



# FP2020

## A Closer Look at Postpartum Family Planning Data and Advocacy

January 31, 2019



FAMILYPLANNING.ORG  
#FP2020PROGRESS  
@FP2020 GLOBAL  
FACEBOOK.COM/FAMILYPLANNING2020



**WELCOME**



Priya Emmart

Deputy Director,  
Track20

# The purpose of the “opportunity briefs”

The purpose of the series of opportunity briefs developed by Track20 are to aid in prioritisation. There are multiple interventions that countries may invest in but choosing the right interventions starts with the data.

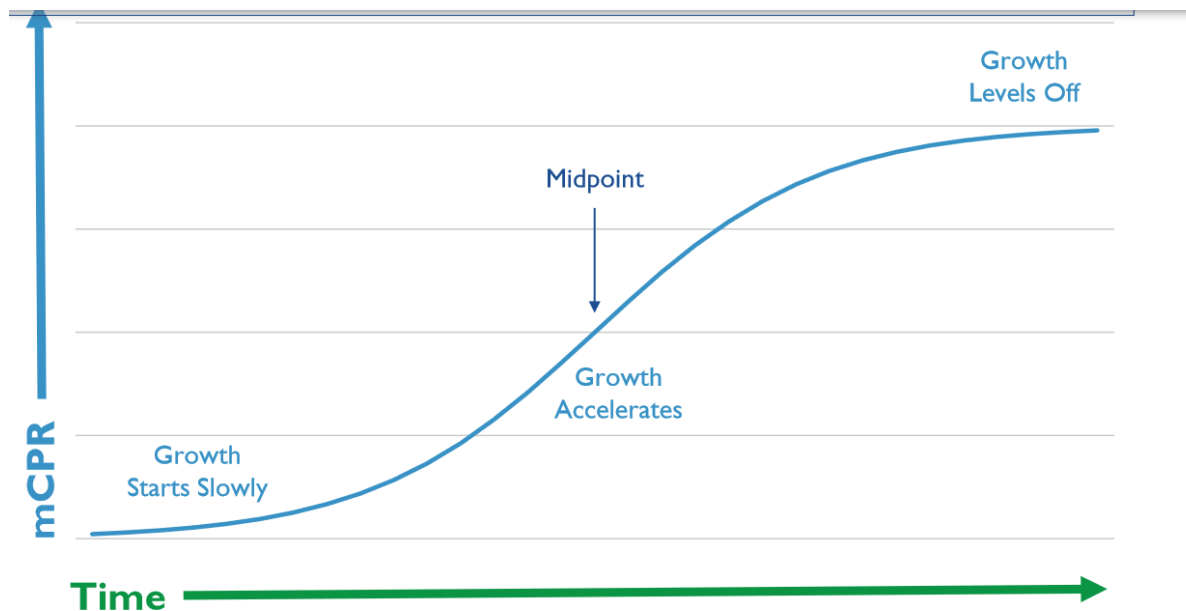
The briefs are drawn from country specific data using DHS surveys to answer questions about the extent to which there are opportunities to grow mCPR within a country context.

Opportunities are not created equal and depend on demographics, on the distribution of variables, and the linkage between factors that influence growth and mCPR

Opportunities assessed include evaluating demand for services, levels of need among sub-populations like youth and post-partum women, the supply of services, the environment for service provision, and quality and equity in provision

# What do we mean by opportunity?

- Opportunity to grow mCPR, to expand quality and equity of services
- To assess opportunity we start with context – a country's position on the S curve



# PPFP as Opportunity

Levels of Fertility



The number of women who are post-partum

Levels of Contraceptive Use Post-Partum



The growth in numbers from expanding coverage in this population

Levels of Current Interaction of WRA with health system



Whether this is a realistic opportunity

# When the opportunity is fraught

## Levels of Fertility

*Low levels of fertility, reduce the number of women who are post-partum AND the # of times a woman will require post-partum protection and the # births poorly spaced*

## Levels of Contraceptive Use Post-Partum

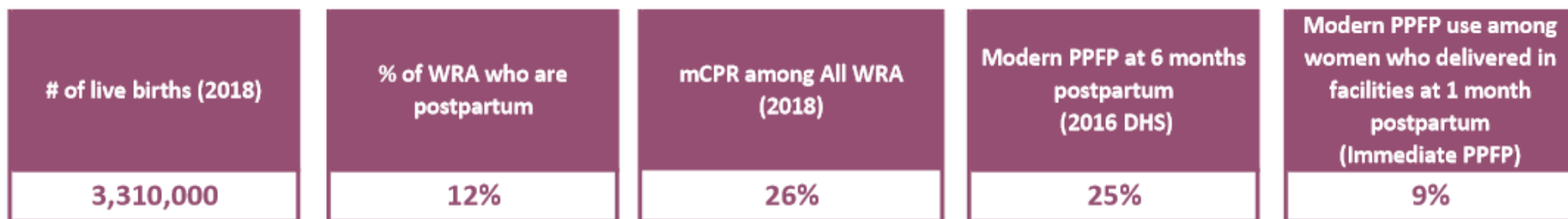
*High levels of contraceptive use post-partum, reduce the opportunity to expand the growth in additional users of contraception\**

## Levels of Current Interaction of WRA with health system

*Not a near term opportunity when large investments have to be made in maternal health prior to seeing the growth in PFP pay off*

*\*unless methods adopted have high discontinuation rates*

# Taking apart a PFPF brief



What might this number signal – if anything?

