

Technical Brief

Does counseling on family planning at maternity care points increase the uptake of postpartum family planning? Evidence from a nationally representative survey.

Background

The World Health Organization (WHO) defines postpartum family planning (PPFP) as a family planning (FP) behavior to prevent unintended and closely spaced pregnancies through the first 12 months following childbirth (1). It is also considered a high impact practice and an essential component of birth care helping avert maternal and newborn health hazards by preventing short-spaced births (1). Many studies in Asia and Africa showed an easy reach and effective pathway to increase PPFP – PPFP counseling during maternity care (antenatal, delivery, and postnatal care) (2). The WHO and USAID’s Knowledge SUCCESS program precisely summarized this evidence and suggested the following possible intervention points to increase PPFP use (1, 3):

- FP counseling during facility-based antenatal care (ANC) and community-based pregnancy screening (in cases when women do not go to facilities for ANC).
- FP counseling and appropriate services during any contact with women delivering in facilities or at home by skilled birth attendants (SBA) during the delivery and 48-hour postpartum periods.
- FP counseling and services to women whenever they receive postnatal care (PNC)—i.e., either at facilities or at home during the 48-hour to six-week postpartum period.
- FP counseling and services whenever the following occur as part of the maternal and child health program, either at facilities or at home: immunizations, well-child visits, nutrition and growth monitoring, event days (such as during Vitamin A supplementation days), illness visits, and preventing mother-to-child transmission of HIV and other antiretroviral care during the period from six weeks to 12 months postpartum.

The National Technical Committee (NTC) of the PPFP action plan in Bangladesh identified no or limited information about PPFP counseling provided to women during pregnancy and postpartum contact (4). The NTC laid out an initial general implementation plan for generating demand, including behavior change communication activities, the availability of the PPFP methods package, the training of providers, logistics and supply management, and quality improvement activities that are likely to increase PPFP use (4). As part of the demand generation actions, the NTC also approved integrating information and counseling about FP during maternity and child care points (e.g., ANC, PNC, child immunization visits) and the provision of FP services (providing short-acting methods including pills, condoms, and injectables) from the child immunization sites (5, 6). However, no published study has examined whether women receive FP counseling during ANC and PNC visits. Also, there is a lack of evidence on whether FP counseling during ANC and PNC visits improves PPFP acceptance among Bangladeshi women.

Methodology

We used data from the nationally represented 2017-18 Bangladesh Demographic and Health Survey. Our analysis focused on whether women who had their last live birth in the past three years received PPFP counseling during any ANC or PNC visits. We also used multivariable logistic regression (MLR) to obtain results adjusted for other characteristics of the women. Finally, we analyzed the 12-month PPFP initiation based on receiving PPFP counseling during ANC and PNC, using self-reported contraceptive calendar data. The study used the life table technique and Cox proportional hazards regression (CPHR) to examine the time from birth to FP initiation.



Key Findings

Respondent characteristics: Among the respondents, 85% were aged below 30 at the time of the last birth, 70% had the first or second order birth, and 8% reported the last child unintended.

Use of maternity care: Eighty-nine percent (89%) of the women received at least one ANC from a medically trained provider (MTP), 50% gave birth in a health facility, 33% went through C-section delivery, and 57% received at least one PNC from an MTP.

PPFP counseling at ANC visits: Only 13% of the women who received at least one ANC received PPFP counseling (Figure 1). The MLR analysis showed that women with three or more children, women with at least 10-years of schooling, and women from the highest household wealth quintiles were more likely to receive PPFP counseling during ANC visits compared to women with 1-2 children, women with no more than five years of schooling, and women from the lowest wealth quintiles.

Additionally, women living in Khulna and Rangpur divisions were more likely to receive PPFP counseling during ANC visits than those in Chattogram, which had the lowest rates of PPFP counseling during ANC visits.

PPFP counseling at PNC visits: Receiving PPFP counseling during PNC visits was more common than during ANC visits (22% vs. 13%) (Figure 1). The highest rate of receiving PPFP counseling during PNC visits was among women who had also received PPFP counseling during ANC (47%). The MLR analysis showed that women who received PPFP counseling during ANC, women with three children or more compared to those with 1-2 children, and women with 6-9 years of schooling compared to those with no more than 5 years of schooling were more likely to receive PPFP counseling during PNC visits. Additionally, women living in Rangpur had a higher likelihood of receiving PPFP counseling during PNC visits compared to women in Chattogram.

PPFP initiation by PPFP counseling at ANC and PNC: Women who did not attend ANC and those who did not receive PPFP counseling during ANC had the same likelihood of initiating PPFP (74%). In contrast, 80% of women who received PPFP counseling during ANC initiated PPFP. The difference in PPFP initiation between women who received PPFP counseling during ANC and those who did not became evident from the fourth month postpartum and continued until 12-months postpartum (Figure 2, Panel A).

