

International Seminar on
Promoting Postpartum and Post-Abortion Family Planning:
Challenges and Opportunities

Cochin, India, 11-13 November 2014

Seminar Report

An estimated 222 million women in low and middle income countries would like to delay or stop childbearing but are not using any method of contraception. Given the impetus provided by Family Planning 2020 (FP2020) to enable 120 million more women and girls to access modern contraceptives by 2020, it is urgent to identify women in need, better understand the obstacles they face in accessing contraceptive services and their preferred methods, and recommend actions to accelerate meeting their contraceptive needs. Among women and girls with an unmet need for family planning are those who have recently given birth or undergone an abortion. Yet, in many settings, women are not using any contraceptive methods following childbirth or abortion, and the reasons for this low use are not well understood. At the same time, effective postpartum family planning programmes are lacking, and the provision of post-abortion family planning (PAFP) services has been seriously neglected in several countries. Despite their strategic importance, topics related to postpartum and post-abortion family planning have received relatively little attention.

Against this background, the IUSSP Scientific Panel on Reproductive Health, in collaboration with the Population Council, India, and the Department of Reproductive Health and Research, World Health Organization held a seminar on “Promoting postpartum and post-abortion family planning: Challenges and Opportunities” in Cochin, India, 11-13 November 2014. Financial support for the seminar was provided by the Department of Reproductive Health and Research, World Health Organization; the Wellcome Trust; the David and Lucile Packard Foundation; and the STEP UP Consortium, Population Council.

The seminar brought together 24 scientists, policy makers, and programme managers to present and discuss a range of issues relating to postpartum and post-abortion family planning. A total of 18 papers were presented, including one paper that provided an overview of the evidence base on postpartum and post-abortion family planning in developing countries. The papers were divided among five different sessions: (1) postpartum and post-abortion contraceptive use and unmet need: the big picture; (2) unmet need for postpartum contraception – gaps, opportunities and the way forward; (3) postpartum contraceptive use-dynamics; (4) post-abortion contraceptive use: patterns and determinants; and (5) strategies to promote postpartum and post-abortion contraceptive use. Papers are available to IUSSP members at <http://activities.iussp.org/workingpapers.php>, and the agenda and list of participants are included in the appendices.

Highlights and findings

The papers presented at the seminar sought to answer several key questions pertaining to postpartum and post-abortion contraception, including: (1) how to measure unmet need for contraception in the postpartum period and what is its magnitude; (2) is unmet need for contraception in the postpartum period higher than at other times in women’s reproductive life; (3) what is the optimal time for postpartum contraceptive uptake; (4) what is the extent of postpartum and post-abortion contraceptive uptake; (5) what methods are used by women who initiate contraception post-partum or post-abortion; (6) what is the method use continuation rate among women who initiate use postpartum or post-abortion; and (7) what are some of the barriers to improving postpartum and post-abortion contraceptive uptake and strategies to overcome those?

Unmet need for contraception in the postpartum period

Measuring the magnitude of unmet need for contraception in the postpartum period is important for designing and evaluating postpartum family planning programmes. Currently, three different methods are used or proposed for the empirical measurement of unmet need: (i) the standard Demographic and Health Survey (DHS) method that classifies postpartum amenorrheic women whose last birth was within two years prior to the survey based on the intendedness of their most recent birth (Bradley et al., 2012); (ii) Bradley and Casterline's (2014) intermediate method that classifies postpartum amenorrheic women whose last birth was within six months prior to the survey based on the intendedness of their most recent birth; and (iii) Ross and Winfrey's (2001) prospective method that classifies women who are amenorrheic or still abstaining since the last birth as having unmet need unless they want a child within two years or are using a method. Two papers presented at the seminar (Cleland and Shah, 2014; Rossier et al., 2014) highlight that these definitions have major limitations; specifically, they do not factor in the protection offered by postpartum abstinence (in the case of standard DHS definition and Bradley and Casterline's intermediate definition) and/or lactational amenorrhea (Ross and Winfrey's prospective definition), although many women are wholly or partially protected by these factors in the postpartum period in many settings. These papers compared the magnitude of postpartum unmet need, using these different definitions, and report that the magnitude widely varied. For example, analysis by Rossier and colleagues, using Demographic and Health Survey data from 56 countries from East and Southern Africa, West and Central Africa, North Africa, West Asia and Europe, Asia and Pacific, and Latin America and Caribbean, estimates that 25-36% of women whose last child was less than one year-old at the time of the survey had an unmet need for contraception, as per the standard DHS method. In comparison, 29-50% and 45-75% of postpartum women had an unmet need as per Bradley and Casterline's (2014) intermediate method and Ross and Winfrey's (2001) prospective method, respectively. Cleland and Shah argue that a "current status" approach that restrict measuring unmet need in the postpartum period to non-contracepting women who have resumed menstruation and sex but wish to postpone childbearing for at least two years can capture the current postpartum unmet need better than the definitions currently used; their estimate of postpartum unmet need in 16 countries ranged from 4% to 22%, with an average of 9%. Rossier and colleagues argue for factoring in protection offered by de facto lactational amenorrhea method (LAM) use and postpartum abstinence; and note that postpartum unmet need in the 56 countries that they had included in their study stood around 21%-29%, when these practices were accounted for. These papers conclude that the protection offered by lactational amenorrhea and/or abstinence needs to be taken into account in estimating the magnitude of unmet need in the postpartum period and is consistent with beliefs and practices in many countries.

