



Postpartum Family Planning Technical Consultation

Meeting Report

Washington, D.C.

14 November 2006

*Synthesizing lessons learned and building
consensus on effective approaches for
postpartum family planning*



USAID
FROM THE AMERICAN PEOPLE

a^occess

Family Planning Initiative
Addressing unmet need for postpartum family planning

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ABBREVIATIONS AND ACRONYMS

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women’s Health Services Program	MMR	Maternal mortality ratio
ACNM	American College of Nurse-Midwives	MNH	Maternal and neonatal health
AED	Academy for Educational Development	MNCH	Maternal, neonatal and child health
AMTSL	Active management of third stage of labor	MSH	Management Sciences for Health
ANC	Antenatal care	NBC	Newborn care
ART	Antiretroviral therapy	NH	Neonatal health
ARV	Antiretroviral	OR	Odds ratio
BASICS	Basic Support for Institutionalizing Child Survival Project	PEPFAR	President’s Emergency Plan for AIDS Relief
BF	Breastfeeding	PMTCT	Prevention of mother-to-child transmission of HIV
BFFP	Breastfeeding for family planning	PNC	Postnatal care
CEDPA	Centre for Development and Population Activities	POPHI	Prevention of Postpartum Hemorrhage Initiative
CH	Child health	PPC	Postpartum care
CHW	Community health worker	PPFP	Postpartum family planning
DHS	Demographic and health survey	RH	Reproductive health
EBF	Exclusive breastfeeding	SBA	Skilled birth attendant
ESD	Extending Service Delivery Project	SDM	Standard days method
FHI	Family Health International	TBA	Traditional birth attendant
FP	Family planning	TL	Tubal ligation
FRONTIERS	Frontiers in Reproductive Health	USAID	United States Agency for International Development
HTSP	Healthy timing and spacing of pregnancy	WHO	World Health Organization
IEC	Information, education and communication	WRA	White Ribbon Alliance
IRH	Institute for Reproductive Health		
IUD	Intrauterine contraceptive device		
JHU	The Johns Hopkins University		
LAM	Lactational amenorrhea method		
LAPM	Long-acting or permanent method		
MCH	Maternal and child health		
MEC	Medical Eligibility Criteria		
MH	Maternal health		

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Academy for Educational Development (AED)
American College of Nurse-Midwives (ACNM)
CARE
Centre for Development and Population Activities (CEDPA)
Constella Futures
EngenderHealth
Family Health International (FHI)
Institute for Reproductive Health (IRH)
JHPIEGO
The Johns Hopkins University (JHU)
Management Sciences for Health (MSH)
Pathfinder International
Population Council
PATH
Save the Children
USAID
White Ribbon Alliance (WRA)

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* A full list of meeting participants (along with their organizational and project affiliations) is presented in Appendix A.

EXECUTIVE SUMMARY

Postpartum family planning (PPFP) as part of a comprehensive maternal, newborn and child health approach has the potential to systematically reach a large number of women with critical, life-saving information and services. In an effort to better understand and thus maximize the opportunity for PPFP that exists during the extended postpartum period, the U.S. Agency for International Development (USAID) and ACCESS-FP organized a technical consultation on PPFP on 14 November 2006, in Washington, D.C. The overall purpose of the meeting was to examine the status of PPFP service delivery through an expert review of key literature, complemented by collective programmatic experience to date, as the basis for further program development.

Over 40 experts and leaders in reproductive health and maternal, neonatal and child health from more than 23 global health organizations and programs were brought together to participate in this intensive, all-day event. Throughout the course of the technical consultation, several areas of general consensus became apparent.

It was agreed that there is a persuasive case for providing family planning during the extended postpartum period—for several reasons. First, this is when women express an important unmet need for such services. Data from 27 demographic and health surveys indicate that there is a large unmet need for contraception among women during the first year postpartum. Nearly 40% said that they planned to use a method in the year after a birth but were not currently doing so. Second, there is clear evidence of the health benefits of FP for women and children. According to a recent article published in *The Lancet*, an estimated 25% to 40% of maternal deaths could be averted if unplanned and unwanted pregnancies were prevented. Another recent *Lancet* study calculates a nearly 10% reduction in child deaths (one million under-five deaths averted annually) by eliminating inter-birth intervals of less than two years. Third, many program approaches have been successful in increasing family planning use during this period, although many of them were of very limited scope.



Indonesia, JHPIEGO

It was acknowledged that the current status of PPFP programming is poor. ACCESS-FP conducted an extensive review of key articles and programmatic materials to assess the status of PPFP programming spanning the last 15 years. The results demonstrated a remarkable lack of consistency in programmatic approaches. While studies repeatedly demonstrated the unmet need for (and interest in) PPFP services among postpartum women, few interventions were found to include a comprehensive postpartum approach or to examine the possibility of extending services through the first year postpartum. Of 60 relevant journal articles and reviews published since 1993, only 13 described facility-level programmatic interventions aimed at increasing PPFP use. Even fewer (three) described approaches beyond facilities that included community-based delivery of PPFP services.

A similar lack of consistency in approaching PPFP was demonstrated in maternal and newborn health curricula and training materials reviewed by ACCESS-FP. These materials frequently refer the reader to other resources for information on family planning. FP messages, if present, are typically not specific to postpartum women. There is little information about return to fertility or the importance of counseling on this subject. Discussion about birth spacing is rare, and there is no discussion of maternal and newborn health risks related to different intervals. Although there is information about breastfeeding, it is only rarely linked with the lactational amenorrhea method (LAM), and little or no emphasis is placed on transitioning from LAM to other methods.

Based on areas of agreement, the following themes and recommendations emerged from the technical consultation:

1. LAM should be de-mystified and the transition to modern methods reinforced. Experience suggests that emphasizing the link between LAM and exclusive breastfeeding is the most logical way to ensure that LAM is well understood.
2. An array of contraceptive options should be made available to all postpartum women. The appropriateness of available options should be ensured through consideration of contraceptive goals, breastfeeding status and need for protection against sexually transmitted infections.
3. There should be an emphasis on incorporating PPFp systematically into pre-service education, including curricula, skills development and clinical practice.
4. The addition of PPFp to existing services or activities should be made as simple as possible for the provider and supported with job aids and information, education and communication materials.
5. The benefits of PPFp should be clearly articulated within the context of the index program, and its integration should be reflected/supported by a performance indicator and change in job description.
6. To expand coverage, private sector partnerships should be explored, particularly private practices run by midwives and nurses.
7. A model of focused postpartum care should be developed to ensure that essential maternal and newborn care, including family planning, is systematically provided.
8. Community-based efforts in PPFp should be more systematically addressed and evaluated, and lessons learned shared.
9. Policy champions for PPFp need to be identified and supported with evidence-based information for policy/advocacy efforts.

Although the technical consultation served to reinvigorate the discussion around this important health issue, it was just one step in a larger effort aimed at improving maternal and child health and survival by addressing unmet need for FP among postpartum women. To keep the momentum going, we must continue the discussion around PPFp and work together to translate recommendations and opportunities identified into appropriate action. As such, we urge you to:

- Become a member of the Implementing Best Practices (IBP) Initiative (www.ibpinitiative.org), a forum through which the global reproductive health community can share evidence-based practices for use in low-resource settings.
- Join the PPFp Community of Practice (through IBP, my.ibpinitiative.org/public/ppfp) to receive notification about PPFp-related events and activities, participate in virtual discussions and presentations, and share information and tools.
- Share information about PPFp activities that your organization is implementing with ACCESS-FP, which will serve as the point agency for collecting and sharing information about PPFp activities.

We look forward to working together with members of the PPFp Community of Practice and others toward reinvigorating PPFp and realizing the vision articulated at the technical consultation—that of integrated maternal, neonatal and child health services to meet the multiple needs of women and infants during the first year postpartum.

OVERVIEW

Current Status of Postpartum Family Planning Programming

The benefits of family planning for both maternal and infant health have been well documented. According to a recent article published in *The Lancet*, an estimated 25% to 40% of maternal deaths could be averted if unplanned and unwanted pregnancies were prevented (Campbell and Graham 2006). Another recent *Lancet* study calculates a nearly 10% reduction in child deaths (one million under-five deaths averted annually) by eliminating inter-birth intervals of less than two years (Cleland et al. 2006).

Despite this accumulation of evidence, the current status of family planning as an integral component of postpartum care for mother and infant is distressingly poor. Postpartum family planning (PPFP), provided through the first year postpartum,¹ should be a relatively straightforward service, yet it has not been systematically addressed by either maternal, neonatal or child health or reproductive health/family planning programs.

ACCESS-FP² conducted an extensive review of key articles and programmatic materials to assess the status of PPFP programming spanning the last 15 years.³ The results showed a remarkable lack of consistency in programmatic approaches. While studies repeatedly demonstrated the unmet need for (and interest in) PPFP services among postpartum women, few interventions were found to include a comprehensive postpartum approach or to examine the possibility of extending services through the first year postpartum. Of 60 relevant journal articles and reviews published since 1993, only 13 described facility-level programmatic interventions aimed at increasing PPFP use. Even fewer (three) described approaches beyond facilities that included community-based delivery of PPFP services. A similar lack of consistency in approaching PPFP was demonstrated in maternal and newborn health curricula and training materials reviewed by ACCESS-FP. These materials frequently referred the reader to other resources for information on family planning. Discussion of return to fertility, the benefits of pregnancy spacing and the contraceptive benefits of exclusive breastfeeding were not consistently presented in these materials. Moreover, the concept of transition to other modern contraceptive methods when the lactational amenorrhea method (LAM) is no longer appropriate was rarely addressed.

Efforts to document current programming efforts in the area of PPFP also indicate a lack of consistency in approach. In a review of 12 U.S. Agency for International Development (USAID)-supported bilateral projects in eight countries in Asia, conducted by the CATALYST Consortium, only one was found to include counseling specific to PPFP and information about birth spacing (Post 2005). These findings are consistent with another program review from 2004, which found that maternal and infant mortality reduction strategies do not include family planning and that policymakers are largely unaware of the role of family planning in mortality reduction (Jansen and Cobb 2004).

Postpartum family planning as a programmatic strategy presents an important opportunity to reach a large number of women with information and services. Several studies have demonstrated that women are interested in receiving family planning information and services during antenatal, postpartum/postnatal and child care visits.

¹ Throughout this document, the term postpartum family planning is used to indicate services provided during the extended postpartum period—that is, the first year postpartum. This period is of particular importance for family planning services because it is a time when women are especially vulnerable to unintended pregnancy.

² See the program description on the inside back cover (as well as the information sheet in Appendix E).

³ The complete annotated bibliography is available at: www.accessstohealth.org/toolres/pdfs/ACCESSFP_PPFPbiblio.pdf.

Postpartum Family Planning Technical Consultation

In an effort to better understand and thus maximize the opportunity that exists during the extended postpartum period, USAID and ACCESS-FP organized a technical consultation about postpartum family planning on 14 November 2006, in Washington, D.C. The overall purpose of the meeting was to examine the current status of PFP service delivery—through an expert review of key literature complemented by collective programmatic experience to date—as a basis for further program development. Specific meeting objectives were to:

1. Develop key guidance with regard to PFP service delivery;
2. Define gaps in knowledge and areas for future research; and
3. Identify and reinforce opportunities for integration to better address the needs of the mother and infant.

More than 40 experts and leaders in reproductive health and maternal, neonatal and child health from the following health organizations were brought together to participate in this intensive, all-day event:

Academy for Educational Development (AED)
 American College of Nurse-Midwives (ACNM)
 CARE
 Centre for Development and Population Activities (CEDPA)
 Constella Futures
 EngenderHealth
 Family Health International (FHI)
 Institute for Reproductive Health (IRH)
 JHPIEGO
 The Johns Hopkins University (JHU)
 Management Sciences for Health (MSH)
 Pathfinder International
 Population Council
 PATH
 Save the Children
 USAID
 White Ribbon Alliance (WRA)

Participants represented a cross-section of maternal, neonatal, and child health and family planning professionals, as well as all levels and facets of the international health care arena. They included program managers, clinicians (midwives, nurses and physicians), researchers, trainers, medical school faculty and several USAID representatives. (A full list of meeting participants, along with their affiliations, is presented in Appendix A.)

Preparations

Before the technical consultation, participants were divided into four small working groups—each focusing on a timeframe relevant to PFP: the antenatal period, the immediate postpartum period, the later postpartum period and the extended postpartum period. They were asked to prepare for the meeting by reviewing and evaluating selected PFP articles, both general in nature and specific to their small group timeframe, according to guidelines provided by the meeting organizers. (Articles reviewed for the meeting and/or referenced in this report appear in the bibliography at the end of the report.)

Meeting Activities

The main activities that made up the technical consultation are summarized below. (A meeting agenda is presented in Appendix B.)

Opening Remarks

USAID's **Dana Vogel** (*Chief, Service Delivery Improvement Division*) welcomed participants to the technical consultation. In her view, the meeting would provide two critical opportunities: one, to focus on the postpartum period, a technical area relevant for both family planning service delivery and the effort to reposition family planning; and two, to bring together experts from across sectors to focus on the “key life-saving strategy” of family planning, and examine how it can be integrated with other services to better address the needs of mothers and infants.

