked to declare any conflict of interest before the meeting commenced; none were declared.

Chapter 1

Postpartum family planning and why it's needed

1.1 Postpartum family planning: definition and parameters

While family planning (FP) is important throughout an individual's and couple's reproductive life, postpartum family planning (PPFP) focuses on the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth. Table 1 identifies the continuum of points of contact within the health care system that can provide opportunities to integrate PPFP with maternal, newborn and child health (MNCH) interventions during the 12-month period after childbirth. While this document's parameters cover the first year postpartum only, programmes should also undertake strategies for continuing contraception, or effective switching, during the second and subsequent years after birth, depending on a woman's desire to space or limit future pregnancies (WHO 2012a).

Table 1. Continuum of points of contact for PPFP

CONTINUUM OF POINTS OF CONTACT FOR PPFP				
→ → → →				
STAGE	Pregnancy	Labour and delivery, Pre-discharge (0–48 hours)	Postnatal, including prevention of mother-to-child transmission of HIV (PMTCT) (48 hours–6 weeks)	Infant care (4–6 weeks through 12 months)
SERVICE DELIVERY	Facility-based antenatal care (ANC) Community-based pregnancy screening	Facility-based or home-based with skilled birth attendant	Facility or household visits: <ul style="list-style-type: none"> • If birth at home, within 24 hours of birth • If birth in facility, prior to discharge • Day 3 (48–72 hours) • Between days 7–14 after birth • 6 weeks 	Facility, home visit, or community-based: <ul style="list-style-type: none"> • Immunizations (diphtheria-pertussis-tetanus [DPT] or Pentavalent 1, 2, 3; measles, rotavirus; boosters; etc.) • Well child visits • Nutrition/growth monitoring • Event days (e.g. vitamin A) • Illness visits (e.g. Integrated Community Case Management/Integrated Management of Childhood Illnesses [iCCM/IMCI]) • PMTCT/antiretroviral care and treatment

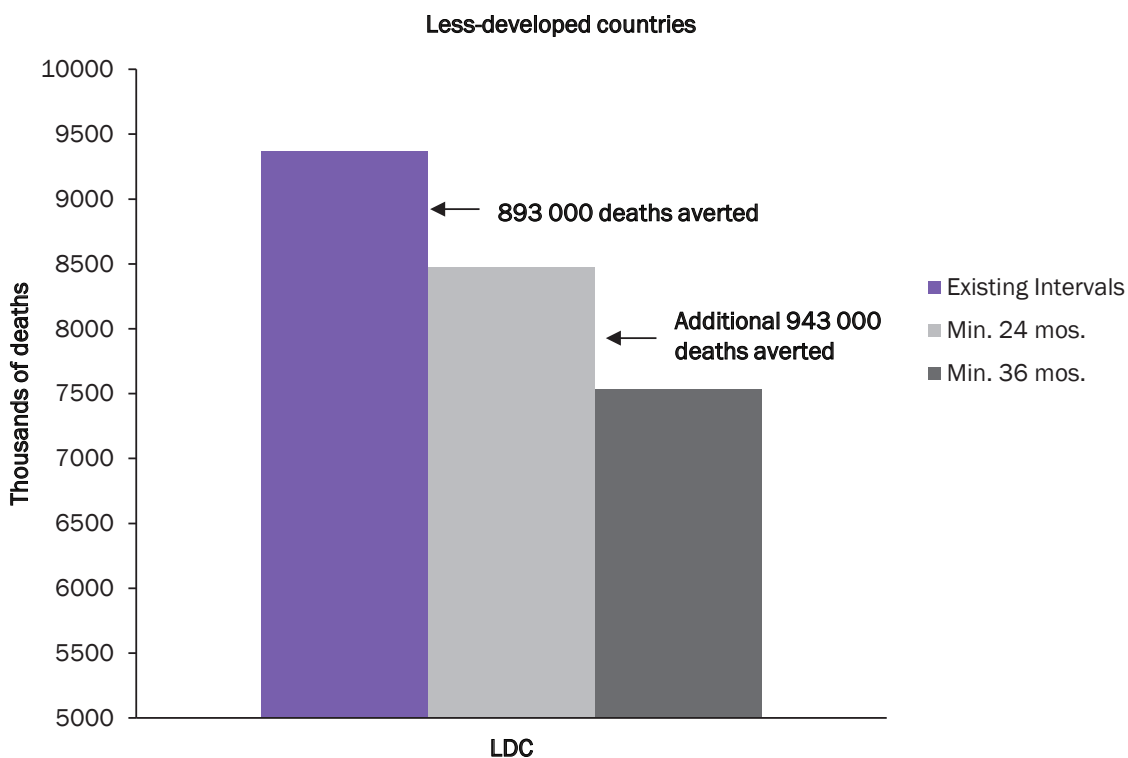
1.2 Rationale for PFP

Globally, FP is recognized as a key life-saving intervention for mothers and their children (WHO 2012b). PFP has an important role to play in strategies to reduce the unmet need for FP. Postpartum women are among those with the greatest unmet need for FP. Yet they often do not receive the services they need to support longer birth intervals or reduce unintended pregnancy and its consequences. PFP addresses the needs of those who wish to have children in the future (referred to as ‘spacers’), as well as those who have reached their desired family size and wish to avoid future pregnancies (referred to as ‘limiters’).

Further rationale for PFP includes the following:

- According to an analysis of Demographic and Health Surveys data from 27 countries, 95% of women who are 0–12 months postpartum want to avoid a pregnancy in the next 24 months; but 70% of them are not using contraception (Ross & Winfrey 2001).
- FP can avert more than 30% of maternal deaths and 10% of child mortality if couples space their pregnancies more than 2 years apart (Cleland et al. 2006).
- 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 (Da Vanzo et al. 2007).
- Risk of child mortality is highest for very short birth-to-pregnancy intervals (<12 months). If all couples waited 24 months to conceive again, under-five mortality would decrease by 13%. If couples waited 36 months, the decrease would be 25% (Figure 2) (Rutstein 2008).

Figure 2. Annual number of under-five deaths with existing birth intervals and minimum intervals of 24 and 36 months



Source: Rutstein 2008

- Many women and couples have reached their desired family size and would like to prevent future pregnancies. Ensuring that every woman has only the number of children she desires is an important means of decreasing maternal mortality. A recent 10-year study of maternal mortality in 46 countries found that the risk of maternal death increases as the number of children per woman rises to four or more. The study also found that maternal deaths declined by 7–35% as the number of children per woman fell (Stover & Ross 2010). PPF, therefore, helps women who have an unmet need to space *and* limit future pregnancies, while helping to lower rates of maternal and child death.

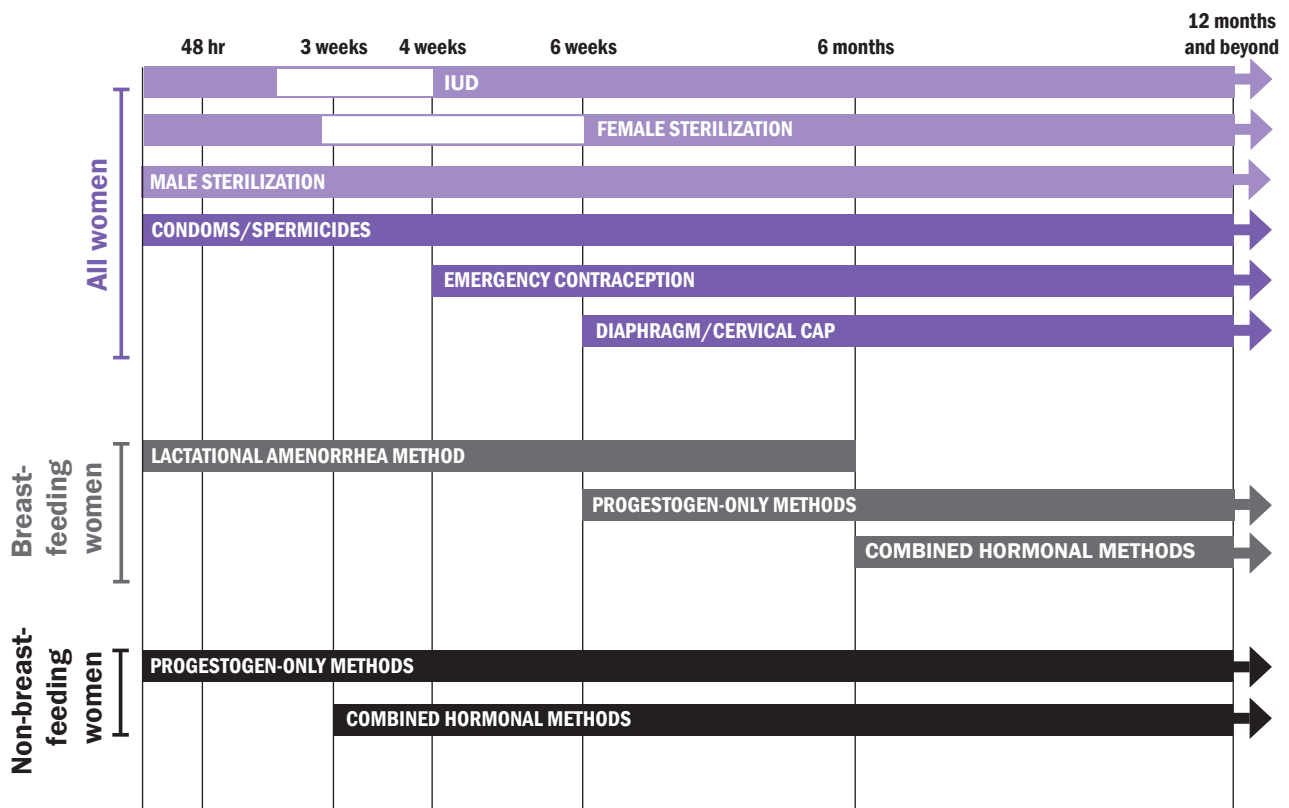
1.3 The unique family planning needs of postpartum women

The purpose of PPF is to help women to **decide** on the contraceptive they want to use, to **initiate** that contraceptive, and to **continue** contraceptive use for 2 years or longer, depending on the reproductive intentions of the woman or couple. There are unique considerations for providing PPF services to women during the 12-month postpartum period:

- A comprehensive PPF intervention entails continuity of care for the woman and her baby at many points of contact in the health system over a relatively long time horizon (i.e. from the antenatal period to 12 months after birth).
- Following birth, postpartum women experience amenorrhea for varying lengths of time, depending on their breastfeeding practices. For women who are not breastfeeding, pregnancy can occur within 45 days of giving birth (Jackson & Glasier 2011). Among women who do not exclusively breastfeed, pregnancy can also occur before menses resumes. Screening for pregnancy following a checklist published within WHO's *Selected practice recommendations for contraceptive use guideline* (SPR) (WHO 2008) or by performing a biochemical pregnancy test (if available) can be done to ensure that postpartum women are not turned away from FP services.
- Sociocultural norms and expectations about resumption of sexual activity following a birth.
- Comprehensive PPF may involve many cadres of health workers at different points along the prenatal to postpartum continuum in both the facility and the community. In 2012, WHO issued evidence-based recommendations in which health workers can offer maternal and newborn interventions, including family planning services (WHO 2012c). Programme managers are advised to refer to this guideline to ensure continuity of care so that all women have access to high-quality PPF services. Coordination within the health system – such as integrating services and providing referral linkages between community and facility, antenatal care (ANC), birthing, postnatal care (PNC), and child health and FP services – may ensure continuity of care and access to services (WHO 2012b).
- An important consideration when planning a PPF programme or intervention is clinical safety, that is, which methods can be used at what point in time following birth and given the mother's breastfeeding status. Figure 3 provides WHO's recommendations for method use during the first year postpartum (and beyond) within the *Medical eligibility criteria for contraceptive use* (MEC) (WHO 2009). Note that these recommendations are also applicable to women living with HIV. (This document will be kept up to date electronically in accordance with WHO guidance.) Briefly, WHO recommends the following regarding the use of contraception among women during the first year postpartum and beyond:
 - Immediately after birth and for up to 6 months following a birth, a woman who is exclusively breastfeeding can use the lactational amenorrhea method (LAM) and several other methods safely. If a mother chooses LAM, she should transition from LAM to another modern contraceptive method by the time the infant reaches 6 months of age, or sooner if LAM criteria (WHO 2009) are not met. She should be provided information in a timely manner to enable her to choose another modern contraceptive method.