Is this a large number? Is this many?

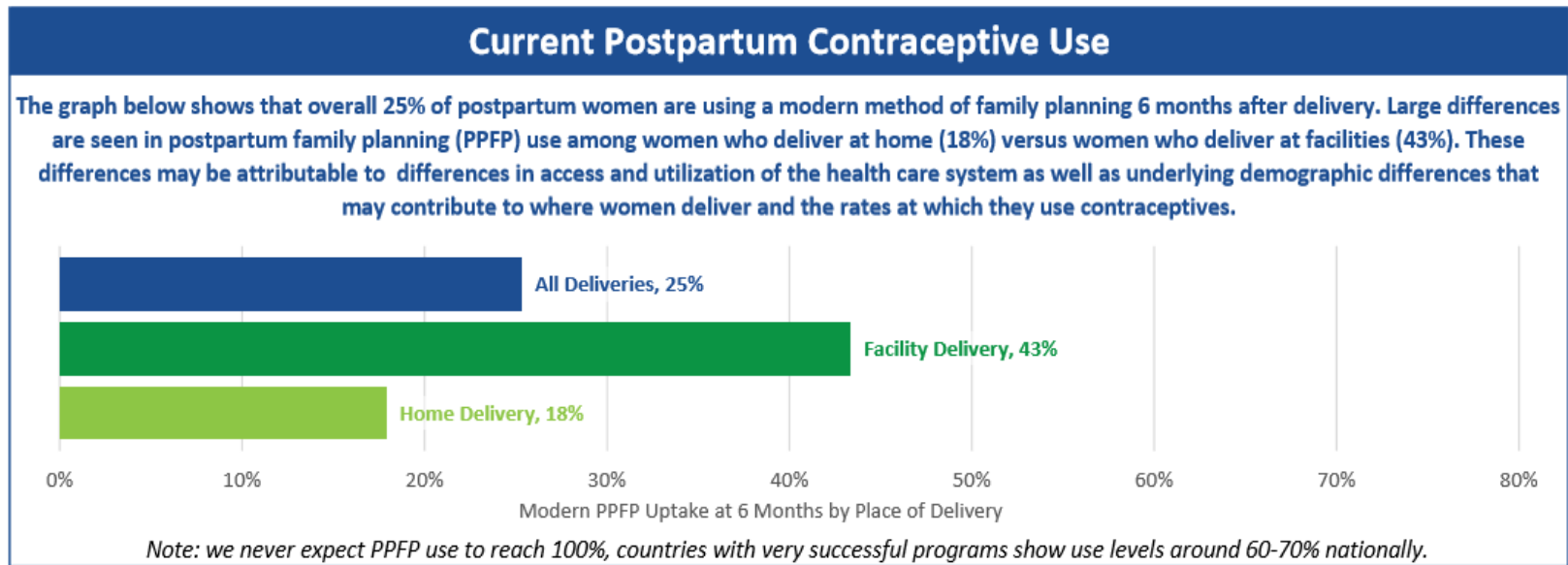
Is this low enough? Where is this along the S curve

Only a quarter of postpartum women are using modern methods at 6 months – less than 1 in 10 of these women take up FP at one month post facility delivery Is this an opportunity? How would you know?

The way to answer this is to know something about post-partum practice in general and in your context



# What is this graph describing?



1. Assessing if there is opportunity based on levels of modern contraceptive use post partum AND opportunity through the maternal health system
2. *But a special case of Post-partum: post-delivery, 6 months*
3. *Because it is the most common entry point?*
4. *Does this data show a reasonable opportunity to grow mCPR through the maternal health system?*

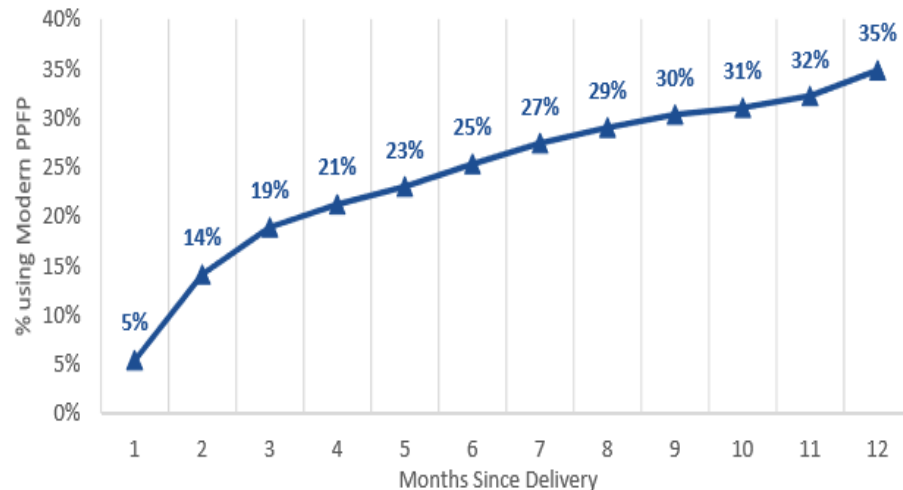
# Use trend data to determine how opportunity is changing for interventions and to deliver interventions through the MCH system

## Trends in Use of Modern Contraception During the Postpartum Period

The graph to the right shows trends in use of modern contraception over the first year postpartum, by month.