An important question related to the magnitude of postpartum unmet need is whether unmet need in the postpartum period is higher than at other times. The analysis presented by Cleland and Shah suggests that contrary to the earlier observation by Ross and Winfrey that 65% of all unmet need is concentrated in the first year postpartum, unmet need tends to be lower in the first year of postpartum period than at longer durations when the focus is on women fully exposed to the risk of conception. Moreover, once sex and menstruation have resumed, recently delivered women exhibit no greater reluctance to adopt contraception than those at other stages of the reproductive cycle.

Optimal timing for postpartum contraceptive uptake

The optimal timing of contraceptive uptake is central to meeting a couple's need for protection during the postpartum period and a hallmark for any successful family planning program. Contraception initiated during insusceptible period represents a redundant protection while that started one or more months after resumption of menstruation implies exposure to the risk of conception. In some regards, the optimal time to start use is the month when 'natural' protection ends. The timing of postpartum contraceptive uptake, however, remains poorly understood in developing countries. A number of papers presented at the seminar delved into this topic, using mathematical modelling and empirical analysis of DHS data.

Mathematical modeling by Jain sought to answer the question about the optimal timing for postpartum contraceptive uptake by comparing the relative effectiveness of four contraceptive methods (pill, condom, injectable and IUD) initiated during the postpartum period, i.e., at immediate postpartum, immediately following the resumption of menstruation, and 1-6 months following the resumption of menstruation. Several observations from this exercise are notable: (1) the initiation of contraception in addition to breastfeeding during the postpartum period averted more births than depending on breastfeeding alone and using no contraception; (2) the use of long acting contraception averted more births than other short acting method, and there was very little difference among short-terms methods; (3) postpartum initiation of contraception averted significantly fewer births than its initiation following the resumption of menstruation; and (4) postpartum initiation was less superior to the initiation during the interval period up to a point. The paper argues that from a demographic perspective, the optimal time to provide contraceptive services is to encourage women to breastfeed their children naturally and initiate contraception immediately following the resumption of menstruation or first birthday of the child, whichever occurs first.

An empirical study, using DHS data from 17 countries, by Ali and colleagues shows that one third of contraceptive adopters in the first year postpartum, or post-abortion (induced abortion or \sqrt miscarriage), initiated use during the period of natural insusceptibility, 58% after the return of menstruation or sex, and 9% in the same month as insusceptibility ended. The extent of redundant protection (i.e., using while insusceptible) was much higher (46%) for non-hormonal methods than for hormonal methods (23%). The duration of overlap between natural protection and contraceptive use was on average of nearly eight months for hormonal methods and close to seven months for non-hormonal methods. The authors argue that when continuation of method use is high or the length of breastfeeding and amenorrhea is short, such redundant or double protection matters little. However, short acting methods with low continuation predominated in the countries included in their analysis and therefore, such early initiation is unlikely to have notable effect on postponing pregnancy because of the high probability that the method will be discontinued at the very time when natural protection ceases and the practice of switching to effective methods is low. The authors call for great caution in counselling women to adopt short acting methods early in the postpartum phase in countries where lactational protection is prolonged.

Postpartum and post-abortion contraceptive uptake

Several papers presented at the seminar focused on the extent of postpartum contraceptive uptake, while a few explored post-abortion contraceptive uptake. Several findings are notable. First, in most regions, the postpartum contraceptive uptake in the first year of delivery remains low. Second, wide variations were observed across regions with regard to postpartum contraceptive uptake. For example, a regional analysis presented by Rossier and colleague shows that postpartum contraceptive uptake ranged from 15% in West and Central Africa to 30%-33% in East and Southern Africa, and Asia and Pacific region to 50% to Latin America and the Caribbean. Third, these regional averages mask wide variations across countries. Of the 56 countries included in their analysis, postpartum contraceptive uptake in the first year of delivery was below 10% in seven countries (Benin, Burkina Faso, Guinea, Liberia, Mali, Mozambique and Sierra Leone), while it was 50% or more in 10 countries (Albania, Columbia, Dominica Republic, Egypt, Honduras, Indonesia, Jordan, Peru, Swaziland and Zimbabwe). Interestingly, the countries characterised by low postpartum contraceptive uptake were also characterised by high proportion of women being naturally protected due to postpartum abstinence or de facto LAM use, and vice-versa.