- A copper-bearing intrauterine contraceptive device (IUD) can be inserted immediately or up to 48 hours after birth, or any time after 4 weeks postpartum. A female sterilization procedure or tubal occlusion (TO) can be performed immediately or up to 4 days after birth, or any time after 6 weeks postpartum.
- For non-breastfeeding women, in addition to IUD and TO, progestogen-only methods can be initiated immediately following birth. Combined oral contraceptives can be initiated starting at 3 weeks after birth.
- For breastfeeding women, all progestogen-only methods – progestogen-only pills, injections, implants – can be initiated at 6 weeks following birth, as per WHO MEC. Combined estrogen and progestin pills cannot be initiated until 6 months after birth.
- All women, breastfeeding or not, can initiate use of condoms immediately after birth, emergency contraception after 4 weeks, and the diaphragm or cervical cap after 6 weeks.

Figure 3. Postpartum contraceptive options (timing of method initiation and breastfeeding considerations)



Chapter 2

General considerations – understanding the landscape for PFP programming

Designing an intervention that will result in effective delivery of services to achieve the greatest impact – for example, serving those with the greatest need – requires a solid understanding of the context. This chapter provides information needed to help guide the general considerations that should be taken into account when shaping the design of programme interventions. At the end of the chapter, there are suggestions for how findings from these analyses might help select programme areas for focus.

2.1 Review of country-level data

To understand the magnitude of need and the opportunities available for PFP programming, managers can review existing available datasets, such as the Demographic and Health Surveys, Multiple Indicator Cluster Surveys, or other trusted local data and surveys. The data points below provide useful markers for the status of MNCH and FP in a country at the national and subnational level, as well as an understanding of the context for PFP information and services. They can be used to advocate for integrating FP with MNCH settings and to show what settings and interventions could be prioritized in the design of PFP programmes.

Table 2. Data points and programme implications

KEY QUESTION/DATA POINT	PROGRAMME IMPLICATIONS
What is the number and percentage of women who are pregnant?	This indicates the potential group to be reached through integration of PFP with MNCH-related service settings.
What is the percentage of pregnancies spaced less than 18, 24 and 36 months apart?	If the majority of pregnancies are spaced less than 2 years apart, this could indicate that most women are unaware of pregnancy risk and/or are unable to access FP services during the extended postpartum period.
What are the levels of unmet need for: <ul style="list-style-type: none"> spacing? limiting? 	Levels of unmet need above 10% indicate a need to review the reach and effectiveness of the overall FP effort. High levels of unmet need for spacing suggest efforts are needed to reach women during postnatal/infant care. High levels of unmet need for limiting suggest the need for a review of contraceptive method mix to determine if adequate, effective options exist immediately postpartum and thereafter.
What is the total contraceptive use and what is the percentage of use by method (i.e. the method mix)? Is LAM part of the contraceptive method mix?	This indicates what options are currently available and used and what needs to be done to improve choices. For example, does the method mix include at least three options for breastfeeding women at 6 weeks? Are there already some levels of IUD and postpartum sterilization use to suggest that strengthening immediate postpartum provision of these methods has potential for impact?
What percentage of women receive ANC?	If the majority of women receive ANC, this indicates high potential to reach pregnant women if a PFP intervention is systematically implemented.

KEY QUESTION/DATA POINT	PROGRAMME IMPLICATIONS
What is the percentage of mothers practising and the median duration of exclusive breastfeeding (EBF)?	Indicates potential for introducing EBF and LAM as a 'win-win' strategy for mothers and babies.
What percentage of deliveries are in health facilities? What is the breakdown of deliveries in facilities by age group, residence and wealth quintile?	If the percentage of facility-based births is significant, there is high potential for reaching women through pre-discharge counselling, as well as for referral back to primary and community-based services for both follow-up and access to other contraceptive methods. There may be potential for offering postpartum IUD (PPIUD) insertion and postpartum tubal occlusion (PPTO). Breakdown by age, residence, and socioeconomic status will help to identify underserved groups.
What percentage of postpartum women receive PNC for either mothers or infants?	If a substantial percentage of women receive PNC, there is good potential for reaching postpartum women with PFP information and services. If this is not the case, exploring routine immunization services may be another option.
What are the immunization rates for children less than 1 year of age (bacille Calmette–Guérin (BCG), DPT and Pentavalent 1, 2, 3, or measles vaccines)?	If there is robust routine immunization coverage through facility-based or outreach services, there is good potential for integrating PFP information, counselling, and referrals. <ul style="list-style-type: none"> • Pentavalent or DPT 1 and BCG: Promote EBF and LAM, and other appropriate contraceptive methods depending on timing • Pentavalent or DPT 3: Promote transition from LAM to other PFP methods PFP for breastfeeding women, depending on timing • Measles: Fail-safe visit to promote all methods of FP • WHO recommendations on routine immunizations for children and immunization schedules can be consulted for further information (WHO 2013a)
What is the percentage of first births in women under 18 years of age?	If there is a significant percentage of first births for women age 18 years and under, there is an opportunity to promote healthy timing and spacing to delay second and subsequent births.
What percentage of women experience violence during pregnancy, childbirth or for using FP?	Significant levels indicate strategic consideration of integrating gender-based violence prevention with overall maternal and PFP efforts. In 2013, WHO published <i>Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines</i> . These guidelines include service delivery and programme recommendations for integrating into existing health services care for women experiencing intimate partner violence and sexual assault (WHO 2013b).

2.2 Health systems issues

An understanding of the national health system (in terms of how it is structured, organized, staffed and financed) and current government policies is essential and can provide insights on existing gaps and opportunities for offering FP to postpartum women. Since PFP information and services encompass a range of contact points and providers within facilities and communities, a clear understanding of how the health system is organized is an essential first step for programme design.

The questions posed in this section are organized according to the key elements of the *Strengthening health systems to improve health outcomes: WHO's framework for action* (WHO 2010a) with an additional element for community and sociocultural issues. The questions provide a basis to assess and identify what is currently in place and how best to approach advocacy and implementation of a PFP programme or intervention. The information can be gathered through discussions with key informants and/or gleaned from published documents and reports. Responses to the inquiries will point to strengths and gaps, and help determine where and how to integrate PFP as a routine component of MNCH services.

Health services

- **Health services structure:** Are FP/RH and MNCH services organized within the same directorate or are they separate? If separate, what mechanisms or opportunities exist for collaboration and joint planning for PFP programming?
- **Health services organization:** What service delivery points (SDPs) exist and how are they organized in relation to one another? (Consider tertiary, secondary, primary and community levels, and the existence of a referral system and how well it functions.)
- **Antenatal care (ANC):** Where and how is ANC generally provided? In facilities? Communities? Or a combination of the two settings?
- **Internal linkages and referrals:** What linkages (formal or informal) exist between maternity and FP clinics? Is there effective referral? Do staff regularly identify and follow up pregnant women along the continuum of care from ANC to PNC?
- **Maternity units:** Do maternity SDPs have adequate infrastructure to provide FP methods that can be used immediately after delivery?
- **Postnatal care (PNC):** Where and how is PNC provided? In facilities? Communities?
- **Contraceptive options:** What contraceptive services, such as long-acting reversible contraception (LARC), are available in maternities, the community health centre, and other SDPs?
- **Immunizations:** How are immunization, nutrition, and other child health services organized and offered?
- **Integrated services:** Does integration of PFP with other MNCH services provide an opportunity for addressing gaps in service delivery or the health system? What gaps exist and can an integrated programme help close them?
- **Access to services:** Do any population groups (e.g. youth, periurban, rural, poorest or high-parity women) have restricted access to MNCH and/or FP/RH services? Why?
- **Communications:** Are there health behaviour change and communication initiatives at the community level or in the mass-media that can be leveraged for PFP awareness?

Health management information system (HMIS)

- **PFP tracking:** Does the HMIS document the provision of PFP services (i.e. the uptake of FP use within the first year after birth)? If not, can the relevant records be adapted to do so?
- **Continuity-of-care tracking:** How well does the system promote and track continuity of care for individual clients? Does any health-care provider support women over the continuum of care from ANC to PNC? Consider how continuity of care and the care provider can be used to support increased access to PFP.
- **Surveys and research:** What monitoring, evaluation, and research data and findings (such as Demographic and Health Surveys) might be helpful for the design of a programme?

Health workforce

- **Staff development:** What policies and plans exist to support the development of MNCH staff to be able to offer high-quality FP/RH services and for FP staff to screen postpartum clients?
- **National tools:** Do national FP guidelines/protocols include explicit instructions for the provision of PPF?P?
- **Task sharing:** Are there policies and guidelines for mid-level staff to insert PPIUDs and for other task sharing that increases access to PPF?P? Do mid-level staff have the support of professional organizations or the health ministry to perform these PPF?P procedures? Is there a need for harmonization of recommendations? What opportunities/challenges exist to advocate for task-shifting to increase health worker capacity and to enable mid-level cadres to deliver high-quality PPF?P services? Recently issued recommendations from WHO on optimizing health-care worker roles to improve access to key maternal interventions, including family planning through task shifting, should be used to guide task-sharing decisions. (WHO 2012c)
- **Skilled personnel:** What gaps exist with respect to the number and/or skills of trained personnel (e.g. physicians, nurses, midwives, other clinical staff and community health workers) in the health system and with specific regard to MNCH and FP/RH services? Are there other cadres of staff who can be trained to provide PPF?P services?
- **Community health workers (CHWs):** What opportunities/challenges exist to support CHWs to provide PPF?P services? Do CHWs regularly identify and follow up pregnant women?
 - Do CHWs provide PNC to mothers and their babies? Which FP methods are they able to provide?
 - Do CHWs provide integrated community case management (iCCM) of childhood illnesses? Is it possible to integrate FP counselling and/or delivery with the iCCM?
- **Pre-service education:** Does pre-service education for physicians, nurses, midwives and CHWs include FP generally and PPF?P specifically? If not, what opportunities exist to add PPF?P to MNCH and FP/RH pre-service curricula? Do practicum sites offer PPF?P services? Are tutors and preceptors applying competency-based training approaches?
- **In-service training:** What opportunities and programmes exist for in-service training and updating of health workers to provide MNCH and FP/RH services? Is training competency-based? Are clinical and counselling skills and competencies for PPF?P services included? How receptive are MNCH providers to offering PPF?P?
- **Performance monitoring:** Are protocols and job aids for PPF?P monitoring and supervision available? Do the performance appraisals address PPF?P for staff working in eligible settings?

Medicines and technology

- **Product registration:** Do current policies facilitate the adoption, registration and procurement of new contraceptive technologies to ensure a wide range of contraceptive methods?
- **Procurement and supply chain:** Is there an integrated system for procurement and supply of MNCH and FP/RH commodities, equipment and supplies, or are there parallel systems?
- **Contraceptive availability:** Are contraceptive commodities, equipment, and supplies consistently available at SDPs at various levels of the health system, in integrated service delivery settings (such as labour and delivery or immunization) or for community distribution within MNCH and FP/RH programmes?
- **Logistics information:** Is there a logistical management information system capable of accurately forecasting needs and tracking usage of FP commodities, equipment and supplies among clients attending for MNCH services?