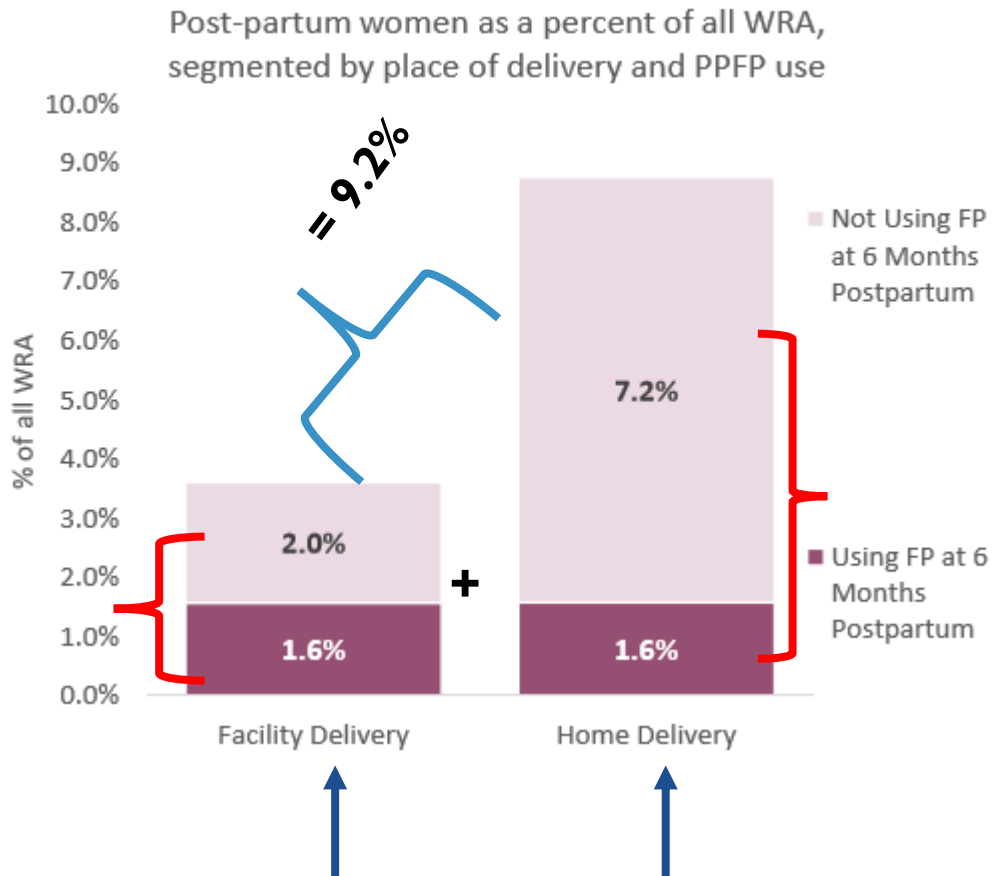
**At one month following delivery, 5% of postpartum women are using a modern method of contraception. At one year, 35% of postpartum women report using a modern method of contraception.**

To help women avoid closely spaced pregnancies, efforts should be made to provide women with access to PPFPP during the first year postpartum. Trend data can help countries identify opportunities to reach women through different PPFPP interventions during this period.



