Importance of postpartum family planning within country maternal and newborn health acceleration plans

Welcome to Cape Town! This tool is designed to inform your efforts to integrate postpartum family planning as an integral part of your maternal and newborn health acceleration plans for Ending Preventable Maternal Mortality and the Every Newborn Action Plan.

The EPMM and ENAP agendas call for countries to set ambitious targets for equitable reduction of maternal and newborn mortality, and stillbirths. Women's ability to make reproductive and fertility decisions critically impacts on their country's MNH results. This is reflected as a core part of EPMM under Target 5. Healthy timing and spacing of pregnancies, including preventing interpregnancy intervals that are too short, reduces both newborn mortality and stillbirths. PPFP and promotion of healthy timing and spacing of pregnancies also seeks to address risks associated with maternal age and parity, which compound the risk to newborns are adds mortality and morbidity risks for the mother. Respectful client-centered care minimizes client discomfort in the PPFP integration process and offers clinical methods, such as postpartum IUDs or implants, as soon after the birth as the mother and baby's condition allow, as opposed to as a separate procedure or a return visit.

The argument for PPFP is clear. This conference and the joint EPMM and ENAP actions focus on the timing of birth and close to birth, so we emphasize those critical timepoints in this brief. Specifically, the Immediate Postpartum Family Planning (iPPFP) High Impact Practice (HIP) brief starts with a theory of change for how the practice leads to desirable outcomes. Below, the HIP theory of change is reframed within the context of EPMM and ENAP.

Reduction in maternal morbidity and mortality

Barriers	High impact Practice	Service Delivery Changes	Benefits for postpartum women	Outcomes	
Health staff bias & lack of knowledge, skills, & support	Offer contraceptive counseling & services as part of facility- based childbirth care prior to discharge from the health facility	National guidelines updated & distributed	Improved understanding & contraceptive options during postpartum period	Increased use of PPFP	**Reduction in newborn mortality & stillbirths**
Methods & supplies not conveniently located		Maternity staff trained & supported to councel & provide methods	Increased social support for PPFP use	Reduction in closely spaced pregnacies	
Clients concerns & limited knowledge about methods		Contraceptives instruments & registers available on the maternity ward		Reduction in unintended pregnacy	
HMIS do not collect or track data on PPFP uptake pre-discharge		Privacy, countinuty of care, & client flow improved			
Sociocultural & gender norms & attitudes		Linkages to community programs strengthened			

PPFP Theory of Change adapted from the High Impact Practice Brief (https://www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning)

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Systematic integration of services...

... along the continuum of maternal, newborn and child health care empowers women and their partners to consider and voluntarily choose postpartum family planning. Evidence shows a direct link between the proportion of women who receive counseling and the proportion who choose a PPFP method during any given visit and those who are contracepting within that critical year after birth. Centering the needs of pregnant and birthing adolescent girls and people with other gender identities may require additional evidence, but there is no reason to believe that they will not benefit from more counseling opportunities.

EPMM Milestone 1: PPFP in MNH and FP Policies

EPMM and ENAP Milestone 1 involves policies and plans. Systematic integration along the continuum of care needs to be reflected in policies and plans. Programs should monitor policy implementation.

EPMM Milestone 2: PPFP Integral to MNH Quality of Care

See the World Health Organization's www.qualityofcarenetwork.org to find practical resources on how countries have defined quality aims for integrating PPFP at the time of birth and how they apply cycles of quality improvements.

Furthermore, PPFP counseling should be respectful, especially for adolescents and unmarried pregnant people, and consider clients' health literacy, ensuring information is delivered in a manageable, understandable manner.

EPMM Milestone 3: Data for Action

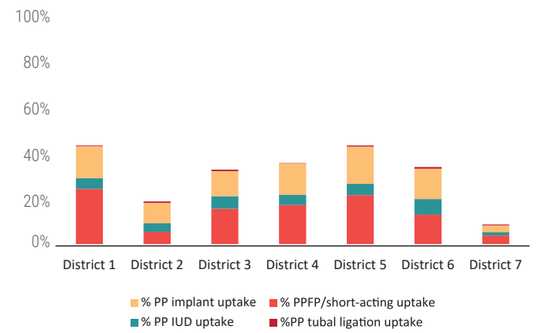
Many countries have integrated PPFP into their health information systems in the last 10 years. If your country has not yet done so, please consider aligning with global indicator recommendations.