“There's an international effort to address healthy motherhood and the newborn, and as this effort gains momentum, postpartum care—which includes family planning as an integral component—can make an important contribution to preventing maternal and newborn morbidity and mortality.”

~ Dana Vogel, USAID

Vogel called it an especially opportune moment to focus on the subject of PFP. “There’s an international effort to address healthy motherhood and the newborn,” she said, “and as this effort gains momentum, postpartum care—which includes family planning as an integral component—can make an important contribution to preventing maternal and newborn morbidity and mortality.” She referred to the new recommendations endorsed by the World Health Organization’s recent technical consultation on healthy timing and spacing of pregnancy (shown in box below). She also emphasized the importance of integration of services as a key strategy in the repositioning of family planning, citing recent efforts to expand access to antiretroviral treatment and advance research on prevention of mother-to-child transmission of HIV (PMTCT). Not only should postpartum services be strengthened to better meet the needs of HIV-infected women and their infants,

but also HIV care and treatment services should be broadened to include quality family planning as a standard component of the general package of HIV services.

“Through this initial meeting and follow-on efforts,” Vogel said in closing, “we expect to see advances to systematically address unmet need for family planning during the postpartum period.”

New Global Recommendations on Healthy Timing and Spacing of Births (WHO 2006)⁴

Before trying to become pregnant again, couples should wait:

- At least two years after birth
- At least six months after miscarriage or abortion

On behalf of **Maureen Norton** (USAID), *Cognizant Technical Officer for ACCESS-FP*, **Patricia MacDonald** (USAID), *Senior Technical Advisor for the program*, continued the opening remarks by delineating the rationale for focusing on family planning, particularly during the postpartum period. Her main points are summarized below:

- Although most women want to wait more than two years before having another baby, there is a high level of unmet need for family planning during the first year following birth—when women are especially vulnerable to unintended pregnancy. There is also a high unmet need

⁴ The full WHO report is presented in Appendix C.

for limiting among postpartum women that should be met. Thus, a family planning program focusing on the postpartum period can greatly contribute to reducing this unmet need for spacing and limiting.

- Healthy timing and spacing of pregnancy optimize the health and survival of the newborn and the mother.
- Family planning reduces a woman's lifetime exposure to the risks of morbidity and mortality associated with each pregnancy, including complications of abortion from unintended pregnancy.
- PPFp provides an opportunity, at both the facility and community levels, to integrate family planning with many maternal and newborn services, and to offer a more holistic and comprehensive set of services to mothers and their infants, including those infected with HIV.
- Although there has been significant work done in PPFp, this critical piece of maternal and neonatal health programming has gotten lost.

“The postpartum period, including PPFp, is a real priority for USAID given the large unmet need among the population group. ACCESS-FP was awarded to help reinvigorate and revitalize PPFp... to get it back on track again.”

~ Patricia MacDonald, USAID

For all of these reasons, MacDonald explained, “the postpartum period, including PPFp, is a real priority for USAID... ACCESS-FP was awarded to help reinvigorate and revitalize PPFp programming.” She went on to describe the day's activities as the “launch for the ACCESS-FP program” and concluded with a direct appeal to participants: “We are pleased to have all of you here, with your wealth of relevant experience and each of you doing incredible work in the fields of postpartum care and family planning. Through this meeting, we intend to take stock of where we are, what we know and where we need to go to build a strong community of practice around PPFp.”

PPFP: A Maternal and Neonatal Life-Saving Intervention

Absolutely! Postpartum interventions aimed at saving the lives of women and their newborns should be a priority, given that:

- 60% of maternal deaths occur by end of first week
- 75% of neonatal deaths occur by end of first week

But PPFp is also a life-saving postpartum intervention ...

- In the year 2000, family planning could have averted:
 - 90% of abortion-related mortality and morbidity
 - 20% of obstetric-related mortality and morbidity
 - 32% of all maternal deaths (Cleland et al. 2006)
- Birth-to-pregnancy intervals of less than 24 months are associated with the highest risk of poor maternal, perinatal, neonatal and infant health outcomes. It is conservatively estimated that about one million of the 11 million annual deaths of children less than five years of age could be prevented by eliminating inter-birth intervals of less than two years (Cleland et al. 2006).

Introductory Presentation

Before participants divided into their pre-assigned working groups, **Catharine McKaig** (JHPIEGO), Director of ACCESS-FP, gave an introductory presentation to “set the stage” for the day’s activities. The presentation narrative appears on pages 11–16. (The accompanying presentation slides are included as a handout in Appendix D.)

Small Group Work and Presentations

After the introductory presentation, the small groups worked independently to define gaps in the current status of PFPF and make recommendations/identify opportunities to better address them—drawing from the literature, as well as their collective programmatic experience. Groups focused on selected high-priority areas, addressing them within their respective timeframes (antenatal and immediate postpartum, later postpartum and extended postpartum periods). After working independently, the small groups reconvened in plenary for reports. Summaries of their presentations are included on pages 17–28.

“We are supporting an integrated approach to caring for the mother and infant during the extended postpartum period—including not only postpartum family planning, but all aspects of postpartum and postnatal care.”

~ **Catharine McKaig, ACCESS-FP**

Discussion and Wrap-Up

The small-group presentations were followed by a lively, open-floor discussion. Discussion highlights and key recommendations

drawn from that discussion are presented on pages 29–30. The meeting wrap-up included a brief discussion of appropriate next steps and follow-up activities, which are summarized on page 31.

Purpose of This Document

The Report Brief for the technical consultation focused on gaps and recommendations around eight major themes that emerged in the course of the day.⁵ This full Meeting Report expands upon the shorter report, providing a more in-depth review of the literature and programmatic experience that helped inform the day’s activities, as well as of the discussions that helped shape its outcomes. It is our hope that these initial findings and areas of agreement will serve as the basis for a broader, comprehensive effort to systematically include PFPF activities in services reaching mothers and infants during the first year postpartum.



Bérençère de Negri (ACCESS-FP) and Ricardo Vernon (FRONTIERS) prepare for the “later postpartum” group’s presentation.

⁵ The “Postpartum Family Planning Technical Consultation–Report Brief” is available at: www.accesstohealth.org/toolres/pdfs/ACCESSFP_PFPFpfbrief_nov06tc.pdf.

SETTING THE STAGE: OVERVIEW OF POSTPARTUM FAMILY PLANNING AND FRAMEWORK

Before participants divided into their pre-assigned small groups, Catharine McKaig, Director of ACCESS-FP (JHPIEGO), gave a presentation to “set the stage” for the day’s activities. Specific objectives of her presentation were to define important terms and concepts related to PFP; highlight key findings from the literature as well as from programmatic experience; and share observations on challenges and opportunities involved in developing a comprehensive, integrated approach to PFP. [SLIDES 1 & 2] (See Appendix D for the accompanying slides.)

Defining Key Terms

Postpartum family planning (PFP) is the initiation and use of family planning methods during the first year after childbirth. This “extended postpartum period” may be divided as follows:

- Post-placental – within 10 minutes after delivery of the placenta
- Immediate postpartum – up to one week after delivery
- Later postpartum – one week up to six weeks after delivery
- Extended postpartum – six weeks up to one year after delivery

Although these timeframes represent “artificial” divisions, they *do* correspond to different groups of contraceptive methods. Thus, from a service delivery standpoint (as well as for the purposes of the meeting⁶), they provide a useful way to break up the extended postpartum period. [SLIDE 3]

Throughout this meeting, we will be using the definition of PFP described by Stephenson and MacDonald (2005) in their global technical brief. Thus, the goals of a PFP program are to:

- Reduce unmet need
- Improve contraceptive choice
- Promote optimum health through breastfeeding
- Facilitate healthy timing and spacing of pregnancy
- Integrate PFP with maternal and newborn services (including prevention of mother-to-child transmission of HIV [PMTCT] and HIV/AIDS care and treatment)

We will also be talking about PFP as part of an integrated approach aimed at ensuring the health of the mother and baby during the first year postpartum. [SLIDE 4]

General Literature on PFP—Past and Present

The following key articles provide important background information and perspectives to be considered in the context of our current efforts.

- The article by Winikoff and Mensch (1991) summarizes the status of PFP through 1991. It may seem—in reviewing the article’s findings—that not a lot has changed since that time and that most of the challenges outlined have persisted. In recent years, however, there has been considerable work done on breastfeeding and LAM, as well as on some aspects of integrating postpartum care with maternal, neonatal and child health services.
- Ross and Winfrey (2001) analyzed data from 27 demographic and health surveys (DHS) between 1993 and 1996 to assess women’s intentions to practice contraception, as well as unmet need in the first year after birth. They found that only 3% to 8% of women want another child within two years of their last birth, and that 40% of women say they intend to use contraception in the first year after birth but are not. Interestingly, the concept of an

⁶ Antenatal, immediate PP, later PP and extended PP periods were the small group timeframes used to organize the meeting activities.

extended postpartum period (from delivery up to the first year) is clearly represented in this article. Also, unmet need for family planning is redefined to focus on the woman's wishes for the future rather than on past pregnancies and births—shifting from the retrospective definition represented in the DHS (where women were asked about past pregnancies) to a prospective definition. This shift in focus is an important contribution in that asking about future fertility intentions presents a more accurate picture of unmet need among women during the first year postpartum.

- The recent article by Koblinsky (2005), which reviewed community-based postpartum care, found very little documentation on community-based PPF (only four studies). This gap in the literature is somewhat surprising given that we, as a field, have a depth of experience in community-based family planning programs that have included aspects of PPF. The article also underscores the need for coordination between family planning and postpartum services to identify potential PPF clients and combine resources. [SLIDE 5]

Other recent articles have focused on the effect of short birth intervals on infant health—findings that are especially critical in our efforts to revitalize PPF. For example, a meta-analysis conducted by Conde-Agudelo et al. (2006) shows that birth-to-pregnancy intervals of <18 and >59 months are associated with significantly increased risk of:

- Preterm birth (OR 1.40),
- Low birth weight (OR 1.61), and
- Small for gestational age (OR 1.26).

The data in support of a minimum two-year birth-to-pregnancy interval (which is a minimum 33-month interval) are very clear now, yet in many countries, more than 30% of births happen within that two-year timeframe. The unintended among these pregnancies are very preventable—but how do we reach these women in time to avoid this outcome?



Postpartum mother in Afghanistan
(by Sheena Currie, JHPIEGO/ACCESS).

According to recommendations coming out of the World Health Organization's recent technical consultation on birth spacing (2006), couples should not begin *trying* to get pregnant again until:

- At least 24 months after a birth, or
- At least six months after a miscarriage or abortion. [SLIDE 6]

Descriptive Literature: What PP Women Want and Need

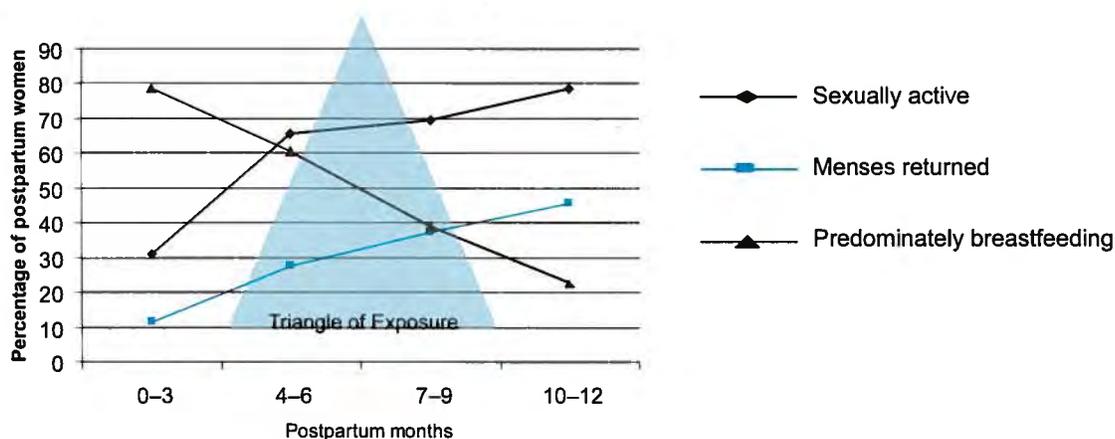
ACCESS-FP conducted a literature review of key articles related to PPF over the past 15 years. Of the more than 60 studies identified, descriptive literature makes up a considerable proportion (25 to 30). Interestingly, these studies, which were conducted in diverse settings, tell a very consistent story with regard to postpartum women's needs and concerns. A few recurring themes are highlighted here:

- Most women want at least a two-year interval between the last birth and subsequent pregnancies (Bulut and Turan 1995; Duong et al. 2005; Medina et al. 2001; Ross and Winfrey 2001).
- Women want to both space and limit births (Bulut and Turan 1995; Romero-Gutierrez et al. 2003; Ross and Winfrey 2001).

