Meeting Unmet Need and Increasing Contraceptive Options and Services with Postpartum Family Planning

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FIGO panel, Post-partum contraception with a focus on post-partum IUDs
Rome, Italy, 10 October 2012

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Questions answered in this presentation

- Why is postpartum (PP) family planning (FP) important?
- Clinical / program definitions
- How is PP FP faring? (opportunities / challenges)
- What's the "payoff" in increasing PP FP?
- Focus on clinical FP methods, especially IUDs, as lead-in to next three presentations

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Why PP FP is important:
High motivation, high unmet need

- 95% of women in 1st year post partum want to delay another pregnancy at least two years (space) or avoid future pregnancies (limit)*
- Unmet need for modern contraception is very high:
  - 222,000,000 women (26%) in developing countries have unmet need**
  - In world's 69 poorest countries, unmet need is growing
- 40% of total unmet need for modern FP is in 1st year postpartum**
- Short inter-pregnancy intervals → low birth weights & pre-term births
- Ovulation occurs as early as 25 days PP in non-breastfeeding women
- Women and providers often unaware of risk of next pregnancy

Sources: *Singh and Darroch, Adding it Up: Costs and Benefits of Contraceptive Services: Estimates for 2012. Guttmacher Institute & UNFPA.
**Ross and Winfrey "Contraceptive use, intention to use, and unmet need during the extended postpartum period, *Intl FP Perspectives*, 2001.