*Note: PPFPP trend analysis is only available for countries with a DHS Calendar*

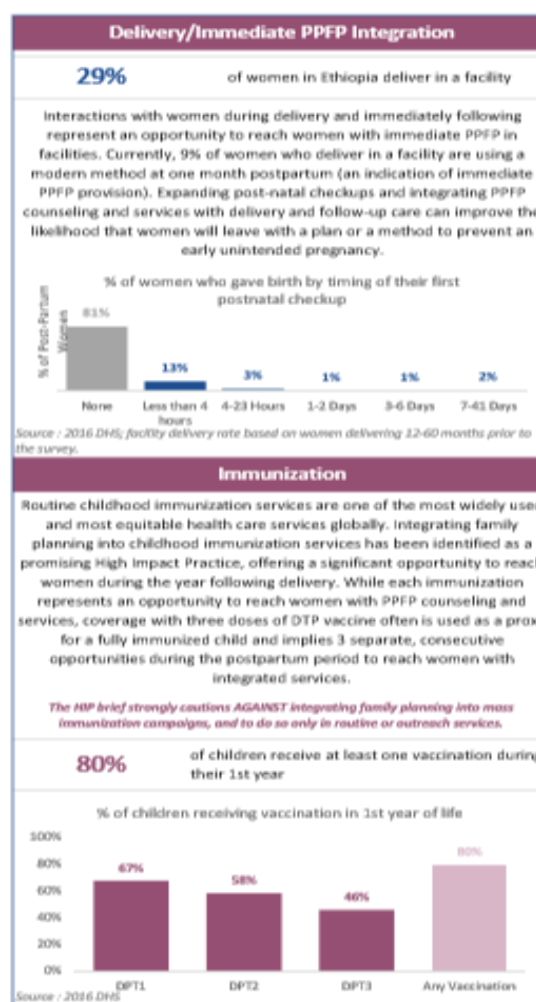
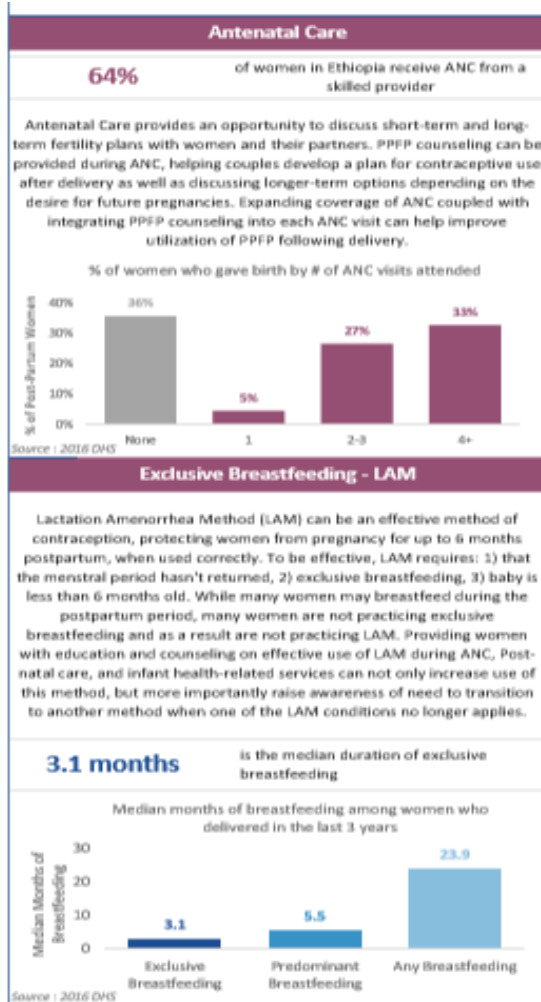
# Combining opportunities



This graph takes you through steps:

1. First takes the proportion of WRA who are post-partum
2. It segments them by whether they delivered at home or at a facility (why?)
3. Then within each segment, asks: if that sub-group of PP WRA used FP at 6 months or not
4. You have to add up the proportion who are not using in both the facility and home deliveries, and that will tell you maximum mCPR could grow – **but no country reaches 100%** of all PP women using contraception

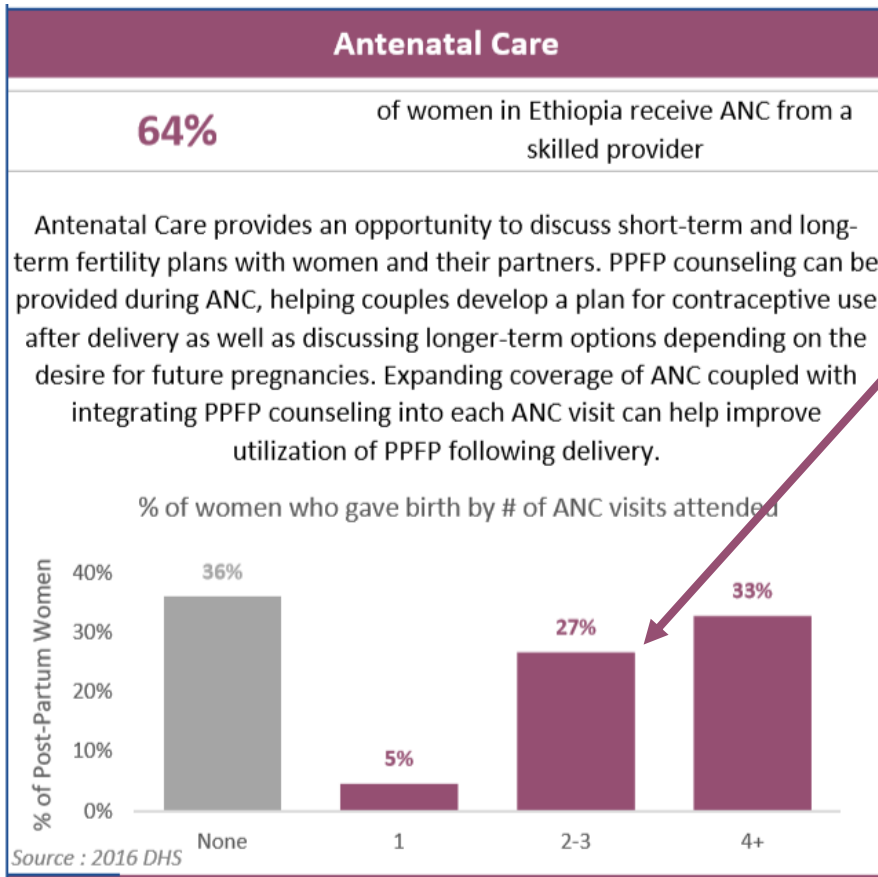
# Timing and intersections with the health system



