Medical eligibility criteria for postpartum use: new recommendations

Maria I. Rodriguez MD, MPH
The Four Cornerstones of evidence-based guidance

- Medical Eligibility Criteria for Contraceptive Use
- Selected Practice Recommendations for Contraceptive Use
- Guidelines for policy-makers and programme managers
- Tools for health-care providers
- Decision-Making Tool for Family Planning Clients and Providers
- Handbook for Family Planning Providers
The Evidence-Based Guidelines

Who can use contraceptive methods

How to use contraceptive methods
Step 1: Identification of new evidence pertaining to contraceptive safety and efficacy

Step 2: Posting of records on CIRE database

Step 3: Screened for relevance

Step 4: Update or conduct systematic review

Step 5: Send for peer review and evaluate need to update guidance
# Simplified Classification of Conditions

<table>
<thead>
<tr>
<th>Classification</th>
<th>With Clinical Judgement</th>
<th>With Limited Clinical Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use method in any circumstance</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Generally use the method</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Use of the method not usually recommended unless other more appropriate methods are not available or not acceptable</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td>No</td>
</tr>
</tbody>
</table>
Translating evidence to clinical practice

Issues identified by literature review

- Postpartum IUD use
- Lactational amenorrhea in HIV positive women
- Use of CHC in non breastfeeding women postpartum

Technical conference convened
A 30 y.o is post cesarean section, ready to be discharged from hospital, and desires contraception with combined hormonal pills. She does not wish to breastfeed. When is the soonest time it would it safe to initiate her birth control pills?

A. Immediately postpartum
B. 3 weeks postpartum
C. 6 weeks postpartum
## Prior recommendation:
**Use of combined hormonal methods**

### Not breastfeeding

<table>
<thead>
<tr>
<th>Postpartum women</th>
<th>Combined hormonal contraception (pill, patch, ring)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 days</td>
<td>3</td>
</tr>
<tr>
<td>&gt;21 days</td>
<td>1</td>
</tr>
</tbody>
</table>

VTE = Venous thromboembolism
CHCs and VTE

VTE risk among non-pregnant non-CHC users:
4-5/10,000 woman-years

VTE risk among CHC users double:
9-10/10,000 woman-years
Highest in first months of use, returns to baseline after use discontinued

VTE risk among pregnant women:
29/10,000

VTE risk in peripartum period:
300-400/10,000

Reid, J Fam Plann Reprod Health Care, 2010
Heinemann, Contraception, 2007
Systematic Review

Exclusions

- DVT or PE only
- Caesarean-section delivery only
- Women with thrombogenic mutations only
- Postpartum period not defined
- Delivery hospitalization only

15 articles (13 studies) included

- 3 reported comparative risk of postpartum VTE
- 12 reported incidence of postpartum VTE
### Studies assessing risk of VTE

<table>
<thead>
<tr>
<th>Study</th>
<th>~0-6 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ros 2001</td>
<td>DVT: 15.2 (13.2-17.6)</td>
</tr>
<tr>
<td></td>
<td>PE: 9.2 (6.5-12.7)</td>
</tr>
<tr>
<td>Heit 2005</td>
<td>21.5</td>
</tr>
<tr>
<td>Pomp 2008</td>
<td>84.0 (31.7-222.6)</td>
</tr>
</tbody>
</table>
# Studies assessing incidence rates

## (per 10,000 WY)

<table>
<thead>
<tr>
<th>Study</th>
<th>Postpartum (~0-6 weeks)</th>
<th>Baseline Rate</th>
<th>Rate Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heit 2005</td>
<td>99</td>
<td>4.6</td>
<td>21.5*</td>
</tr>
<tr>
<td>Ros 2001</td>
<td>33</td>
<td>2.4</td>
<td>13.8*</td>
</tr>
<tr>
<td>McColl 1997</td>
<td>25</td>
<td></td>
<td>2.5-8.3*</td>
</tr>
<tr>
<td>Lidegaard 2009</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Heinemann 2007</td>
<td></td>
<td>5-10</td>
<td></td>
</tr>
</tbody>
</table>

*Calculated by review authors.*
VTE by week postpartum

- Jacobsen
- Pomp
- Heit
Systematic Review Conclusions

3 studies compare postpartum risk to non-pregnant women
   Risk is 22 to 84 higher in PP women

Rate ratio of postpartum risk to non-pregnant women
calculated for 3 studies
   Rate Ratio: 2.5 to 21.5 in postpartum women

3 studies provide weekly data
   Indicate that risk decreases markedly after first 3 to 4 weeks postpartum
   Most studies convey no significant increase after 6 weeks
## Guideline Update: Postpartum Contraception

