



Leveraging Antenatal Care to Increase Uptake of Postpartum Family Planning A Key Time for Counseling

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Background

Prevention of unwanted and closely spaced pregnancies substantially reduces maternal, infant, and child mortality (Ahmed 2012; Cleland et al. 2012). Postpartum family planning (PPFP) plays an important role in strategies to prevent these pregnancies in the first year after childbirth. The World Health Organization (WHO) recommends the integration of family planning (FP) as an essential component of antenatal care (ANC) and care after birth or abortion (WHO 2012; WHO 2016). Opportunities to integrate FP information, counseling, and services exist throughout the health system—at both the community and facility levels and across the continuum of pregnancy, birth, and postnatal care. ANC is an ideal platform for FP education and counseling because ANC clients interact with health care providers on a regular basis throughout pregnancy and can prepare to initiate an FP method after childbirth. Although providers have often neglected this window to increase demand for PPFP, the new WHO recommendations offer an opportunity to make FP education and counseling during ANC a higher priority.

Antenatal care offers valuable opportunities to counsel clients on family planning.

Effects of Family Planning Integration during Antenatal Care

Recent reviews of interventions to provide effective care during pregnancy and to improve PPFP in low- and middle-income countries suggest that repeated FP counseling during ANC increases uptake of PPFP (Cleland, Shah, and Daniele 2015; Hodgins et al. 2016). In a systematic review examining care during pregnancy, Hodgins et al. (2016) note that “there is documented program experience from a wide variety of settings for increased rates of postpartum family planning achieved through antenatal counseling” (p. 50). The authors suggest that FP counseling during pregnancy is particularly appropriate for populations in which women tend to have short birth intervals.



A midwife leads a prenatal care talk for a group of pregnant women in Ethiopia.

Photo by Karen Kasmauski/MCSP

Cleland, Shah, and Daniele (2015) found evidence from several countries that multiple FP counseling sessions during ANC led to large increases in postpartum contraceptive use, whereas single, short counseling sessions had no impact. Recently published studies also support the idea that brief sessions alone might not be sufficient to affect PPFP behaviors. In India, one study found no association between discussion of FP during an antenatal visit from a community health worker and uptake of PPFP (Rajan et al. 2016). In Tanzania, inclusion of a 10-minute FP counseling session during ANC increased women’s intention to use FP, but not their actual use of a method after birth (Keogh et al. 2015). Cleland, Shah,

and Daniele also note that combined antenatal and postnatal interventions had a sizeable positive effect on contraceptive use during the first year postpartum, concluding that, ideally, FP counseling and services should be included throughout the reproductive continuum of care. This conclusion underscores the importance of integrating FP during ANC, care at the time of birth, and later contacts to help close the gap between intention and behavior. Because more women receive ANC than postnatal care, ANC is a valuable time for FP counseling. In turn, increasing the frequency of attendance at ANC can increase the odds that women will receive counseling on FP and other important health topics.

WHO 2016 Antenatal Care Recommendations: Implications for Family Planning

As ministries of health, technical working groups, and maternal and child health programs and advocates adopt and disseminate WHO's 2016 guidance on ANC—*WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience*—they will need to promote and implement FP counseling as an essential element of ANC. The recommendations for health systems include increasing the number of ANC contacts, improving communication and support for pregnant women and their families through community-based interventions, and task-shifting components of ANC across a range of cadres. Implementation of these recommendations will enable greater inclusion of FP counseling during ANC. In addition, WHO's recommendation that pregnant women carry their own case notes supports better PFP communication and documentation.



In Mozambique, a community health worker trained on nutrition and family planning meets an expectant mother for a counseling discussion.

Photo by Kate Holt/MCSP and Jhpiego

The increase in the recommended number of ANC visits from four to a minimum of eight means that there are more contact points for discussing healthy timing and spacing of pregnancies, return to fecundity after birth, and safe and effective contraceptive choices for postpartum women. Community-based interventions such as community mobilization and antenatal home visits provide opportunities for FP education and counseling, including counseling on return to fertility within the context of breastfeeding.

For women who deliver at a facility, the immediate postpartum period, before discharge, is another critical window during which the provider can counsel the woman on FP, initiate her method of

choice, and link her to follow-up FP services. Too often, women and couples wish to start a method soon after birth but leave the facility without getting their desired method, leading to a gap between intention and practice. In some cases, women and families, and sometimes providers, are not aware of or informed about the availability and safety of FP methods in the immediate postpartum period. In other cases, women want time to consult with their partners before making a decision. Discussion of FP during ANC helps women and couples decide on a method in advance, making it more likely that they obtain their chosen method, especially if the facility offers it at the time of birth. The new WHO recommendations endorse task-shifting the promotion of FP and other health behaviors across cadres, including doctors, midwives, nurses, auxiliary nurses, and lay health workers, to improve access to key interventions.

Finally, documentation and routine monitoring of PFP can provide important information for improving services. If systems are in place to capture women's contraceptive choice and plan during ANC and to coordinate with maternity providers for services, FP integration during ANC can strengthen PFP on the day of birth. The WHO-recommended woman-held health records provide an additional way to collect information about FP choices and improve communication and continuity of care.

Key Considerations

The new WHO recommendations for ANC highlight important opportunities to introduce and reinforce PPFp counseling and to document PPFp. Greater frequency of ANC contacts is achievable through a mix of facility and community or home visits. Countries can determine the best routes for PPFp counseling, based on their country context.

Service Delivery Interventions

Suggested antenatal and postnatal care interventions to improve PPFp uptake include the following:

- Incorporate client-centered PPFp discussions during ANC, providing FP counseling and information on healthy timing and spacing of pregnancies and return to fecundity.
- Establish a plan with the client, during ANC and before 36 weeks' gestation, for how she and her partner wish to address their postpartum FP needs.
- Document the woman's PPFp method choice—for example, through a notation or stamp on her health care record, her ANC chart, or her own record—so her maternity provider can confirm and prepare to provide her PPFp choice or encourage her to obtain the method when she returns for a later visit, such as for postnatal care or immunization.
- Coordinate with maternity facilities and referral networks to ensure that they are able and ready to provide PPFp methods before a woman's discharge from the maternity.
- Integrate FP follow-up with other postnatal care components for mothers and infants, such as breastfeeding support, nutrition, newborn care, and immunization.



A PPFp stamp records a woman's method choice on her ANC chart.

Policy and Program Considerations

- Develop or update national ANC policies and guidelines to promote FP counseling during ANC and to specify which cadres can provide which PPFp methods at each level of the health system.
- Update national policies and training curricula to reflect the postpartum contraception recommendations in the latest edition of the *Medical Eligibility Criteria for Contraceptive Use* (WHO 2015), which now allow for initiation of most progestin-only hormonal contraceptives (implants, progestin-only pills, and hormonal intrauterine devices) immediately after delivery for breastfeeding women.
- Build the capacity of providers through pre- and in-service training, supportive supervision, mentoring, and reinforcement of skills (in particular for provision of long-acting and permanent methods) to ensure the availability of high-quality services.
- Conduct and support quality improvement efforts to identify and overcome barriers to the provision of FP counseling during ANC and subsequent uptake of PPFp.
- Disseminate counseling materials and job aids for providers that are adapted to the local context.
- If feasible, adjust facility registers to routinely measure PPFp outcomes and track key indicators, such as the proportion of ANC clients receiving PPFp counseling and the proportion of women who initiate a modern contraceptive method before discharge.

Family Planning Counseling Tools

Balanced Counseling Strategy Plus (BCS+) Toolkit

Providing Long-Acting Reversible Contraception Learning Resource Package: Counseling Module

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