- Postpartum women are concerned about infant health (Bulut and Turan 1995; Romero-Gutierrez et al. 2003; Salway and Nurani 1998).
- Postpartum women tend toward natural methods—in particular as a way to protect the infant’s health (Adinma et al. 1998; Romero-Gutierrez et al. 2001; Salway and Nurani 1998).
- Women say husbands’ opinions are a determining factor in whether or not they use family planning (Adinma et al. 1998; Duong et al. 2005; Romero-Gutierrez et al. 2003; Susu et al. 1996; Tehrani et al. 2001; Turan et al. 2001).
- Contraceptive knowledge and past use are strong predictors of whether a woman will use family planning in the postpartum period—this is especially important for adolescents and first-time mothers (Romero-Gutierrez et al. 2003; Susu et al. 1996; Tehrani et al. 2001; Zerai and Tsui 2001).
- Confusion persists about breastfeeding and return to fertility, as well as about the relationship between the two (Adeyemi et al. 2005; Bulut and Turan 1995; Salway and Nurani 1998; Thapa et al. 1992). [SLIDE 7]

Complementing such descriptive information on women’s needs during the first year postpartum, the following data help clarify their vulnerability to pregnancy during this time. This graphic (Exhibit 1) is drawn from an ACCESS-FP analysis of existing DHS data on more than 1,000 Nigerian women during the first year postpartum. It dramatically illustrates the dilemma of PPF, showing factors that increase the risk of conception during this period. We often hear that there is a long period of abstinence after the birth of the baby, but the reality is that 30% of women return to sexual activity during the first three months postpartum, and 12% to 25% of women during the first two months. As shown, while predominant breastfeeding typically drops off, sexual contact increases and finally the menses return. This crossover period—termed here the “triangle of exposure”—helps to explain why 11% of births in Nigeria are to women during the first year postpartum, even though breastfeeding is common and the median return of menses is 13 months. [SLIDE 8]

Exhibit 1. Factors That Influence Fertility: Nigeria (2003)



Studies have repeatedly demonstrated that women are interested in information on family planning—even immediately postpartum (Bradley et al. 1995; Bulut and Turan 1995; Medina et al. 2001; Smith et al. 2002). In a study done in Kenya (Bradley et al. 1995), 66% of antenatal care clients, 92.5% of postpartum care clients and 95% of women attending the well-baby clinic expressed interest in PPF. Given such overwhelming interest in this service, it is useful to look at the reasons why it is generally not provided—from both client and provider points of view. Clients felt that the nurse was too busy, were too intimidated to approach the nurse, and/or did not know that they could ask

questions of the nurse. Nursing staff felt constrained by lack of family planning knowledge, which we see as a major barrier from a programmatic standpoint (i.e., midwives do not feel up to date in PPFp and thus are not inclined to provide the service). They also felt limited by lack of time and privacy, which is certainly an issue in many postpartum wards. In another, more recent study (Senarath et al. 2006), which assessed satisfaction among women who received hospital-based perinatal care, family planning counseling was found to be a significant determinant in client satisfaction. [SLIDE 9]

“Gems” for Formulating a Comprehensive Approach to PPFp

It is difficult to synthesize some of the most important PPFp-related studies done since 1993. This is because they vary greatly in terms of overall approach, including postpartum timeframes observed and interventions tested, and also in terms of outcomes measured. Individually, however, many of these studies offer real “gems”—important lessons from which to draw in formulating a more comprehensive approach to PPFp programming. A few such gems are highlighted here:

- The study by Vernon et al. (1993) shows that a comprehensive approach to increasing uptake of reproductive health services (including antenatal counseling, a 40-day postpartum clinic, expanded contraceptive options) dramatically increased women’s acceptance of PPFp (9–47%), as well as the proportion of women returning for postpartum care (15–40%).
- Huntington and Aplogan (1994) found that when FP messages were given to women bringing their children for immunization services, there was a 54% increase in uptake of FP services.
- In a study by Hardy et al. (1998), the percentage of women not using an FP method decreased from 17.7% to 7.4% when LAM services were introduced in a hospital setting. [SLIDE 10]
- Extensive outreach of thoroughly integrated postpartum and newborn care services proved very effective in the study by Alvarado et al. (1999), with 74% of women from the intervention group (versus 10%) exclusively breastfeeding. Significantly better infant growth and health were also found in the intervention group, and the women reported valuing the integrated services.
- On the down side, Smith et al. (2002) found no differences in PPFp use or 12-month pregnancy rate between women who received standard advice and those who received contraceptive advice also as part of their antenatal care (ANC) visit (n = 500). We talk a lot about the importance of limiting a PPFp intervention that is incorporated with ANC (as ANC is already overburdened), but these findings may suggest that an intervention can indeed be “too limited” to be effective.
- The study by Bongiovanni et al. (2005) offers a wealth of important insights on using LAM and proposes defining criteria for LAM users and transitioning from LAM to other modern methods. [SLIDE 11]

Much of this programmatic literature focuses on demonstrating the feasibility of specific interventions related to PPFp. However, studies that include comprehensive approaches to PPFp are very limited, with only four of the 13 studies reviewed linking ANC and postpartum follow-up (Alvarado et al. 1999; Huntington and Aplogan 1994; Medina et al. 2001; Vernon et al. 1993). Fewer studies describe community-based approaches with any intention of capturing the FP or PPFp piece (Bolam et al. 1998; Fullerton et al. 2005). For example, one study evaluating maternal and newborn outcomes showed very good family planning outcomes, although family planning was not the focus of the study (Fullerton et al. 2005). Studies on the impact of male involvement in PPFp, which have yielded mixed results, are ongoing (Kunene et al. 2004; Soliman 1999; Turan et al. 2001; Varkey et al. 2004). [SLIDE 12]

Review of PFP Content in MNH Training Materials

ACCESS-FP has conducted an extensive review of maternal and neonatal health training manuals, curricula and guidelines to determine if and how PFP is represented in these materials. Thus far, the following trends have been identified:

- FP messages, if present, are typically not specific to postpartum women.
 - There is little information about return to fertility or the importance of counseling on this subject.
 - Discussion about birth spacing is rare, and there is no discussion of maternal and newborn health risks related to different intervals.
- LAM is infrequently discussed as such, although there is a lot of information about breastfeeding.
 - Breastfeeding and LAM are not linked.
 - There is little or no emphasis placed on transitioning from LAM to other methods.
- In the context of ANC, PFP counseling is not a systematically included component. Also, there is little emphasis on long-acting or permanent methods, which is especially significant given that the antenatal period is the time when such methods should be discussed with the woman.

An overall impression gained through the review is that family planning is often regarded as a separate activity, as many of the existing materials refer the user to other sources for guidance on FP (rather than incorporate it). [SLIDE 13]

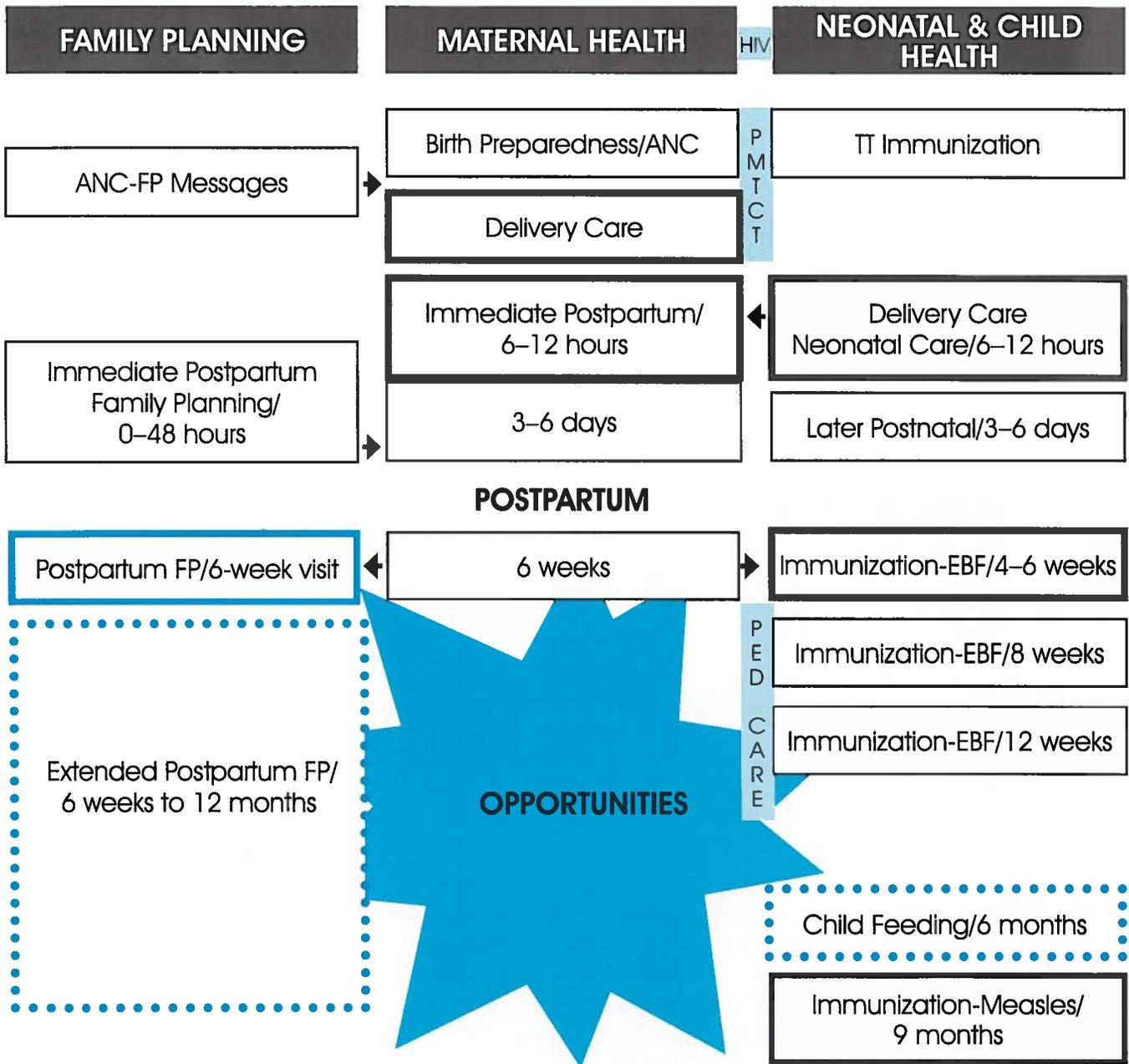
Programmatic Framework: PFP in an Integrated Context

This graphic (Exhibit 2) shows the programming streams as they are now. (Dotted lines indicate services that are more theoretical than existent, whereas thick/bold lines indicate those that are most operational.) In the global public health community, what people are referring to when they talk about PFP often depends on the programmatic context within which they operate.

- The first stream shows traditional FP programming. Here, some emphasis is placed on the antenatal period, for integrating FP messages with ANC; and on the immediate postpartum period, for long-acting and permanent methods (at higher-level facilities). The greatest emphasis, however, is on the six-week postpartum visit. Although this is the traditional “slot” for PFP, it seems to happen only rarely. There has recently been some emphasis on “transitioning” from LAM to other methods at six months, but this has not yet been formalized by a systematic visit at five to six months postpartum.
- In the maternal health programming stream, emphasis is placed on birth preparedness in ANC and on skilled attendance during childbirth and the immediate postpartum period. This emphasis is appropriate as these are very important and potentially life-saving services. Within this context, the six-week visit tends to focus on maternal recovery/healing—that is, on whether “*everything is in the right place*” (i.e., the uterus has involuted or returned to a pre-pregnancy state).
- In the neonatal and infant health programming stream, emphasis remains on care during childbirth and the immediate postnatal period—again, potentially life-saving services. Within this context, there has also been considerable success with regard to childhood immunization, in terms of coverage. HIV/PMTCT services and transition to pediatric care are other important aspects of this picture.

The empty space in the lower center of the diagram may represent a sort of “perfect storm” in terms of potential for delivering PFP in an integrated context. This is where, we believe, there may be a wealth of facility- and community-based opportunities that can be exploited to meet the great unmet need for FP among postpartum women. [SLIDE 14]

Exhibit 2. Programmatic Framework: PFP in an Integrated Context



During a recent trip to Nigeria, we heard women describe the problems associated with having children spaced too closely: “Having babies too close together is a problem since nursing an older baby and newborn is very fatiguing for the mother...” (See front cover photo.) These women’s voices provide a compelling call to action to support the advancement of PFP in the global health agenda. [SLIDE 15]

SMALL GROUP WORK AND PRESENTATIONS

After the introductory presentation, participants divided into their pre-assigned groups—each dedicated to a timeframe relevant to PFP (the antenatal, immediate postpartum, later postpartum and extended postpartum periods). Focusing on their respective timeframes, the groups worked independently to identify gaps, recommendations and opportunities drawn from the key literature reviewed before the meeting, as well as from their collective programmatic experience. They organized their efforts around areas judged to be “high priority” in the context of PFP: lactational amenorrhea method, including transition to other methods; long-acting and permanent methods; and integration of PFP with maternal, newborn/infant health and HIV/AIDS services and programs. The small groups then reconvened in plenary for report-outs.

This section summarizes the small group work sessions and presentations, two of the main activities of the technical consultation.