Findings from small-scale studies also reaffirm limited uptake of postpartum contraception. One such study, using longitudinal data from rural Malawi, reports that 28% had initiated a modern method by six months postpartum and 46% by one year postpartum (Dasgupta et al., 2014). Yet another study from urban slums in Nairobi, again using longitudinal data, shows 60% had initiated a modern method by one year postpartum (although 90% had resumed sex and 70% had their menstruation resumed in the first year postpartum) (Mumah et al., 2014).

Trends in postpartum contraceptive uptake were also explored, although for a small number of countries in sub-Saharan Africa (Alva et al., 2014). Findings from this study show that it increased from 11% to 19% in Ethiopia, 26% to 33% in Kenya, 30% to 45% in Malawi, 15% to 21% in Uganda, 18% to 21% in Tanzania over a five-year period. Much of this increase was associated with the increase in use of injectables in most of these countries, except Tanzania.

Although contraception following an induced abortion is highly recommended for preventing another unintended pregnancy and repeat abortion, little is known about globally or regionally on the number of women who adopt contraception following an induced abortion. A few papers presented at the seminar, drawing on facility-based data, shed some light on the extent of post-abortion contraceptive uptake in selected countries (India, Bangladesh and Mexico). Although these data are not exactly comparable as the samples were drawn from facilities in which some intervention models were tested (in the case of study from India and Bangladesh) and from clinics where abortion is allowed in request (in the case of study from Mexico) and the laws regarding provision of abortion services differed in these countries, they suggest country-wide differentials in post-abortion contraceptive uptake. The study from India analysed individual records of some 292,508 women from nearly 2,500 facilities where Ipas implemented a comprehensive abortion care model in partnership with the public sector in six states, and the authors note that 81% of women initiated contraception immediately following the procedure (Banerjee et al., 2014). Another study from Bangladesh, again drawing on 498 women who sought menstrual regulation service or post-abortion care from 16 facilities in which Ipas had trained providers, reports that 72% of women initiated use immediately following the procedure (Pearson et al., 2014). Finally, a study of women who sought abortion services from four facilities in Mexico City shows that 67% of women adopted contraception immediately following the procedure (Olavarrieta et al., 2014). The synthesis of evidence on post-abortion contraceptive uptake presented by Cleland and Shah also suggests variation across countries, depending on the samples used, i.e., population based or facility based samples.

Yet another empirical study, using again DHS data from 17 countries, assessed the cumulative incidence of contraceptive uptake following live births and pregnancy terminations (miscarriage or induced abortions) and reports that the cumulative incidence of contraceptive adoption (prior to conception) by month 12 was 64%, while 8% of women had used no method and conceived while the remainder had also used no method but had not conceived (Ali et al., 2014). This study also notes that country variations in the 12-month cumulative incidence rate of contraception uptake were striking. In sub-Saharan Africa and Maldives, contraceptive adoption was low at 34% or less, while it was highest, at over 70%, in Colombia, Moldova, Morocco and Turkey.

Postpartum and post-abortion contraceptive method-mix

The type of first contraceptive method used postpartum varied across countries. At the same time, a preference towards short-acting methods was apparent, even in settings where long-acting and permanent methods predominated among women in general. The analysis presented by Ali and colleagues show that injectables were the most commonly initiated postpartum/post-abortion method in six of the 17 countries included in their analysis, oral contraceptives in four others, withdrawal in three countries, condoms and IUDs in two countries each. Evidence presented also indicates that postpartum sterilization is uncommon and wide inter-country variations exist in the proportion of sterilizations that are performed immediately or very soon after delivery, even in populations where it is the dominant method (Ali et al., 2014; Cleland and Shah, 2014). For example in India where female sterilization accounted for two-thirds of the total current contraceptive use in married women in general, 60% initiated postpartum contraception with methods other than female sterilization (Paul et al., 2014).

Although reported use of lactational amenorrhea method is rare, analysis conducted by Rossier and colleagues indicates that among women who gave birth in the six months preceding the survey, a substantial proportion of women who did not report using LAM were de facto LAM users – ranging from 22%-24% in North Africa, West Asia and the European region and West and central African

region to 40%-43% in East and Southern Africa region and Asia and Pacific region (Rossier et al., 2014). The authors argue that acknowledging this point is central to the renewal of family planning programmes for the postpartum period, and at the same time, they note the need for informing women about the return of fecundity.