What do these graphs represent?  
 Three health system interventions +  
 One health education and counseling

How to use this data?  
 First, it signals how much interaction mothers have with your health systems

# The long but reasonable road to increasing coverage – “growth” – the ANC opportunity



Majority of pregnant women have 2 or more contacts with a skilled provider before they deliver

You could include PFP counseling for all ANC  
You could expect to expand information **not coverage** to say 80% of these women. Depending on their preferences, uptake post delivery could expand

**The Theory:** Women who know more about return to fertility and contraceptive options and where to access may be more likely to take up contraception

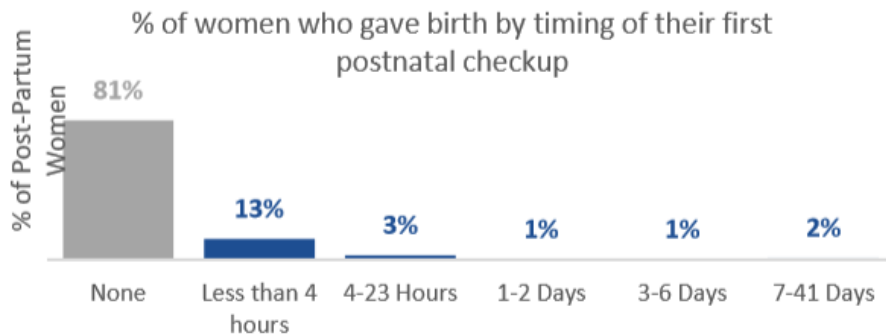
# A more immediate opportunity – examining facility delivery rates

## Delivery/Immediate PFP Integration

29%

of women in Ethiopia deliver in a facility

Interactions with women during delivery and immediately following represent an opportunity to reach women with immediate PFP in facilities. Currently, 9% of women who deliver in a facility are using a modern method at one month postpartum (an indication of immediate PFP provision). Expanding post-natal checkups and integrating PFP counseling and services with delivery and follow-up care can improve the likelihood that women will leave with a plan or a method to prevent an early unintended pregnancy.



Source : 2016 DHS; facility delivery rate based on women delivering 12-60 months prior to the survey.

This graph is looking at timing of postnatal checkup among women who delivered anywhere AND % who deliver in a facility

**The Theory:** Facility delivery is a safe opportunity to deliver contraception and information. Timing of checkups represent the scope of opportunity for providing contraception since this is facility based

Only 1 in 3 women are delivering in a facility (but you know this is an intervention that is likely to scale up quickly), and only 1 in 10 of those use at 1 moth.

Most women do not have a post-natal check-up.

What is the opportunity here?

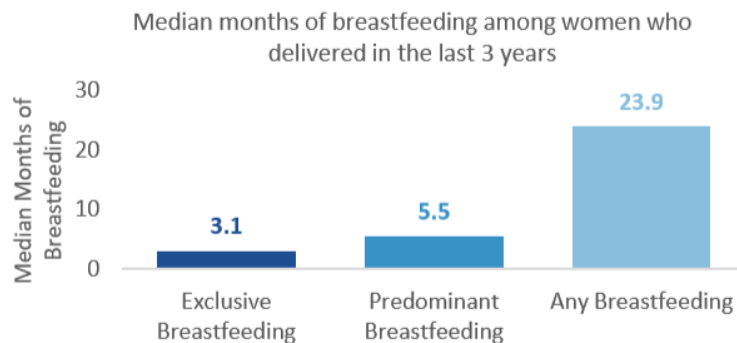
# Should health workers spend their time counseling women on LAM?

## Exclusive Breastfeeding - LAM

Lactation Amenorrhea Method (LAM) can be an effective method of contraception, protecting women from pregnancy for up to 6 months postpartum, when used correctly. To be effective, LAM requires: 1) that the menstrual period hasn't returned, 2) exclusive breastfeeding, 3) baby is less than 6 months old. While many women may breastfeed during the postpartum period, many women are not practicing exclusive breastfeeding and as a result are not practicing LAM. Providing women with education and counseling on effective use of LAM during ANC, Post-natal care, and infant health-related services can not only increase use of this method, but more importantly raise awareness of need to transition to another method when one of the LAM conditions no longer applies.

**3.1 months**

is the median duration of exclusive breastfeeding



Source : 2016 DHS

The odds of becoming pregnant in the first six months post-partum are quite low – equal to failure rate of Oral contraception  
In countries where exclusive breastfeeding is usually limited, there is a child nutrition benefit to promoting exclusive breastfeeding for longer. But the costs of HW time for FP may be too high.