All groups were given the following **general PFP-related articles** to review before the meeting:

Conde-Agudelo A, Rosas-Bermudez A and Kafury-Goeta A. 2006. Birth spacing and risk of adverse perinatal outcomes: A meta-analysis. *JAMA* 295(15): 1809–1822.

Koblinsky MA. 2005. Community-based postpartum care: An urgent unmet need. *CATALYST Consortium* www.pathfind.org/site/DocServer/Community-based_postpartum_care.pdf?docID=4881

Ross JA and Winfrey WL. 2001. Contraceptive use, intention to use and unmet needs during the extended postpartum period. *International Family Planning Perspectives* 27: 20–27.

Stephenson P and MacDonald P. 2005. Postpartum family planning: Seizing a missed opportunity. *Global Health Technical Briefs* www.maqweb.org/techbriefs/tb16postpartum.shtml

Winikoff B and Mensch B. 1991. Rethinking postpartum family planning. *Studies in Family Planning* 22(5): 294–307.

World Health Organization (WHO). 2006. *Report of a WHO Technical Consultation on Birth Spacing*. Geneva, Switzerland, 13–15 June 2005. WHO: Geneva, Switzerland. www.who.int/reproductive-health/publications/birthspacing/birth_spacing.pdf

Groups were also given a selection of articles that were more relevant to their particular timeframes. For each small group, these additional articles as well as group members are listed, and a summary table of the group’s presentation is also included. Together, the summaries provide insight into the breadth of issues that may be involved in addressing unmet need for FP among postpartum women. They reflect a broad range of interests and perspectives, which is not surprising given the programmatic diversity of the participant group, as well as a remarkable consistency in suggested approaches.

SMALL GROUP 1: ANTENATAL PERIOD

The **additional articles** reviewed by the antenatal group before the meeting were:

FRONTIERS. 2004. *OR Summary 45—India: Men’s Involvement in Partner’s Pregnancy Yields Health Benefits*. Washington, D.C.: Population Council, Frontiers in Reproductive Health. www.popcouncil.org/frontiers/orsummaries/ors45.html

Smith KB et al. 2002. Is postpartum contraceptive advice given antenatally of value? *Contraception* 65(3): 237–243.

Soliman MH. 1999. Impact of antenatal counseling on couples' knowledge and practice of contraception in Mansoura, Egypt. *East Mediterranean Health Journal* 5(5): 1002–1013.

Turan JM et al. 2001. Including expectant fathers in antenatal education programmes in Istanbul, Turkey. *Reproductive Health Matters* 9(18): 114–125.

Antenatal care **group members** were:

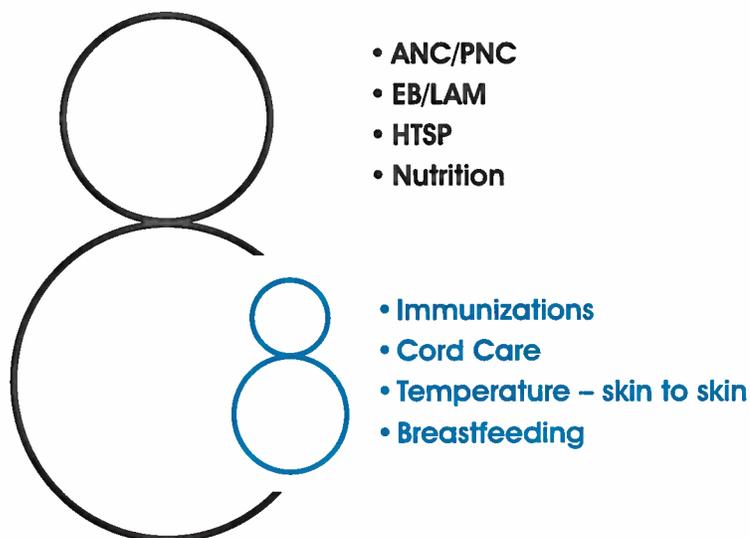
Koki Agarwal	Angela Nash-Mercado (group leader)
Abdullah Baqui	Michelle Prosser
Sarla Chand	Rushna Ravji
Barbara Deller (notetaker)	Theresa Shaver
Betty Farrell (reporter)	Dana Vogel
Nancy Murray	

Small group **discussion highlights** (submitted by the group leader) were:

- Teach LAM and other family planning methods in pre-service education.
- Include planning for postpartum contraception as a part of birth planning.
- Identify PFP champions.
- Engage the private sector.
- Address integration with a “continuum of care” approach.

A **summary** of the small group report-out is presented in the table on the next page.

Involve significant persons in women's lives...



The antenatal group presented a drawing (graphically depicted here), as part of its presentation, to show an integrated approach to care for the mother and newborn.

ANTENATAL GROUP REPORT		
Priority Area	Gaps	Recommendations/Opportunities
Lactational Amenorrhea Method	<p>Breastfeeding (BF) counseling not linked to LAM</p> <p>Concept of full/exclusive BF (EBF) not well understood</p> <p>Low ANC attendance and only one visit for those who do attend</p> <p>Focus is on facility-based ANC without link to community</p> <p>Little knowledge of LAM among health workers, including ANC providers</p> <p>Community groups – an untapped resource for communicating about LAM and other FP methods</p> <p>Partnerships for community-based distribution of FP as part of PPC – also untapped</p> <p>ANC population not segmented by age and parity to tailor birth spacing/FP messages and counseling (e.g., adolescents and first-time mothers may need different messages than older women/women with more children)</p>	<p>Involve significant/influential persons in women's lives in ANC, LAM and FP messaging</p> <p>Use LAM to address women's concerns about infant survival</p> <p>Use LAM as "bridge" to other methods</p> <p>Explore group counseling including significant persons (i.e., "centering" care)</p> <p>Identify the "golden nuggets" (a few essential messages) that should be part of facility- and community-based counseling/care</p> <p>Use community health workers (CHWs) to reach out to pregnant couples and increase their awareness of LAM</p> <p>Include LAM and other FP methods in pre-service education</p> <p>Take advantage of strong association between ANC and FP use during postpartum period (as shown in ACCESS-FP's Nigeria DHS study and others)</p>
Long-Acting and Permanent Methods	<p>Service delivery in childbirth care needs to expand to include provision of/counseling for long-acting/permanent methods (LAPMs) (e.g., intrauterine contraceptive devices [IUDs])</p> <p>Service providers need job aids to help women identify and meet their RH goals and to support healthy fertility planning (including spacing and limiting)</p> <p>No information, education and communication (IEC) materials for LAPMs, LAM or other FP methods</p> <p>Lack of services and knowledge about permanent methods; increase in unmet need for PPF</p>	<p>Piggy-back postpartum IUD (PP-IUD) on the reinvigorating IUD initiative (in Kenya, Rwanda, etc.)</p> <p>Ensure counseling and informed decision-making for permanent methods</p> <p>Include planning for PPF as part of birth planning</p> <p>Work with the private sector</p> <p>Develop FP skills among traditional birth attendants (TBAs)</p> <p>Create job aids for providers based on subgroups of potential PPF users (age, parity, HIV status)</p> <p>Include FP in mobile care units that include ANC, PNC, etc.</p>
Integration – Maternal Health	<p>Programs are vertical – FP not included</p> <p>Have not asked women what services they want</p> <p>Have not developed programs (assessed how) to meet perceived needs</p> <p>Budgets are small; funding streams are vertical</p> <p>Competing programs have pulled skilled providers away from FP</p>	<p>Find local maternal health champions to promote FP (e.g., J. Musseveni in Uganda)</p> <p>Include FP in skills and training of skilled birth attendants</p> <p>De-medicalize PPF services (explore ways to involve pharmacists, CHWs, youth, social networks)</p> <p>Expand the role of the primary care provider</p> <p>Move research into action – there is enough evidence to act now!</p>

ANTENATAL GROUP REPORT (continued)		
Priority Area	Gaps	Recommendations/Opportunities
Integration – Maternal Health (continued)	<p>Human resource crisis – providers drawn into vertical programs, as well as exported (“brain drain”)</p> <p>Maternal health providers fear HIV/AIDS</p> <p>CHWs may receive no salary but are asked to do more and more</p> <p>Providers lack job aids</p> <p>Integration has been poorly marketed</p>	<p>Engage private sector (e.g., midwives, TBAs) and provide them business skills</p> <p>Ensure that postabortion care emphasizes FP; have contraceptives available on site</p> <p>Assess integration across a “continuum of care” to see where different types of services can be integrated</p>
Integration – Newborn Health	<p>Essential newborn care initiatives do not include FP</p> <p>Indicators do not include FP or maternal health</p>	<p>Capitalize on positive impact of FP on well-being of newborn and family – we have clear evidence that FP is important for newborn health</p> <p>Reach out through immunization programs</p> <p>Include FP in home visits for newborns</p> <p>Link BF promotion to LAM</p> <p>Involve global partners (e.g., Partnership for Maternal, Newborn and Child Health) to promote FP</p> <p>Include pregnancy spacing as part of Integrated Management of Childhood Illness programming</p>
Integration – HIV	<p>FP cannot be integrated because of vertical funding streams</p> <p>PMCT is separate from antiretroviral therapy (ARV), so adding FP means adding another separate intervention</p> <p>Providers do not think of FP:</p> <ul style="list-style-type: none"> - Gaps are at knowledge and service levels - FP knowledge, skills and attitudes are lacking among HIV service providers 	<p>Make FP services available at site of HIV services</p> <p>Find opportunity in community-based voluntary counseling and testing programs</p> <p>Integrate FP with psychosocial support for HIV-infected (HIV+) women/clients</p> <p>Take advantage of PEPFAR’s “Positive Prevention Program,” which is integrating FP</p> <p>Take advantage of congressional support for integrating FP services</p> <p>Find opportunity in promotion of exclusive BF through PMCT</p> <p>Incorporate FP messages, including LAM, as part of ART provision</p> <p>Include/add-on FP in existing HIV programs</p> <p>Include FP in the HIV counseling component of pre-service education</p> <p>Reach men at facilities and in the community</p> <p>Find opportunity in HIV community outreach programs that are using drama groups – FP can be added</p>

SMALL GROUP 2: IMMEDIATE POSTPARTUM (up to one week after delivery)

The **additional articles** reviewed by the immediate PP group before the meeting were:

Bolam A et al. 1998. The effects of postnatal health education for mothers on infant care and family planning practices in Nepal: A randomized controlled trial. *BMJ* 316(7134): 805–811.

Grimes D et al. 2003. Immediate post-partum insertion of intrauterine devices. [Review] *Cochrane Database Systematic Review* (1): CD003036.

Hardy E et al. 1998. Contraceptive use and pregnancy before and after introducing lactational amenorrhea (LAM) in a postpartum program. *Advances in Contraception* 14(1): 59–68.

Winikoff B and Mensch B. 1991. Rethinking postpartum family planning. *Studies in Family Planning* 22(5): 294–307.

Immediate PP **group members** were:

Deborah Armbruster (notetaker)	Douglas Huber
Holly Blanchard (group leader)	Patricia MacDonald
Rebecca Chase	Tsigué Pleah
Patricia Gomez (reporter)	Charlotte Warren

Small group **discussion highlights** (submitted by the group leader) were:

- No real/identified immediate postpartum care exists in most developing countries at this time.
- Basic care should be promoted, and LAM identified as a temporary method.
- The LAM message should be kept simple: exclusive breastfeeding, amenorrhea, infant less than six months.
- A mother's lactation and fertility intentions should be assessed prior to discharge, and she should be given a clear return date for postpartum evaluation (before return of fertility).
- International health care providers and nongovernmental organizations have been discussing the need for immediate postpartum care for 20 years, but nothing has changed. This has been a real frustration.
- There seems to be a lot of interest in postpartum IUDs.

A **summary** of the small group report-out is presented in the table on the next page.