Health financing

- **FP funding:** Are FP services part of basic health services in the country?
- **PPFP funding:** Is there specific funding dedicated to PPFP?
 - Do budget allocations exist for FP services and commodity support?
 - Does the government have an annual budgeted (work) plan for MNCH and/or FP/RH that also includes PPFP?
 - Are there private insurance options that cover births/emergencies? Do they extend into the postpartum period? If so, do they include PPFP?
- **Private sector:** Do private-sector initiatives exist that can be leveraged for PPFP programming?
- **Client fees:** What fees are charged to clients for antenatal, delivery, postpartum/postnatal checks, and for RH and FP services within each sector (i.e. public, commercial and nongovernmental or faith-based organizations)?
 - What happens when clients are unable to pay?
 - Do fees vary by contraceptive method?
 - If services are free, are there hidden costs such as the need for the client to purchase supplies for PPIUD or PPTO services?
- **Funding sources:** How much of the budget for MNCH and FP/RH consists of external contributions?
 - Which donors are most involved in these programmes?
 - Is external donor support earmarked for certain line-items (e.g. training or commodities) or specific districts/facilities?
 - How might government and donor priorities support increased attention to PPFP programmes?

Leadership and governance

- **Safe motherhood strategy and plan:** Does the government have a safe motherhood strategy or operational plan that promotes access to high-quality safe motherhood services?
 - Does it specifically promote the integration of FP?
 - Does it include PPFP? If so, how is PPFP defined?
 - Does it include counselling during ANC and initiation of modern FP methods during the 12-month postpartum period?
 - Does it address measures to support voluntary continuation of contraceptive use to support healthy child-spacing intervals and for fertility interventions to complete family size?
 - Do MNCH policies promote PPFP as a life-saving intervention to reduce maternal and newborn mortality in an effort to reach Millennium Development Goals 4 and 5? If not, what advocacy efforts are needed?
- **PPFP strategy and plan:** Alternatively, does the government have an FP/RH strategy or operational plan that promotes access to FP by postpartum women?
 - Does it specifically promote integration with MNCH services?
 - Does it ensure a broad range of contraceptive methods?
 - Does it promote interventions (e.g. counselling) to support healthy timing and spacing of pregnancy (HTSP)?

- Does it include interventions that respond to the needs of limiters for preventing future pregnancies?
- **Resource allocation:** Where is the authority for resource allocation and prioritization specifically for MNCH and FP/RH services within the public health system?
- **Government collaboration:** To what extent does the government collaborate with and/or rely on efforts of nongovernmental and private-sector partners in MNCH and FP/RH services? How might these relationships be leveraged to support PPFPP programming?
- **National standards, guidelines and protocols:** Do national FP standards, guidelines and protocols exist? Are they widely available in service sites and to providers? Do they explicitly include PPFPP-related issues? Do these include policies and guidelines for mid-level staff to insert PPIUDs, implants and permanent methods? Do mid-level staff have the support of professional organizations or the health ministry to provide these PPFPP services? Is there a need for harmonization of recommendations?

Community and sociocultural issues

- **Client perspective:** What do policy-makers, programme managers, and providers know and understand about the needs, desires, and constraints of postpartum women for FP services? How is this information used to offer services?
- **Cultural norms:** What are the prevailing cultural norms (including health worker attitudes) pertaining to postpartum women, both breastfeeding and non-breastfeeding, in relation to:
 - return to fertility?
 - pregnancy intervals?
 - family size?
 - return to sexual activity, including stigma regarding early return to sexual activity?
- **Stopping breastfeeding:** Do women stop breastfeeding infants when they become pregnant again with another child?
- **Mother and newborn residence:** Do mothers of new babies return to their mother's home or back to their husband's?
- **PPFP perceptions:** Are there beliefs and perceptions regarding contraceptive use after childbirth that might affect or promote PPFPP?
- **Status of women and girls:** How does women's and girls' status affect FP use? Are there traditional practices (e.g. *pardah*, female genital cutting) that might jeopardize women's access to PPFPP?
- **Male involvement:** Are there constructive or harmful gender norms that influence male involvement in MNCH and FP/RH care for women and girls, specifically within first year postpartum, or about women's economic participation and working outside the home?
- **PPFP and HIV/AIDS:** Do FP guidelines exist for persons living with HIV and AIDS? Do PMTCT programmes include PPFPP information, services and commodities?

2.3 Moving from the general to the specific

The table below provides some illustrative examples showing linkages between responses to the questions in Section 2.2 and potential programmes and interventions. These options may prompt further exploration and discussion with stakeholders about the type of interventions that can be undertaken to address needs within specific contexts and situations. These examples are not intended to be exhaustive, as there are many ways the findings might array and point in a programmatic direction.

Table 3. Illustrative findings and potential programme interventions

ILLUSTRATIVE FINDINGS	→ POTENTIAL PFP PROGRAMME INTERVENTIONS
<ul style="list-style-type: none"> • High unmet need for limiting future pregnancies • High percentage of births in facilities • Health system with infrastructure at district level for IUD and female sterilization services 	<p>Facility-based intrapartum services:</p> <ul style="list-style-type: none"> • Expand counselling and method mix to include LARCs and permanent methods • Integrate counselling and services for immediate IUD insertion, tubal occlusion and counselling on EBF within labour and delivery units and in postpartum maternity wards at facilities at the district or sub-district level if appropriate
<ul style="list-style-type: none"> • Low modern contraceptive prevalence • High use of traditional methods • Existing network of CHWs who provide home-based ANC and PNC • Short birth intervals • High percentage of home births 	<p>Community:</p> <ul style="list-style-type: none"> • Train CHWs to integrate community education and individual counselling about HTSP, EBF and LAM with referral for other FP methods as a routine part of care • Promote early PNC visits for home births to provide essential newborn care and EBF/LAM • Focus on LAM as a gateway method to the use of other modern contraceptives • Discuss women's reproductive intentions for spacing or limiting and provide information on contraceptive methods and where to get them • Use community-based integrated MNCH/FP services
<ul style="list-style-type: none"> • Insurance or other finance mechanisms, such as vouchers, exist for basic maternity services and PNC 	<p>Financing:</p> <ul style="list-style-type: none"> • Bundle PFP with the birthing package to ensure that all contraceptive methods are covered during the extended postpartum period
<ul style="list-style-type: none"> • High breastfeeding rates • Successful routine immunization sessions at health centres 	<p>PNC and infant care:</p> <ul style="list-style-type: none"> • Introduce LAM and counsel on transitioning to other effective contraceptive methods • Add a dedicated FP provider to existing routine immunization programmes or link/refer women to the FP unit at the clinic
<ul style="list-style-type: none"> • High rates of staff rotation within and among facilities • Lack of skills and knowledge about PFP among facility staff, including the provision of LARCs/permanent methods • Facilities lack available and trained staff to provide MNCH and FP services 	<p>Strengthening human resources capacity:</p> <ul style="list-style-type: none"> • Strengthen policies and practices to address staff development and retention to ensure that providers with FP skills are available within ANC, labour and delivery, and PNC • Introduce or strengthen a comprehensive RH education curriculum that addresses safe motherhood, family planning, and neonatal and child health training issues • Integrate concepts of PFP within pre-service education and ensure that PFP and HTSP are well-covered in teaching curricula, practical training and examinations • Dispatch mobile outreach teams to facilities in the short term in order to provide services while building capacity of staff for the long term • Focus on community-based PFP interventions, including EBF, LAM, pills, injectables and condoms, while addressing health worker and capacity needs at facility level

ILLUSTRATIVE FINDINGS	→ POTENTIAL PFP PROGRAMME INTERVENTIONS
<ul style="list-style-type: none">• High HIV prevalence and existence of PMTCT services	<p>Meeting the needs of women living with HIV:</p> <ul style="list-style-type: none">• Integrate PFP with PMTCT services, promotion of EBF and LAM use, as well as appropriate complementary feeding at 6 months, with transition to another effective contraceptive method

Chapter 3

Integrating PFP across contact points – setting considerations

PFP programmes and interventions are designed to reach women at one or more specific contacts with the health system for information and services, including: 1) ANC, 2) labour and delivery including pre-discharge, 3) PNC and 4) immunization and child health care visits. Chapter 3 provides information for designing a PFP intervention for one or more of the specific contact points, including illustrative programme goals, strategies, activities and indicators. Although not meant to be exhaustive, the information is presented as a menu for a range of strategies and actions to illustrate the kinds of programme interventions that could be used to integrate PFP within the various health care services offered to women. These strategies can apply to the national, institutional, site or community level, depending on the scope and scale of the programme intervention envisioned. Further, they can be used to either design a new programme or strengthen an existing one. The strategies and activities can be adopted or adapted to respond to context-specific needs and situations as defined by the results of the landscape review in Chapter 2. In addition, each section includes examples from selected countries of actual strategies used to reach postpartum women. Annex 2 summarizes published and unpublished evidence evaluating programmatic interventions related to postpartum family planning. The supporting evidence was used to inform the development of the illustrative programme strategies highlighted in the tables within this chapter.

3.1 Antenatal care

ANC refers to the health services that a woman receives to monitor the health and progress of her pregnancy and her well-being during her pregnancy. ANC provides an opportunity to encourage deliveries with a skilled birth attendant and to advise and counsel on the importance of family planning and the contraceptive options available to her, including those that can be provided at the time of a facility-based birth (WHO 2006, WHO 2010b). Information and counselling about PPIUD insertion can be provided and consent prior to labour can be obtained if a woman chooses this method. For the couple or woman who does not desire future pregnancies, ANC also provides a time when counselling about permanent methods can be offered, and voluntary informed consent can be obtained confirming the understanding that these methods are permanent options. ANC can be provided as part of home-based practices and/or in facilities. Thus, ANC helps support the essential link between health care services that are provided in the community and those provided in the facility. It also provides an opportunity to engage husbands and family members to support healthy pregnancy and postpartum behaviours.

Table 4. Contacts during antenatal care

<p>Overall programme goal:</p> <ul style="list-style-type: none"> • Pregnant women discuss reproductive intentions for spacing or limiting and choose a PFP method during ANC. <p>Programme outcomes:</p> <ul style="list-style-type: none"> • Number/percentage of ANC clients who have received information and counselling regarding PFP and EBF • Number/percentage of ANC clients who have chosen a PFP method and have it marked on their ANC card/client card 		
ILLUSTRATIVE PROGRAMME STRATEGIES	ILLUSTRATIVE PROGRAMME ACTIVITIES	ILLUSTRATIVE INDICATORS
Strengthen awareness of and demand for PFP during the ANC period	<ul style="list-style-type: none"> • Integrate PFP information and counselling with ANC and PMTCT services offered at facility and community levels • Provide counselling that includes discussion of a woman's or couples' reproductive desires and the range of contraceptive options available, including vasectomy • Assign health workers to routinely provide group education on PFP, HTSP and EBF during ANC sessions • Make information, education and communication (IEC) materials on PFP available at facilities for women to take home and for use in home visits • Promote the inclusion of husbands and other family members in ANC education and counselling 	<ul style="list-style-type: none"> • Number/percentage of ANC sessions that include PFP information and counselling • Proportion of client records that are completed and have PFP counselling and method choice, if any, documented • Number/percentage of ANC service providers who are competent in providing PFP counselling • Number/percentage of women attending ANC who receive IEC materials about PFP options • Number/percentage of PMTCT sessions that include PFP information and counselling