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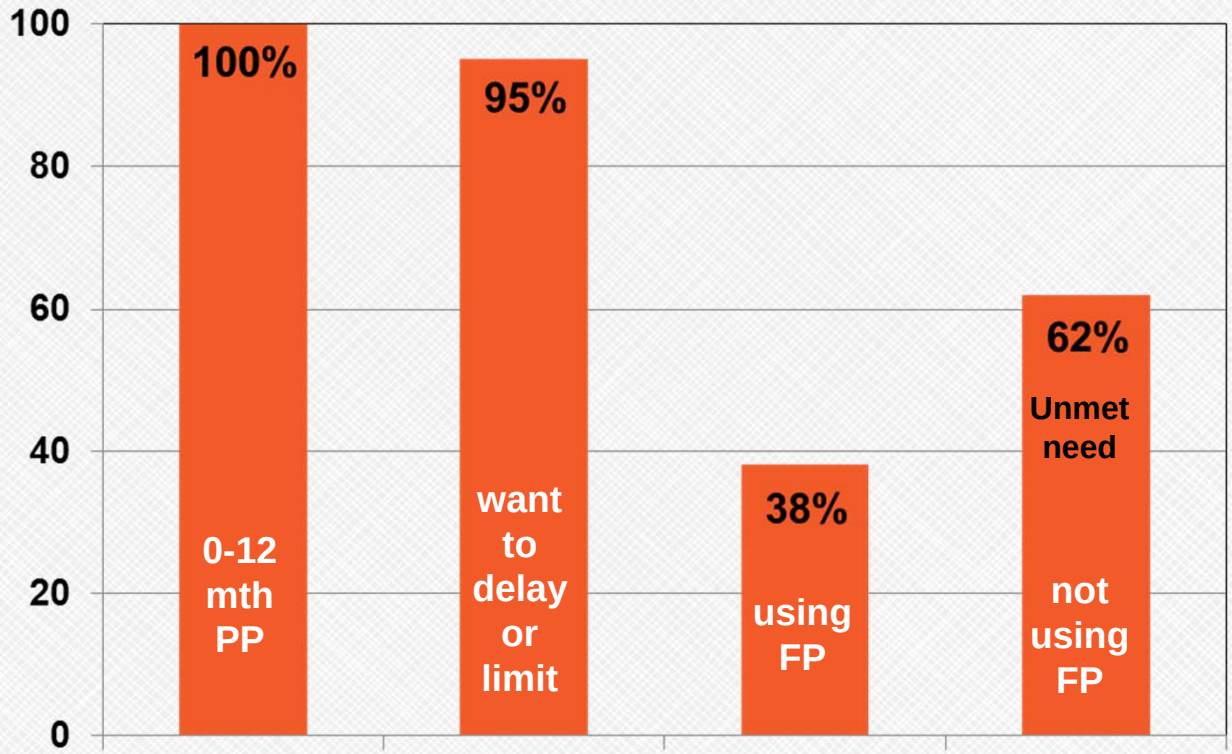
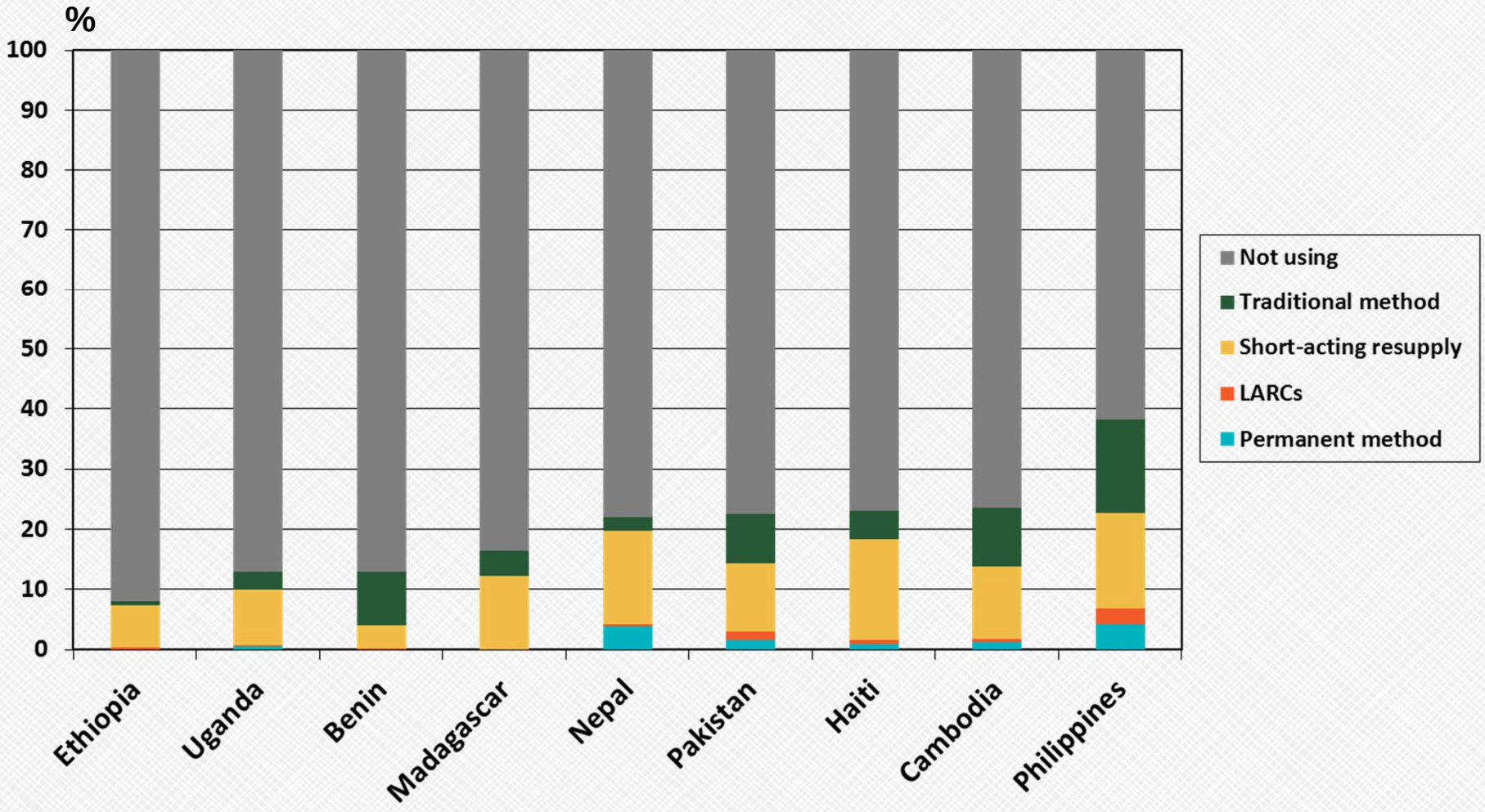
High unmet need, low use



Source: Ross and Winfrey "Contraceptive use, Intention to use, and unmet need during the extended postpartum period, Intl FP Perspectives, 2001.