IMMEDIATE POSTPARTUM GROUP REPORT		
Priority Area	Gaps	Recommendations/Opportunities
Lactational Amenorrhea Method	<p>Providers are not confident about the efficacy of LAM; need to gain provider buy-in</p> <p>Poor transition from LAM to modern methods; need detailed information on how to make transition</p> <p>More studies needed to look at effective transition methods; standard days method (SDM) is very difficult to transition to for most lactating women (studies on developing a transition piece from LAM to SDM are under way)</p> <p>Studies needed to look at feasibility of women practicing LAM after 40 days (e.g., what is the cultural practice around bringing baby to work?)</p> <p>Missed opportunities at child survival visits (but can this provider deliver high-quality FP services?)</p> <p>Women may not be seen at all during the postpartum period; those who are seen come at six weeks (for traditional visit) and are not advised to come back before fertility is likely to return</p> <p>No discussion about return to fertility based on the woman's lactation intentions at time of delivery</p>	<p>Ensure that all hospitals/facilities are baby-friendly (e.g., encourage/initiate early and exclusive BF while mother-baby dyad still in facility, do not give glucose water to babies)</p> <p>Create a PP/PPFP plan:</p> <ul style="list-style-type: none"> - What does woman want in terms of spacing/limiting? - What is her previous BF practice? - What is her previous FP practice? - Give her information on return to fertility and contraception - Give her return slip with date/time for PP follow-up <p>Include BF, LAM and PPFP in pre-service education</p> <p>Recognize reality of 2- to 24-hour postpartum stay at facility; must keep PPFP messages minimal/simple/clear:</p> <ul style="list-style-type: none"> - EBF - LAM – three points to remember: EBF, amenorrhea, infant less than six months <p>Explain/reinforce that PPFP is a maternal and child survival method</p> <p>Recognize importance of community in getting woman to see provider within first week PP</p> <p>Ensure that women are seen between six weeks and six months postpartum, before fertility returns</p> <p>Establish “fertility planning” as part of PPC (e.g., learn whether woman intends to breastfeed, and for how long?) – these discussions are essential</p> <p>Give woman a reminder card (with date to return for a PPFP visit) at time of delivery – studies show this is critical</p>
Long-Acting and Permanent Methods	<p>Providers do not know that HIV+ women can get an IUD (Category 2 in the WHO Medical Eligibility Criteria [MEC])</p> <p>Study needed on effect of active management of the third stage of labor (AMTSL) on PP-IUD expulsion rate</p> <p>Staff and clients may have misconceptions about IUDs</p> <p>Lack of providers experienced in PP-IUD and permanent methods</p>	<p>Train the “provider at the perineum” to be knowledgeable about PPFP and advocate to women</p> <p>Provide good counseling on LAPMs and/or confirm that woman received such counseling (ideally during ANC)—especially in the case of permanent methods</p> <p>Avoid spreading misinformation about these methods (e.g., greatly exaggerated correlation between IUD and pelvic inflammatory disease [PID])</p> <p>Convince service providers and staff that IUDs/PP-IUDs are acceptable</p> <p>Recognize that PP-IUD programs are more likely to succeed where IUD is already accepted and providers are skilled in IUD insertion</p> <p>Develop strategies for rolling out PP-IUD programs (along with permanent methods)</p>

IMMEDIATE POSTPARTUM GROUP REPORT <i>(continued)</i>		
Priority Area	Gaps	Recommendations/Opportunities
Long-Acting and Permanent Methods <i>(continued)</i>		<p>Advocate to ministries of health to improve/correct reputation of IUDs</p> <p>Involve men in counseling</p> <p>Recognize that women can be referred for PPF from community/home (if not delivered in facility), if method must be given in facility</p> <p>Recognize that tubal ligations (TLs) can be referred from community if woman had safe delivery with a skilled birth attendant and counseling (e.g., in Dominican Republic, midwives refer patients after delivery to hospital for TL)</p> <p>Act on need for providers trained in all LAPMs, and for experienced teachers</p>
Integration – Maternal Health, Newborn Health	<p>Mothers do not seem to come for PPC; mothers may not see the merit in coming for PPC</p> <p>PPC is not always offered</p> <p>In some countries, no policy on RH, let alone PPF or integration of PPF</p> <p>Lack of availability of methods and method mix</p> <p>Providers not cross-trained to integrate PPF with other services</p> <p>Providers reluctant to let go of what they have been doing, or add tasks to their already overburdened work schedule</p>	<p>Use fact that 60% of maternal deaths occur during first week postpartum to advocate for increased PPC during this time, and adherence to WHO standards, to decrease MMR</p> <p>Develop and advocate for a targeted/focused PPC (FPPC) package inclusive of FP; FPPC includes:</p> <ul style="list-style-type: none"> - Newborn care and danger signs - Maternal PPC and danger signs - LAM - FP methods for lactating women and HIV+ women <p>Look at ways to reorganize services</p> <p>Ensure that pre-service education includes PPC that addresses return to fertility, healthy timing and spacing of pregnancy (HTSP), and FP (old information should be replaced by new, updated information)</p>
Integration – HIV	<p>HIV+ women need information on all FP methods, but providers are not trained in this</p> <p>National-level as well as facility-based policies needed for PPC that includes mother and baby, HIV testing and care/treatment, HTSP and PPF</p> <p>FP is one pillar of PMTCT but is often ignored, forgotten or left out due to time constraints</p> <p>Need study on whether HIV+ women want spacing/limiting at the same rate as HIV-negative women</p> <p>Health care providers are hesitant to offer PP-IUDs to HIV+ women</p>	<p>Include range of FP methods for HIV+ women in FPPC</p> <p>Conduct more studies on what HIV+ couples want for FP</p> <p>Always promote condoms and other methods (experts agree benefits of effective FP outweigh potential risks for HIV+ couples)</p> <p>Determine whether availability of ART increases uptake of voluntary counseling and testing and acceptability of FP</p> <p>Reinvigorate link between PMTCT and PPF</p> <p>Train providers on WHO MEC 2004, which state that IUDs are Category 2 for women with HIV, and for women with AIDS who are clinically well and on ART</p> <p>Train providers in infection prevention to reduce risk of exposure/transmission</p>

SMALL GROUP 3: LATER POSTPARTUM (one week up to six weeks after delivery)

The **additional articles** reviewed by the later PP group before the meeting were:

FRONTIERS. 2001. *OR Summary 25: Postpartum and Postabortion Patients Want Family Planning*. Honduras Contraceptive Choice. Washington, D.C.: Population Council, Frontiers in Reproductive Health. www.popcouncil.org/pdfs/frontiers/orsummaries/orsum25.pdf

Tazhibayev S et al. 2004. *Promotion of Lactation Amenorrhea Method Intervention Trial, Kazakhstan*. Academy of Preventive Medicine, Republic of Kazakhstan. FRONTIERS, Final Report. Washington, D.C.: Population Council, Frontiers in Reproductive Health. www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Kazakhstan_LAM.pdf

Vernon R et al. 1993. The impact of perinatal reproductive health programs in Honduras. *International Family Planning Perspectives* 19(3): 103–109.

Winikoff B and Mensch B. 1991. Rethinking postpartum family planning. *Studies in Family Planning* 22(5): 294–307.

Later PP **group members** were:

Harriet Birungi	Patricia Stephenson
Bérengère de Negri	Uzma Syed
Carolyn Curtis (notetaker)	Ricardo Vernon (reporter)
Catharine McKaig (group leader)	Donna Vivio
May Post	

The small group **discussion highlight** (submitted by the group leader) was:

While approximately half of women do not deliver in health facilities, they are often reached by other services. Unfortunately, these services are not organized to maximize this contact and sometimes offer completely separate tracks for health care for mothers and infants. The challenge is to efficiently integrate services, while making the package manageable for the service provider.

A **summary** of the small group report-out is presented in the table below.

LATER POSTPARTUM GROUP REPORT		
Priority Area	Gaps	Recommendations/Opportunities
Lactational Amenorrhea Method	<p>LAM is difficult to promote</p> <p>Transition from LAM to other methods not systematically addressed</p> <p>Providers are not aware that it is possible to overlap methods (women can use both LAM and another method)</p> <p>Experience demonstrates that EBF is difficult for HIV+ women since they want to avoid breastfeeding to protect the health of their children but are not always able to afford breastmilk substitutes</p>	<p>Provide EBF/LAM and transition counseling in all settings</p> <p>Ensure provider education and cross-training in PFP at all levels</p> <p>Take advantage of BF opportunities to counsel on LAM, and LAM opportunities to encourage EBF</p> <p>Recommend at least two visits during the postpartum period (immediate and before six months) to support LAM and transition to other methods</p>

LATER POSTPARTUM GROUP REPORT (continued)		
Priority Area	Gaps	Recommendations/Opportunities
Long-Acting and Permanent Methods	ANC counseling for LAPMs is often neglected	Ensure proper counseling for LAPMs during ANC and also in immediate postpartum period
Integration – Maternal Health, Newborn Health	<p>There are two service tracks for mother and child with different timetables and the service content of each is not clear (some messages for women, others for infants)</p> <p>Most models of care focus on the facility (assuming it as place of service), but half of all women do not delivery in facilities</p> <p>The focus is often on the “menu of services” – not client needs; services are not structured for the client</p> <p>It is not clear who is reaching women with which services</p> <p>PPFP is not regarded as a priority in MNH service provision</p> <p>Vertical programs are driven by indicators; it is difficult to add components that are not measured, and for which programs will not get credit</p> <p>Provider issues that limit service integration:</p> <ul style="list-style-type: none"> - Workload - Knowledge and skills - “Turf” issues 	<p>Integrate mother and child care into a single service track:</p> <ul style="list-style-type: none"> - Assess interest/needs of clients and how to address them - Determine what the services are and which services “match”; clarify service content - Keep interventions as simple/manageable as possible - Strengthen continuum between ANC and PNC <p>(Note: There were different opinions about whether a set schedule should be established for PNC.)</p> <p>Use all platforms available to reach women/newborns:</p> <ul style="list-style-type: none"> - PPFP counseling proactively offered as part of routine care - Postpartum home visits to reach women in seclusion after home birth - Integration of PPFP/LAM with BF <p>Analyze contacts with mothers and infants during postpartum/natal period – these opportunities need to be researched</p> <p>Base advocacy efforts on evidence-based risks and benefits of FP/PPFP to mother and child</p> <p>Figure out how to “position” PPFP so that it:</p> <ul style="list-style-type: none"> - Contributes more clearly to outcomes - Can be counted as an achievement (is an indicator) <p>Develop guidelines and other materials to support PPFP integration with other services:</p> <ul style="list-style-type: none"> - Integrated national curricula/guidelines - Systematic screening tool to assess needs of client - IEC materials for clients to take home - Job aids for providers and other staff
Integration – HIV	<p>Little focus on FP/HIV integration in PP period</p> <p>Lack of definition of when PMTCT begins and ends</p> <p>Protocols around LAM and EBF for HIV+ women are not well understood</p> <p>Providers hesitant regarding FP for HIV+ women – their knowledge is not updated</p>	<p>Focus on needs of HIV+ women in the extended PP period because BF is such an important consideration</p> <p>Determine the start and end points for PMTCT services to facilitate transition to FP/HIV services</p> <p>Update providers to ensure contraceptive choice for HIV+ women</p>

SMALL GROUP 4: EXTENDED POSTPARTUM (six weeks up to one year after delivery)

The **additional articles** reviewed by the extended PP group before the meeting were:

Adeyemi AB et al. 2005. The unmet need for contraception among Nigerian women in the first year post-partum. *European Journal of Contraception and Reproductive Health Care* 10(4): 229–234.

Bongiovanni A et al. 2005. *Promoting the Lactational Amenorrhea Method (LAM) in Jordan Increases Modern Contraception Use in the Extended Postpartum Period, The Linkages Project*. Washington, D.C.: Academy for Educational Development. www.linkagesproject.org/media/publications/LAM%20Research%20Report,%20Final,%20November%201,%202005.pdf

Bulut A and Turan JM. 1995. Postpartum family planning and health needs of women of low income in Istanbul. *Studies in Family Planning* 26(2): 88–100.

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.

LINKAGES. 2005. Spotlight: LAM Users—Transition to Other Modern Methods of Contraception after Six Months Postpartum. [Summary of previous publication] www.linkagesproject.org/media/publications/Spotlight//Spotlight_LAM-Users.pdf

Extended PP **group members** were:

Marcos Arevalo (reporter)	Robin Anthony Kouyate (group leader/notetaker)
Jean Baker	Milly Kayongo
Annette Bongiovanni	Heidi Reynolds
Gloria Ekpo	Allison Zimmerman
Lois Schaefer	

Small group **discussion highlight(s)** (submitted by the group leader) were:

- Specific strategies with key messages and job-aid materials need to be developed for service providers and tailored to each service setting with which PPF is integrated, as well as to different cadres (e.g., managers, service providers, etc.). Such tailoring is important because one strategy or set of messages/materials will not fit all situations.
- New ways of marketing integration of PPF into various service sectors need to be developed, highlighting the specific benefits of integration for each of those sectors (e.g., healthy timing and spacing of pregnancies improve infant health outcomes).

A **summary** of the small group report-out is presented in the table on the next page.

