Postpartum Family Planning
New Research Findings and Program Implications

On July 19, 2012, at a meeting in Washington DC, the PROGRESS project presented findings from its research studies on topics related to postpartum family planning. The meeting offered an opportunity for partner agencies, including the U.S. Agency for International Development (USAID) and the World Health Organization (WHO), to discuss how these findings might contribute to expanding access to family planning information and services in the postpartum period.

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PROGRESS IN FAMILY PLANNING

Dr. Scott Radloff, Director of the USAID Office of Population and Reproductive Health, opened the July 19 meeting. "We see postpartum family planning as one of our most important program areas," he said. "On the continuum of care, postpartum family planning may be the biggest missed opportunity in front of us."

Women have a high demand for both limiting and spacing pregnancies in the postpartum period, with some two out of three women expressing an unmet need for preventing a pregnancy.[1] Births that are spaced too closely together pose substantial health risks for the mother and child. Women have a high likelihood of contact with the health care system, making the postpartum period a time for high-impact, cost-effective programs. USAID has made integration a technical priority, particularly ensuring that family planning is part of comprehensive maternal and child health services.

"We are in a time of revitalization of family planning," Radloff said, mentioning the London Summit on Family Planning held in early July. "The organizers of the Summit are now focusing on high impact practices that are cost-effective so as to maximize the impact of new global commitments and resources. The time is right to look at important high impact practices in the postpartum area."

Scott Radloff, Director of the USAID Office of Population and Reproductive Health, opened the meeting.

1 See: Ross JA, Winfry WL. Contraceptive use, intention to use and unmet needs during the extended postpartum period. Int Fam Plann Perspect 2001;27(1):20-7.

Key Findings and Program Implications

Return to Menses and Postpartum Family Planning Use

Key Finding: An analysis of data from six studies found that resumption of menses is a critical and persistent factor that influences key decisions and behaviors by women and providers in initiation of postpartum family planning use.

Program Implications: Programs need effective messages to use with women and in training providers about pregnancy risk vis-à-vis return of menses, including that women have the right to receive a method even if they are not menstruating.

Pregnancy Tests

Key Finding: A randomized intervention study in Zambia found that provision of free pregnancy tests in clinics decreased the chances that non-menstruating women would be turned away, at a very low cost per woman provided with a family planning method.

Program Implications: If country programs make pregnancy tests available at little or no cost, access to same-day provision of family planning methods for amenorrheic women, including postpartum women, will likely improve.

Integrating Family Planning with Immunization Services

Key Finding: A randomized intervention study in Rwanda found that integrating family planning information, screening, and same-day service provision into public-sector child immunization services led to a statistically significant increase in use of family planning methods in the study sites, with no detrimental effect on immunization services.

Program Implications: Policymakers and advocates can use the new evidence to support with more confidence existing country programs that are trying to integrate family planning and immunization services and promote wider use of this integrated service.

Postpartum IUDs: Feasibility and Scale Up

Key Finding: Postpartum IUD service provision can be incorporated into routine services at public sector district hospitals and health centers, including provision by nurses.

Program Implications: For successful scale up into existing heath systems, programs need to identify and support champions, integrate this service into maternal care, monitor performance, provide supervision, recognize exemplary performance, and generate demand.

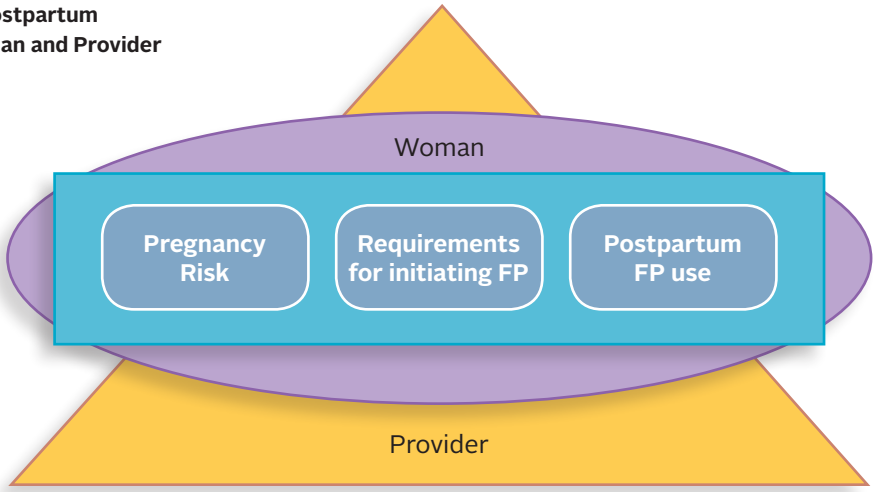
Return to Menses and Postpartum Family Planning Use