… FP use and method mix among women giving birth in previous 12 months, selected country examples



Source: RESPOND Project, secondary analysis of respective DHS, 2010.

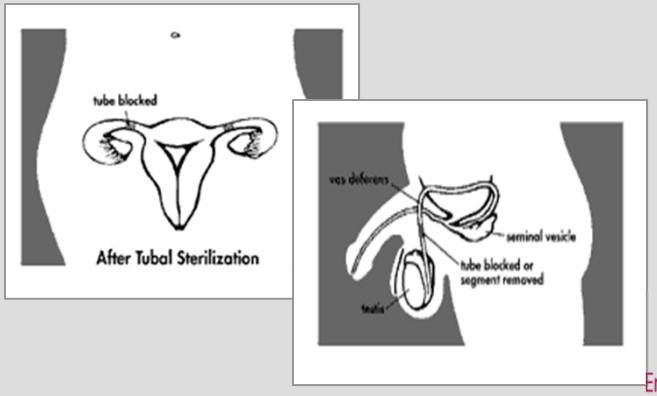
The four long-acting and permanent methods (LA/PMs)
Characteristics and PP FP service requirements

- Characteristics:
  - Highly effective
  - Most cost-effective over time
  - Popular when accessible
    (good fit with reproductive intentions)
- Clinical methods, thus require:
  - Skilled, motivated, enabled providers
    - > ***"No provider, no program"***
  - Suitable service setting
  - Essential instruments and supplies
  - Training and supervision systems
  - Voluntary, informed choice (always)

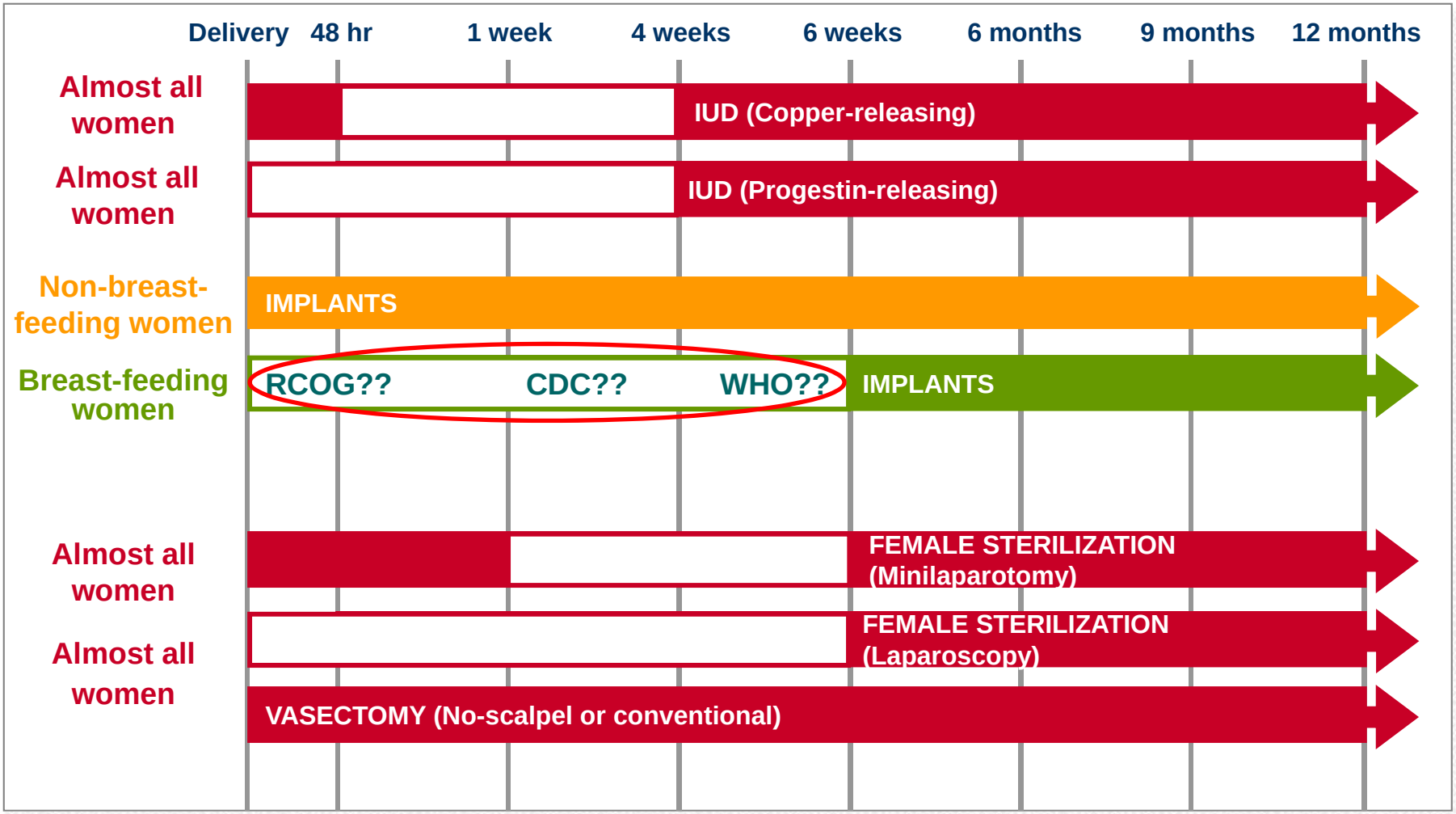
Source: RESPOND Project, 2012.