ILLUSTRATIVE PROGRAMME STRATEGIES	ILLUSTRATIVE PROGRAMME ACTIVITIES	ILLUSTRATIVE INDICATORS
Strengthen continuity of care linkages and referrals between facility and community and ANC and birthing services	<ul style="list-style-type: none"> • CHWs regularly identify, refer and follow up pregnant women for ANC services and provide/reinforce PPFp messages • Referral linkages developed or strengthened between ANC services and labour and delivery services, whether they are located in the same place or in different facilities/settings • A mechanism is in place, such as the client card, that accurately captures and communicates data about clients' health needs and immediate PPFp choices • For women living with HIV, ensure there is a linkage to FP services during HIV services for infant care and continued HIV treatment for the mother 	<ul style="list-style-type: none"> • Proportion of pregnant women who have some level of continuity of care (defined as the same provider, the same place, or the same team of facility/community providers) • Proportion of ANC SDPs with referral protocols that include documentation of clients referred • Number/percentage of ANC clients whose client cards are filled in completely with pregnancy information and PPFp counselling and immediate PPFp method choice • Number/percentage of PMTCT clients whose client cards are filled in completely with pregnancy information and PPFp counselling and immediate PPFp method choice
Improve the enabling environment for PPFp as a routine part of ANC services	<ul style="list-style-type: none"> • Integrate PPFp with national MNCH and FP policies and strategies • Integrate PPFp with service delivery guidelines and quality-of-care monitoring for ANC services • Work to improve the knowledge, attitudes and practices of ANC providers and CHWs to ensure they support the provision of PPFp information and services • Integrate PPFp with pre-service education curricula • Verify that PPFp is included within the national PMTCT programme 	<ul style="list-style-type: none"> • Number of national MNCH, FP and PMTCT policies and strategies that include PPFp • Number/percentage of SDPs that have service delivery guidelines for PPFp; number/percentage of SDPs that monitor the inclusion of PPFp with ANC and PMTCT services • Number/percentage of ANC and PMTCT providers and CHWs who provide PPFp information and counselling to all ANC clients • Number/percentage of pre-service schools with PPFp included in curricula, service guidelines and protocols, and aligned with international MEC and national PPFp policies and strategy guidance; number/percentage of pre-service graduates competent in providing PPFp talks and counselling during ANC and PMTCT

3.2 Labour and delivery/pre-discharge

This point of contact involves various points throughout the stay in the facility, including admission, early labour, delivery room, maternity ward, immediate postpartum and pre-discharge. Counselling on the importance of family planning and available contraceptive method options, including LAM, is recommended during this period (WHO 2006, WHO 2010b). For women with limited access to health care in facilities, delivery at a facility affords a unique opportunity to address their fertility intentions and need for contraception: it does not require a return visit that may be prohibitively expensive or inconvenient. If a woman seeks to have an IUD inserted or a sterilization procedure immediately after delivery, special care must be taken to ensure that high-quality counselling has been done to verify the woman's choice. According to WHO's MEC guideline (WHO 2009), appropriate methods for FP service provision during the immediate postpartum period include: LAM, IUD, condoms and sterilization (male or female). Progestogen-only methods are appropriate for non-breastfeeding women prior to discharge.

Table 5. Contacts during labour and delivery/pre-discharge

<p>Overall programme goals:</p> <ul style="list-style-type: none"> • Postpartum women who choose a method during ANC or at time of delivery receive high-quality PFP services prior to discharge. • Postpartum women are counselled about EBF and LAM prior to discharge and begin breastfeeding immediately. <p>Programme outcomes:</p> <ul style="list-style-type: none"> • Proportion of women who select a method during ANC and who request and receive desired method prior to discharge • Proportion of maternity clients who request a method during early labour or pre-discharge counselling and receive their desired method before leaving the facility • Proportion of women who intend to exclusively breastfeed who begin to breastfeed prior to discharge and practice LAM after discharge 		
ILLUSTRATIVE PROGRAMME STRATEGIES	ILLUSTRATIVE PROGRAMME ACTIVITIES	ILLUSTRATIVE INDICATORS
<p>Effective linkages and protocols are in place to support FP counselling and referrals of maternity clients for PFP information and services and continuity of care</p>	<ul style="list-style-type: none"> • Strengthen capacity of skilled birth attendants to provide accurate and effective FP counselling, including LAM, to women who deliver at home and, when requested, referrals for PPIUD (within 48 hours) or PPTO (within 1 week) • Ensure pre-discharge counselling includes messages about danger signs for mothers and infants, EBF, LAM, fertility desires for spacing and limiting, and HTSP, return to fertility, return to sexual activity, safe modern methods to use while breastfeeding, and transition from LAM to a modern method (if she is using this method), as well as when and where to go for return visits 	<ul style="list-style-type: none"> • Proportion of skilled birth attendants trained to competency in PFP information, counselling, service provision (where appropriate) and referrals • Number/percentage of client cards and facility registers that are accurately completed and include data on PFP counselling, contraceptive method selected, services provided and follow-up care

ILLUSTRATIVE PROGRAMME STRATEGIES	ILLUSTRATIVE PROGRAMME ACTIVITIES	ILLUSTRATIVE INDICATORS
Infrastructure of maternity SDPs is adequate for providing high-quality PFFP services	<ul style="list-style-type: none"> • Select and/or upgrade maternity SDPs to provide PPIUD or PPTO services, including the availability of running water, electricity and space available for private counselling and surgical or procedure rooms; procurement is managed so that there is a continuous supply of FP commodities, equipment, instruments and expendable supplies 	<ul style="list-style-type: none"> • Proportion of maternity SDPs that have on-site supplies, IEC materials, provider reference materials and job aids (protocols, standards and guidelines), commodities, equipment and instruments for PFFP, including PPIUD and PPTO
High-quality PFFP information, counselling and services, including PPIUDs and PPTOs, are provided at maternity SDPs by competent, confident and committed providers	<ul style="list-style-type: none"> • Conduct competency-based counselling and clinical skills training in pre-service and in-service settings • Provide health-care workers with job aids, up-to-date service protocols, guidelines, screening checklists and other reference materials (WHO 2012c) • Introduce or strengthen supervision to support providers, including providing routine feedback and updates • Develop/improve the protocol for ensuring that informed and voluntary consent is obtained for all clients requesting PPTO prior to labour and delivery • Conduct other educational activities beyond one-on-one counselling to increase informed demand, such as group information sessions in the postpartum ward, videos and posters, ensuring that messages resonate with clients and communities 	<ul style="list-style-type: none"> • Number of clinical staff trained to competency in PFFP counselling and PPIUD and/or PPTO services; number of in-service and/or pre-service curricula that include clinical skills for PPIUD and PPTO provision • Indicator for job aids, protocols • Number of providers who reach 80% of PFFP standards • 100% of informed consent forms properly executed for clients who adopted immediate PPTO as their method
EBF and LAM counselling are routine components of pre-discharge counselling	<ul style="list-style-type: none"> • Conduct training to ensure providers are competent to provide accurate counselling and messages regarding LAM • Develop and implement guidelines and protocols to assist mothers in breastfeeding their baby within the first hour postpartum and to provide them with support during their stay 	<ul style="list-style-type: none"> • Proportion of health-care providers who can cite the 3 LAM criteria • Proportion of maternity clients who are counselled on EBF and LAM

3.3 Postnatal care

PNC presents an opportune moment when women should be counselled on birth spacing and family planning. Contraceptive options should be discussed and contraceptive methods should be provided if requested (WHO 2010b, WHO 2013c). WHO recommends that women who have delivered in a health facility should receive PNC for at least 24 hours after birth. If a birth is at home, the first postnatal contact should be as early as possible within 24 hours of birth. Three additional PNC contacts are recommended on day 3, between days 7–14 after birth and 6 weeks after birth (WHO 2013c). It is important to reach women before they are at risk for an unintended pregnancy with information about return of fertility, their options to space or limit future pregnancies, and the benefits to their own and their newborn's health of doing so. Community-based interventions are critical during the vulnerable period when women return home from a facility-based birth, as well as for those women who do not give birth in a facility. For both facility-based and community-based births, WHO recommends that counselling and support for EBF should be part of each postnatal contact. It is further recommended that women should be counselled on birth spacing and family planning during PNC contacts. Contraceptive options should be discussed and contraceptive methods should be provided if requested. Women should also be counselled on safer sex, including use of condoms. For women living with HIV, PPFPP can be integrated with routine PNC services if these exist within the PMTCT programme.

Table 6. Contacts during postnatal care

<p>Overall programme goals:</p> <ul style="list-style-type: none"> • Postpartum women have initiated immediate breastfeeding and are exclusively breastfeeding and practising LAM. • Postpartum women who are not exclusively breastfeeding or non-breastfeeding are using a modern contraceptive method by/before 6 weeks postpartum to avoid a closely spaced pregnancy (pregnancy can occur as soon as 45 days after birth if not exclusively breastfeeding). <p>Programme outcomes:</p> <ul style="list-style-type: none"> • Number and proportion of postpartum women exclusively breastfeeding and practising LAM at 6 weeks postpartum • Number and proportion of postpartum women who are not exclusively breastfeeding or non-breastfeeding who are using a modern contraceptive method by 6 weeks postpartum • Number and proportion of women referred for and using contraception by 6 weeks postpartum. 		
ILLUSTRATIVE PROGRAMME STRATEGIES	ILLUSTRATIVE PROGRAMME ACTIVITIES	ILLUSTRATIVE INDICATORS
Home-based maternal and newborn care is provided to postpartum women by midwives and other health-care providers, including CHWs	<ul style="list-style-type: none"> • Midwives and other health-care providers, including CHWs provide PPFPP messages and referrals for PNC and PPFPP services, including HTSP, EBF/LAM, return to fertility, and contraceptive options for breastfeeding and non-breastfeeding women • CHWs are able to provide short-term methods, such as pills, condoms and injections, to the postpartum woman in her home 	<ul style="list-style-type: none"> • Proportion of CHWs providing PPFPP interventions (screening, referral and method provision, where approved) • Number of community mobilization activities conducted that include PPFPP (including home visits, community meetings and health fairs) • Number of CHWs supervised (and resupplied with contraceptive commodities) in their PPFPP activities by staff at the primary health centre

ILLUSTRATIVE PROGRAMME STRATEGIES	ILLUSTRATIVE PROGRAMME ACTIVITIES	ILLUSTRATIVE INDICATORS
	<ul style="list-style-type: none"> • CHWs are trained in counselling skills and interpersonal communication, equipped with job aids and contraceptive supplies, and receive updates and supportive supervision to ensure high-quality PPF information, referrals and services • CHWs conduct community education activities that engage men, families and communities to support PPF 	<ul style="list-style-type: none"> • Number/percentage of postpartum women who started contraceptive use by 6 weeks postpartum • Number of fathers reached with PPF messages
SDPs provide PNC including PPF information, counselling and services	<ul style="list-style-type: none"> • At the time of the 6-week postpartum check-up, women are provided PPF information and counselling, and are offered appropriate methods depending on their breastfeeding status • PNC providers are trained and competent to counsel and provide appropriate methods for breastfeeding and non-breastfeeding women and for women with medical conditions that limit which options can be provided • Strong referral linkages exist between the various postpartum/ PNC providers and facilities, including FP clinics, to ensure continuity of care 	<ul style="list-style-type: none"> • Proportion of facilities offering at least three FP methods, plus LAM • Proportion of postpartum women with children under 6 weeks of age counselled on PPF during PNC, or PMTCT visits • Proportion of SDPs that have at least one PNC or PMTCT provider trained in PPF counselling and method provision • Proportion of facilities with stock-outs of FP methods within the last 3 months • Proportion of facilities that have job aids specific to PPF, including counselling and timing of method provision • Proportion of facilities that have referral system in place with community and higher-level facilities • Proportion of postpartum women who were referred for IUD, implant, or surgical methods

3.4 Infant health and immunization services

Infant and child health care visits are often the woman's most frequent or only visits to the health facility during the first year after birth. Routine immunization services; maternal, infant and young child nutrition information, education and communication (MIYCN) visits; and healthy and sick child visits offer important opportunities to discuss FP with postpartum women. Immunization contacts occur regularly according to the country schedule, such as at 6 weeks, 10 weeks, 14 weeks and 9 months. Infant nutrition and feeding sessions, including growth monitoring and promotion and/or distribution of vitamin A, also occur regularly and offer an opportunity to reach many postpartum women during group education talks about PFP. Mothers are advised to transition from LAM to another modern FP method when they initiate complementary foods to their infants, if not before. When a sick child is seen by CHWs or health providers during Integrated Community Case Management/Integrated Management of Childhood Illnesses (iCCM/IMCI) visits (WHO 2008b), the mother can be asked about her own health and FP needs. Women and health workers alike are often unaware of the risk of pregnancy during the postpartum period and may not consider contraception important until the return of menses. Advocacy efforts can promote positive partnerships between child health and FP programmes as a 'win-win' for the health of both the mother and the infant.