Dr. Aurelie Brunie of FHI 360 summarized findings related to return of menses following childbirth and use of family planning that came from six separate PROGRESS studies conducted in four countries. The study topics were integration of family planning and child immunization (4 studies: Ghana, India, Rwanda, and Zambia), non-use of family planning (Rwanda), and postpartum IUD use (Rwanda). Data for the latter study were collected post-intervention; all other data came from baseline or cross-sectional formative assessments. The total data reviewed included more than 7,300 women, 127 providers (2 studies), and 54 in-depth interviews (1 study). The postpartum period for data collection varied by study, including 0-12 months, 3-5 months, 6-12 months, and 9-12 months; the Rwanda non-use study was not specific to postpartum women. The return of menses following childbirth emerged as an important theme in all six studies.

"The findings can be organized according to three major themes – women's and providers' understanding of pregnancy risk, provider-imposed requirements for contraceptive method initiation, and women's postpartum family planning use," said Brunie.

Women's understanding of pregnancy risk. In data from four of the studies (3 different countries), 24% to 48% of women did not know that a woman could get pregnant before her menses returned during the postpartum period. But even those women who did understand their pregnancy risk did not necessarily act on this knowledge. In the Ghana and Zambia integration studies, among women 9-12 months postpartum (when pregnancy risk is higher than in earlier postpartum months), knowledge of pregnancy risk was not associated with family planning use among sexually active, amenorrheic women. Also, women who were aware of pregnancy risk were as likely to cite waiting return of menses as a reason for non-use as were women who were not aware of this risk.

Menses as a Trigger for Postpartum Family Planning Use: Woman and Provider



Providers' understanding of medical requirements for initiation of family planning. Findings suggest that some providers require that women be menstruating at the time of their visit in order to give them a method. While this issue is not specific to return of menses following childbirth, it affects postpartum women specifically since they are often amenorrheic. In one study, 53% of the immunization providers (Rwanda) were unsure or agreed with the statement "a woman must be menstruating to start a family planning method." Many women also confirmed that providers would require menstruation before giving a method. In the non-use study (Rwanda), 43% of women agreed with the statement: "If I go for family planning, the nurse will ask to see my pad." In the qualitative sample in this study, 7 out of 35 current or past family planning users reported being asked to show proof they were menstruating or told to come back during their next period.

"When you get there for the first time, they ask if you are having your period," one woman reported. "When it is no, they give you another appointment. But when it is yes, they give you cotton wool and you go somewhere discreet to put some blood and come back to show it to the provider. It is only then that the provider shows you the methods."

Postpartum family planning use. Modern contraceptive use was consistently higher among women whose menses had returned following childbirth than among amenorrheic women across five studies. Moreover, women reported menses as a main reason for not using a method in several studies. In the non-use study (Rwanda), 73 out of the 120 women not currently using a method who cited this reason were more than 6 months postpartum, when the risk of pregnancy begins to increase for breastfeeding, amenorrheic women.

"They say that menses make it possible to conceive. I don't know what happened that the woman got pregnant without menses," said a 23 year-old woman with one child in an in-depth interview. "It is not time yet, I haven't had my period to go get a method or use a condom."

Conclusions and Next Steps

"Findings from these studies confirm the relationship between resumption of menses and use of family planning among postpartum women that has been seen primarily in aggregate DHS data," said Brunie. The study data highlight misperceptions about pregnancy risk among amenorrheic women and the importance of addressing both knowledge and behavior issues related to this risk. The data also highlight the need to address the denial of methods to postpartum amenorrheic women by providers. "Some women may be left with what some might call a Catch 22," Brunie concluded, summarizing the analysis of the studies. "A postpartum woman is amenorrheic and doesn't want to get pregnant. But she cannot get a method because the provider won't give it to her – because she is amenorrheic."