EXTENDED POSTPARTUM GROUP REPORT		
Priority Area	Gaps	Recommendations/Opportunities
Lactational Amenorrhea Method	<p>No question of LAM efficacy, but people/ programs in the field are not convinced</p> <p>Many women using BF for FP (BFFP); the problem is getting them to understand LAM</p> <p>Not clear how to accurately identify and record LAM users</p> <p>Need improved messages at various levels (policy, program management, community, men) to "sell" LAM better</p> <p>Need strategies to convince maternal health (MH), newborn health (NH) and child health (CH) providers to promote LAM; need to determine how strategies/messages should differ for FP service providers vs. other service providers (e.g., those providing MH or CH services)</p> <p>LAM may be a challenge for women with limited access to health facilities:</p> <ul style="list-style-type: none"> - They may not return after the immediate PP period - Providers may be uncomfortable recommending LAM because of limited opportunity to facilitate transition to other methods - Program managers and providers may have concerns about "missed opportunities" for other methods 	<p>Recognize that LAM may work better in sites/cultures where BF is the norm</p> <p>Standardize definition of LAM vs. BFFP</p> <p>Ensure that health management information systems, DHS and reproductive health surveys are accurate and consistent in collecting data on LAM use</p>
Long-Acting and Permanent Methods	<p>Need more evidence that LAM facilitates the transition to modern method use (but might be costly)</p> <p>"What's in it for me?" – less clear for non-FP service providers when promoting LAPMs</p> <ul style="list-style-type: none"> - LAM may be more natural for non-FP providers (NH, MH, etc.) to promote - Getting non-FP providers to talk about other methods is very difficult - LAPMs are more of an integration challenge than LAM 	<p>Convince providers to promote LAM by showing how it facilitates "new users" of FP through transition to modern methods, including LAPMs</p> <p>Get message out about safety and effectiveness of IUDs (and other LAPMs) to providers – "what's in it for providers?"</p> <p>Identify how LAPM promotion contributes to goals across sectors to gain support of MH/NH programs</p> <p>Identify key messages that are easy for providers to integrate during FP counseling sessions</p> <p>Recognize that promotion of LAPMs requires more community outreach</p> <p>Use immunization services as an opportunity for promoting LAPMs</p>

EXTENDED POSTPARTUM GROUP REPORT <i>(continued)</i>		
Priority Area	Gaps	Recommendations/Opportunities
Integration – General	<p>Providers lack strategies for integrating services; need messages for integration</p> <p>Integration is difficult because of time constraints during visits (at several health care levels), including ANC</p> <p>Integration of services does not address women who do not reach the clinic level</p>	<p>Develop pre-service education that incorporates basic knowledge about MH, NH and FP and sets expectations for providing integrated services</p> <p>Train staff to be “multi-competent” in delivering messages for MH, NH, HIV/AIDS and FP services</p> <p>Create policies to support the integration of services</p> <p>Profit from the new trend toward integrated services as a platform for promoting integration of PPFPP with other health services</p> <p>Avoid “cookie cutter” messages – need to tailor</p> <p>Evaluate staff division of labor to enable greater efficiency in delivering messages (e.g., reduce paperwork to free up time so providers can do more)</p> <ul style="list-style-type: none"> - Look at who is doing what job and rationales for different organizational structures (will differ across countries) - Help improve worker productivity <p>Make all services available at each site</p>
Integration – Maternal Health	<p>Develop strategies to reach women delivering at home</p>	<p>In talking to women about the benefits of PPFPP for their children, incorporate evidence that HTSP reduces child mortality</p>
Integration – Newborn Health	<p>Research is needed on best messages/ strategies to support providers in different settings when they are promoting integration of PPFPP services</p> <p>Not clear how integration can be promoted for home-based births, after which women may not access services until 40 days postpartum</p> <p>Not clear how PPFPP services can be integrated with community-based services</p>	<p>Take advantage of well-child visits as an opportunity for integration of PPFPP (e.g., during vitamin A visits twice per year)</p> <p>Use immunizations as an opportunity for PPFPP</p> <p>Use evidence of HTSP benefits to the newborn to help sell PPFPP</p>
Integration – HIV	<p>Not clear how providers can incorporate FP messages when counseling HIV+ women</p>	<p>Promote EBF through HIV/AIDS service providers:</p> <ul style="list-style-type: none"> - Benefits of EBF are mutual for HIV prevention and LAM (in absence of knowledge of HIV status, safe feeding alternative) - Benefits of EBF and LAM for HIV+ women who are breastfeeding (be sure that mothers and providers understand those benefits) <p>Ensure that providers have the latest FP information for HIV+ and HIV-negative women</p>

DISCUSSION HIGHLIGHTS AND KEY RECOMMENDATIONS

This section captures recurring themes and areas of general agreement from the open-floor discussion, which followed the small group work and presentations. The **left column** represents a synthesis of commonly identified gaps, challenges and other issues related to the current status of PFP. The **right column** articulates recommendations for action, as well as priorities and strategies, which can help guide ongoing and future efforts to support/expand PFP within an integrated service delivery context.

<p>LAM and Transition to Modern Methods</p> <p>The field is struggling with the implementation of LAM. To date, there is only one study that demonstrates increased adoption of other modern methods for LAM users. Among meeting participants, opinions were divided as to whether LAM—including transition to other modern methods—has been systematically, fully implemented. Yet, there is overwhelming evidence for supporting exclusive breastfeeding as a natural link with PFP. However, implementation of exclusive breastfeeding has also faced significant challenges.</p>	<p><i>Recommendation 1:</i> LAM should be demystified and the transition to other modern methods reinforced. Experience suggests that emphasizing the link with exclusive breastfeeding is the most logical way to ensure that LAM is well understood.</p> <p><i>There was interest in a possible working group on this topic.</i></p>
<p>Ensuring a Method Mix</p> <p>Findings from studies are clear that women in the postpartum period have a need for contraceptive methods for pregnancy spacing and limiting. In addition to LAM, other methods to be considered during the postpartum period include emergency contraception, intrauterine contraceptive devices (IUDs), postpartum tubectomies, vasectomies, progestin-only methods and, after six months postpartum, combined oral contraceptives.</p>	<p><i>Recommendation 2:</i> An array of contraceptive options should be made available to all postpartum women; the appropriateness of available options to each woman's contraceptive goals, breastfeeding status and need for protection against sexually transmitted infections should be ensured.</p>
<p>Service Integration</p> <p>Service integration presents both challenges and opportunities. Antenatal care, immediate postpartum care, immunizations and well-baby care all provide opportunities for contact with postpartum mothers and infants, yet services and program activities are not organized for maximum efficiency. It was noted that these service contacts are relatively rare, even in the best programs, which underscores the importance of maximizing each opportunity.</p> <p>The vertical nature of many programs compels them to demonstrate their effectiveness through the achievement of specific targets, which may preclude a more holistic/integrated approach.</p>	<p><i>Recommendation 3:</i> Participants agreed that the addition of PFP to an existing service or program activity should be made as simple as possible for the provider, and supported with job aids and information, education and communication materials.</p> <p><i>Recommendation 4:</i> The benefits of integrating PFP should be clearly articulated within the context of the index program, and integration should be measured by a performance indicator and change in job description for providers.</p>

<p>Addressing Service Provision Gaps</p> <p>Participants emphasized that the shortage in human resources cannot be overestimated. In addition to integrating PPF with existing services, other opportunities for reaching women and families during the extended postpartum period deserve exploration. It is unrealistic to expect existing services to extend to all postpartum women; thus, it will be necessary to expand service provision beyond traditional service providers.</p>	<p><i>Recommendation 5:</i> To expand coverage, private sector partnerships should be explored, particularly private practices run by midwives and nurses.</p>
<p>Pre-Service Education</p> <p>Findings demonstrate, and participants acknowledged, that PPF is not systematically integrated with pre-service curricula, nor is it always addressed as a specific part of family planning training (aside from noting which methods are appropriate for breastfeeding women). Family planning clinical skills are often taught separately from maternal and newborn health skills.</p>	<p><i>Recommendation 6:</i> More emphasis should be placed on incorporating PPF systematically in pre-service education, including curricula, skills development and clinical practice.</p>
<p>Focused Postpartum Care</p> <p>Building on advances in service provision achieved through promoting the concept of focused antenatal care, a similar effort should be undertaken for the postpartum period. Focused postpartum care should explicitly address women's postpartum needs—including the concept of fertility planning—and, at the same time, provide continuity among antenatal, postpartum/postnatal and child care. Services have traditionally separated maternal and infant health during this continuum, and many programs still follow separate tracks for mother and infant care during the postpartum/natal period.</p>	<p><i>Recommendation 7:</i> A model of focused postpartum care should be developed to ensure that essential maternal and newborn care, including family planning, is systematically provided.</p>
<p>Community-Based PPF</p> <p>Despite considerable experience in providing community-based distribution of family planning, there is little documentation of postpartum services. Participants felt that this was a major constraint and allowed only a superficial discussion of the potential for PPF. It was also noted that, in contrast with the emphasis on skilled birth attendants, PPF allows for a different cadre of community worker to provide a different type of life-saving service.</p>	<p><i>Recommendation 8:</i> Community-based efforts in PPF should be more systematically addressed and evaluated, and lessons learned shared.</p> <p><i>There was interest in a possible working group on this topic.</i></p>
<p>Advocacy for PPF</p> <p>Despite compelling evidence of the health benefits of family planning, services often are not meaningfully included in antenatal, postpartum/postnatal and child care. Evidence of the benefits of birth spacing and of addressing unmet need in preventing maternal mortality presents an opportunity for advocacy related to PPF and for appropriate policy action. Similar opportunities exist within HIV/AIDS programming.</p>	<p><i>Recommendation 9:</i> Policy champions for PPF should be identified within institutions and supported with evidence-based information for policy/advocacy efforts.</p>

CALL TO ACTION

The Postpartum Family Planning Technical Consultation served to reinvigorate the discussion around this important health issue, and to identify a group of individuals and institutions committed to PPFp. However, the meeting was just one step in a larger effort aimed at improving maternal and child health and survival by addressing unmet need for FP among postpartum women. To keep the momentum going, we must continue the discussion around PPFp and work together to translate recommendations and opportunities identified into appropriate action.

Follow-up actions that were suggested during the meeting wrap-up included:

- **Becoming a member of the Implementing Best Practices (IBP) Initiative:** This initiative was developed by the World Health Organization and USAID to provide a forum through which key stakeholders within the global reproductive health community can share evidence-based practices for use in low-resource settings. Visit www.ibpinitiative.org to learn more.
- **Joining the Postpartum Family Planning Community of Practice:** When joining IBP (above), request membership in the PPFp Community of Practice. As a member of the PPFp Community of Practice, you will receive notification about events and activities related to PPFp and be able to participate in virtual discussions and presentations about this important issue. You can also share any PPFp-related information or tools by posting or linking to them on the Web site (my.ibpinitiative.org/public/ppfp/). (See also the information sheet on the PPFp Community of Practice, presented in Appendix F.)
- **Sharing information about PPFp activities that your organization is implementing:** ACCESS-FP will serve as the point agency for collecting and sharing information about PPFp activities. Please let us know of any publications or tools that you may have available to share with other organizations. ACCESS-FP will maintain a listserv and forward such information to others interested in PPFp.

We look forward to working together toward reinvigorating PPFp and realizing the vision articulated at the technical consultation—that of integrated maternal, neonatal and child health services to meet the multiple needs of women and infants during the first year postpartum.



Nurse at Karurumo primary health center in Kenya consults the PPFp schedule posted on the wall (by Holly Blanchard, ACNM/ACCESS-FP).



Kenyan mother practices LAM (by Holly Blanchard, ACNM/ACCESS-FP).

APPENDIX A

PPFP Technical Consultation Participant List

Agarwal, Koki (ACCESS Program, JHPIEGO)	Matta, Nahed (USAID)
Agarwal-Harding, Priya (student)	McKaig, Catharine (ACCESS-FP Program, JHPIEGO)
Arevalo, Marcos (IRH)	Murray, Nancy (Constella Futures)
Armbruster, Deborah (POPPHI, PATH)	Nash-Mercado, Angela (ACCESS-FP Program, JHPIEGO)
Baker, Jean (A2Z Project)	Neason, Elizabeth (CEDPA)
Baqi, Abdullah (JHU)	Patricia Stephenson (USAID)
Birungi, Harriet (Population Council)	Pleah, Tsigucé (JHPIEGO)
Blanchard, Holly (ACCESS-FP Program, ACNM)	Post, May (ESD Project)
Bongiovanni, Annette (AED)	Prosser, Michelle (Constella Futures)
Chand, Sarla (ACCESS Program, JHPIEGO)	Ravji, Rushna (USAID)
Chase, Rebecca (JHPIEGO)	Reynolds, Heidi (FHI)
Curtis, Carolyn (USAID)	Schaefer, Lois (USAID)
de Negri, Bérengère (ACCESS-FP Program, AED)	Shaver, Theresa (WRA)
Deller, Barbara (JHPIEGO)	Shelton, Jim (USAID)
Ekpo, Gloria (BASICS)	Stewart, Holley (Africa 2010)
Farmand, Taroub (ESD Project)	Syed, Uzma (Saving Newborn Lives)
Farrell, Betty (EngenderHealth)	Vernon, Ricardo (FRONTIERS)
Gomez, Patricia (ACCESS Program, JHPIEGO)	Vivio, Donna (JHPIEGO)
Haberle, Heather (USAID)	Vogel, Dana (USAID)
Huber, Douglas (MSH)	Warren, Charlotte (FRONTIERS, Population Council)
Kayongo, Milly (CARE)	Zimmerman, Allison (USAID)
Kouyate, Robin Anthony (ACCESS-FP Program, AED)	
MacDonald, Patricia (USAID)	

APPENDIX B*

PPFP Technical Consultation Meeting Agenda

Tuesday, 14 November 2006
9:00AM–5:00PM
AED Conference Center, Vista Room

8:45	Check-in and Continental Breakfast	
9:00–9:45	Welcome	Dana Vogel, Chief, Service Delivery Improvement Division, USAID
	Introduction	Maureen Norton, Sr. Technical Advisor, Office of Population and Reproductive Health, USAID
	Overview of PFPF & Framework	Catharine McKaig, ACCESS-IP Project Director
	Meeting Objectives	Elizabeth Neason, CEDPA, Meeting Facilitator
9:45–1:00	Small Group Work & Working Lunch	Individual Groups ANC Group – Vista Room Immediate PP Group – Balcony Room C Later PP Group – Balcony Room D Extended PP Group – Balcony Room E
1:00–1:45	Group 1: Presentation and Discussion	
1:45–2:30	Group 2: Presentation and Discussion	
2:30–2:45	Break	
2:45–3:30	Group 3: Presentation and Discussion	
3:30–4:15	Group 4: Presentation and Discussion	
4:30–5:00	Wrap-up and Next Steps	Elizabeth Neason Catharine McKaig Patricia MacDonald, Sr. Technical Advisor, Service Delivery Improvement Division, USAID

* Maureen Norton was unable to attend the meeting. USAID colleague Patricia MacDonald delivered the Introduction in her place.