The methods adopted following abortion also reflect a preference toward short-term methods. In India, Banerjee and colleagues in their facility-based study in India found that 66% of users adopted such short-term methods as the condom, the oral pill and the injectable (Banerjee et al., 2014). Likewise in Bangladesh, all women who accepted contraception post-abortion opted for short-term methods, viz., the oral pill followed by the injectable and the condom (Pearson et al., 2014). A study from Mexico City by Olavarrieta and colleagues (2014) also showed a somewhat similar pattern.

Are the current programmes enabling postpartum women to adopt methods they would like to? A longitudinal study from the US sought to answer this question (Potter et al., 2014). The authors note that many more women would have preferred to use a long acting and permanent methods than were using at six months postpartum, and that women may be using less effective methods, which they would rather not be using, for lack of access to a preferred highly-effective method. The synthesis of evidence presented by Cleland and Shah also highlights that method-mixes in many countries, particularly those in sub-Saharan Africa, are not currently conducive to postpartum delivery of sterilization, IUDs or implants because they are dominated by hormonal methods with high discontinuation rates (Cleland and Shah, 2014).

Method use continuation

Very little is known about method use discontinuation and switching among postpartum/post-abortion contraceptive users. Some evidence is presented at the seminar on method use continuation, and suggests that a substantial proportion of women tend to discontinue use within the first year postpartum. Ali and colleagues, in their analysis of DHS data from 17 countries, observe that about 30% of all postpartum/post abortion contraceptive episodes were discontinued within the first 12 months of adoption. Discontinuation of condoms and injectables was particularly high while IUD discontinuation was particularly low. The study also notes that for all methods combined, timing of contraceptive adoption was unrelated to discontinuation. However, among those initiated with injectables, withdrawal and periodic abstinence, discontinuation was lower among women who started use before the end of insusceptibility. When the authors excluded discontinuation due to failure from the analysis, the only method for which a clear association between timing of adoption and discontinuation was injectables for which discontinuation was lowest for women who started use before the end of insusceptibility but, unexpectedly, higher in women who initiated use in the same month than in those who delayed adoption. The authors argue that early adopters were more likely to want to limit family size than later adopters. The study by Mumah and colleagues in urban slums in Nairobi notes that 19% of women discontinued their first contraceptive method by three months postpartum, 31% by sixth month, and 47% by 12th month (Mumah et al., 2014). Condoms, pills and injectables were the most discontinued methods. For example, 50% of women who adopted condoms as a method had discontinued by three months, with the rate reaching 84% by 12 months. Similarly, about 30% of women who had adopted pills had discontinued by three months, with the rate reaching 65% by 12 months. The study further notes that women who adopted after resumption of menstruation were more likely to discontinue than those who initiated use before resumption of menstruation. Overall, majority of women reported discontinuing a method because of method related dissatisfaction (43%), which include side effects and health concerns.

While none of the papers that focused on post-abortion contraception discussed post-abortion continuation rates, Cleland and Shah, based on their review of four published papers, observe that the post-abortion discontinuation rates were found to be lower for traditional than for modern spacing methods. They also note that rural women with low income and education were more likely to discontinue use than others, and women who had an abortion were more likely to discontinue use within 12 months than postpartum women.

Correlates of postpartum and post-abortion contraception

Several papers at the seminar explored the individual and health system-related correlates of postpartum and post-abortion contraceptive initiation, although the analytical approaches used in these studies were not typically able to establish a causal relationship. Better educated women were found to be more likely than their less educated or not educated counterparts to initiate postpartum contraception in India, urban slums in Nairobi and rural Mozambique (Paul et al., 2014; Mumah et al., 2014; Agadjanian and Hayford, 2014). In India, women from urban areas and economically better-off households were also more likely than others to have adopted postpartum contraception (Paul et al., 2014), so were socially connected women in rural Mozambique (Agadjanian and Hayford, 2014).

In several studies, women who had sought maternal and child health services were observed to more likely than others to have used contraception in the first year postpartum. For example, Alva and colleagues in their analysis of five sub-Saharan African countries report that institutional delivery has a positive effect on uptake in the first year postpartum in all five countries, but child immunization was not universally associated with increased uptake – only in three countries. In India too, women who sought antenatal services and institutional delivery were found to be more likely than others to have initiated use in the postpartum period (Paul et al., 2014; Zavier and Padmadas, 2014). Likewise, receiving family planning advice in the antenatal and perinatal periods was positively associated with early initiation of contraception, while patient flow at the facility was inversely associated with it in rural Mozambique (Agadjanian and Hayford, 2014).