Dr. Halida Akhter, of the Evidence to Action project and the discussant for this presentation, emphasized some of the points from the presentation. "The key issue is to give women the understanding of risk and the understanding that they can access services. But a complex framework needs to be addressed. They have grown up with the cultural norms and barriers prevailing in the community." She also noted that providers are keen to rule out pregnancy, so we have to focus on provider barriers and their knowledge gaps as well as enhance their knowledge on consequences of unwanted pregnancy.

Key messages from this session were:

- Programs need effective messages to use with women about pregnancy risk vis-à-vis return of menses and about their right to a method even if they are not menstruating.
- Programs need to provide better training and supervision of providers to ensure their knowledge of pregnancy risk, to increase their use of protocols for assessing pregnancy risk (i.e., the pregnancy checklist), and to provide contraception even if a woman is not menstruating.

Pregnancy Tests

Dr. John Stanback presented findings from recent studies in Zambia and Ghana, which addressed the role that pregnancy tests can play in family planning programs. The studies attempted to address the ongoing issue that non-menstruating women, including postpartum amenorrheic women, are commonly denied a family planning method even though very few of these women are actually pregnant.

WHO advises that a woman can start most methods immediately if a provider is "reasonably sure" she is not pregnant.[2] However, Stanback pointed out, "Sometimes overly strict interpretation of the WHO guidelines by providers creates medical barriers."

Many providers narrowly focus on presence of menses to rule out pregnancy, so amenorrhea in the postpartum period and at other times often presents a stumbling block to immediate method provision. The pregnancy checklist contains a series of questions that a provider can ask to assess the possibility that a client may be pregnant, and has been shown to be effective through multiple studies. However, the checklist cannot rule out pregnancy in all cases and some providers don't trust the tool or clients' responses.

To address this limitation, FHI 360 in collaboration with the two Ministries of Health tested an intervention in which free pregnancy test strips were supplied to family planning clinics. There is a common perception that pregnancy tests are prohibitively expensive; however, in truth, international procurement groups purchase test strips for as little as US $0.09.[3] The primary objective of the study was to assess whether access to free pregnancy tests would reduce the proportion of family planning clients who are denied an effective method. Stanback explained, "We don't want to undermine our good work on the pregnancy checklist or overly rely on a technological 'crutch.' However, at such a low price, pregnancy tests may be a cost-effective way to increase immediate family planning uptake, especially during the postpartum period."

Study results. In both Ghana and Zambia, five clinics were randomly assigned to receive free pregnancy tests and five clinics were assigned to be controls. In Zambia, results showed that new, non-menstruating clients were four times more likely (17% vs. 4%) to be denied a family planning method in control sites where free pregnancy tests had not been introduced.

The results also showed the cost of offering pregnancy tests was very low. In the intervention clinics in Zambia, the estimated cost to provide each additional woman who would have otherwise been turned away without a method because she was not menstruating was only US $0.57.

The results from Ghana were less clear; there was a decrease in the number of clients who were denied a method in the control group, while there was a small increase in the intervention group, though neither difference was statistically significant. Stanback explained that the proportion of clients denied a method in Ghana was low to begin with and, based on key informant reports, may have been largely due to stock-outs.

Implications for introduction of pregnancy tests in family planning clinics. In addition to potentially increasing immediate uptake of family planning methods among non-menstruating clients, including postpartum women, access to pregnancy tests offers other possible advantages. Free pregnancy

2 World Health Organization. Selected Practice Recommendations for Contraceptive Use, 2nd Ed. Geneva: WHO, 2004.
3 International Drug Price Indicator Guide. Available at: http://erc.msh.org/dmpguide/

testing could be a way to encourage women to enter the health system, first to know their status and then, in the process, to serve as a "teachable moment" to subsequently increase demand for family planning services. Pregnancy tests could also be used to rule out pregnancy among clients using injectable contraception who come late for their re-injections. In addition, because the pregnancy tests that are sold in pharmacies and drug shops include a large mark-up, social marketing groups could potentially sell test strips at a more modest price and increase access to a highly desired commodity. Finally, pregnancy tests could provide reassurance to amenorrheic women using progestin-only hormonal methods such as injectables or implants who return to providers because they are worried that they might be pregnant, and thus possibly improve continuation rates.