Table 7. Contacts during infant health and immunization services

Overall programme goals:		
<ul style="list-style-type: none"> • Postpartum women begin using a modern contraceptive within the first year following birth. • Postpartum women are exclusively breastfeeding and practising LAM until the infant is 6 months old, then transitioning to another modern contraceptive method (if not already using another method by 6 months). 		
Programme outcomes:		
<ul style="list-style-type: none"> • Number and percentage of postpartum women attending child health/immunization visits that initiate using a modern contraceptive method within the first year following a birth (this includes practising LAM for up to 6 months and transitioning from LAM to another modern method by/before 6 months) 		
ILLUSTRATIVE PROGRAMME STRATEGIES	ILLUSTRATIVE PROGRAMME ACTIVITIES	ILLUSTRATIVE INDICATORS
Integrate PFP with routine immunization services	<ul style="list-style-type: none"> • Group talks are provided during immunization sessions on HTSP, return to fertility, EBF/LAM, fertility desires to space or limit, and FP methods • Immunization providers screen women about their FP needs and give a voucher or referral card for FP services • Dedicated FP provider offers co-located FP services, including LARCs, the same day, before mother returns home • Linkages and protocols exist among immunization and FP staff and clinics to support effective referrals for PFP • Community-based workers mobilize mothers for immunization days and assist with/participate in FP group education sessions, and follow up mothers in the household for FP 	<ul style="list-style-type: none"> • Number/proportion of SDPs that have integrated PFP with routine immunization visits • Number/proportion of mothers at immunization sessions screened for PFP needs • Number/proportion of screened mothers referred for FP services • Number/proportion of mothers attending immunization sessions who accept an FP method the day of immunization services • Number/proportion of women with a child 12 months of age or younger who are currently using a contraceptive method (by type of FP method used)

ILLUSTRATIVE PROGRAMME STRATEGIES	ILLUSTRATIVE PROGRAMME ACTIVITIES	ILLUSTRATIVE INDICATORS
<p>Integrate PFP messages with MIYCN interventions (e.g. growth monitoring, nutrition promotion, food distribution and vitamin A distribution)</p>	<ul style="list-style-type: none"> • FP information, counselling and referrals are provided through structured contact with mothers attending growth monitoring and nutrition visits • Mothers with infants under 6 months of age are supported to continue EBF and LAM, and mothers with infants 6 months of age or older are counselled to transition from LAM to another modern method of FP • Providers are trained to rule out pregnancy among breastfeeding women 	<ul style="list-style-type: none"> • Number/proportion of MIYCN staff who are trained to counsel women on EBF, the three LAM criteria, and transition to another method of FP if any of the criteria are no longer met (or by the time the infant is 6 months of age) • Number/proportion of MIYCN staff who are trained to screen women about their FP needs and refer them to FP services • Number/proportion of postpartum women attending MIYCN services who received FP messages, were screened for contraception needs and referred for an FP method • Number/proportion of women with a child 12 months or younger who are currently using a contraceptive method (by type of FP method used)
<p>Integrate PFP with child health services (e.g. iCCM/IMCI)</p>	<ul style="list-style-type: none"> • Providers treating a sick infant/child ask the mother about her FP needs, and provide referral or linkage to FP services • CHWs screening a sick child also screen the mother for her FP needs and provide, resupply or refer her for FP services 	<ul style="list-style-type: none"> • Number/proportion of SDPs that have integrated PFP with child health visits • Number/proportion of SDPs that have implemented protocols to counsel women about HTSP, and risk of pregnancy, and refer her for contraception • Number/proportion of postpartum women with a child 12 months of age or younger provided/using a contraceptive method

3.5 Country programme case examples

Below are several examples – published and unpublished – from a range of settings that illustrate how various programmes have implemented PFP interventions in different countries and across one or more of the contact points described in this chapter. For each case example, additional references are provided.

Table 8. Country programme case examples

COUNTRY/PARTNER INSTITUTIONS/DATE/ REFERENCES	PFP CONTACT POINT(S)/PROGRAMME DESCRIPTION/RESULTS
<p>Country: Bangladesh</p> <p>Partners: Bangladesh Ministry of Health and Family Welfare, Shimantik (in-country nongovernmental organization), MCHIP and Johns Hopkins Bloomberg School of Public Health; with funding from USAID</p> <p>Date: 2007–2012</p>	<p>PFP contact points: Antenatal and postnatal care</p> <p>Programme description: The Healthy Fertility Study was designed to examine the impact of integrating FP with a community-based MNH programme and the effect on prospective pregnancy spacing and adverse newborn outcomes. The strategy used a two-pronged approach: the first component focused on system and capacity-building of service providers, including the referral system; the second focused on community-based advocacy and behaviour change communication at the household, community and facility levels. Both study groups received a basic package of MNCH information and services through CHWs during antenatal and postpartum periods. The intervention group received additional FP information and community-based services during counselling visits.</p> <p>Results: Contraceptive method use was approximately 2.5 times higher in the intervention arm than in the control arm at 24 months postpartum. The incidence of a subsequent pregnancy up to 24 months after a live birth was significantly lower in the intervention arm and the duration and exclusivity of breastfeeding until 6 months was higher in the intervention arm. The integration did not adversely affect the MNH programme and increased equity in FP coverage. Findings from this study are currently being applied in MaMoni, the Integrated Safe Motherhood, Newborn Care and Family Planning Project implemented by Jhpiego and Save the Children in the Sylhet and Habiganj Districts in northeast Bangladesh.</p> <p>Reference:</p> <p>Salahuddin A et al. Operations research to address unmet need for contraception in the postpartum period in Sylhet District, Bangladesh. Submitted for publication, 2012 (http://apps.who.int/trialsearch/trial.aspx?trialid=NCT01702402).</p>

COUNTRY/PARTNER INSTITUTIONS/DATE/ REFERENCES	PPFP CONTACT POINT(S)/PROGRAMME DESCRIPTION/RESULTS
<p>Country: Egypt</p> <p>Partners: Population Council, Ministry of Health and Population (MOHP), Social Planning, Analysis and Administration Consultants (SPACC), with funding from USAID through the Extending Service Delivery (ESD) Project</p> <p>Date: 2005–2007 (operations research phase) and 2009–2011 (scale-up phase)</p>	<p>PPFP contact points: Antenatal and postnatal care</p> <p>Programme description: To respond to the challenge of supporting women in achieving healthier birth intervals of at least 2 years, an operations research study was conducted to compare the acceptability and effectiveness of two clinic and community-based behaviour communication change (BCC) and service delivery models. The ‘health services’ model communicated birth spacing and PPFP messages to women via health workers during their prenatal and postpartum care visits. The ‘community awareness’ model, in addition to providing this education for women, also involved an awareness-raising component that targeted men. The study used an experimental design in 20 health facilities in 6 health districts.</p> <p>Findings from the operations research study were applied to scale up the original intervention into the entire governorates of Assiut and Sohag. Activities included: 1) revising and updating HTSP messages protocol for pregnant and postpartum women; 2) training of trainers for FP and MCH managers and supervisors; 3) on-the-job training of clinic staff (doctors, nurses, <i>RRs</i> (FP outreach workers) and provision of job aids; 4) providing information, education and communication materials to clients; 5) monitoring and supervision by MOHP and Council staff; 6) educational seminars for husbands; 7) Steering committee meetings; and 8) a national orientation and dissemination workshop.</p> <p>Results: The operations research study demonstrated that using the health services and community models to provide birth spacing and PPFP messages to low-parity women and their husbands was both feasible and acceptable. Both models proved effective in changing knowledge and attitudes towards HTSP and in enhancing use of PPFP at 10–11 months postpartum. Both models were associated with increased use of services, especially for FP, by women who only had one child. However, a fear of contraceptive side-effects continues to be a major concern among women and men in both groups and is an obstacle in achieving healthy birth intervals.</p> <p>The PPFP intervention was scaled up in a total of eight districts in Assiut and Sohag, which created conditions for scale-up in other districts within those two governorates as well as other governorates in Egypt. The main achievement, however, was securing the support and investment of senior MOHP officials at the central level, as well as the support and commitment of managers and supervisors at governorate and district levels. With the rise of more conservative Islamist forces and concern over negative reactions against FP in Egypt, adopting the HTSP approach to providing FP messages may prove to be a useful and politically acceptable approach.</p> <p>References:</p> <p><i>Scaling up the provision of family planning messages in antenatal and postpartum services in Upper Egypt.</i> New York, Population Council (no date) (http://www.popcouncil.org/projects/305_ScaleUpFPUpperEgypt.asp)</p>

COUNTRY/PARTNER INSTITUTIONS/DATE/ REFERENCES	PPFP CONTACT POINT(S)/PROGRAMME DESCRIPTION/RESULTS
<p>Country: El Salvador</p> <p>Partners: PASMO/El Salvador, The Salvadoran Ministry of Health (MINSAL), the Salvadoran Social Insurance Institute, and Population Services International (PSI), with funding from the large anonymous donor</p> <p>Date: 2009–present</p>	<p>PPFP contact points: Antenatal care and labour and delivery/pre-discharge</p> <p>Programme description: The purpose of this intervention is to increase access to PPFP by increasing the number of providers and facilities that perform post-obstetric IUD insertions and by improving the quality of FP consultations conducted during pregnancy. The intervention is a public-private partnership which started as an externally driven approach, whereby PASMO/El Salvador co-located providers at two public-sector maternities to provide PPIUD services alongside residents and doctors. As new sites were added, the approach shifted to capacity-building by PASMO/El Salvador master trainers who trained and supervised staff from eight public and two private-sector maternities, including nurses. PASMO/El Salvador provided trainers and providers, training and education materials and models, quarterly supervision visits and socially marketed IUD commodities and insertion equipment.</p> <p>Results: Prior to 2009, PPIUD services were not offered in maternity hospitals. By training doctors on post-obstetric IUD insertions and gaining the support of nurses, PPIUD services have been offered since late 2011 on a regular basis by host clinic staff at 10 maternity hospitals (eight public-sector and two private-sector Salvadoran Social Insurance Institute maternity hospitals), with PASMO/El Salvador providing ongoing support to high-level trainers and directors in the form of quarterly supervision. To date, 134 providers (28 private) were trained in PPIUD insertions and the number of PPIUD insertions has increased from 747 in 2009 to 993 in 2010 and 1044 in 2011. In 2012, IUD insertion training was incorporated with the existing post-graduate curricula at a Salvadoran medical school.</p> <p>Reference: none</p>