# Immunisation when delivered through campaigns should be seen as an opportunity for education NOT service provision

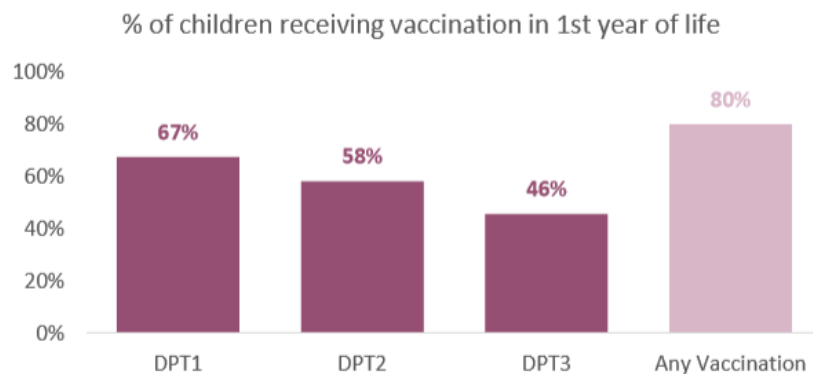
## Immunization

Routine childhood immunization services are one of the most widely used and most equitable health care services globally. Integrating family planning into childhood immunization services has been identified as a promising High Impact Practice, offering a significant opportunity to reach women during the year following delivery. While each immunization represents an opportunity to reach women with PFP counseling and services, coverage with three doses of DTP vaccine often is used as a proxy for a fully immunized child and implies 3 separate, consecutive opportunities during the postpartum period to reach women with integrated services.

*The HIP brief strongly cautions AGAINST integrating family planning into mass immunization campaigns, and to do so only in routine or outreach services.*

**80%**

of children receive at least one vaccination during their 1st year



Source : 2016 DHS



# In Summary

- The picture for PFP is mixed in Ethiopia
- There is opportunity based on the high fertility rates, high proportion of WRA who are post-partum and who do not use contraception 6 months after delivery, when they may be at risk
- The 9% point gap in PFP contribution to mCPR is the outer limit for growth, the potential will fall well below - because all post partum women do not contracept in practice, because health systems are not perfect
- There is some opportunity to piggy-back on the expansion in MCH interventions to educate/prepare women for fertility risks in the post partum period and stage contraception supplies and skills to match timing of interactions

# Further information on our website

[http://track20.org/pages/data\\_analysis/in\\_depth/PPFP/trends.php](http://track20.org/pages/data_analysis/in_depth/PPFP/trends.php)



# Questions?

# Enhancing Postpartum Family Planning (PPFP) Coverage at Subnational Level (Manyara and Katavi regions)

PPFP Webinar presentation

31<sup>st</sup> January 2019

# Background: TCDC in Family Planning Advocacy

TCDC is one of AFP's advocacy partners in Tanzania on:

- Increasing funding for FP
- Improving policy environment
- Enhancing visibility for FP - making it a key development agenda

Compliments the FP2020 global agenda by advocating for implementation of Tanzania's FP2020 commitments.

# What does TCDC do on the PFPF Agenda?

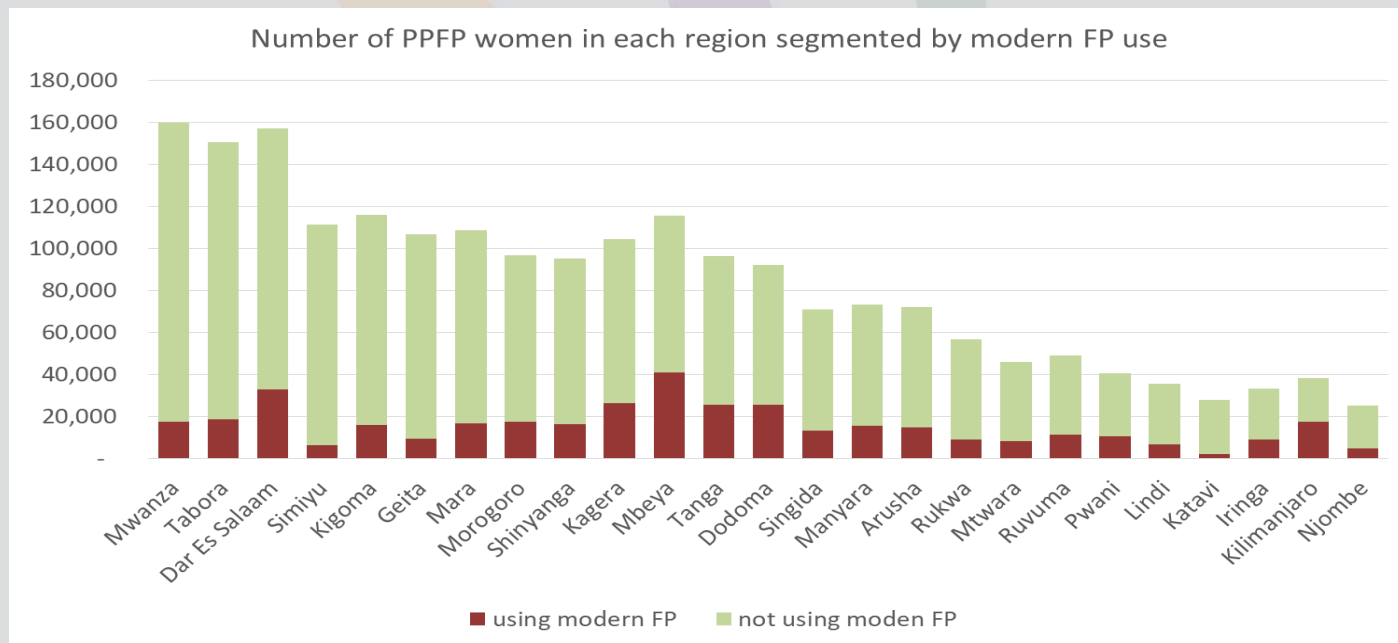
- Engage Regional and Council Health Management Teams in Katavi and Manyara regions to set Regional strategic plans for expanding coverage of PFPF services as a high impact intervention in addressing MMR



