Importance of Postpartum Family Planning* for Maternal and Child Health

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A review of evidence submitted at a technical consultation by USAID to a WHO technical panel led to the panel’s conclusion that short pregnancy intervals following a live birth were associated with adverse maternal outcomes – specifically, maternal mortality, induced abortion, still births and miscarriages- and adverse perinatal outcomes-specifically, preterm birth, small for gestational age and low birth weight. The technical consultation resulted in a WHO policy brief\(^1\) which included the recommendation to wait at least 24 months (a birth-to-pregnancy interval of 24 months equivalent to a birth-to-birth interval of 33 months) after a live birth, before attempting the next pregnancy to reduce health risks for the mother and the baby.

For the past decade, the WHO has upheld three evidence-based recommendations related to healthy timing and spacing of pregnancy (HTSP):

- After a miscarriage or induced abortion wait at least 6 months before attempting the next pregnancy to reduce health risks for the mother and baby
- Women should delay their first pregnancy until at least age 18.

HTSP promotes informed decision making about delaying, spacing or limiting pregnancies for the healthiest outcomes for the mother and the baby. HTSP helps women bear children at healthy times in their reproductive lives. HTSP is a family planning investment strategy for accelerating the pace of improvements in child survival. A U.S. Agency for International Development (USAID) analysis found that if all birth-to-pregnancy intervals were increased to three years, 1.6 million under-5 deaths could be prevented annually.

This article focuses on the first recommendation related to postpartum family planning – i.e., pregnancy spacing after a live birth.

The physiological postpartum period is six weeks. In family planning, the postpartum family planning (PPFP) period is the first year/the first 12 months following a birth. It is also called the extended PP period. PPFP is the initiation and use of FP during the first year after a delivery. The first year is an important time for both mothers and

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\(^1\) WHO 2006 Policy Brief on Birth Spacing-Report from a WHO technical Consultation WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe
*The term birth spacing is used in Myanmar
Method for PP Exclusively Breastfeeding Women

**Immediate postpartum:** LAM (first 6 months); IUD (post placental: 10 minutes after placenta delivery; immediate postpartum: within 48 hours after delivery; intraccesarean: during cesarean section; interval/delayed postpartum: 4 weeks after delivery or six weeks and after); postpartum tubal ligation (first 48 hours ideally or first seven days); new woman-initiated methods: progesterone vaginal ring (PVR); SILCS contoured diaphragm (CAYA); Amphora non-hormonal gel; new Woman’s Condom; vasectomy and condoms

**Six weeks postpartum:** Progestin-only methods; Implants

**Six months postpartum:** Combined pills and injectables

Method for PP Non-Breastfeeding Women

**Immediate:** IUD, Implant, Progestin-only methods, tubal ligation (first seven days), vasectomy and condoms

**Three weeks postpartum:** Combined pills and injectables

Based on an analysis of DHS data from 27 countries, 65% of postpartum women do not want to have another child in the next two years, but only 35% are using a FP method. A 2012 Statement for Collective Action for Postpartum Family Planning issued by USAID, Australian AID, WHO, UNFPA, Gates Foundation, The World Bank, IPPF and FIGO calls for “all programs that reach postpartum women during the first year following a birth to integrate postpartum family planning counseling and services into their programs.”

Postpartum FP counseling should include: information on return to fertility; return to sexual activity; breastfeeding; messages for healthy timing and spacing of pregnancy (HTSP); and postpartum family planning options including lactational amenorrhea method (LAM). It is critical to expand the range of PPFP options available.

Substantial evidence indicates that a restricted choice of contraceptive methods has constrained the opportunity of individual couples to obtain a method that suits their needs, resulting in lower levels of contraceptive prevalence. Appropriate FP methods for PP breastfeeding women can be given immediately after delivery, 6 weeks after delivery or 6 months after delivery. For non-breast feeding babies, because this is the time when women are most vulnerable to a closely spaced pregnancy. This happens because many postpartum mothers do not know they can get pregnant again before the menses return (Return to Fertility RTF). Research shows women did not believe they could get pregnant before menses return; some health care workers also may not know. Exactly when a woman can become pregnant after a birth is not predictable. She can become pregnant as early as three weeks after a birth- if she is not breastfeeding; six weeks if she breastfeeds but is not breastfeeding exclusively; and six months if she is breastfeeding exclusively. Pregnancies occurring within six months of the last delivery holds a 7.5 fold increased risk for induced abortion and a 1.6 fold increased risk of still birth.²


² Da Vanzo J et al.2007. Effects of inter-pregnancy interval and outcome of the preceding pregnancy on pregnancy outcomes in Matlab, Bangladesh BJOB 114(9):1079-1087
women, appropriate FP methods can be provided immediately after delivery, and oral contraceptives can be given as early as 3 months after delivery. Several new woman-initiated methods and non-hormonal methods are now available and should be discussed.

Family planning can avert more than 30% of maternal deaths and 10% of child mortality if couples spaced their next pregnancy at least two years apart after a live birth (a birth-to-pregnancy interval of 24 months). We need to: raise awareness of family planning needs for postpartum women and the importance of postpartum family planning; ensure there are no missed opportunities across the continuum of care; maximize community based care; and expand the range of postpartum family planning options available.

We need to see family planning as an investment strategy for improving the health and wellbeing of mothers and children, and as an investment strategy for sustaining and accelerating the pace of improvements gained in child survival.