Department of Reproductive Health and Research

Department of Making Pregnancy Safer



Policy brief

Policy brief



World Health Organization

Birth spacing – report from a WHO technical consultation¹

The World Health Organization (WHO) and other international organizations recommend that individuals and couples should wait for at least 2–3 years between births in order to reduce the risk of adverse maternal and child health outcomes. Recent studies supported by the United States Agency for International Development (USAID) suggest that an interval of 3–5 years might help to reduce these risks even further. Programme managers responsible for maternal and child health at the country and regional levels have requested WHO to clarify the significance of the new USAID-supported findings for health-care practice.

To review the available evidence, WHO, with support from USAID, organized a technical consultation on birth spacing on 13–15 June 2005 in Geneva, Switzerland. The participants included 35 independent experts as well as staff of the United Nations Children's Fund (UNICEF), WHO and USAID. The specific objectives of the meeting were to review evidence on the relationship between different birth-spacing intervals and maternal, infant and child health outcomes, and to provide advice on recommended birth-spacing intervals.

Method of review and findings of the consultation

Prior to the meeting, USAID submitted to WHO for review six unpublished, draft papers emanating from studies the Agency had supported on birth spacing. These, along with a supplementary paper (also unpublished at the time), served as background papers for the technical consultation.

WHO sent the six draft papers to a selected group of experts, and received a total of 30 reviews. The reviewers' comments were compiled and circulated to all meeting par-

ticipants. At the meeting, the authors of the background papers presented their findings, and selected discussants presented the consolidated set of reviewers' comments, including their own observations. Together, the draft papers and the various commentaries constituted the basis for the consultation's deliberations.

The background papers² (see list on the back page of this policy brief) were based on studies that had used a variety of research designs and data analysis techniques. The meeting participants noted that the length of the intervals analysed and the terminology used in the papers varied

¹ This policy brief is based on the report of the WHO technical consultation on birth spacing, held in Geneva, Switzerland, on 13–15 June 2005. This report can be found on the following Internet site: www.who.int/reproductive-health/publications

² It was planned that after the meeting the draft papers would be revised by the authors, taking into account the comments of the participants in the technical consultation.

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considerably, making it difficult to compare the results. They therefore agreed to use “birth-to-pregnancy interval” as a standard term in making their recommendations. Specifically, this term refers to the interval between the date of a live birth and the start of the next pregnancy.

The participants discussed the strengths and limitations of the studies, identified areas requiring further work and requested the authors to conduct additional analyses and research. The authors are currently responding to the reviewers’ questions and undertaking the requested analyses. They are to revise their papers and resubmit them to WHO for a second review, following which WHO will issue a supplementary report.

Conclusions and recommendations

The group came to separate conclusions for the different health outcomes considered, i.e. one on birth spacing after a live birth, and one on birth spacing after an abortion. Details of the discussions, the process of achieving final agreement on the recommendations and the necessary caveats are documented in detail in the full report.

The participants emphasized that their recommendations (in bold below) must be read in conjunction with the following preamble:

In choosing the timing of the next pregnancy, individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health-care services, child-rearing support, social and economic circumstances, and personal preferences.

Recommendation for spacing after a live birth

- **After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes.**³

Recommendation for spacing after an abortion

- **After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy should be at least six months in order to reduce risks of adverse maternal and perinatal outcomes.**

Caveat. The recommendation on spacing after an abortion is based on one Latin America study that examined hospital records of 258 108 women (delivering singleton infants) whose previous pregnancy had ended in an abortion. Because this was the only available study of this scale, it was considered important to use its findings, but with some qualifications. Abortion events in the study were of three types: safe abortion, unsafe abortion and spontaneous pregnancy loss (miscarriage). The relative proportion of each of these types was unknown. The study sample was taken from public hospitals only, with much of the data coming from only two countries (Argentina and Uruguay). Thus, the results may neither be generalizable within the Latin American region nor applicable to other regions, which have different legal and service contexts and conditions. Additional research was recommended to clarify these findings.

Suggestions for future research

The consultation made the following suggestions for further research in the area of birth spacing:

- Coherent theoretical frameworks need to be developed that can explain and analyse the possible causal relationships between birth-to-pregnancy intervals and maternal, perinatal and infant outcomes, particularly child mortality.

³ Some participants felt that it was important to note in the report that, in the case of birth-to-pregnancy intervals of five years or more, there is evidence of an increased risk of pre-eclampsia, and of some adverse perinatal outcomes, namely pre-term birth, low birth weight and small infant size for gestational age.

- It would be useful to include in ongoing studies analyses of relationships between birth spacing and maternal morbidity. For instance, examination of the effects of multiple short birth-to-pregnancy intervals would be useful, as would be more detailed data on the effects of very long intervals. Further analysis of the relationship between birth spacing and maternal mortality would help confirm or refute existing findings, although it is acknowledged that this may not always be feasible as it may require a very large number of cases.
- There is a need to investigate the relationship between birth spacing and outcomes other than mortality – for instance, maternal and child nutrition outcomes, or impact on the psychological development of children. Also, it would be helpful to have information on possible benefits, as well as possible risks, of particular birth spacing intervals.
- More studies are needed on the effects of postabortion pregnancy intervals in different regions. A distinction between induced and spontaneous abortion, and between safe and unsafe induced abortion, would be particularly helpful in future studies.
- Good-quality longitudinal studies that take more potential confounding factors into account are needed to:
 - (i) clarify the observed associations between birth-to-pregnancy intervals and maternal, infant and child outcomes; (ii) estimate the potential level of bias in the use of different measures of intervals (birth-to-birth vs. inter-pregnancy interval, for instance); and (iii) clarify the potentially confounding effect of short intervals following a child death, both because of shortened breastfeeding and because parents may seek to replace the dead child.
- Finally, there is a need to develop an evidence base for effective interventions to put recommendations on birth spacing into practice.

Papers reviewed at the meeting

1. Conde-Agudelo A (draft, 2004). Effect of birth spacing on maternal and perinatal health: a systematic review and meta-analysis. Report prepared for The Academy for Educational Development and The CATALYST Consortium.

An amended and abridged version of this report (not reviewed by the WHO consultation) has now been published as follows:

Conde-Agudelo A, Rosas-Bermúdez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. *JAMA*, 2006, 295:1809–1823.

2. Conde-Agudelo A, Belizán, JM, Breman R, Brockman SC, Rosas-Bermúdez A (draft, 2004). Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America.

This paper has now been published as follows:

Conde-Agudelo A, Belizán, JM, Breman R, Brockman SC, Rosas-Bermúdez A. Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. *International Journal of Gynaecology and Obstetrics*, 2005, 89: S34–S40 (supplement).

3. DaVanzo J, Razzaque A, Rahman M, Hale L, Ahmed K, Khan MA, Mustafa AG, Gausia K (draft, no date). The effects of birth spacing on infant and child mortality, pregnancy outcomes and maternal morbidity and mortality in Matlab, Bangladesh.

4. Dewey KG, Cohen RJ (draft, 2004). Birth-spacing literature: maternal and child nutrition outcomes. Report prepared for The Academy for Educational Development and The CATALYST Consortium.

5. Rutstein SO (draft, no date). Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the Demographic and Health Surveys.

This paper has now been published as follows:

Rutstein SO. Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the Demographic and Health Surveys. *International Journal of Gynaecology and Obstetrics*, 2005, 89:S7–S24 (supplement).

6. Rutstein SO, Johnson K, Conde-Agudelo A (draft, 2004). Systematic literature review and meta-analysis of the relationship between interpregnancy or interbirth intervals and infant and child mortality. Report prepared for The CATALYST Consortium.

Supplementary paper

7. Zhu BP (draft, 2004). Effect of interpregnancy interval on birth outcomes: findings from three recent US studies.

This paper has now been published as follows:

Zhu BP. Effect of interpregnancy interval on birth outcomes: findings from three recent US studies. *International Journal of Gynaecology and Obstetrics*, 2005, 89:S25–S33 (supplement).

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APPENDIX D

[SLIDE 1]



Overview of Postpartum Family Planning and Framework
Postpartum Family Planning Technical Consultation
Catharine McKaig
14 November 2006

JHPIEGO in partnership with Save the Children, Constock Futuro, The Academy for Educational Development, The American College of Nurse-Midwives and Interchurch Medical Assistance

[SLIDE 2]

Overview

- Definitions
- General literature
- Specific findings
- Observations on literature
- Integration
- Challenges & opportunities



[SLIDE 3]

Definitions used in this meeting

Postpartum family planning is the initiation and use of family planning methods during the first year after delivery

- **Post-placental** – within 10 minutes after delivery of placenta
- **Immediate postpartum** – delivery up to 1 week
- **Later postpartum** – 1 week up to 6 weeks
- **Extended postpartum** – 6 weeks up to 1 year



[SLIDE 4]

Goals of PFP programs

Stephenson & MacDonald. 2005. "FP for postpartum women: Seizing a missed opportunity."

- Reduce unmet need
- Improve contraceptive choice
- Promote optimum health through breastfeeding
- Healthy timing and spacing of pregnancy
- Integrate with maternal and newborn services (infant health, including PMTCT and HIV/AIDS care & treatment)



[SLIDE 5]

General literature on PFP

Winikoff & Mensch 1991

- Summary of status of PFP through 1991
- Breastfeeding status and LAM
- Integration with MNCH, postpartum care needs

Ross & Winfrey 2001

- Redefines unmet need to focus on next pregnancy
- Only 3–8% of women want another child within 2 years
- 40% of women say they intend to use contraception within the next year, but are not

Koblinsky 2005

- Very little on community postpartum care including FP
- Need for coordination between FP & postpartum services to identify PFP clients and combine resources



[SLIDE 6]

General literature on PFP (cont.)

Conde-Agudelo et al. "Birth spacing and the risk of adverse perinatal outcomes: A meta-analysis." JAMA 2006

- Birth-to-pregnancy intervals of <18 and >59 months are associated with significant increased risk of:
 - Preterm birth: OR 1.40
 - Low birth weight: OR 1.61
 - Small for gestational age: OR 1.26

"Birth spacing—Report from a WHO technical consultation." 2005

- Consensus on recommendations on birth spacing:
 - After-birth minimum interval of at least 24 months
 - After-miscarriage/abortion minimum interval of at least six months



Postpartum women & FP: Findings from descriptive literature

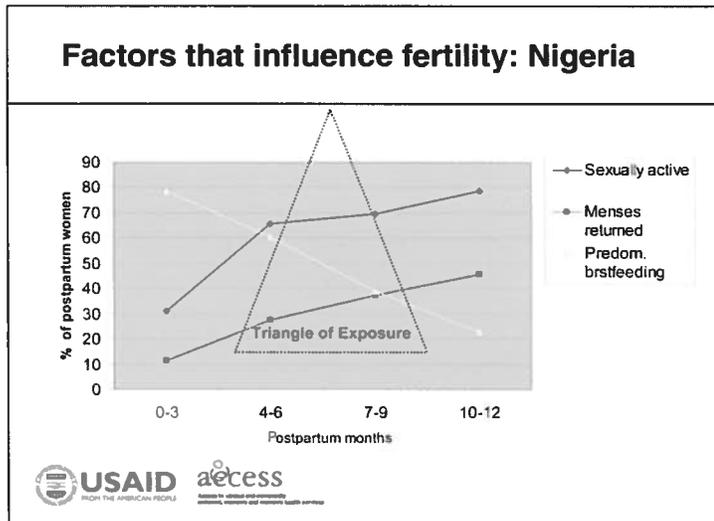
- Most women want at least a two-year interval between last birth and next pregnancy (4 studies)
- Women want to both space and limit births (4 studies)
- PP women are concerned about infant health (3 studies)
- PP women tend towards natural methods (3 studies)
- Women say husbands' opinions matter (6 studies)
- Contraceptive knowledge and past use matter (3 studies)
- Confusion about breastfeeding and return to fertility persists (4 studies)

N = 12 descriptive studies reviewed



[SLIDE 7]

REFERENCES—*Wait two years*: Bulut and Turan 1995, Duong et al. 2005, Medina et al. 2001, Ross and Winfrey 2001; *Space/limit*: Bulut and Turan 1995, Romero-Gutierrez et al. 2003, Ross and Winfrey 2001; *Infant health*: Bulut and Turan 1995, Romero-Gutierrez et al. 2003, Salway and Nurani 1998; *Natural methods*: Adinma et al. 1998, Romero-Gutierrez et al. 2001, Salway and Nurani 1998; *Husbands' opinions*: Adinma et al. 1998, Duong et al. 2005, Romero-Gutierrez et al. 2003, Susu et al. 1996, Tehrani et al. 2001, Turan et al. 2001; *Knowledge and past use*: Romero-Gutierrez et al. 2003, Susu et al. 1996, Tehrani et al. 2001, Zerai and Tsui 2001; *Breastfeeding and return to fertility*: Adeyemi et al. 2005, Bulut and Turan 1995, Salway and Nurani 1998, Thapa et al. 1992



[SLIDE 8]

Postpartum women

Studies have repeatedly demonstrated that **women are interested in FP information**, even immediately postpartum.