Engages President's Office Regional Administration & Local Governments (PO-RALG) in PFPF policy dialogues.

# What TCDC does at National Level

- Sharing and accessing information, data, and other evidence through the National FP Technical Group (NFPTWG);
- Participating in Track20 annual consensus building workshops to learn about new evidence and high impact interventions.



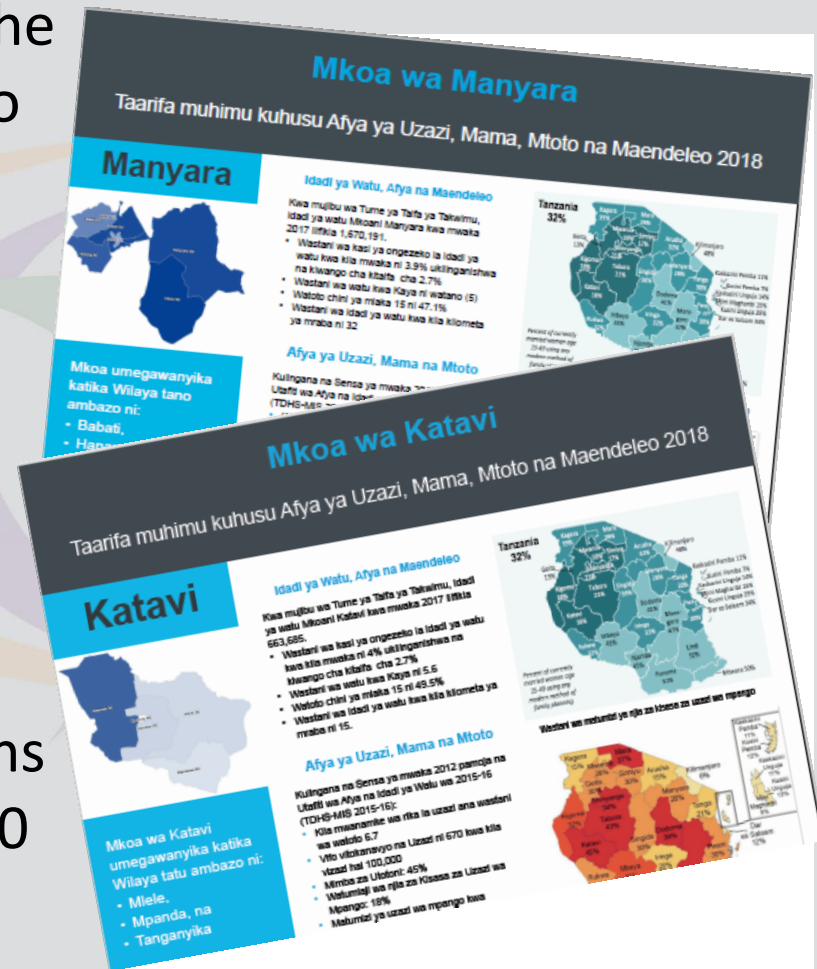
Source: Track20

# TCDC's role at Sub-national level

1. Conducted rapid assessments on the status of PFP in the two regions to determine the situation on:

- Facilities that offer family planning services
- Facilities that offer PFP services
- Number of skilled staff for PFP
- Challenges faced in providing PFP
- Perspectives on PFP

2. Packaged the evidence in policy briefs and PowerPoint presentations – combining local data with Track20 evidence to show how the regions can make progress





# Findings from the Landscape Assessments in Katavi and Manyara regions

## Women who received PFPF in Katavi region

Council	Facility Name	2015	2016	2017
Mpanda MC	Mpanda Municipal Hospital	109	408	9
Mpanda DC	Sibwesa Dispensary	204	377	209
Nsimbo	Itenka Dispensary	189	126	52
Mlele	Inyonga Dispensary	54	107	251
Mpimbwe	Mamba Health Center	51	195	104