Long-acting reversible (LARCS)

Permanent methods



LAPMs in the extended postpartum period (0-1yr): An opportune time for service access and provision



Source: RESPOND Project, 2012.

Relative effectiveness of contraceptive methods

Method	# of unintended pregnancies among 1,000 women in 1st year of typical use
No method	850
Withdrawal	220
Female condom	210
Male condom	180
Pill	90
Injectable	60
IUD	8 / 2 (Cu-T / LNG-IUS)
Female sterilization	5
Vasectomy	1.5
Implant	0.5

Source: Trussell J. Contraceptive failure in the United States. Contraception 2011; 83:397–404.

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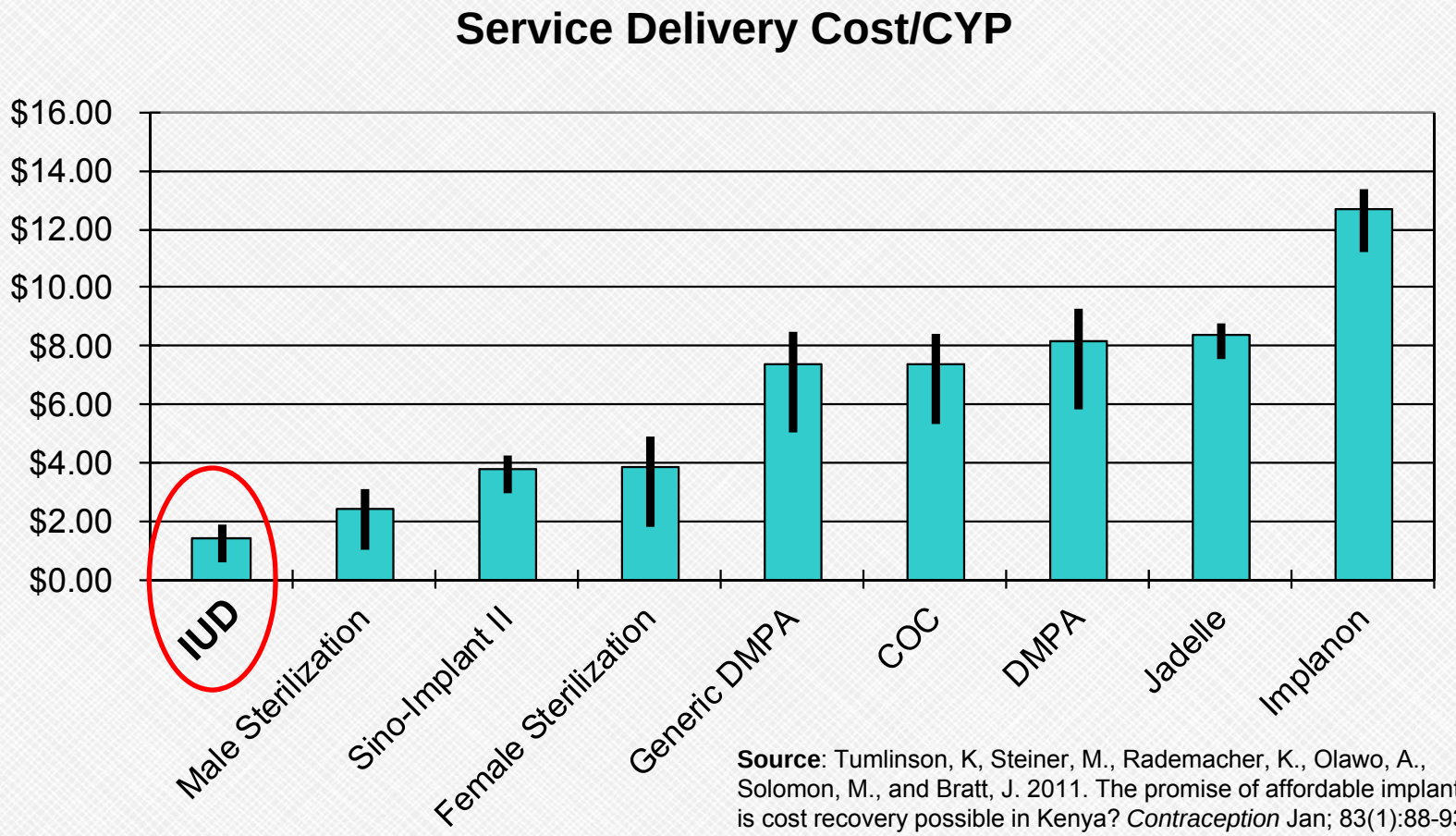
Unit costs of modern methods

Typical unit costs in public sector FP programs

Method	Unit Cost
Male condom	$0.025
Pill	$0.21
IUD	**$0.37**
Female condom	$0.77
Injectable	$0.87
Male sterilization	$4.95
Sino-implant (II)	~$8.00
Female sterilization	$9.09
Implant (Jadelle; Implanon)*	$18.00*

Ross, Weissman, and Stover, 2009
*latest USAID commodity price, 2012

Cost-effectiveness per couple-year of protection



Source: Tumlinson, K, Steiner, M., Rademacher, K., Olawo, A., Solomon, M., and Bratt, J. 2011. The promise of affordable implants: is cost recovery possible in Kenya? *Contraception* Jan; 83(1):88-93.

* Costs include the commodity, materials and supplies, labor time inputs and annual staff salaries. The height of each bar shows the average value of costs per CYP across 13 USAID priority countries.

IUD use in the world, overview

- The IUD is the most commonly used temporary method in the world*
  - 169 million MWRA (14% MWRA)
- Wide regional and country differences, e.g.:
  - 42% in Central Asia; 38% Eastern Asia (Vietnam, 44%, China, 41%)
  - 12% in Northern Europe; 11% in Western Europe (France, 23%; Italy, 6%)
  - 5% in Northern America (in U.S., 5% and rising: Mirena)
- "Underutilized" in Southern Asia (2%) and sub-Saharan Africa (0.5%)
  - India, 1.7% (3.7 million women); Bangladesh, 0.3%
  - Kenya, 1.6%
  - Nigeria & South Africa, 1.0%
  - Ethiopia & DRC, 0.2%; Zambia, 0.1%

Source: UN Dept of Economic and Social Affairs, Population Div., 2012. "World Contraceptive Use, 2011"

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Increasing program opportunities for PP FP

