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Family Planning for Postpartum Women: Seizing a Missed Opportunity

- ***Postpartum women have a high unmet need for family planning (FP).***
- ***Health services often pay little attention to postpartum care, including FP.***
- ***Women who are breastfeeding have special needs when selecting a FP method; however, in the right circumstances, all methods of modern contraception may be used.***
- ***The goals of a postpartum FP program are to: reduce unmet need; improve contraceptive choice; promote optimum health for both mother and baby through breastfeeding; encourage birth spacing of three to five years; and integrate FP with other maternal health and newborn services.***
- ***Contraception is the primary method of reducing mother-to-child transmission of HIV.***

The Postpartum Period: The postpartum period has traditionally been understood as the first six weeks after the birth of a child. By six weeks the woman's body has largely returned to its pre-pregnancy state. Family planning programs, however, need to focus on the "extended postpartum period;" i.e., the first six months after birth. By six months a woman's fertility is likely to return even if she is exclusively breastfeeding.

Contraception is critical for postpartum women: Demographic and Health Survey data show that very few women (3%-8%) want another child within two years after giving birth; 40 percent of women in the first year postpartum intend to use a FP method but are not doing so. Use of FP by women who do not wish to become pregnant helps:

- Reduce unwanted pregnancies and possible resulting deaths;
- Prevent pregnancies at the extremes of reproductive age, when risk of maternal and infant mortality is greatest;
- Enable women to space their births three to five years apart thus optimizing the health and survival prospects of women and infants, and among HIV-positive women;
- Reduce the number of cases of mother-to-child transmission of HIV/AIDS.

Appropriate method mix: The Lactational Amenorrhea Method (LAM) is a first-line (albeit short-term) contraceptive method for postpartum women. If a woman who is fully or nearly fully breastfeeding has not resumed her period and is less than six months postpartum, she is 98 percent protected against becoming pregnant. In addition to its benefit in delaying subsequent pregnancy, breastfeeding also contributes to improved child survival. If any of the three criteria for using LAM changes, however, the woman is no longer adequately protected, even if she continues breastfeeding. Breastfeeding does not and should not preclude initiation of another modern contraceptive method. The transition to another or additional contraceptive method can occur at any time following delivery whether or not a woman is breastfeeding and whether or not she is practicing LAM. The choice of most appropriate method largely depends on timing, as illustrated in the following table.

Contraceptive methods appropriate in the extended postpartum period for breastfeeding women

First-choice methods do not interfere with breastfeeding and are safe to use any time after birth.	Second-choice methods contain the hormone progestin. These methods do not affect a woman's milk supply. However, to avoid any risk, **it is recommended to wait six weeks after delivery** before using a progestin-only method. This is not an absolute requirement.	Third-choice methods contain the hormone estrogen, which can reduce a woman's milk supply. Women should be informed of this risk and advised to **delay the use of such methods until six months postpartum**.
• LAM • Condoms • Diaphragm • IUD (nonhormonal) (see note) • Vasectomy • Tubal Ligation	• Mini-pill • Progestin-only injectables (such as Depo-Provera®) • Implants (such as Norplant®)	• Combined oral contraceptives • Combined injectables • Contraceptive patch • Vaginal ring

Note: If performed by a specifically trained and experienced provider, postpartum IUD insertion within 48 hours after delivery is safe and convenient, with no increased risk of infection, perforation, or bleeding. The major disadvantage of postpartum insertion is a somewhat higher expulsion rate. Expulsion rates following postpartum IUD insertion are lowest when the IUD is inserted within 10 minutes after the expulsion of the placenta, when a copper IUD rather than an unmedicated IUD is used, and when the provider is skilled and experienced and places the IUD correctly, high in the fundus (World Health Organization, 2005 #37; World Health Organization, 2004 #38; Grimes et al., 2004 #9).

Implementation issues: Research has documented the advantages of an integrated approach to service delivery. Where FP services have been integrated with postpartum services, acceptance rates have been high. For example, in Santiago, Chile, where community health workers supported clinic efforts through home visits and group sessions, a high percentage of postpartum women chose modern contraceptives, with continuation rates of 96 to 100 percent at the end of one year.[1] In Honduras, when hospital-based staff were trained, equipped and provided materials, and began offering FP counseling and services to postpartum women prior to discharge from hospital, the proportion of women who received information about contraceptive methods during their postpartum hospital stay increased from 43 to 87 percent; the proportion of women who received a contraceptive method during their stay increased from 10 to 33 percent.[2] Similarly, in Russia when midwives began offering postpartum FP services prior to discharge from hospital, acceptance of modern methods rose from nil to 66 percent.[3] Where FP and other services were linked, levels of contraceptive use also typically increased.[4] A study in Togo demonstrated that telling mothers about FP services when they brought their children for immunizations increased awareness of FP services from 40 to 58 percent, and the average monthly number of new FP clients rose by 54 percent.[5]

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