The research suggests that the pregnancy checklist and pregnancy tests should be used in combination in family programs. Each tool has benefits and limitations. Most notably, for a woman between two normal menstrual periods, a pregnancy test will not be effective; a standard pregnancy test cannot detect a pregnancy reliably until 1-2 weeks after a missed period. Similarly, the checklist does not conclusively rule out pregnancy for women who fail to meet one of its six criteria. Simple clinical guidance should be developed, advising providers to use the pregnancy checklist first, and if pregnancy cannot be ruled out, to use a pregnancy test. Stanback noted two exceptions to this guidance: 1) if a woman's menses are late, a provider should skip the checklist and use a pregnancy test, and 2) if a woman is between two normal menses, a pregnancy test will not be effective and should not be used.

Ideally, family planning providers should be equipped with and trained in use of both the pregnancy checklist and pregnancy tests. A key next step would be to address procurement considerations, such as logistics and quality control, to ensure that pregnancy tests are reliably delivered to family planning clinics along with other routine commodities such as contraceptives, syringes, and gloves.

Trish MacDonald of USAID, the discussant for this session, addressed some of these issues. First, she noted, "Sixty cents for each woman not denied a contraceptive method is a great investment, considering all the costs associated with an unplanned pregnancy." She also pointed out that we want to be careful that providers do not become overly reliant on pregnancy tests, especially because commodity stock-outs are an ongoing concern.

Conclusions and Next Steps

Pregnancy tests are much less expensive than is widely assumed. Where service denial to non-menstruating clients is a problem, such as in Zambia, free pregnancy testing in family planning clinics may facilitate increased immediate uptake of methods. And, as the Zambia experience showed, the cost of reaching each additional client who would have otherwise been turned away was modest.

Key messages from this session were:

- In the Zambia intervention study, results showed that new, non-menstruating clients were four times more likely (17% vs. 4%) to be denied a family planning method in control sites where free pregnancy tests had not been introduced.
- Making pregnancy tests available at no cost to family planning clients provides an important and affordable opportunity to reduce medical barriers by providing more postpartum women with immediate provision of a method when they are not menstruating.
- Programs need to develop and disseminate simple guidance to providers regarding how the pregnancy checklist and pregnancy tests can be used in combination.
- Providing a free pregnancy test may offer broader advantages such as offering a "teachable moment" about family planning among clients who want to know their pregnancy status.

Pregnancy Tests Can Increase Access

Integration of Family Planning and Child Immunization Services

Dr. Lisa Dulli presented new findings from a study conducted in Rwanda in collaboration with the Ministry of Health, which tested an intervention designed to reach postpartum women with family planning education, screening, and services through child immunization contacts. Reaching women with family planning after the birth of a child is often difficult. Although women typically attend at least one antenatal care visit during their pregnancy, many women do not access postpartum services after delivery. In contrast, most women seek routine health care services for their infants. The WHO recommends infant immunizations at 6 weeks, 10 weeks, 14 weeks, and 9 months after birth. "Infant immunization services offer multiple and timely opportunities to reach postpartum women with family planning," said Dulli.

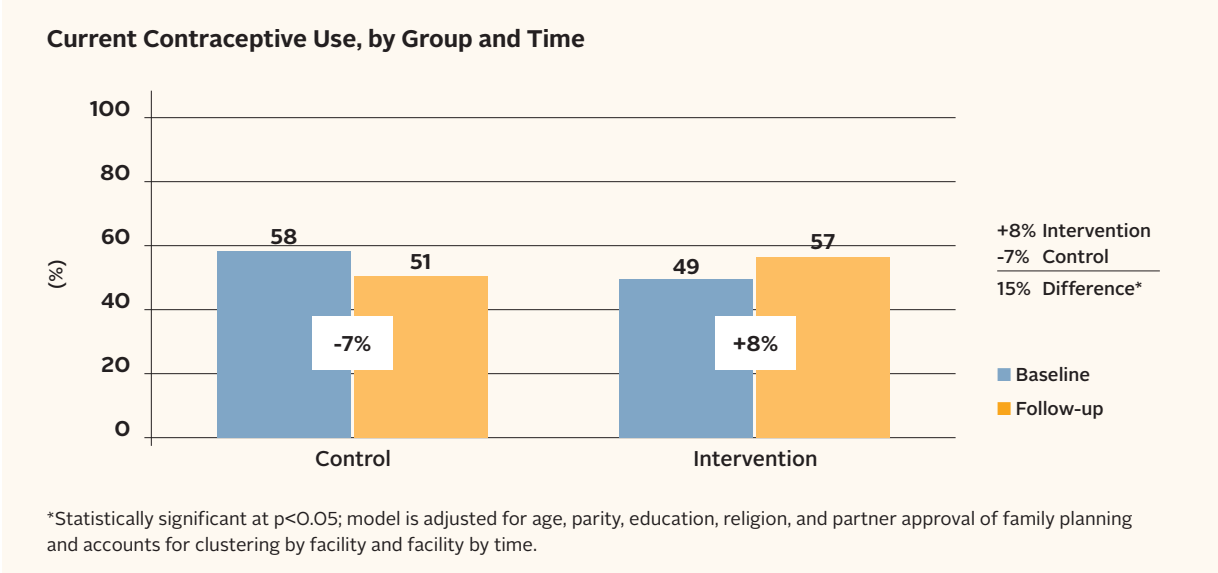
Despite the opportunity for integrated service provision, limited evidence exists on the feasibility and effectiveness of integrating family planning and immunization services. The study in Rwanda was designed to help fill this gap. The primary goal of the intervention was to reach postpartum women when bringing their child for an immunization with information so as to improve their knowledge regarding return to fertility, pregnancy risk, the benefits of healthy timing and spacing of pregnancies, and contraceptive options available for postpartum women, as well as to increase access to same-day family planning services.