Figure 1. Receiving PPFP counseling at ANC and PNC

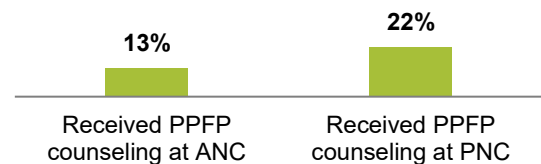
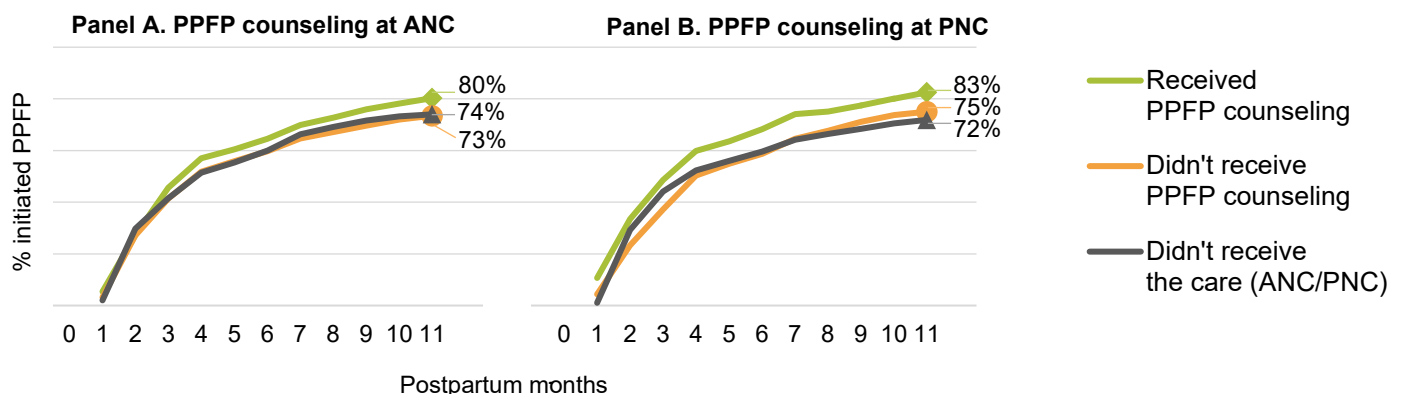


Figure 2. PPFP initiation by postpartum months and PPFP counseling during ANC and PNC



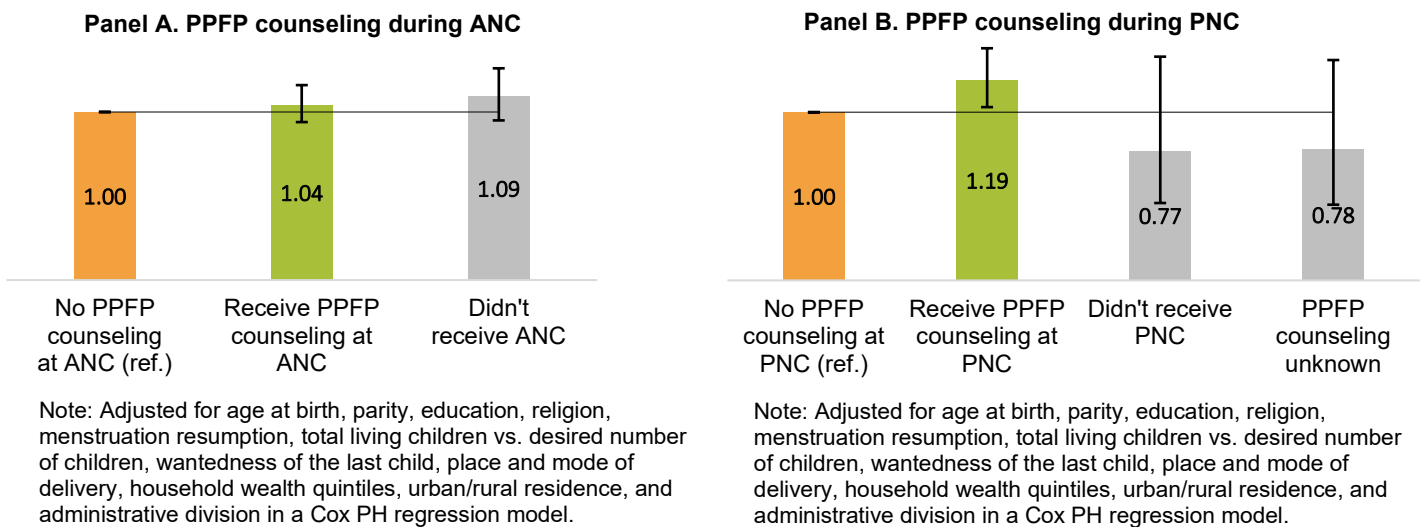
Notes: 1) PPFP initiation in the 0 postpartum month (birth month) is unknown; 2) There is a small group whose status of receiving PPFP counseling at PNC is unknown. PPFP initiation of that group is not shown.