- **Clients interested in FP:**
 - ANC – 66% (n = 400)
 - Postpartum – 92.5% (n = 200)
 - Well-baby clinic – 95% (n = 400)
- **Reasons for not discussing FP:**
 - Clients – 1) nurse too busy; 2) scared to approach/waiting for nurse; 3) didn't know they could ask nurse questions
 - Staff – 1) constrained by lack of FP knowledge; 2) lack of time and privacy
- **Recent study on hospital-based perinatal care:**
 - FP counseling – factor in determining client satisfaction



[SLIDE 9]

REFERENCES—*Studies have repeatedly demonstrated*: Bradley et al. 1995, Bulut and Turan 1995, Medina et al. 2001, Smith et al. 2002; *Clients interested/reasons for not discussing*: Bradley et al. 1995; *Hospital-based care*: Senarath et al. 2006

[SLIDE 10]

Selected studies		
STUDY	DESCRIPTION	FINDINGS
Vernon et al. 1993	Pre/post design: hospital services Five components: ANC, RH counseling, contraceptive options, 40-day clinic, plus data collection	PPFP client knowledge increased 9–47% Return for PP check-up increased 15–40%
Huntington & Aplogan 1994	Stratified sample of 16 urban and rural clinics with MCH/FP clinics Referral message linking EPI and FP services	Awareness of FP services increased 18% Monthly average of new clients increased 54%
Hardy et al. 1998	Pre/post design: 350/348 women Integrating LAM in hospital delivery setting	No method use before 17.7% No method use after 7.4%




[SLIDE 11]

Selected studies (cont.)		
STUDY	DESCRIPTION	FINDINGS
Alvarado et al. 1999	Intervention: monthly visits to end of first year – integrated care for mother and child	Initial FP use rates similar Continuation for intervention group appears better Fully BF: 74% compared to 10%
Smith et al. 2002	Over 500 women attending ANC in three centers in Scotland, China and South Africa randomized to receive contraceptive advice or standard advice	No differences between groups observed in contraceptive use No impact on 12-month pregnancy rate Women reported FP advice received to be useful
Bongiovanni et al. 2005	Assessment of LAM intervention: women with children 13–24 months of age in 11 child health centers (n = 3,183) asked about BF, LAM and contraceptive practices	FP use for LAM users – 40%; BFFP users – 23%; non-users –14%, LAM users switched earlier (6 months) Among previous non-users, LAM users more likely to be using FP at 12 months. LAM users had better BF practices




[SLIDE 12]

Observations on programmatic literature	
	<ul style="list-style-type: none"> ▪ Focus on feasibility of interventions ▪ Comprehensive approaches limited (ANC, immediate PPC, PNC, infant care) (4 studies) ▪ Few studies with strong community approaches (2 studies) ▪ Male involvement (4 studies)




REFERENCES—*Comprehensive approaches limited:* Alvarado et al. 1999, Huntington and Aplogan 1994, Medina et al. 2001, Vernon et al. 1993; *Few community approaches:* Bolam et al. 1998, Fullerton et al. 2005; *Male involvement:* Kunene et al. 2004, Soliman 1999, Turan et al. 2001, Varkey et al. 2004

PHOTO: Family in Afghanistan (by Deldre Russo, JHPIEGO/ACCESS).

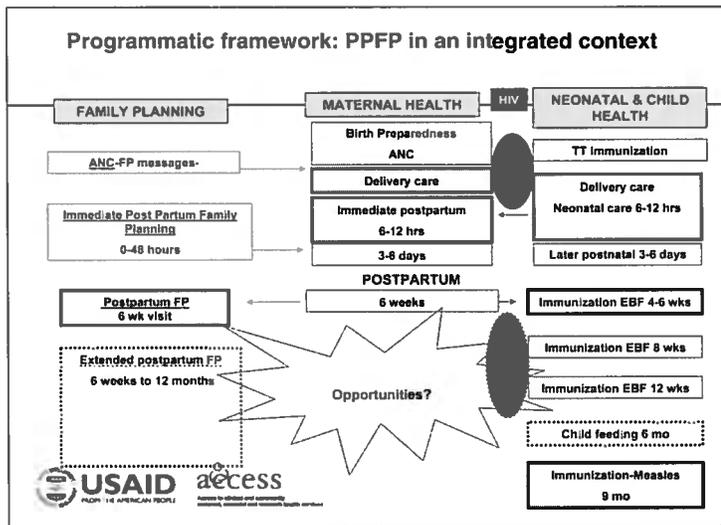
Review of MNH training materials/guidelines

- FP messages not specific to PP women
- Little information about return to fertility
- Rarely discuss spacing; no discussion of risks related to intervals
- Infrequently discuss LAM; little or no emphasis on transition
- Breastfeeding and LAM not linked
- ANC – not systematic for FP counseling; does not include long-acting method choice

FP often viewed as separate activity – referred to other materials



[SLIDE 13]



[SLIDE 14]



“Having babies too close together is a problem since nursing an older baby and newborn is very fatiguing for the mother...”

Women’s group in Kano, Nigeria



[SLIDE 15]



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Family Planning Initiative
Addressing unmet need for postpartum family planning

ADDRESSING UNMET NEED FOR POSTPARTUM FAMILY PLANNING: THE ACCESS-FP PROGRAM

What is ACCESS-FP?

Designed by the USAID Office of Population & Reproductive Health as a centrally-funded associate award under the ACCESS Program, ACCESS-FP focuses specifically on meeting the family planning and reproductive health needs of women in the extended postpartum period. ACCESS-FP interventions are designed to complement those of the ACCESS Program in the promotion and scale-up of postpartum family planning through community and clinical approaches suitable for low-resource settings. ACCESS-FP repositions family planning through integration with maternal, newborn and child health programs, including prevention of mother-to-child transmission of HIV.

In recognition of the need to ensure access to family planning beyond the traditional end of the postpartum period—to help women transition from exclusive breastfeeding and the Lactational Amenorrhea Method to other modern contraceptive methods, and to support uptake and continuation of family planning methods—ACCESS-FP activities extend a full year post-birth. This approach helps the reproductive health needs of the mother, as well as the health care needs of the infant, to be fully met.

What does ACCESS-FP do?

Through partners JHPIEGO, Save the Children, Constella Futures, the Academy for Educational Development, the American College of Nurse-Midwives and Interchurch Medical Assistance, ACCESS-FP works to strengthen and expand the integration of birth spacing and family planning with maternal, newborn and child health programs in the following priority areas:

- National maternal and newborn policies and strategies to ensure the inclusion of family planning in the development of essential packages of care;
- Curricula, standards and guidelines for preservice education, inservice training and service delivery to include postpartum information such as return to fertility, birth spacing and the full range of family planning methods;
- Behavior change communication strategies to educate people and support birth spacing and family planning, including the Lactational Amenorrhea Method; and
- Facility and community approaches for integrating family planning messages and services with antenatal care, safe delivery, essential newborn care, postpartum care for the mother and newborn, and essential child care.

Prominent Themes in ACCESS-FP

Integration: There are multiple opportunities to provide birth spacing and family planning information and services in the context of maternal, infant and child health care services. These opportunities include antenatal care and early and extended postpartum visits, as well as immunization and well child care.

For HIV-infected women—whether enrolled in a program aimed at the prevention of mother-to-child transmission of HIV or not—there are special needs for counseling on exclusive breastfeeding and the effect of abrupt weaning on a woman's return to fertility. Prevention programs have an additional need to provide ongoing care and support to the mother and infant during the postpartum period,

both to support exclusive breastfeeding and for follow-up testing and treatment. ACCESS-FP, with its focus on the extended postpartum period, works with these programs to build or strengthen postpartum follow-up services for mother and infant.

In Nigeria, ACCESS-FP works to incorporate a postpartum family planning approach complementary to essential maternal and newborn care (EMNC). The FP activities in Nigeria are designed to build on the platform created by the EMNC activities. In the coming year, 20 rural facilities in two districts in Northern Nigeria will be revitalizing their family planning services with a particular emphasis on PFP, and a complementary behavior change strategy to support initiation and use will be developed.

No Missed Opportunities: ACCESS-FP is uniquely positioned to work effectively with facilities on a “no missed opportunity” concept. This ensures that all women who receive antenatal care, deliver in a health facility, are referred for emergency care services or come for postnatal services have the necessary information on birth spacing, family planning and services. An important part of ACCESS-FP’s work will be the development of a model of focused postpartum/postnatal care that includes FP.

In light of the fact that most women in the developing world do not give birth in health facilities, ACCESS-FP builds on any initial point of contact—either facility- or community-based—for linking follow-up postpartum family planning services. In Kenya, the Program is working with FRONTIERS in the development of focused postpartum/postnatal care and also working to reestablish the IUD as a postpartum contraception option.

Learning About What Works: As with many programs that work toward integrated services, it is often necessary to test and adapt approaches to ensure their viability. To accomplish this, ACCESS-FP collaborates with researchers to design and document both educational messages and service approaches to integrate postpartum family planning with ongoing maternal, newborn, infant and child health services. In Bangladesh, the Program is working with The Johns Hopkins Bloomberg School of Public Health to support the development and testing of birth spacing messages and integration with a community-based newborn care model.

Focused Populations: ACCESS-FP designs and implements interventions to meet the postpartum birth spacing/limiting and family planning needs of specific population groups such as: married adolescents, young women and couples, women and couples in the poorest economic quintiles, HIV-infected women, and the social networks surrounding and influencing these women and couples such as their elders or religious leaders. For example, in Haiti, ACCESS-FP is developing a participatory reproductive health model for young girls and young mothers.

Scaling Up: ACCESS-FP promotes and scales up demonstrated, successful practices through: individual and organizational capacity building; Standards-Based Management and Recognition; performance improvement mechanisms; collaboration; and partnerships. These approaches empower communities to be active users of health care and active participants in planning services. The Program also maintains a global community of practice for those interested in learning and exchanging information, tools and resources related to postpartum family planning.

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POSTPARTUM FAMILY PLANNING COMMUNITY OF PRACTICE

The Postpartum Family Planning (PPFP) Community of Practice will serve as a global forum for those interested in learning and exchanging information, tools and resources related to family planning through the first year postpartum. As best practices have rapidly evolved in maternal and neonatal health care, family planning information and services provided during the extended postpartum period have been influenced by these changes. In light of this evolution as well as the significant amount of program experience that has been developed over the years, the PPFP Community of Practice will serve as a point of exchange for those interested in supporting and expanding family planning within an integrated service delivery context.



Photo: Holly Blanchard

Through the Implementing Best Practices (IBP) Initiative, the wider reproductive health community comes within easy—and virtual—reach for effective information exchange. The IBP Initiative has adapted a Web-based system to promote a concept of collaboration and knowledge sharing.

Through the IBP system, the PPFP Community of Practice will:

- Organize on-line global discussions on selected PPFP topics identified by the members.
- Facilitate further information sharing through Web-based global discussions
- Serve as central library for key PPFP resources including research, programmatic information and tools.
- Bring together diverse groups working in maternal and newborn health and family planning.
- Serve as a platform for subcommittees and working groups related to PPFP.

Visit the Postpartum Family Planning
Community of Practice to request membership:
<http://my.ibpinitiative.org/public/ppfp/>

For more information about the PPFP Community of Practice, please contact: Cat McKaig, Director, ACCESS-FP, cmckaig@jhpigo.net or Angela Nash-Mercado, Senior Program Coordinator, ACCESS-FP, anash-mercado@jhpigo.net

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ACCESS-FP, a five-year, U.S. Agency for International Development (USAID)-sponsored global program, is an associate award under the ACCESS Program. ACCESS-FP focuses on meeting the family planning and reproductive health needs of women through the extended postpartum period. Interventions are designed to complement those of the ACCESS Program in the promotion and scale-up of postpartum family planning through community and clinical interventions. ACCESS-FP will reposition family planning through integration with maternal, newborn and child health programs, including the prevention of mother-to-child transmission of HIV. JHPIEGO implements the program in partnership with Save the Children, Constella Futures, the Academy for Educational Development, the American College of Nurse-Midwives and Interchurch Medical Assistance.

For more information about ACCESS-FP, please visit www.accesstohealth.org/about/assoc_fp.htm, or contact Catharine McKaig, ACCESS-FP Program Director, at cmckaig@jhpiego.net.