In the intervention, routine child immunization providers gave concise messages to women during group education sessions, distributed brochures, and used a screening tool with all mothers to assess pregnancy risk using criteria from the Lactational Amenorrhea Method (LAM). The screening tool also instructed vaccinators to give a brief counseling message depending upon a mother's pregnancy risk classification, including a referral for same-day family planning services for those at such risk. All facilities in the study offered family planning provision on the same day, at the same time, and in the same building as immunization services.

The main objective of the study was to assess the effectiveness of the intervention. In addition, the intervention was informed by the Health Belief Model (HBM)[4] as a guiding framework, and a secondary objective was to examine the relationships between HBM perceptions and contraceptive use. In particular, the study looked at cognitive factors among women to determine which, if any, mediated the effect of the intervention. The study used a cluster randomized, two-group, separate sample, pre/post-test design in 14 randomly selected health facilities with over 800 women included in both the baseline and follow-up groups, as well as an overall total of 118 providers interviewed. The facilities were from all areas of the country. The post-test data collection occurred after a 12-month intervention.

The key finding in the study concerned change in contraceptive use over time. At baseline, contraceptive prevalence in the intervention sites was 49% and increased to 57% at follow-up. In the control sites, prevalence at baseline was 58% and declined to 51% at follow-up. The 8% increase in the intervention together with the 7% decrease in

4 Strecher VJ, Rosenstock IM. The Health Belief Model. In: Glanz K, Lewis FM, Rimer BK, editors. Health Behavior and Health Education, 2nd Ed. San Francisco: Jossey-Bass, Inc., 1997(41-59).



the control resulted in a 15% difference between the intervention and control groups when comparing baseline to follow-up results. This change was statistically significant (p<0.05).

Also of note was that immunization services appeared not to have been affected by the intervention. Data on the use of the measles and other vaccines over a 14-month period were collected, and there was no evidence that immunization service visits declined in the intervention facilities once the intervention was implemented, and no obvious difference between the intervention and control groups. "There have been questions within the immunization community about the impact of integration on vaccine rates, so it is reassuring to see that there was no detrimental effect," Dulli said.

The presentation included findings on the health beliefs that were associated with family planning method use at both baseline and follow-up. Women in the intervention group with higher perceived susceptibility to an unplanned pregnancy were more likely to use a method than those with lower perceived susceptibility (linear mixed model regression estimate was 0.24; p=.05). Perceived severity of an unplanned pregnancy and perceived benefits of family planning, which were high among both intervention and control groups, were also associated with family planning use, while women who perceived that there were barriers to accessing family planning services were less likely to use a method.

There was a small, statistically significant change observed in perceived susceptibility between the intervention and control groups from baseline to follow-up; however, there was no significant change observed among any of the other HBM factors. The most common reason for non-use among both intervention and control groups was that women were waiting for return of menses (50% of non-users in the intervention group and 46% in the control), and breastfeeding status was also cited as a reason by some (11% of non-users in the intervention group and 8% in the control).