Papers presented at the seminar also shed some light on the characteristics of women who are likely to adopt contraception post-abortion. Banerjee and colleagues observe that adult women (25+ year-olds) were more likely than young women (24 years or below) to adopt post-abortion contraception. In Bangladesh, women who experienced physical violence perpetrated by an intimate partner in the year preceding the abortion were less likely than others to have adopted post-abortion contraception (Pearson et al., 2014). Findings from these studies also suggest that post-abortion contraceptive uptake is associated with timing of abortion, the condition for which women sought services from the facility and the type of abortion procedure used, although it is difficult to discern the direction of causation from these studies. Specifically, women who had an abortion in the second trimester were less likely to adopt post-abortion contraception compared to those who had a first trimester abortion (Banerjee et al., 2014). Furthermore, women who visited the health facility for an induced abortion were more likely to have adopted post-abortion contraception than those who sought care for incomplete abortion; so were women who opted for surgical abortion than medical abortion in India (Banerjee et al., 2014). In Bangladesh too, women who had undergone manual vacuum aspiration were more likely than those who had undergone medical abortion to have adopted post-abortion contraception (Pearson et al., 2014). Finally, the papers presented at the seminar suggest that post-abortion contraceptive uptake is also correlated with health system related characteristics, including access to family planning services. The paper by Banerjee and colleagues (2014) suggests that compared to women who had undergone abortion procedure in public sector facility, those who had their abortion in NGO-run facility were more likely to have adopted post-abortion contraception, while those who had their abortion in private facility were less likely to have done so. They also report that post-abortion contraceptive uptake was higher among women who had their abortion in primary care facilities than secondary or tertiary care facilities. Another study from Ghana reports that post-abortion contraceptive uptake was higher in facilities that offered family planning services in the same structures where the abortion services were offered than others (Antobam et al., 2014).

Barriers to postpartum and post-abortion contraceptive uptake

Studies presented at the seminar identified a number of barriers to postpartum and post-abortion contraceptive uptake. As noted by Cleland and Shah, the postpartum phase is regarded as a time of vulnerability for mother and infant, and any perception that use of modern contraceptive methods may be a potential hazard to health acts as a powerful disincentive for early postpartum use. Such misperceptions may include fear that use of contraceptives may cause infertility, and may deter

women, particularly young women who are in the process of family formation (Keesara et al., 2014). Similarly, poor quality of individual counselling; provision of inadequate information; offering limited range of methods due to the lack of competent staff, stock out issues, and provider biases; legal barriers to providing long acting reversible contraceptive (LARC); geographical and cost barriers; and traditional social norms were also identified as barriers to postpartum contraceptive uptake in some settings (Daniele and Filippi, 2014). Also, although reliance on the absence of menses to prevent pregnancy is widespread, accurate information on risks is low, and family planning staff may exacerbate the problem of confusion and delayed initiation of use by insisting on evidence of menstruation before offering methods in some settings (Cleland and Shah, 2014).

Strategies to promote postpartum and post-abortion contraception

The synthesis paper by Cleland and Shah and several others at the seminar explored strategies to promote postpartum and post-abortion contraception. Cleland and Shah note that while some models focussed on providing information only, other combined it with service provision; most were facility based initiatives though a minority were community-based; some intervened during pregnancy, some before discharge from postnatal wards and others at varying times postpartum; and most involved only mothers while a few focussed also on husbands, relatives or community leaders. They conclude that counselling during pregnancy, counselling in the postpartum period with or without provision of immediate postpartum contraception, integration of family planning with immunization and child health services and broader community efforts can all be effective at raising contraceptive use in the months following childbirth, although the current evidence is least positive for antenatal interventions. Several other papers at the seminar also mirrored these observations (Agadjanian and Hayford, 2014; Alva et al., 2014; Paul et al., 2014; Wadhwa and Pillai, 2014; Zavier and Padmadas, 2014)

With regard to strategies for improving post-abortion contraception, available evidence suggests that providing family planning counselling and services to women who seek abortion is encouraging (Cleland and Shah, 2014). Training health care providers in giving comprehensive abortion care and providing them long term post-training follow-up support as well as integrating structures to accommodate provision of both comprehensive or post abortion care and post-abortion family planning within the same structure can be effective (Banerjee et al., 2014; Antobam et al., 2014).

Conclusions

Several conclusions can be drawn from the evidence presented at the seminar. First, strategies for family planning following childbirth need to take account of prevailing behaviours and beliefs. In settings where lactational protection is of short duration, early uptake of contraception, particularly LARC and permanent methods may be promoted. In settings where lactational protection is of long duration, in addition to promoting LARC and permanent methods, counselling women on LAM, including on the risks associated with solely relying on lactational amenorrhea may be considered.