COUNTRY/PARTNER INSTITUTIONS/DATE/ REFERENCES	PPFP CONTACT POINT(S)/PROGRAMME DESCRIPTION/RESULTS
<p>Country: India</p> <p>Partners: Jhpiego, the Government of India and state governments, National Rural Health Mission, with funding from USAID, the Bill & Melinda Gates Foundation, David and Lucille Packard Foundation, and Norway India Partnership Initiative</p> <p>Date: 2007–present</p>	<p>PPFP contact points: Antenatal care and labour and delivery/pre-discharge</p> <p>Programme description: This programme builds on Jhpiego’s ongoing support of the Ministry of Health and Family Welfare, Government of India to introduce an alternative training approach that uses competency-based training, anatomical models, service delivery performance standards and technical support for strengthening interval IUD services in India. There has been a more than 15-fold increase in institutional deliveries after the Janani Suraksha Yojna (a conditional cash transfer scheme) was initiated by the Government under the National Rural Health Mission, providing an excellent opportunity to strengthen PPIUD services as part of PPFP programming at scale.</p> <p>To institutionalize the PPFP/PPIUD services at the participating sites, a holistic set of interventions included: setting up of clinical training sites in respective states; training a team of four providers at each facility to provide PPFP/PPIUD services; on-site orientation of the entire obstetrics and gynaecology department and facility management to provide a supportive environment; the provision of instruments and IEC materials; dedicated counsellors to provide routine counselling and referral for PPFP at ANC clinics and follow up of PPIUD clients; national and state-level workshops to set standards and share experiences, successes and challenges; supportive supervision and monitoring, including additional needs-based training where needed; and advocacy among professional organizations and policy-makers.</p> <p>Results: India’s PPIUD programme has successfully expanded the method mix and the service delivery timing of FP options available to women and couples. As of December 2012, almost 82 000 women received a PPIUD, based on data from 260 facilities in 19 states,. Some states had an IUD adoption rate more than 10% among women who had delivered in that facility (highest at 33%). Follow-up results revealed an expulsion rate of 2% and infection rate of 1%, demonstrating the high quality of services despite the rapid scale-up of these services. The effort has leveraged funding and is being scaled up in more than 20 states. Through sustained advocacy efforts, the programme has succeeded in creating a major policy shift, resulting in nurse-midwives being allowed in India to insert PPIUD at their respective health facilities and the hiring of MNCH counsellors at all high-volume SDPs throughout country.</p>

COUNTRY/PARTNER INSTITUTIONS/DATE/ REFERENCES	PPFP CONTACT POINT(S)/PROGRAMME DESCRIPTION/RESULTS
<p>Country: India</p> <p>Partners: Population Council, Lala Lajpat Rai Medical College, district-level units of the Ministry of Health and Family Welfare, and Ministry of Women and Child Development, with funding through USAID the Population Council Frontiers, and the Pathfinder ESD Project</p> <p>Date: 2006–2007 for the pilot phase; 2009–2011 for the scale-up phase</p>	<p>PPFP contact points: Unspecified</p> <p>Programme description: The objective of this programme is to mobilize the community to promote PPFP for healthy birth spacing in rural India among young couples. The approach used existing community workers from the Ministry of Health and Family Welfare and from the Ministry of Women and Child Development to implement a community-based BCC intervention conducted through integrated public delivery systems. Key intervention components included the reorientation of community workers; provision of counselling aids to community workers; provision of a storybook to pregnant women to share with family members; wall paintings at prominent places in villages; and group meetings with men and women separately. The topics for the community worker reorientation included maternal and child health, safe delivery, LAM and different methods of contraception. The messages in the counselling aids and storybook were developed through participatory approach and were pre-tested in community for clarity, word choice, appropriateness of pictures, etc. A checklist was developed to assist in monitoring and supervision. The supervisors were trained to use these findings to help community workers improve their skills in conveying messages to pregnant women. A project advisory committee was formed with the district collector – the highest development and administrative authority of the district – as its chairperson. The committee met every quarter to review the progress of the work and passed on advice to all concerned. The main challenge experienced was related to collaboration between both the departments of the Ministry and in encouraging their community workers to work together on the BCC approach.</p> <p>Results: Correct knowledge among community workers on topics covered in training rose from 32–44% to 91–93% in pre/post-test questionnaires. In the pilot phase, significant use of modern contraceptives for spacing at 9 months postpartum was reported: 57% women from the experimental (intervention) area versus 30% women from control sites. The intervention also successfully increased spousal communication; 60% of women shared and discussed the BCC materials with their husbands. The pilot phase intervention was implemented in two blocks of the district covering a population of 1 million. It demonstrated that the PPFP BCC model is not only feasible and effective, but can be introduced without any additional human resources or organizational changes in the existing health structure. Expansion and the scale-up to the entire district of 2 million people has been planned and implemented by district authorities, with limited technical assistance from research partners.</p> <p>References:</p> <p>Sebastian MP et al. Increasing postpartum contraception in rural India: evaluation of a community-based behaviour change communication intervention. <i>International Perspectives on Sexual and Reproductive Health</i>, 2012, 38(2):68–77.</p> <p>Sebastian MP, Khan ME & Roychowdhury S. Promoting healthy spacing between pregnancies in India: need for differential education campaigns. <i>Patient Education and Counseling</i>, 2010, 81:395–401.</p> <p>Sebastian MP & Khan ME. <i>Promoting optimal inter-pregnancy interval in India through integrated public delivery systems</i>. New Delhi, Population Council, 2007 (http://paa2007.princeton.edu/papers/70351).</p>

COUNTRY/PARTNER INSTITUTIONS/DATE/ REFERENCES	PPFP CONTACT POINT(S)/PROGRAMME DESCRIPTION/RESULTS
<p>Countries: Kenya and Swaziland (Integra Initiative)</p> <p>Partners: International Planned Parenthood Federation (IPPF), the Population Council, and the London School of Hygiene and Tropical Medicine (LSHTM), funded by Bill & Melinda Gates Foundation</p> <p>Dates: 2008–2013</p>	<p>PPFP contact points: Postnatal care</p> <p>Programme description: The PPFP intervention is part of a 5-year research project that seeks to generate rigorous evidence on the feasibility, effectiveness, cost and impact of different models for delivering integrated HIV and sexual and reproductive health services in high and medium HIV prevalence settings to reduce HIV infection (and the associated stigma) and unintended pregnancy. Its objective is to determine the benefits of different integrated models (HIV/FP and HIV/PNC) to increase range, uptake and quality of selected sexual and reproductive health and HIV services.</p> <p>Using the postnatal consultation as the entry point, HIV and FP services were strengthened for postpartum women attending facilities following childbirth in Kenya and Swaziland. The interventions included strengthening provider skills to offer both HIV counselling and testing (and/or referral to antiretroviral therapy units) and PPFP services through a mentorship approach. Mentors skilled in (for example) provision of LARCs, were encouraged to impart their skills to colleagues within the same health facilities through a structured process. All women attending PNC were offered the following: HIV counselling and testing, a list of danger signs for the mother and newborn, immunizations, and PPFP counselling and provision. The Balanced Counselling Strategy Plus toolkit, which includes PPFP counselling cards, was used as the core job aid.</p> <p>Results: Health facility assessments and client interviews with women leaving postnatal services documented improved client-provider interactions. There were statistically significant increases in the proportion of observations where providers discussed return to sexual activity (from 13.8% to 41.7%), return to fertility (17.4% to 53.4%), HTSP (from 34.9% to 60.8%), and the benefits of spacing for both the mother and baby (7.3% to 52%). A composite mean score of the four attributes increased from 0.7 to 2.1.</p> <p>References:</p> <p>www.integrainitiative.org</p>

COUNTRY/PARTNER INSTITUTIONS/DATE/ REFERENCES	PPFP CONTACT POINT(S)/PROGRAMME DESCRIPTION/RESULTS
<p>Country: Mali</p> <p>Partners: PSI/Mali, ProFam, the Malian Ministry of Health (MOH) Department of Reproductive Health, and the Bamako Regional Department of Health, with funding from the Dutch Government's Choices and Opportunities Fund, USAID's MCHIP and KFW</p> <p>Date: 2009–present</p>	<p>PPFP contact points: Child health/immunizations</p> <p>Programme description: This intervention aims to increase women's access to PPFP, particularly LARC, and relies on immunization services as the point of access to expand the provision of on-site FP counselling and services. By applying a social marketing approach as well as lessons learned from FP programmes in other countries, the model overcomes historical challenges to increasing LARC uptake. Building on the success of a pilot effort at ProFam private-sector clinics, a partnership was developed with the MOH to facilitate its replication in the public sector at community health centres.</p> <p>The strategy builds on women's existing health-seeking behaviour by integrating FP counselling and service delivery efforts with routine child immunization events. Thirty-minute group presentations were provided to women waiting to have their child immunized, followed by individual counselling sessions with those interested in obtaining FP. In this partnership, PSI/Mali midwives were embedded in MOH facilities to provide services and to train and coach public-sector providers in counselling and service delivery. LARC services were subsidized along with products, equipment and consumables.</p> <p>Results: By the end of 2011, 149 public-sector providers from 73 community health centres were trained and certified in LARC counselling and service delivery and over 41 000 Malian women had received a LARC method. Through multisectoral collaboration, the prices of LARCs in the government central medicines store were reduced. LARC was identified as a key priority in the national strategic plan around FP.</p> <p>References:</p> <p><i>ProFam urban outreach: a high impact model for family planning.</i> Washington, DC, Population Services International, 2012.</p>

COUNTRY/PARTNER INSTITUTIONS/DATE/ REFERENCES	PPFP CONTACT POINT(S)/PROGRAMME DESCRIPTION/RESULTS
<p>Country: Zambia</p> <p>Partners: The Zambian Ministry of Health, the Society for Family Health (SFH) and PSI with funding from USAID, the Dutch Ministry of Foreign Affairs and an anonymous donor</p> <p>Date: 2008–present</p>	<p>PPFP contact point: Labour and delivery/pre-discharge</p> <p>Programme description: PPIUD insertion services were among those introduced within a larger Dedicated LARC Provider Programme, designed to offer LARCs at public-sector MCH facilities. The approach involved attaching LARC services to existing, high-volume public health centres that were offering MCH and only limited FP services. It aimed to generate informed demand for and provide increased access to LARC by leveraging existing infrastructure to reach large audiences for women with an unmet need for FP in the postpartum period. Contraceptive implants and IUDs were introduced at all programme sites; PPIUD insertion services were added to one third of the sites. Providers offered a range of short- and long-acting contraception and used client feedback to guide and improve the quality of the education they provided.</p> <p>The interventions included training and placing SFH midwives as dedicated LARC providers at high-volume facilities, where they supplemented the work of MCH staff. This enabled providers to increase the number of days and hours that services were offered at the clinics. In addition the programme supported the capacity building of MCH staff in LARC, improving the availability of educational materials, providing on-site counselling to prospective clients waiting to receive services, and performing on-site insertions.</p> <p>Results: A total of 38 midwives were placed as of December 2012 and 176 880 women were provided the LARC of their choice, including 3926 PPIUD insertions (representing 5% of the total IUDs provided by the program). The overall programme reached an unexpectedly younger demographic and lower-parity demographic, and 50% of programme participants were not using any contraception at the time of insertion.</p> <p>Reference:</p> <p>Neukom J et al. Dedicated providers of long-acting reversible contraception: new approach in Zambia. <i>Contraception</i>, 2011, 83:447–452.</p>

COUNTRY/PARTNER INSTITUTIONS/DATE/ REFERENCES	PPFP CONTACT POINT(S)/PROGRAMME DESCRIPTION/RESULTS
<p>Country: Zambia</p> <p>Partners: Zambian Ministry of Health and the Population Council, with support from WHO/RHR</p> <p>Date: 2011–2012</p>	<p>PPFP contact point: Postnatal care</p> <p>Programme Description: To improve the health and survival of mothers and infants in the postnatal period, and to address the gap between PMTCT, FP and maternal health programmes, the partners collaborated to develop <i>The Integrated Postnatal Care Guidelines</i> and implement an intervention to strengthen PNC and PPFP for both women and their infants. The guidelines focus on the core elements of care every woman and newborn should receive during the postnatal period (prior to discharge, at 1-week and 6-week consultations, and at 6 months) to enable women to access time-relevant services for themselves and their babies.</p> <p>Eight intervention areas were identified for strengthening service delivery of postpartum and postnatal care, including: development and adaptation of guidelines and protocols; organizational change and role clarification with all staff in intervention sites; ensuring availability of minimum equipment, supplies and materials; and strengthening data collection, recording systems and the referral system. The programme was conducted in two districts in Eastern Province and two districts in Southern Province, from June 2011 to April 2012. The study used a pre-/post- intervention design for assessing quality of care within facilities before and after introduction of the intervention.</p> <p>Results: Comparisons within and between groups at baseline and end line showed that conducting integrated PNC was feasible for all health facilities and that intervention activities had a positive effect on competence in providing FP and PNC in intervention facilities, as well as on availability of guidelines. However, there were limited changes between the baseline and end line, and few differences between intervention and comparison sites. Intervention hospitals were more likely to be better equipped, however. At end line, more providers in intervention sites used the Balanced Counselling Strategy Plus (BCS+) toolkit to address women's postpartum needs related to HIV, sexually transmitted infections (STIs) and FP, as well as their knowledge improved on FP commodities, STIs, and danger signs during the early postpartum period and for the newborn. Of note was the fact that traditional birth attendants were providing much PNC at end line in intervention facilities.</p> <p>References:</p> <p>Warren C et al. <i>Evaluating the feasibility, acceptability, quality and effectiveness for strengthening postnatal care in Zambia</i>. New York, Population Council, 2012.</p>

Chapter 4

Monitoring and evaluation

An indispensable tool for programme management, monitoring and evaluation is used to define goals and objectives, determine what 'success' looks like if the goals and objectives are achieved, and assess progress (and adjust, if needed, along the way) towards achieving the goals and objectives. Being clear from the beginning about the indicators that will be used for monitoring and evaluating progress is an important component of programme design. Determining how and where data can be obtained and collected is also an important step. Monitoring and evaluating PFP programmes is especially important as evidence about the effectiveness of various programme models is currently limited. Monitoring and evaluation data help programme planners advocate for additional and/or continued funding and support for programmes. A key limitation within the published literature concerns a lack of information about the design and process elements that underpin the intervention studies. Programme leaders are encouraged to give priority to systematically evaluating their PFP efforts and, as part of that effort, to fully describe processes undertaken to implement the interventions.