Process data from supervision visits also revealed important insights. The delivery of the intervention, particularly the use of the screening tool during one-on-one encounters with mothers, required reinforcement, and some messages were not delivered consistently in all settings. Provider attrition was a problem in some facilities, and providers who did not complete the training often did not deliver messages correctly. In addition, engaging both central-level and district-level Ministry of Health personnel in supervision visits and having buy-in from the Family Planning Technical Working Group were essential to successful implementation.

continued on page 13

Postpartum IUD: Feasibility and Scale Up

Dr. Theresa Hoke presented findings from a demonstration study designed to produce guidance on the feasibility of offering postpartum IUD insertion services in hospitals and health centers in Rwanda, with the goal of scaling up the service nationwide. The Ministry of Health conducted the study with technical support from PROGRESS and Jhpiego.

The study involved introducing the intervention in four hospitals and eight health centers selected from all regions of the country, reflecting the MOH's goal of potentially scaling up the service. The intervention included training providers in postpartum family planning counseling and IUD insertion and removal; adjustments to the antenatal care and maternity procedures; supportive supervision; and provision of equipment, commodities, and a brochure on family planning methods available to postpartum women. Six months after full implementation of the intervention, the study assessed the feasibility of including postpartum IUD services in the contraceptive method mix using a combination of data collection methods. Investigators compiled data on insertions performed, examined service delivery practices, and assessed providers' and clients' knowledge and perspectives about the procedure.

Rwanda

Study was conducted in four hospitals and eight health centers selected from all regions of the country, shown here.

Results. A total of 478 postpartum IUD insertions were performed, 278 in the four district hospitals and 200 in the eight health centers. About two of every three done at the hospitals were intra-cesarean insertions; all of those done in health centers followed vaginal deliveries. The number of insertions varied extensively by facility. More than 40% of all insertions in health centers took place in one center, while three health centers had a fewer than 20 insertions total. Similarly, one hospital had about half of the hospital insertions. The high-performing sites are attributed primarily to highly motivated providers supported by engaged managers. The overall number of deliveries in the centers may have also affected the number of IUD insertions.

The study tested provider job knowledge using measurement scales covering healthy timing and spacing of pregnancy, LAM, safe and effective family planning methods in the postpartum period, appropriateness of postpartum IUD as a method, insertion procedures, infection prevention, routine side effects, timing of routine follow-up visits, and other issues. The training was effective in imparting

job knowledge, with 81% of those trained demonstrating competence in counseling, with similar levels among doctors and nurses. (The project also interviewed antenatal care and maternity providers responsible for counseling on family planning who did not participate in project-sponsored training; 50% of those demonstrated competence.) Similarly, 86% of providers trained to perform insertions demonstrated adequate levels of clinical knowledge, with nurses scoring slightly higher than doctors. Providers expressed near unanimous support for this new service. Nearly all said counseling clients on postpartum IUD services should be part of their job, and all but one provider trained to perform insertions wanted to continue offering the service.

Observations of service delivery showed that messages about postpartum family planning are more commonly communicated through group education than individual counseling. While information on postpartum family planning was communicated in the majority of observed antenatal sessions, education and counseling on postpartum family planning was less commonly observed in the maternity wards.

Post-intervention, when clients were asked why they did not consider postpartum IUD insertion, they mainly replied that they were not interested in this method or did not know enough about it. Only half of 277 women had ever heard of the IUD. Those who had heard of the IUD were asked about benefits of the method; these women emphasized the long-term use and its effectiveness. When asked about disadvantages, clients did not have any overwhelming concerns. Demand generation for postpartum IUDs was not part of this study.

Conclusions and Next Steps

The post-intervention evaluation found that most providers demonstrated adequate job knowledge on postpartum IUD delivery and expressed willingness to deliver the services involved. The evaluation also found that insertion services can be successfully delivered in hospitals and health centers by nurses as well as doctors.

From the evaluation, challenges also emerged. Services were not delivered systematically among the sites. Also, most postpartum women did not

Photo by Theophile Nsengiyumva, FHI 360

Provider is conducting group education to the couples coming for antenatal care at the Kirambo Health Center, one of the study sites in Rwanda.

Postpartum IUD: Feasibility and Scale Up

continued from page 11

consider a postpartum IUD as a contraceptive option. Knowledge gaps contributed to low client uptake of postpartum IUD services.