<table>
<thead>
<tr>
<th>Condition</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Postpartum (non breastfeeding)</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;21 days</td>
<td>4</td>
</tr>
<tr>
<td>21-42 days</td>
<td></td>
</tr>
<tr>
<td>With other risk factors for VTE (such as age ≥ 35, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥ 30, post cesarean delivery, preeclampsia, or smoking)</td>
<td>3</td>
</tr>
<tr>
<td>Without other risk factors for VTE</td>
<td>2</td>
</tr>
<tr>
<td>&gt; 42 days</td>
<td>1</td>
</tr>
</tbody>
</table>
Integration of Family Planning Services and Emergency Obstetric and Neonatal Care

An Analysis of UNFPA EmONC Needs Assessments in Ten Developing Countries

Nuriye Ortayli and Valerie Scott, UNFPA
More than 90% of women during the first year postpartum want to either delay or avoid future pregnancies\(^1\)

Globally, nearly 65% of women have an unmet need for family planning in their first year postpartum\(^2\)

After a live birth, the recommended interval before the next pregnancy is at least 24 months to reduce adverse maternal, perinatal and infant outcomes\(^3\)

The immediate postpartum period is a critical opportunity to introduce family planning to women in need while they are already within the health system

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Emergency Obstetric and Neonatal Care (EmONC) Needs Assessments

- Between 2005 and 2011, UNFPA and partner organizations carried out national EmONC needs assessments in 19 countries
- Used for policy guidance, strategy design, planning and priority-setting to accelerate achievement of MDGs 4 and 5 and strengthening of health systems
Ten of these assessments which have been finalized have been analyzed and ranked according to inclusion of family planning data:

- **GOOD:** ≥ 13 FP Indicators
  - Ethiopia, Malawi, Afghanistan and Ghana
- **SUFFICIENT:** 7-12 FP Indicators
  - Benin, Madagascar, Burundi and Pacific Countries
- **INSUFFICIENT:** 0-6 FP Indicators
  - Cambodia, Rwanda
These cross-sectional, facility-based surveys collected data via direct observation, registry and record data, and interviews with health workers.

The phrasing of survey questions varies somewhat across countries.

The term “provided” is used here to indicate services provided by facilities according to record data, as well as the reported provision of services by health worker staff in interviews.

Some data, such as the provision of emergency contraception to victims of sexual violence, were obtained only through self-report and were not verified with hospital records.

The term “stocked” is used here to indicate the availability (NOT actual provision) of contraceptive methods supplies.
797 facilities (751 providing delivery services) were surveyed out of approximately 820 total hospitals and health clinics*.

98% of facilities provided temporary FP methods in the past 3 months.

Most commonly available methods: injectables, combined oral contraceptives and male condoms.

IUDs and implants were stocked by 24% and 55% of facilities, respectively.

Emergency contraception was provided to victims of sexual violence by 67% of providers.

Post-abortion contraception was provided in 73% of facilities.

Unavailability of human resources was the top reason for non-provision of temporary FP methods, while training issues and problems with supplies/equipment/drugs were most problematic for provision of surgical FP.

*Designed as a census, but some facilities in Somali Region and Addis Ababa were missed due to logistical reasons.
Malawi

- 289 facilities* (all providing delivery services) were surveyed out of 534 total facilities
- 85% of facilities provided family planning methods
- Most commonly available methods in both hospitals and health centers: injectables, combined oral contraceptives and implants
- IUDs were stocked by only 11% of facilities, while 48% of facilities stocked implants
- Emergency contraception was provided to victims of sexual violence by 55.1% of providers
- Family planning counseling and services were provided after unsafe or incomplete abortion by 82.4% of providers
- Policy issues were the top reason for non-provision of both temporary and surgical FP methods; training issues were also problematic for provision of surgical FP

*Includes all hospitals and a random selection of 50% of health centers providing maternal and neonatal health services
Afghanistan*

- 78 facilities were surveyed out of 127 total first-level referral EmONC facilities
- 76% of facilities provided temporary FP methods and 52% provided surgical FP in the last 3 months
- Most commonly available methods: injectables, combined oral contraceptives and male condoms
- IUDs were stocked by 91% of facilities; no data on implants
- Emergency contraception was stocked by 41% of facilities
- Post-abortion contraception was provided in nearly ¾ of facilities
- Availability of human resources was the top reason for non-provision of temporary and surgical FP methods, while training issues were also problematic for provision of surgical FP

*UNFPA did not participate in this needs assessment conducted by UNICEF and partners
1,268 facilities (1,159 providing delivery services) were surveyed*

86% of facilities provided temporary FP methods and 16% provided surgical FP methods in the last 3 months

IUDs and implants were stocked by 35% and 39% of facilities, respectively

Emergency contraception was provided to victims of sexual violence by 32% of providers

Family planning counseling and services were provided after unsafe or incomplete abortion by 90% of providers

*Includes all hospitals and health facilities with at least 5 deliveries per month; # of deliveries required was less strict in the three Northern regions due to low population density
Benin