Among women who received PPFP counseling during PNC, 83% initiated PPFP within the first year after birth. This rate was 75% among women who did not receive PPFP counseling during PNC, and 72% for those who did not receive PNC at all. The difference in PPFP initiation between women who received PPFP counseling during PNC and those who did not (or did not receive PNC) appeared in the very first month postpartum and continued until 12-months postpartum (*Figure 2, Panel B*).

Figure 3 shows that PPFP initiation did not vary by PPFP counseling at ANC. However, PPFP counseling at PNC was positively associated with PPFP initiation. The adjusted hazard ratio of PPFP initiation was 1.19 times among women who received PPFP counseling at PNC compared to women who did not receive counseling during PNC.

Figure 3. Adjusted hazard ratios of initiating FP within 12 months postpartum by PPFP counseling during ANC and PNC



Other correlates of PPFP initiation were menstruation resumption after birth, having the same or a higher number of living children than desired, unwantedness of the last child, and urban residence. However, receiving PPFP counseling during both ANC and PNC did not make a difference in initiating FP within 12-months postpartum.

Strengths and Limitations

This study is one of the first to examine whether PPFP counseling during ANC and PNC facilitates FP initiation within 12 months postpartum, using data from a nationally representative survey (the BDHS 2017-18). A key strength is the use of the self-reported contraceptive history (calendar) section of the 2017-18 BDHS which facilitated the longitudinal analysis by linking data to the duration of postpartum amenorrhea.

However, the study also has some limitations. The BDHS 2017-18 did not collect data on who initiated the PPFP counseling during ANC and PNC, whether women received PPFP information and counseling from other sources, or what information was provided during counseling. Another limitation is the unavailability of information about PPFP counseling during delivery.

To address these methodological issues, an appropriately designed study is required to estimate the effect of counseling that is provided during pregnancy, at discharge from the health center after delivery, or during PNC visits on subsequent contraceptive adoption. A longitudinal study following women from childbirth through the postpartum period would likely provide an unbiased estimate of these effects.



Conclusion

PPFP counseling during ANC and PNC is extremely low in Bangladesh. PPFP counseling during PNC helps increase 12-month PPFP initiation, but PPFP counseling during ANC does not. However, several other studies in Asia and Africa have found evidence of higher PPFP use among women who received PPFP counseling during ANC. Therefore, we suggest well-designed intervention studies to understand the effects of PPFP counseling during ANC on 12-month PPFP use.

Contributors

M. Moinuddin Haider, icddr,b

Md. Mahabubur Rahman, icddr,b

Shusmita Khan, University of North Carolina at Chapel Hill

Mizanur Rahman, University of North Carolina at Chapel Hill

Suggested Citation

Haider MM, Rahman MM, Khan S, Rahman M. (2024). Technical Brief: Does counseling at maternity care points increase the uptake of postpartum Family Planning (PPFP): Evidence from nationally representative survey. Chapel Hill, NC, USA: Data for Impact.

References

1. World Health Organization. Programming Strategies for Postpartum Family Planning Geneva, Switzerland: World Health Organization; 2013 [Available from: <https://www.who.int/publications/i/item/9789241506496>].
2. Cleland J, Shah IH, Daniele M. Interventions to improve postpartum family planning in low-and middle-income countries: program implications and research priorities. *Studies in family planning*. 2015;46(4):423-41.
3. Maternal and Child Health Integrated Program. Synthesis of postpartum family planning program literature. Draft report. 2012 [Available from: https://toolkits.knowledgesuccess.org/sites/default/files/Synthesis%20of%20PPFP%20Program%20Literature_DRAFT_Nov2012.pdf].
4. Government of the People's Republic of Bangladesh. Postpartum family planning (PPFP) national action plan Dhaka, Bangladesh: Government of the People's Republic of Bangladesh; 2016.
5. Directorate General of Family Planning. Proceedings of the 66th meeting of the National Technical Committee (NTC). Memo No: DGFP/MCH-S/NTC-4/138/5 (Part- 05)/320. Dhaka, Bangladesh: Government of the People's Republic of Bangladesh; 2016.
6. Government of the People's Republic of Bangladesh. Notice to provide PPFP care during ANC, PNC and visit at EPI center. (in Bangla). Memo No: DGFP/CCSDP/NTC – 63/2010/5403. Dhaka, Bangladesh: Government of the People's Republic of Bangladesh; 2016.

For more information

D4I supports countries to realize the power of data as actionable evidence that can improve programs, policies, and—ultimately—health outcomes. We strengthen the technical and organizational capacity of local partners to collect, analyze, and use data to support sustainable development. For more information, visit <https://www.data4impactproject.org/>

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of the Data for Impact (D4I) associate award 7200AA18LA00008, which is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Palladium International, LLC; ICF Macro, Inc.; John Snow, Inc.; and Tulane University. The views expressed in this publication do not necessarily reflect the views of USAID or the United States government. FS-24-707 D4I

