

Increasing the use of effective postpartum contraception: urgent and possible



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Family planning is a life-saving intervention for mothers and their children, and is critical to meeting the Sustainable Development Goal target of universal access to sexual and reproductive health. Postpartum family planning, defined as the prevention of unintended or closely spaced pregnancies throughout the first 12 months after childbirth,¹ has an important role to play in reinforcing women's rights to determine the number and spacing of their children and in strategies to reduce unmet need for contraception among the 225 million women of reproductive age in low-income and middle-income countries (LMICs) who want to avoid pregnancy but are not using a modern contraceptive method.² Postpartum family planning integrates contraceptive services with existing care provided during childbirth and in the 12 months after delivery—a time when women are frequently in contact with the health system—offering multiple opportunities to ensure that women's contraceptive needs are being met.

The first 12 months after giving birth is a vulnerable time in a woman's life, and often when her need for contraception is greatest.³ After a livebirth, the recommended minimum interval before next pregnancy is 24 months in order to reduce the risk of adverse maternal, perinatal, and infant outcomes.⁴ Yet women often do not receive the services they need to support longer birth intervals or avoid unintended pregnancy. More than 90% of postpartum women in low-income and middle-income countries want to avoid pregnancy in the next 12–24 months, yet over two-thirds are not using contraception.⁵

In this issue of *The Lancet Global Health*, Nguyen Toan Tran and colleagues⁶ report on a study designed to test a low-technology postpartum family planning intervention package. The six-component “Yam Daabo” intervention, which aims to increase modern contraceptive use at 12 months post partum, is comprised of three facility-level interventions (service provider training, supervision of providers, and improved availability of contraceptive services), and three individual-level interventions (a counselling tool, appointment system, and partner invitations).

The study was conducted in eight primary health-care centres (four intervention and four control) in Kinshasa, Democratic Republic of Congo. Single interventions designed to improve uptake and effective use of contraceptive methods have often proved disappointing,⁷ and evidence suggests that multifaceted interventions may be more likely to have an impact;⁸ Tran and colleagues are therefore to be commended for going down this road.

After 12 months, prevalence of modern contraceptive use was 46% in the intervention arm and 35% in the control arm (this difference was not significant), with the difference driven primarily by increased use of the contraceptive implant (22% and 6%, respectively). There were no differences in the use of intrauterine contraception (IUC), permanent methods, or shorter-acting modern contraceptives.

Although the study's relatively small sample size with few clusters, coupled with significant interference in the control arm by other family planning interventions, were considerable limitations, the finding of increased uptake of the contraceptive implant, a highly effective long-acting reversible contraceptive (LARC) method, in the intervention arm is an encouraging outcome, with considerable potential for clinical impact.⁹ However, the limited effect of this broad-based intervention requires further explanation; in particular, the lack of impact on uptake of a wider range of modern methods including the IUC, another important LARC option. More detailed information on approaches to implant provision compared with approaches to provision of other methods during the intervention would be illuminating, as would data to elicit which component or components of this multifaceted intervention may have worked and why. Ensuring women have meaningful contraceptive choice through access to a full range of methods, particularly long-acting methods, is integral to reducing unintended pregnancy. A further key question for all postpartum family planning intervention research is whether increased contraceptive uptake is sustained post-intervention. Little is known about continuation of contraceptive use after specific interventions end or about the impact of interventions on birth spacing and

unintended pregnancy. These are evidence gaps that should be priorities for future studies.

The need for postpartum family planning is high, and we know that demand can be generated. More women than ever before are giving birth in health facilities, and this means increased potential for women to initiate a family planning method before leaving the clinic, or to be linked to contraceptive care later through postpartum, immunisation, and paediatric services. Coupled with updates to the WHO's Medical Eligibility Criteria for Contraceptive Use allowing for immediate postpartum initiation of implants and IUC,¹⁰ and the growing movement for respectful maternity care, an opportunity exists for accelerated progress in this field. Building on the evidence generated from studies such as the Yam Daabo trial and others, we need to develop, test, and implement effective and sustainable postpartum family planning interventions worldwide, particularly in LMICs, where unmet need for contraception is unacceptably high.

We declare no competing interests.

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