Chapter 3 provided illustrative programme goals and activities with related indicators to show how one might approach monitoring and evaluating a PFP programme component or intervention. Ideally, recordkeeping of FP delivery is available within existing HMIS for ANC, childbirth, PNC and child health services. Additional indicators are provided in this chapter, along with definitions and suggestions for the data source and frequency of data collection are included for reference. These indicators are organized into sections on policy/enabling environment, service delivery, and client and demand factors.

Table 9. Sample programme indicators and data collection methods

INDICATOR	DEFINITION	NUMERATOR/ DENOMINATOR	DATA COLLECTION	FREQUENCY
Policy/Enabling Environment				
Number of improvements to PFP law, policy, regulations, protocols, curricula, or guidelines related to improved access to and use of health services drafted or changed with programme support	Number of laws, policies, or guidelines developed or changed to improve access to and use of PFP services	Numerator: Number of laws, policies, regulations, protocols, or guidelines developed and changed to improve access to and use of PFP services Denominator: N/A	Programme report including a review of national and subnational policies	Annually

INDICATOR	DEFINITION	NUMERATOR/ DENOMINATOR	DATA COLLECTION	FREQUENCY
Percentage of pre-service education institutions implementing curricula that include PPF core competencies	Curricula include explicit content on PPF and core competencies required for the relevant cadre of health-care provider	Numerator: Number of pre-service institutions implementing curricula that include PPF core competencies Denominator: Total number of pre-service institutions	Review of curricula and training reports	Annually
Service delivery/capacity				
Number and proportion of SDPs providing PPF counselling or services	Counselling includes discussion of client's experience with FP, desire for spacing or limiting, preferred method, HTSP, plans for breastfeeding, medical history, information on appropriate options (how it works, effectiveness, benefits, disadvantages, common side-effects, warning signs, where to go with problems, and information on STI/HIV prevention) Number of SDPs (excluding community-based distribution) providing counselling or services, by type of service (vertical FP/RH, HIV, including PMTCT, prenatal, postnatal or other MNCH services)	Numerator: Number of SDPs by type where PPF counselling or services are provided Denominator: Total number/type of SDPs	Observation, supervision visits	Quarterly
Number/percentage of SDPs in programme-supported areas that offer a range of appropriate contraceptive options for postpartum women	Proportion of SDPs that offer at least three FP methods appropriate for postpartum women (including LAM) and have at least a 3-month supply of IUD, progestogen-only pills, injectables, implants or condoms for postpartum women	Numerator: Number of SDPs that offer at least three FP methods (including LAM) and have a 3-month supply of IUD, progestin-only pills, injectables, implants or condoms for postpartum women Denominator: Total number of SDPs	Direct observation	Semi-annually

INDICATOR	DEFINITION	NUMERATOR/ DENOMINATOR	DATA COLLECTION	FREQUENCY
Proportion of SDPs that have PPFPP IEC materials for clients and PPFPP job aids for providers	Client IEC materials, such as brochures, posters and provider job aids, are visible and used	Numerator: Number of SDPs with client and provider materials Denominator: Total number of SDPs	Observation, supervision visits	Quarterly
Percentage of SDPs that have implemented pre-discharge protocols that include PPFPP	SDPs that conduct pre-discharge PPFPP counselling, IEC and/or method provision in the maternity according to protocol	Numerator: Number of SDPs that have PPFPP in the maternity pre-discharge protocol Denominator: Total number of SDPs	Observation, supervision visits	Semi-annually
Proportion of providers who know the timing for initiation of PPFPP methods	Proportion of providers trained by the programme who know what methods can be used during the postpartum period, including timing, correct use, side-effects and complications, along with their prevention and management, and follow-up	Numerator: Number of providers trained who meet the definition Denominator: Total number of providers trained in the PPFPP program	Programme reports	Semi-annually
Number/ proportion of SDPs demonstrating improved compliance with clinical standards for provision of PPFPP	Improved compliance refers to SDPs implementing a standards-based quality improvement process that achieves a predetermined level of acceptable quality (e.g. 80% of PPFPP standards)	Numerator: Number of SDPs who meet the definition Denominator: Total number of SDPs implementing a standards-based quality improvement process	Self- or supervisor-administered assessments using standard checklists and observations or simulations of client-provider interactions	Semi-annually
Demand/client and community				
Number/ proportion of maternal health clients at programme-supported SDPs or events who received information and/or counselling about PPFPP	Proportion of postpartum women interviewed who report receiving information and/or counselling about PPFPP, including LAM	Numerator: Number of postpartum women interviewed as per the definition Denominator: Total number of postpartum women interviewed	Client exit interview	Semi-annually

INDICATOR	DEFINITION	NUMERATOR/ DENOMINATOR	DATA COLLECTION	FREQUENCY
Proportion of CHWs trained in PPFPP	Proportion of CHWs trained in PPFPP, including screening, referral and method provision, where approved	Numerator: Number of CHW trained as per the definition Denominator: Total number of CHWs trained by the program	Programme report	Quarterly
Number/ proportion of CHWs providing PPFPP interventions, information and referral	Proportion of CHWs providing PPFPP screening, referral and method provision, where approved	Numerator: Number of CHWs providing interventions as per the definition Denominator: Total number of programme-supported CHWs	Programme report, including CHW and supervisory reports	Quarterly
FP service coverage				
Couple-years protection (CYP) provided by MNCH programme	The estimated protection provided by FP services during a 1-year period, based on the volume of all contraceptive methods provided to PPFPP clients during that period. CYP is used as an interim measure of coverage, as contraceptive prevalence rates are generally calculated at 3- or 5-year intervals. CYP is calculated by multiplying the quantity of each method distributed or provided to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYPs for each method are then summed over all methods to obtain a total CYP figure (see www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp for conversion factors).	Numerator: CYP calculation Denominator: N/A	Service statistics or logistics data from HMIS	Annually

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Annex 1: Statement for collective action for postpartum planning



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 PFP 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 PFP 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 PFP



Why Is PFP Important?

Even though PFP 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 PFP

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 PFP 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 PFP.

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 PPFPP 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 PPFPP counseling and services.

Maximize Community-Based Care: A recent review indicated that 50% of all births occur outside of health institutions⁸ 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 PPFPP in their role in decision-making, in influencing the attitudes of families and communities, and as clients.

Expand the Range of Options: PPFPP 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 PPFPP

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 PPFPP 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.

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, Glasier 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.

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

Annex 2

Supporting evidence for programme design

A review of literature was conducted to identify evidence on programmatic interventions for PPF from 2000 through July 2012. The searches of the grey and peer-reviewed literature were performed using PubMed and The Cochrane Library, as well as Google and Bing Internet search engines. Key findings and their programme design implications gleaned from the literature are presented in the table below for each of the contact points where there are opportunities for integrating PPF with MNCH services. This supporting evidence was reviewed by the experts participating in the 2012 WHO Technical Consultation to inform the development of the illustrative programme strategies featured in Chapter 3. Citations for the studies noted in this table follow.

KEY FINDINGS/CONSIDERATIONS FOR PROGRAMMING	SUPPORTING EVIDENCE IN LITERATURE
Antenatal care	
<p>FP counselling during the antenatal period may increase postpartum contraceptive use. The quality of FP counselling appears to make a difference</p>	<ul style="list-style-type: none"> • A randomized controlled trial (RCT) in Egypt demonstrated increased adoption of PPF in the immediate postpartum period and within 3 months as a result of an antenatal education intervention (Soliman 1999). Two other RCTs in Turkey and Scotland and China and South Africa found no difference (Akman et al. 2010; Smith et al. 2002). • A non-equivalent control group study found increased use of postpartum contraception following ANC counselling that included husbands. However, this article included little description of the intervention (Varkey et al. 2004). • One RCT conducted in a facility was preceded by a qualitative study of focus group discussions and also included a community component (Turan et al. 2001). • One RCT looked at knowledge rather than contraceptive usage as its outcome (Mullaney et al. 2010).
<p>Interventions conducted during ANC were more effective when part of multiple contacts than when conducted during ANC alone</p>	<ul style="list-style-type: none"> • An RCT in four countries found that the addition of one antenatal counselling session to standard care did not influence contraceptive use or pregnancy rates (Smith et al. 2002). This is in contrast to studies above with multiple sessions showing positive influence on contraceptive knowledge and/or usage.
Labour, delivery and pre-discharge	
<p>Provision of pre-discharge PPF counselling (including IEC materials) can increase use of contraception</p>	<ul style="list-style-type: none"> • An RCT in Pakistan compared contraceptive uptake among women who were provided with an informal didactic counselling session of 20 minutes duration (with husbands or close relatives) along with a one-page leaflet about PPF prior to discharge versus controls who received routine care. Women who received the intervention were more likely to be using any form of contraception, as well as modern contraceptive methods, at 8–12 weeks postpartum (Saeed et al. 2008). • In Nepal, immediate postpartum health education of 20 minutes duration focussing on FP provided by trained female health workers showed a small improvement in contraceptive uptake at 6 months after birth versus controls (Bolam et al. 1998).