Integration of postpartum family planning services with antenatal and delivery services, as well as with child health programs, i.e. breastfeeding and vaccination programs appears to be the key. However, such opportunities are often missed. Given competing priorities and pressure on budgets and staff, outlining the ideal way of integrating the services is difficult to suggest, and choices have to be made, taking into account the policy, programmatic and cultural context in each country.

Several research gaps remain; for example, how to capture postpartum unmet need precisely? What is the extent of method switching in the year following abortion or delivery? To what extent are the PFP and PAFP needs of such disadvantaged groups as adolescents, the unmarried, HIV-positive women met and what are the barriers in meeting their needs? To what extent are men involved in postpartum and post-abortion contraceptive decisions and what are successful ways of engaging male partners in promoting PFP and PAFP? How to reach women who seek abortion from the private sector and to provide them family planning counselling and services? What is the continuation of use after specific interventions and their impact on birth spacing?

The Panel reviewed and recommended a set of papers for publication in a Special Issue of *Studies in Family Planning*.

Acknowledgements

The IUSSP Panel on Reproductive Health gratefully acknowledges Population Council, India and the Department of Reproductive Health and Research, World Health Organization for co-hosting the seminar; KG Santhya for organizing the seminar, Paul Monet for coordinating the various activities; MA Jose for providing administrative and logistical support; and the Department of Reproductive Health and Research, World Health Organization; the Wellcome Trust; the David and Lucile Packard Foundation; and the STEP UP Consortium, Population Council for the financial support. The Panel also acknowledges the invaluable inputs made by authors of papers, discussants, chairs of sessions and participants of the seminar. This report was drafted by KG Santhya.

IUSSP Scientific Panel on Reproductive Health

Chair: Iqbal H. Shah

Members: John Cleland, Sarah Harbison, Ondina Fachel Leal, K.G. Santhya, Eliya Msiyaphazi Zulu.

IUSSP Council Liaison: Anastasia Gage

References

Agadjanian, V. and Hayford, S.R. 2014. Postpartum contraceptive use in rural Mozambique: individual, household and institutional determinants

Ali, M.M., Cleland, J. and Shah, I.H. 2014. Uptake and continuation of contraception following childbirth or pregnancy termination in 17 developing countries

Alva, S., Dougherty, L., Stammer, E. 2014. The dynamics and implications of postpartum contraceptive use in selected countries in sub-Saharan Africa

Antobam, S.K., Smith, M., Jehu-Appiah, K. 2014. Factors affecting post-abortion family planning uptake: a need to revisit service integration

Banerjee, S.K., Gulati, S., Anderson, K.L. et al. 2014. Factors influencing post-abortion contraceptive uptake in six states in India

Bradley, S.E.K., Croft, T.N., Fishel, J.D. et al. 2012. Revising unmet need for family planning, *DHS Analytical Study # 25*, Calverton, MD: ICF International

Bradley, S.E.K. and Casterline, J.B. 2014. Understanding unmet need: history, theory, and measurement. *Studies in Family Planning*, 45(2): 123-50

Cleland, J. and Shah, I.H. 2014. Postpartum and post-abortion contraception: a synthesis of the evidence

Daniele, M. and Filippi, V. 2014. Postpartum family planning in Burkina Faso: a formative study

Dasgupta, A.N., Chihana, M., Zaba, B. et al. 2014. Postpartum uptake of contraception in rural northern Malawi

Jain, A.K. 2014. Relative effectiveness of contraceptive methods during postpartum period

Keesara, S., Juma, P.A., Newman, S. et al. 2014. The impact of the infertility myth on determining motivation to use postpartum contraception: a longitudinal qualitative study in Nairobi, Kenya

- Mumah, J.N., Machiyama, K., Mutua, M. et al. 2014. Contraceptive use and discontinuation among postpartum women in Nairobi urban slums
- Olavarrieta, C.D., Romero, M., Eckart, C. et al. 2014. Contraceptive initiation and continuation post-abortion among women attending private clinics offering legal abortion in Mexico City
- Paul, L., Mondal, S.K., Nanda, G. et al. 2014. Tapping the untapped: huge potential to increase family planning users in India
- Pearson, E., Biswas, K.K., Chowdhury, R. et al. 2014. Determinants of post-abortion contraceptive uptake and method selection in Bangladesh
- Potter, J.E., Hopkins, K., Hubert, C. et al. 2014. A prospective study of contraceptive preference and use in the postpartum period: how well is demand being met in Texas
- Ross, J.A. and Winfrey, W.I. 2001. Contraceptive use, intention to use and unmet need during the extended postpartum period, *International Family Planning Perspectives*, 27: 20-27
- Rossier, C., Bradley, S.E.K., Ross, J.A. et al. 2014. Unmet need for family planning and contraceptive use in the postpartum period: an update
- Wadhwa, R. and Pillai, G. 2014. Strategies to increase postpartum family planning services
- Zavier, A.J.F. and Padmadas, S.S. 2014. Prenatal family planning counselling and postpartum contraceptive use in India