In Rwanda, the Ministry of Health and its partners are reviewing the study findings as they consider strategies for providing this service throughout the country's health system. This will require training, commodities, and raising awareness of this contraceptive option among both providers and clients. "With the technical foundation now in place through this feasibility study, attention must now be directed toward supportive leadership, provider motivation, and demand generation," said Hoke. The study team recognized that attention to demand generation is needed when integrating this service into the MOH service structure.

Holly Blanchard from Jhpiego, the discussant for this session, commented that the study demonstrated that skilled nurse attendants can deliver this method. "This is a great addition to the method mix that can help women achieve healthy timing and spacing of pregnancies, as well as for those women wanting to avoid future pregnancies," she said. She also noted the importance of supportive supervision.

The key messages from the session were:

- Immediate postpartum IUD service provision can be incorporated into routine services at public sector district hospitals and health centers, including provision by nurses.
- Successful programs need to identify and support champions of the new service, establish clear performance expectations to integrate this service into routine maternal care, monitor provider performance, provide supportive supervision, and recognize exemplary performance.
- Programs will be more successful if they generate demand among women by building community awareness of this method and its benefits in the postpartum period.

Participants at the July 19 meeting listen as Roy Jacobstein, EngenderHealth (3rd from left), makes a point regarding the postpartum IUD study.

Integration of Family Planning and Child Immunization Services

continued from page 9

The discussant for the session, Maxine Eber from PSI said, "It's encouraging to see positive results for this approach. To date, there has been little evidence available to support our assumption that integration leads to positive impact." She emphasized another key finding as well. "In the Family Planning and Immunization Working Group, we hear consistently from our immunization colleagues that there's a need to track the impact of family planning integration on immunization programs. I'm glad that this study took this into consideration and that the results demonstrated no negative impact."

A third important point noted by Eber related to the delivery system. In Rwanda, family planning services were co-located within the immunization clinic. This is similar to the efforts within PSI to integrate family planning efforts with child immunization, which have utilized a dedicated provider model, she explained. This offers clients a "one-stop shop," while allowing for careful oversight and supportive supervision of staff. "It is exciting that the model that FHI 360 tested in Rwanda builds on existing infrastructure in terms of same-day, co-located services, as this will support long-term sustainability."

Conclusions and Next Steps

Currently, reaching postpartum women with family planning services through immunization contacts is considered a promising High Impact Practice (HIP) according to USAID.[5] The evidence for promising HIPs is limited, and more information is needed to fully document implementation experience and impact. Stanback, who moderated the session, highlighted that the results from Rwanda will play an important role moving forward in informing work in this technical area.

Key messages from this session were:

- The findings that the intervention increased use of contraception among postpartum women provides important new evidence from a randomized control study that this approach can be successful.
- In addition, evidence that there was no negative impact on immunization services should be disseminated widely including to the immunization community. These findings have the potential to help shape advocacy messages and gain support within the immunization community.
- Process data from the study points to the need for adequate and ongoing training, supportive supervision, and stakeholder involvement including among Ministry of Health officials.
- Programs may need to adjust messages delivered to clients to lead to a larger effect on perceived susceptibility and other HBM perceptions, which would in turn increase the impact of this type of integrated service. In particular, messages should attempt to reduce misperceptions associated with the relationship between return of menses, breastfeeding status, and initiation of a family planning method in the postpartum period.

5 The HIP reads: "Offer family planning services to postpartum women (up to 12 months after birth), such as screening women during routine child immunization contacts." USAID. High Impact Practices in Family Planning, November 2011. Available at: http://transition.usaid.gov/our_work/global_health/pop/publications/docs/high_impact_practices.pdf

Postpartum Family Planning: *Voices of Experience*

The meeting ended with a panel of experts who synthesized ideas and programmatic priorities about postpartum family planning. Shawn Malarcher of USAID facilitated the discussion; panelists were Jeff Spieler of USAID, Mary Lyn Gaffield of WHO, and John Stanback of PROGRESS. Others from the audience added important comments throughout the day.

"We've been working on increasing access to postpartum family planning since the early 1990s. Why hasn't it stuck? We know the postpartum period is the greatest missed opportunity when demand is high, risk is high, and we have lots of contact.... Today, we learned that pregnancy tests might help, costing only about 60 cents to ensure service to each woman who would have been turned away. The cost of denying a contraceptive method is huge compared to the cost of these tests. And, we were reminded from the postpartum IUD study about the critical importance of champions."