KEY FINDINGS/CONSIDERATIONS FOR PROGRAMMING	SUPPORTING EVIDENCE IN LITERATURE
Access to contraceptive methods in the immediate postpartum increases contraceptive uptake (including LAM, IUD and sterilization services)	<ul style="list-style-type: none"> • A randomized prospective cohort study in Peru included an experimental labour ward, where women were offered pre-discharge IUD insertion, barrier methods or oral contraceptives for non-breastfeeding women. Women in the control group were referred for desired FP services after discharge. Women in the experimental group had significantly more reported contraceptive use at 40 days (44.7% versus 25.9%) and at 6 months (81.8% versus 68.7%) than women in the control group (Foreit et al. 1993). • Potter et al. (2003) demonstrate a high unmet need for female sterilization at time of birth in Brazil but do not describe subsequent contraceptive use after an unfulfilled request. • An RCT evaluating the timing of IUD insertion (immediate post-placental, 10 minutes to 48 hours after delivery and interval) found very little difference in IUD use at 3 and 6 months between groups. This was a United States feasibility study that was included in the literature review (Dahlke et al. 2011).
Supportive government policies can play an important role in facilitating access to TO when desired in the postpartum	<ul style="list-style-type: none"> • A prospective study of 1612 pregnant women in Brazil found that when legislation discouraged PPTO following caesarean section, 47.5% of ANC clients in the public sector and 14.6% in the private sector stated that they wanted to be sterilized before leaving the hospital after the birth of their baby. Of these women, 69% in the private sector and only 33% in the public sector received PPTO (Potter et al. 2003).
Improving provider ability to offer high-quality counselling and competent services with consistent commodities improves use of PFP in the immediate postpartum	<ul style="list-style-type: none"> • In Honduras, intensive staff training focused on effective FP counselling, and service promotion was provided to physicians, nurses, nurse auxiliaries, social workers and educators in obstetrics and gynaecology wards at hospitals. Additionally, physicians and nurses completed proficiency training in IUD insertion and equipment to support subsequent IUD insertion (including post-placental and pre-discharge). The programme demonstrated an increase in the proportion of women receiving contraceptive education at the time of birth, the proportion of women interested in contraceptive use, and the proportion of women receiving a method during their hospital stay (Medina 2001*).
Pre-discharge counselling that includes information on vasectomy to discuss with partner can identify clients	<ul style="list-style-type: none"> • Project data from a vasectomy programme in Guatemala yielded evidence that providing information on vasectomy to women in the immediate postpartum period increased vasectomy use among their partners (Vernon, Solórzano & Muñoz 2007).
Task-shifting that encourages the provision of PFP services by non-physician skilled birth attendants should be considered	<ul style="list-style-type: none"> • A pre-/post-intervention longitudinal cohort study in Kenya found that when a comprehensive postpartum care package, that included PFP services was introduced, significantly more women in the post-intervention group received a method of family planning (65% versus 35%), including IUD (30% versus 3%), than prior to the intervention. All but one of the service providers was a nurse or nurse-midwife (Mwangi et al. 2008*; Warren et al. 2010). • A project evaluation in Kenya demonstrated that clients who had an IUD inserted immediately postpartum by nurses and nurse-midwives had a 76% continuation rate at 3–6 months postpartum (Chaurat et al. 2011*).

KEY FINDINGS/CONSIDERATIONS FOR PROGRAMMING	SUPPORTING EVIDENCE IN LITERATURE
LAM counselling, including supportive home visits and breastfeeding support, increase LAM use	<ul style="list-style-type: none"> • A quasi-experimental design study nested within a community-based RCT in Bangladesh found that women in the intervention group who received family planning messages and commodities provided by a CHW were more likely to use LAM at 3 months (23% versus 0%), to use any method of contraception at 3 months (36.4% versus 10.8%) and to use any method at 12 months (42.1% versus 27.1%) (Baqui et al. 2011, unpublished). • A quasi-experimental pre-/post- control group study in India found that women in the experimental group were more likely to use a contraceptive at 9 months postpartum (62% versus 31%) and more likely to use LAM at 4 months postpartum (22% versus 0%). The intervention included facility- and community-based counselling and an educational campaign with CHWs that included husbands and mothers-in-law (Khan et al. 2008, Sebastian, Khan & Roychowdhury 2010).
Include LAM in any programme that aims to increase prevalence of other modern methods of contraception by 12 months postpartum and EBF up to 6 months	<ul style="list-style-type: none"> • A study of 519 LAM users from 10 countries found that among all women studied, 68% were using a contraceptive method at 9 months, which was 79% of women who reported wanting to space their births (Labbok et al. 1997). • A study in Brazil showed that the proportion of women who were counselled on and accepted LAM were more than twice as likely to be using contraception at 12 months than women who had not been counselled on and accepted LAM (Hardy et al. 1998). • A post-intervention survey in Jordan found that LAM users were more likely than breastfeeding non-LAM users (38% versus 20%) and non-family planning users (16%) to be using a modern method of contraception at 12 months (Bongiovanni 2005*).
Postpartum/postnatal care	
A community-based programme that involves training and support of CHWs to provide PFP counselling, together with effective IEC and coordinated district support, can increase postpartum contraceptive use, including early uptake at 3 or 4 months postpartum	<ul style="list-style-type: none"> • A quasi-experimental pre-/post- control group study in India found that women in the experimental group were more likely to use a contraceptive at 9 months postpartum (62% versus 31%) and more likely to use LAM at 4 months postpartum (22% versus 0%). The intervention included a community educational campaign and coordination between district authorities and CHWs (Khan et al. 2008).
Supportive home-based care during the antenatal and/or postpartum periods can increase postpartum contraceptive use, including LAM	<ul style="list-style-type: none"> • A prospective cohort study in India found a significant increase (61.8% versus 30.6%) in contraceptive use at 9 months postpartum by women in the intervention group compared with the control group. The intervention included an educational campaign carried out by community workers using leaflets, posters, wall paintings and booklets. The campaign addressed pregnant women, their husbands, mothers-in-law and community opinion leaders (Sebastian et al. 2010 and 2012). • A quasi-experimental design study nested within a community-based RCT in Bangladesh found that women in the intervention group who received FP messages and commodities provided by a CHW were more likely to use any method of contraception at 3 months (36.4% versus 10.8%), to use any method at 12 months (42.1% versus 27.1%) and to use LAM at 3 months (23% versus 0%) (Baqui et al. 2011*).

KEY FINDINGS/CONSIDERATIONS FOR PROGRAMMING	SUPPORTING EVIDENCE IN LITERATURE
Home-visits during ANC and PNC may not increase contraceptive use	<ul style="list-style-type: none"> • One prospective cohort study in Chile found no positive effect on contraceptive usage or pregnancy rates for ANC and PNC home visits compared with women seen in public clinics in contraceptive usage or pregnancy rates. Of the control/clinic group, 21% was lost to follow-up, while none in the community arm were lost to follow-up (Alvarado et al. 1999). • An RCT in Syria found no positive effect on contraceptive usage among for women who had 1–4 postpartum home visits compared with women who had no home visit in contraceptive usage. There was a significant increase in breastfeeding in the intervention groups, but LAM was not included in this study (Bashour et al. 2008). • A prospective cohort study in Palestine found no significant difference between women who received home visits in addition to basic care, compared with women who only received basic care in relation to use of contraception at <2 months and at 6 months postpartum (Center for Development in Primary Health Care 2003*).
Community-based care that includes husbands and mothers-in-law, as well as IEC material, may effectively increase the use of PFP	<ul style="list-style-type: none"> • A prospective cohort study in India found a significant increase (61.8% versus 30.6%) in contraceptive use at 9 months postpartum by women in the intervention group compared with the control group. The intervention included an educational campaign carried out by community workers using leaflets, posters, wall paintings and booklets. The campaign addressed pregnant women, their husbands, mothers-in-law and community opinion leaders (Sebastian et al. 2010 and 2012). • A similar study in India examined a quasi-experimental pre-/post- control group and found that women in the experimental group were more likely to use a contraceptive at 9 months postpartum (62% versus 31%) and more likely to use LAM at 4 months postpartum (22% versus 0%). The intervention included a community educational campaign with CHWs that included husbands and mothers-in-law (Khan et al. 2008).
Longer programmes with multiple contacts across the continuum of care may have more effect on PFP use than short programmes with few contacts	<ul style="list-style-type: none"> • A study in Egypt used a post-test panel design with a non-equivalent control group with Model 1 delivering PFP messages in ANC and PNC at facilities and Model 2 including a community component in addition. This study found that women in the intervention groups were more likely to use contraception at 10 and 11 months postpartum (48% and 43% versus 31%) and to have a longer duration of protection against pregnancy than women in the control group (6.8 months and 4.5 months versus 2.9 months) (Abdel-Tawab, Loza & Zaki 2008*). • A pre-/post-intervention study in Honduras that included multiple ANC and postpartum encounters for counselling and wider method choice resulted in an increase for acceptance of sterilization, IUD and oral contraceptives from 8.8% at the beginning of the programme to 41.2% after 14 months (Vernon et al. 1993).

KEY FINDINGS/CONSIDERATIONS FOR PROGRAMMING	SUPPORTING EVIDENCE IN LITERATURE
<p>The implementation of a comprehensive PNC package that includes PFP may result in earlier and increased use of contraception by postpartum women</p>	<ul style="list-style-type: none"> • An experimental pre-/post-intervention design with control in Guatemala found an increase at <3 months postpartum from 7% to 19% in experimental group and reduction from 23% to 15% in the control group, as well as an increase at 3 months postpartum from 18% to 25% in the experimental group and decrease from 20% to 14% in the control group. The intervention included IEC materials, training of health-care providers, and monitoring at the community and facility levels (Jacobs, Brambila & Vernon 2002*). • A pre-/post-intervention survey in the Russian Federation found an increase in postpartum contraceptive use from 0% to 65% following a comprehensive ANC and PNC intervention that included providing supplies, training providers and improving quality of care for comprehensive services (Stephenson et al. 1998).
<p>Infant health and immunization services</p>	
<p>FP uptake may increase if contraception is offered during immunization services</p>	<ul style="list-style-type: none"> • A cluster, randomized two-group pre-/post-intervention study in Rwanda in which FP was integrated with immunization services found an increase of FP use from 51% to 57% in the intervention group, and a decrease from 58% to 49% in the control group without a detrimental effect on immunization rates (Dulli et al. 2012*). • A comparative time series survey in Togo found a significant increase in contraceptive acceptors from 200/month to 307/month in the intervention group, and compared with a non-significant increase from 144/month to 167/month (NS) in the control group after introducing referrals for FP at the expanded programme on immunization (EPI) clinic. There was also a significant increase in mean users, from 1035/month to 1311/month in the intervention group compared with a non-significant 704/month to 768/month in the control group during the same period (Huntington and Aplogan 1994). • A case study from Mali found that after introduction of family planning messages and services at immunization event days, uptake increased from 330 IUDs and implants annually before the intervention to 3997 annually after 1 year and 292 event days, and to 5600 annually after 2 years and 1100 event days. (PSI 2010*). • A pre-/post-experimental and control group designed study in India found that women attending clinic for immunization services who also obtained FP services increased from 0.42 per visit to 0.62 per visit in the intervention group while it decreased from 0.37 per visit to 0.36 per visit in the control group. The intervention included use of a systematic screening tool to identify women bringing a child for immunization services who also needed FP services (Das et al. 2005*). • A cluster RCT in Guinea Bissau in which breastfeeding and FP messages were included in a first ANC visit, plus immunization sessions at 6, 10 and 14 weeks, resulted in 31 IUD insertions in the intervention group and only 14 insertions in the control group (RR=2.45) (Jakobsen et al. 1999).

KEY FINDINGS/CONSIDERATIONS FOR PROGRAMMING	SUPPORTING EVIDENCE IN LITERATURE
Expanded Programme on Immunization (EPI) providers may need FP skills development, while FP providers may need skills development in EPI.	<ul style="list-style-type: none"> Most of the studies cited above mention the training of immunization service providers in providing FP messages (Huntington and Aplogan 1994; PSI 2010*; Das et al. 2005; Jakobsen et al. 1999).
Postpartum family planning for women living with HIV	
High rates of contraceptive coverage can be attained among women living with HIV if they are given ANC counselling and referral to a FP clinic in the postpartum	Among 319 women living with HIV who were counselled in ANC and referred after birth for FP, 72% of women were using hormonal contraception for at least 2 months during the postpartum, initiating use at approximately 3 months postpartum (range: 1–11 months). Overall, 44% used DMPA, 31% used oral contraception, and 25% switched methods during follow-up. Partner notification, infant mortality and condom use were similar between those using and not using other forms of contraception (Balkus et al. 2007).
Use of LARC among postpartum women living with HIV is increased where access (availability and cost) issues are addressed	In a prospective cohort study, the uptake of implants was significantly higher (38%) at the site where contraceptives were provided free and on-site, than at the site (6%) from which a woman was referred for contraceptive services. The IUD uptake was extremely low at both sites (2%) (Dhont et al. 2009).

*Article not published in a peer-reviewed journal

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