International Union for the Scientific Study of Population (IUSSP)

Scientific Panel on Reproductive Health

and

Population Council, India

and

World Health Organization - Department of Reproductive Health and Research

**International Seminar on
Promoting Postpartum and Post-Abortion Family Planning:
Challenges and Opportunities**

Cochin, India, 11-13 November 2014

Agenda

Tuesday, 11 November

08:30	Registration	
Session 1:	Opening of the seminar	
Chair:	John Cleland	
09:00-09:30	Opening remarks	Paul Monet Mary Lyn Gaffield KG Santhya
09:30-09:40	Background and agenda	KG Santhya
	Introductions	
09:40-09:45	Logistics	MA Jose
09:45-10:15	Postpartum and post-abortion contraception: an overview of the evidence base	<u>John Cleland</u> & Iqbal Shah
10:15-10:45	<i>Discussion</i>	
10:45-11:00	<i>Coffee/Tea</i>	

Session 2:	Postpartum and post-abortion contraceptive use and unmet need: the big picture
Chair:	Nancy Godfrey
<i>Discussant:</i>	KG Santhya
11:00-11:20	Unmet need for family planning and contraceptive use in the postpartum period: an update <u>Sarah E.K Bradley</u> , Clémentine Rossier, John Ross and William Winfrey
11:20-11:40	The dynamics and implications of postpartum contraceptive use in selected countries in Sub-Saharan Africa <u>Soumya Alva</u> , Dougherty Leanne and Emily Stammer
11:40-12:00	Relative effectiveness of contraceptive methods during the postpartum period Jain Anrudh
12:00-12:20	Uptake of contraception following childbirth or pregnancy termination; implications for quality of care in developing countries Mohammed M Ali, <u>John Cleland</u> and Iqbal Shah
12:20-12:40	<i>Discussant comments</i>
12:40-13:15	Discussion
13:15-14:30	Lunch
Session 3:	Unmet need for postpartum contraception – gaps, opportunities and the way forward
Chair:	Sarah E.K Bradley
<i>Discussant:</i>	Joseph Potter
14:30-14:50	Tapping the untapped: huge potential to increase family planning users in India Lopamudra Paul, <u>Subrato Kumar Mondal</u> , Geeta Nanda, Kara Tureski, Ajay Singh and Tara Sharma
14:50-15:10	Strategies to increase postpartum family planning services <u>Rajni Wadhwa</u> , Gita Pillai
15:10-15:30	Postpartum family planning in Burkina Faso: a formative study <u>Marina Daniele</u> and Veronique Filippi
15:30-15:45	<i>Discussant comments</i>
15:45-16:00	Coffee/Tea
16:00-16:45	Discussion
19:00	Group Dinner

Wednesday, 12 November

Session 4: Postpartum contraceptive use-dynamics

Chair: Mary Lyn Gaffield

Discussants **Victor Agadjanian & Sarah E.K Bradley**

09:00-09:20 Postpartum uptake of contraception in rural Northern Malawi
Aisha Dasgupta, Menard Chihana, Basia Zaba and Amelia Crampin

09:20-09:40 Contraceptive use and discontinuation among married postpartum women in Nairobi urban slums
Joyce Mumah, Kazuyo Machiyama, John Cleland, Mike Mutua and Caroline Kabiru

09:40-10:00 The impact of the infertility myth on determining motivation to use postpartum contraception: a longitudinal qualitative study in Nairobi, Kenya
Sirina Keesara, Pamela A. Juma, Sara Newmann, Christina Mwachari, Moses Owino and Cynthia Harper

10:00-10:20 A prospective study of contraceptive preference and use in the postpartum period: how well is demand being met in Texas?
Joseph Potter, Kristine Hopkins, Celia Hubert, Amanda Stevenson, Emily Hendrick, Abigail R. A. Aiken, Kari White, Daniel Grossman

10:20-10:40 *Discussant comments*

10:40-11:15 Discussion

11:15-11:30 *Coffee/Tea*

Session 5: Post-abortion contraceptive use: patterns and determinants

Chair: KG Santhya

Discussant **Anrudh Jain**

11:30-11:50 Factors influencing post-abortion contraceptive uptake in six states of India
Sushanta Banerjee, Sumit Gulati, Kathryn Andersen, Valerie Acre, Janardan Warvedekar and Deepa Navin