Jeff Spieler,
USAID

"The finding from the Rwanda study that offered family planning services at immunization clinics is an important step that can bolster efforts to integrate services. Today's discussion also highlighted that we must continue to find ways to address the troubling medical barrier of requiring a woman to be menstruating before providing contraception."

John Stanback,
FHI 360/PROGRESS

Closing panel (L to R): Jeff Spieler, USAID; Shawn Malarcher, USAID (moderator); John Stanback, FHI 360/ PROGRESS; and Mary Lyn Gaffield, WHO.

"WHO leadership has recently taken notice of family planning at the London Summit and in other channels. And, the postpartum perspective is an important element of this. We are working with USAID and other partners to develop guidance on programmatic issues related to postpartum family planning. The research reported today on menses return will be helpful for the guidance document. Also, the presenters today provided good detail on the interventions. This is helpful for programmatic guidance, to see clearly what the intervention is."

Mary Lyn Gaffield,
WHO

"Knowing the difference in a planned intervention and how it was carried out is the level of detail that we need to focus on. It shows us the programmatic importance of research."

Jim Shelton,
USAID

"Transition to another method should be part of clear LAM guidance. There is no requirement that the user practice LAM until the very last moment. She can transition at any point. The process of following LAM can be helpful for initiating use of postpartum family planning."

Victoria Jennings,
Institute for Reproductive Health

"At the meeting today, we're seeing more research to practice, taking lessons from research and focusing on the context in which programs can make them stick more broadly. But we still need to understand why we haven't made more progress."

Trish MacDonald,
USAID

"The dialogue during the day between researchers and the programmatic community was gratifying. This has been an exciting day. We are making great progress, but we need to include our maternal health colleagues in this dialogue on postpartum family planning."

Shawn Malarcher,
USAID

PROGRESS
IN FAMILY PLANNING

Postpartum family planning activities cut across all aspects of the PROGRESS project design, which focuses on: maximizing human resources and reducing medical barriers, expanding service delivery options and opportunities, and expanding the contraceptive method mix. USAID and PROGRESS hosted the July 19, 2012, meeting in Washington as the project approaches the end of the five-year award (2008-13). The objectives of the meeting were to share PROGRESS research findings, provide an opportunity for others working in the field to discuss the findings, and to share strategic priorities and lessons among USAID partners on next steps for postpartum family planning.

The planning team for the meeting included from PROGRESS: Bill Finger, Maggwa Ndugga, Kate Rademacher, John Stanback, and Trinity Zan. FHI 360 researchers who presented findings from the PROGRESS studies were Drs. Aurelie Brunie, Lisa Dulli, Theresa Hatzell Hoke, and John Stanback. Shawn Malarcher of USAID coordinated the planning process with the PROGRESS team.

In addition, PROGRESS appreciates the important contributions made by partner organizations in planning and participating in the meeting. Discussants for the four presentations worked with PROGRESS staff prior to the meeting and added important insights about programmatic implications of the research findings in their comments. The discussants were: Halida Akhter, Evidence to Action project; Holly Blanchard, Jhpiego/MCHIP; Maxine Eber, PSI; and Trish MacDonald, USAID. Malarcher of USAID facilitated a closing panel of experts in the field, who discussed the issues together prior to the meeting and added keen thinking during their closing comments. The panelists were Mary Lyn Gaffield, WHO; Jeff Spieler, USAID; and John Stanback of FHI 360/PROGRESS. This collaborative effort among USAID, FHI 360, and partners was essential for the success of the meeting.

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Postpartum Family Planning: Key Resources from PROGRESS Meeting

Postpartum Family Planning, PROGRESS Research Findings and Next Steps. Meeting, Washington, D.C., July 19, 2012. Meeting agenda with PowerPoint slides available at:

http://fhi.org/en/Research/Projects/Progress/GTL/Mtgs/PPFPmeetingJuly2012.htm

Statement for Collective Action for Postpartum Family Planning. WHO, USAID, and other partners have developed this as part of the efforts to highlight operational guidance for postpartum family planning. 2012. Available at:

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Strengthening Health System Response: No Opportunity Missed. Produced for the 2012 London Summit on Family Planning, this technical brief emphasizes the importance of reaching women in the postpartum period with family planning services. 2012. Available at:

http://www.who.int/reproductivehealth/topics/family_planning/policybriefs/en/index.html

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