## PPFP situation in Manyara region

Council	2015		2016		2017	
	Deliveries	PPFP	Deliveries	PPFP	Deliveries	PPFP
Babati TC	3,787	76	3,352	221	1,479	82
Babati DC	3,530	51	3,078	240	1,502	94
Hanang	2,291	114	2,508	290	1,387	204
Mbulu TC	3,469	680	3,672	1,263	1,877	436
Mbulu DC	3,661	35	3,730	136	1,791	119
Simanjiro	409	84	413	52	223	36
Kiteto	1,446	46	1,616	409	784	406

# TCDC's role at Sub-national level

3. Conducted one-on one meetings with Regional Reproductive Child Health Coordinators (RRCHCOs) and District Reproductive Child Health Coordinators (DRCHCOs);
4. Made presentations on findings of regional PFP landscape in meetings with Regional Health Management Teams (RHMTs) and Council Health Management Teams (CHMTs);
5. Shared policy briefs on PFP during those meetings to present asks;
6. Gathered commitments and action points from these meetings to facilitate development of Action Plans to enhance coverage of PFP in the regions.

# OUTCOMES

## Key outcomes:

- Both regions developed Regional Strategic Plans on RMNCAH with a focus on PFP to expand its coverage as a high impact intervention in addressing MMR

## Strategic Plan Targets:

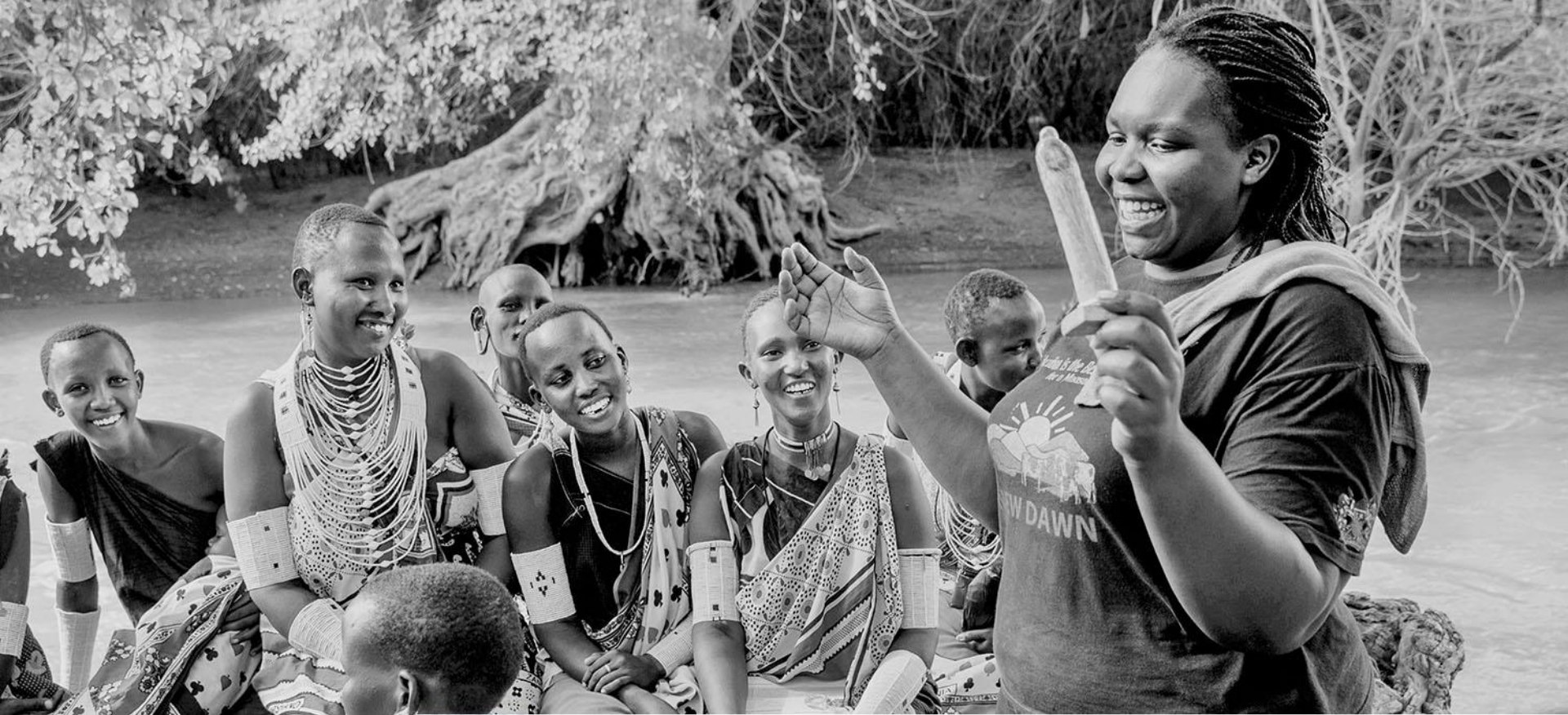
- Increase uptake of PFP from 8% to 18% by 2020 in Katavi region
- Expand coverage of PFP from 5 health facilities to 15 health facilities in Katavi regions
- Increase uptake of PFP from 21% to 30% by 2020 in Manyara region



Thank you for Listening!



# Questions?



**THANK YOU!**