11:50-12:10 Contraception initiation and continuation post-abortion among women attending private clinics offering legal abortion in Mexico City
Claudia Diaz, Martin Romero, Carla Eckart, Luis Arturo Cruz

12:10-12:30 Determinants of post-abortion contraceptive uptake and method selection in Bangladesh
Erin Pearson, Kamal Kanti Biswas, Rezwana Chowdhury, Kathryn Andersen, Sharmin Sultana, S.M. Shahidullah, and Michele R. Decker

12:30-12:45 *Discussant comments*

12:45-13:15 Discussion

13:15-14:15 *Lunch*

Thursday, 13 November

Session 6:	Strategies to promote postpartum and post-abortion contraceptive use
Chair:	Claudia Diaz
<i>Discussant</i>	John Cleland
09:00-09:20	Postpartum contraceptive use in rural Mozambique: individual, household, and institutional determinants <u>Victor Agadjanian</u> and Sarah R. Hayford
09:20-09:40	Prenatal family planning counselling and postpartum contraceptive use in India <u>AJ Francis Zavier</u> and Sabu Padmadas
09:40-10:00	Factors affecting post-abortion family planning uptake: a need to revisit service integration Samuel Kojo Antobam, <u>Marian Smith</u> , Jehu-Appiah and J.C. Mills
10:00-10:15	<i>Discussant comments</i>
10:15-11:00	Discussion
11:00-11:15	<i>Coffee/Tea</i>
Session 7:	Closing Session
Chair:	Paul Monet
11:15-12:00	Highlights of key findings and of implications for programmes and policies Nandita Saikia (Junior Demographer)
12:00-12:45	<i>Discussion</i>
12:45-13:00	Plans for publication and dissemination KG Santhya
13:00-13:15	Any other matter
13:15-13:30	Closing the seminar
13:30-14:30	Lunch

.....
Note: For papers with more than one author, the name of the presenter is underlined.

**International Seminar on
Promoting Postpartum and Post-Abortion Family Planning:
Challenges and Opportunities**

Cochin, India, 11-13 November 2014

Organized by the IUSSP Scientific Panel on Reproductive Health

List of Participants

<i>Last name</i>	<i>First name</i>	<i>Organisation</i>	<i>Email</i>
Agadjanian	Victor	Arizona State University (USA)	vag@asu.edu
Alva	Soumya	John Snow, Inc. (USA)	soumya_alva@jsi.com
AJ	Francis Zavier	Population Council (India)	fzavier@popcouncil.org
Bradley	Sarah E.K.	University of California Berkeley (USA)	sekbradley@gmail.com
Cleland	John	London School of Hygiene and Tropical Medicine (UK)	john.cleland@lshtm.ac.uk
Daniele	Marina	London School of Hygiene and Tropical Medicine (UK)	marina.daniele@lshtm.ac.uk
Dasgupta	Aisha	London School of Hygiene and Tropical Medicine (UK)	aisha.dasgupta@lshtm.ac.uk
Diaz	Claudia	National Institute of Public Health (Mexico)	cdiaz@popcouncil.org
Gaffield	Mary Lyn	World Health Organization	gaffieldm@who.int
Godfrey	Nancy	USAID India	ngodfrey@usaid.gov
Jain	Anrudh	Population Council (USA)	ajain@popcouncil.org
Jose	MA	Population Council (India)	majose@popcouncil.org
Keesara	Sirina	University of California San Francisco (USA)	sirina.keesara@gmail.com
Mondal	Subrato Kumar	FHI 360 (India)	subratom@gmail.com
Monet	Paul	International Union for the Scientific Study of Population	monet@iusssp.org
Mumah	Joyce	African Population and Health Research Center (Kenya)	jmumah@aphrc.org
Navin	Deepa	Ipas (India)	navind@ipas.org
Pearson	Erin	Johns Hopkins Bloomberg School of Public Health (USA)	epearson@jhsph.edu
Potter	Joseph	University of Texas at Austin (USA)	joe@prc.utexas.edu
Saikia	Nandita	Jawaharlal Nehru University (India)	nanditasts@gmail.com
Santhya	K.G.	Population Council (India)	kgsanthya@popcouncil.org
Shah	Amit	USAID India	ashah@usaid.gov
Smith	Marian	Ipas (Ghana)	smithm@ipas.org
Wadhwa	Rajni	FHI 360 (Urban Health Initiative) (India)	doctorrajni@hotmail.com