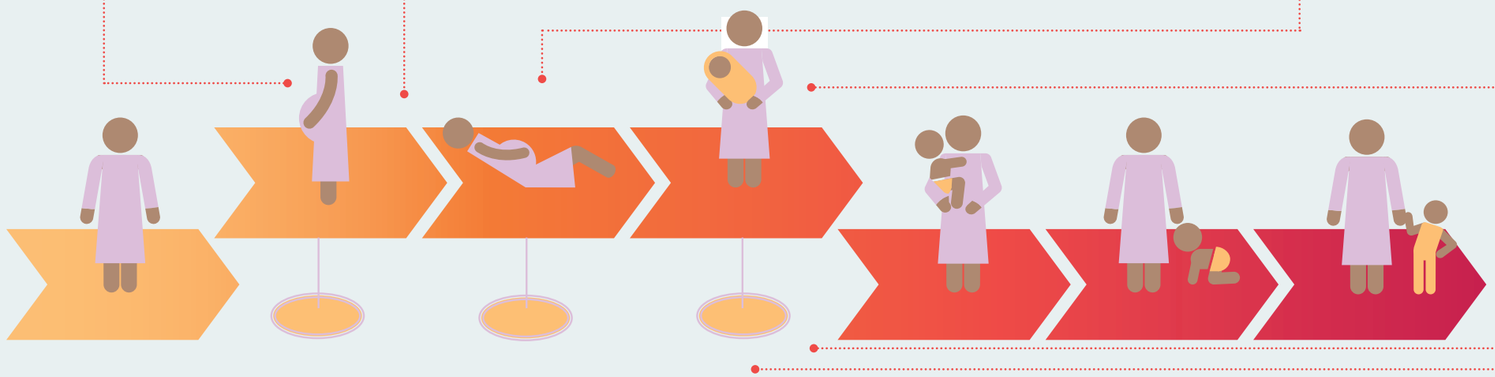
The PPFP Community of Practice recommends collecting, at a minimum, PPFP prior to discharge after facility delivery. This measure is clearly defined and actionable because it can be divided by number of deliveries to obtain a coverage indicator: % of women who deliver in a facility initiate or leave with modern contraceptive before discharge.

How data is collected: some countries have integrated data in MNH registers and others into FP registers. The postpartum timing is often different. In any case, linking PPFP data with birth denominator (within a facility or catchment area) provides actionable information about coverage, which is not available from indicators on numbers without a denominator.

Data visualizations helps with interpretation across geographic areas or target populations to indicate where more attention is needed.

Immediate PPFP uptake by type of contraceptive method





Pre-Pregnacy | Antenatal Care | Birth | PNC visits | BF Support first 6mo. | Infancy 6+ mo. | Well and sick child visits

Pregnacy | Neonatal period | Post-neonatal - 1st and 2nd year

PPFP begins in pregnancy!

Counseling during this time helps pregnant people and their families understand that ovulation can return before their menses and what their options are to prevent another pregnancy too soon.

This requires the health system to:

- Ensure PPFP counseling during every antenatal care (ANC) visit
- National guidelines ensure PPFP counseling during ANC
- Clarify role of service providers
- Manage workloads of ANC providers
- Record client's choices in:
  - Client-held cards/records
  - Facility ANC records (registers or client cards)
- Support task-sharing with community-based or lay providers to reinforce
- Engage communities, first-time young parents and other marginalized groups
- Partner engagement (and family) if present and pregnant person desires them to join counseling

Time of birth is ideal for PPFP integration!

People delivering in facilities who are counseled on PPFP had a higher chance of using PPFP 12 months later.

Integration at time of birth requires:

- Counseling for every mother!
- National guidelines mandate pre-discharge PPFP counseling and services in maternity
- Clarify role of labor and delivery service providers
- Manage workloads of labor and delivery providers
- Offer a broad method choice
- Reminders about opportunities in later MCH visits if they are not ready (reinforcing PNC, immunization, and well-child visits)
- Partner engagement (and family) if present and birthing person desires them to join counseling
- Services on demand when mothers choose a method
- Maternity providers trained in FP, including postpartum IUDs and implants
- Entire maternity staff engaged (even cleaners!)
- Availability of contraceptive commodities, consumable supplies, and instruments in maternity/postnatal wards
- Data recording and reporting tools
- Take-home materials about the method chosen or to encourage further couple communication

Although postnatal care (PNC) return visits have low coverage, experience shows the uptake for PPFP is high when services are integrated.