- Opportunities to provide / receive FP are increasing
  - 88% of women delivering in previous 5 years received antenatal care*
  - 59% delivered in a health facility (50% in sub-Saharan Africa)*
- Task-shifting / task-sharing to midlevel providers is long-proven and widely-accepted (midwives, nurses, clinical officers: LARCs)
- Convenient for women (and programs?)
- Cost-effective for FP programs, e.g., for IUD:
  - Immediate post-placental IUD $2.14-$3.37
  - Before discharge $2.79-$3.97
  - Interval $3.75-$4.70

***Source:** StatCompiler Macro. 2012, 50 countries with a Demographic and Health Survey (DHS) in past 5 years.

Many barriers to improved FP access, quality & use (whether PP, IUD, other methods, other times)

Barriers to effective PP IUD and other FP services

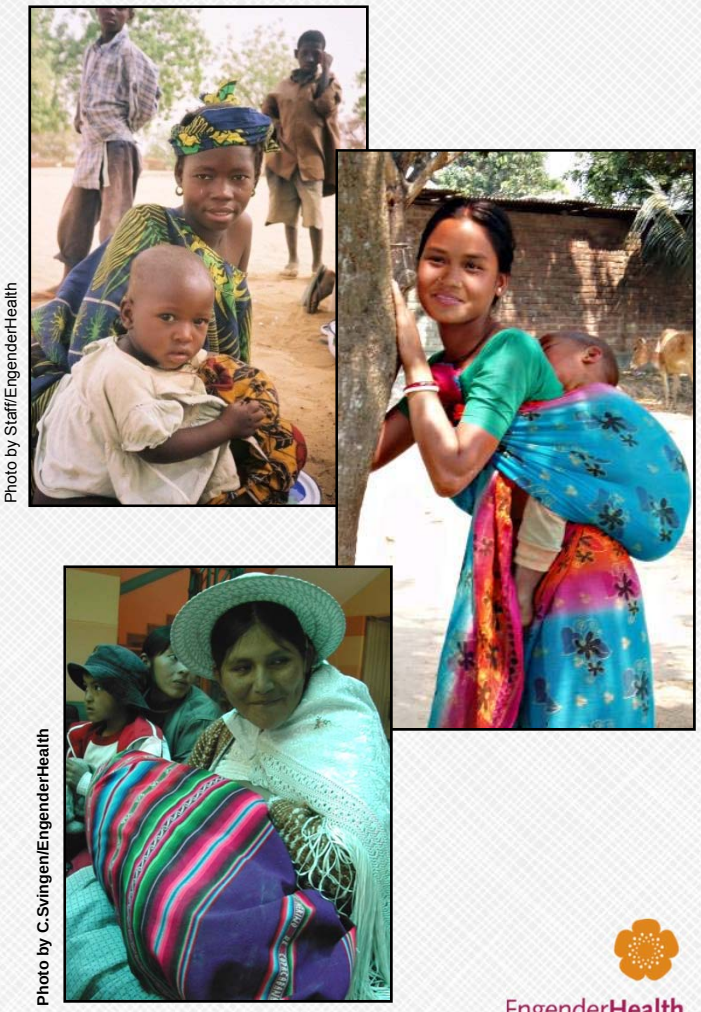
Source: RESPOND Project, 2012.

Other PP IUD training & service challenges

- "No provider, no program"
  - Adequate caseload for training and to maintain skills
  - Supervision
- Integration often "easier said than done":
  - "Will it negatively affect my already-existing other program (e.g., safe delivery or immunization)?"
  - "Whose job is it?"
  - "Can I do it?"
  - "Is this a reward, or a punishment?"
- "Who cares?" (enough to do something about it, every day):
  - "Champions needed"

The "payoff" if choice of / access to PP FP is increased and unmet need for FP is met

- 222 million women in developing countries have unmet need for modern FP*
- 40% of unmet need is in first year PP**
- Meeting this unmet need would prevent 54 million unintended pregnancies*, incl:
  - 26,000,000 fewer abortions
  - ~ 80,000 fewer maternal deaths
  - 2,400,000 fewer serious morbidities
  - 1,100,000 fewer infant deaths
  - > 300,000 fewer children lose mother
- Many other individual, family, societal and national benefits



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