Integration during PNC requires:

- Counseling every postnatal mother, whether she returns to a facility or is visited at home
- National guidelines ensure PPFP counseling and services during PNC
- Offer a broad range of methods
- Reminders about opportunities to integrate in later MCH visits (reinforcing follow-up PNC, immunization, and well-child return visits)
- Partner engagement (and other family) if present and postpartum person desires their involvement in counseling
- Data recording and reporting tools link to call out box
- Take-home materials about method chosen or to encourage further couple communication

EPMM Milestone 4: Investment or Financing Issues Related to PPFP

In the context of universal health coverage, the health financing landscape is evolving with no single model across countries. Perspectives to explore include:

- Facility administrators and providers (who must recover their costs for MNH care and PPFP services)
- Payers such as governments whose policy is to offer maternity and other MNH services at no cost to clients with or without national health insurance schemes
- Private or subsidized insurers
- Clients and their families

To ensure equitable access to quality integrated services, there are many regulatory issues for covering PPFP in the same visit as childbirth or PNC. Clients and families, especially those in lower quintiles of wealth, may decline or delay PPFP services for costs, but this may actually be more costly to the health system as a whole if it leads to rapid repeat pregnancies and maternal and newborn complications associated with these higher risk pregnancies. Expecting clients and families to pay for PPFP at the time of birth takes second or third priority to managing care for mother and newborn.

Financing issues can be thorny especially in private sector facilities where the financial incentives for integration are poorly aligned. Public sector burdens shift as clients and families opt for private sector services, but policy-makers may consider schemes to better align private sector incentives to integrate PPFP to ensure that burden is not shifted to later pregnancies and births.

EPMM Milestone 5: Health Workforce

As noted, scopes of practice or job descriptions for providers of ANC, childbirth, and PNC should clearly include PPFP across the continuum of care, with strong competencies for supporting counseling, balancing shared decision-making with ensuring clients, including adolescents, feel empowered to exercise their rights to make sexual and reproductive health decisions.

In addition, pre-service education curricula for nurses, midwives, doctors, and other labor attendants should cover key PPFP topics, including physiological mechanism for lactational amenorrhea, the return to fecundity in the postpartum period, medical eligibility criteria, and contraceptive counseling and service delivery.

EPMM Milestone 6: Commodity Management in Context of Integrated Service Delivery

Client-centered care principles encourage offering birthing people PPFP at the same time as immediate postnatal care rather than as a separately schedule "procedure," especially if antenatal counseling has been completed and contraceptive and method choice assured. Thus, contraceptive commodities should be available in labor and delivery (especially long-acting and reversible contraceptives) and/or postnatal wards. Policies and pharmacy protocols need to ensure contraceptive commodities for 24-hour service provision in maternity facilities.

Postpartum IUDs are a "best buy" in terms of cost per couple-years of protection, but long Kelly forceps (unless the country has a reliable supply of IUDs with long inserters) are key to quality care in the post-placental and immediate postpartum time frame. Budgets for maternity facilities should include procurement lines for these instruments.

Checklist for PPFP integration

As you gather for the IMNHC 2023 and formulate ideas and plans for how you take lessons back to your country and renew efforts to align, accelerate, and save maternal and newborn lives, please include integration of postpartum family planning.

Consider using the questions below to start a conversation. Does your country have:

- ☐ Policies to integrate PPFP into MNCH services along the continuum of care?
- ☐ Strategies to improve facility readiness to offer PPFP integrated with MNH services?
- ☐ ANC, maternity, and PNC guidance and care protocols that clearly incorporate PPFP?
- ☐ Quality of care guidelines and tools that incorporate the World Health Organization approach and standards, including the PPFP quality aims and measurement tools?
- ☐ Globally recommended PPFP indicators as part of the health management information system?
- ☐ Health financing schemes that remove cost barriers for clients to access immediate PPFP at the time of a facility birth or a PNC visit in both public and private sector facilities?
- ☐ PPFP competencies in maternity health workers' scopes of practice and pre-service education requirements?
- ☐ PPFP information and education integrated into community health strategies, community health worker tasks and scopes of practice, tools, and materials?
- ☐ Contraceptive and related commodity forecasting and supply management that allow for pre-positioning stocks in maternity areas for 24/7 access?

Unless you have ticked every box, please advocate for your country's MNH acceleration plans for EPMM/ENAP to include addressing the gaps identified and take PPFP to scale.

PPFP contributes to both maternal and newborn outcomes—no missed opportunity for integration! PPFP is MNH business!

Join TOGETHER with your family planning colleagues to scale up PPFP so that every mother and baby benefits!

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