- 417 facilities (all health facilities with at least 20 deliveries per month) were surveyed
- Post-partum contraception was provided by 33.4% of facilities in the last 3 months (only country where PPC was asked)
- 90% of facilities provided at least 3 temporary FP methods and only 8.2% provided surgical FP methods in the last 3 months
- Most commonly available methods: injectables, oral contraceptives and male condoms
- IUDs and implants were stocked by 23.1% and 8.7% of large pharmacies*, respectively
- Emergency contraception was provided to victims of sexual violence by 13.4% of providers; however, supplies were virtually unavailable, stocked by only 1.4% of large pharmacies
- Post-abortion contraception was provided by 55.5% of facilities in the last 3 months

* “Pharmacie de gros”; no data on facilities
294 facilities (all health facilities with at least 20 deliveries per month) were surveyed

90% of facilities provided FP methods

Most commonly available methods: oral contraceptives, injectables and male condoms

IUDs and implants were stocked by 23.5% and 56.4% of facilities, respectively

Emergency contraception was stocked by 30.7% of facilities

Between 61-80% of facilities (depending on type) provided contraception after abortion

Supply/equipment/drug issues were the most common reason for non-provision of both temporary and permanent FP methods
Burundi

- 276 health facilities were surveyed
- Nearly 80% of facilities provided FP methods
- Most commonly available methods: combined oral contraceptives, injectables and male condoms
- IUDs were stocked by 90.1% of facilities, while only 6.4% of facilities stocked implants
- Emergency contraception was stocked by 50% of facilities
FP is one of the key prongs to decrease maternal mortality and morbidity.

Yet, assessing the availability of FP services has not been a major concern for steering committees in many countries.

EmONC assessments provided some useful information on availability of FP Services at EmONC facilities but there are several methodological shortcomings, such as, self-reported behaviours, no measurement of FP coverage for women who had given birth.

There is a need to strengthen these results with observational studies on the provision of post-partum family planning.

IUDs and surgical contraception are the least available methods in nearly all countries.

Improved family planning services can prevent maternal and neonatal morbidity and mortality, thus reducing the overall burden of care in EmONC facilities. A fact to be remembered by all.
Addressing service delivery issues for family planning to postpartum women: a proposal for programmatic guidance

Mary Lyn Gaffield, Shauna Gunaratne, Joy Fest

Department of Reproductive Health and Research
World Health Organization
Background

- Brainstorming meetings (March & November 2010, April 2011)
  - Preliminary plan of work and products
  - Panel session during First Global Forum for Health Services Research (Montreux, Switzerland)

- Develop programmatic guidance within SPR
  - 'Map' existing guidance on the topic
  - Interview public health officials from selected countries for contextual input
  - Systematic review of published evidence
  - Accompany guidance with 'Call to Action'
Guidance mapping

- Review of 41 published family planning documents (guidelines, reports, books, bulletins, manuals, articles)
  - Programme structure (n=9)
  - Counselling (n=15)
  - Training and education (n=10)
  - Service integration (n=8)
  - Creative financing (n=1)
Country interview methods

- Research questions
- Study participants
  - Key informants from 17 countries with high unmet need for PPFP from DHS data (from ACCESS–FP report)
- Observational cross-sectional study design
- Data collection and analysis
  - Each informant interviewed by 3 people
  - Collated response emailed back to interviewee
  - Key phrases examined for analysis
    - reviewed by team of 3 people
## Countries interviewed so far

<table>
<thead>
<tr>
<th>Country</th>
<th>Government official</th>
<th>NGO/International Organization</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td></td>
<td>Engender Health</td>
<td>1</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Ministry of Health</td>
<td>Family Guidance Association of Ethiopia, Pathfinder, UNFPA</td>
<td>4</td>
</tr>
<tr>
<td>India</td>
<td></td>
<td>PSI</td>
<td>1</td>
</tr>
<tr>
<td>Kenya</td>
<td>Ministry of Health</td>
<td>JHPIEGO, KURHI Tupange Deputy Director</td>
<td>3</td>
</tr>
<tr>
<td>Madagascar</td>
<td></td>
<td>Santé net 2 Project</td>
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</tr>
<tr>
<td>Malawi</td>
<td>Ministry of Health</td>
<td>PSI</td>
<td>2</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Ministry of Health</td>
<td>PSI, Greenstar</td>
<td>3</td>
</tr>
<tr>
<td>Zambia</td>
<td>Ministry of Health</td>
<td>PSI</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>12</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>
Most common definitions of PPFP were services offered either:
- 6 weeks postpartum
- Up to 12 months postpartum
Policy, budget, monitoring systems

- Interviewees mentioned a need for advocacy for PPFP
- None of the countries have specific PPFP budgets
- Funding for PPFP falls under general categories (ex. FP, maternal health)
- Monitoring and evaluation systems are non-existent
Contraceptive methods

Contraceptive methods provided to postpartum women

Availability of methods

- Yes: 25%
- No: 37%
- Depends (on contraceptive, where services are being provided, when it's being provided)
- No answer: 19%
Community health workers are essential to address unmet need

Services provided mainly occur during antenatal care and immediately after delivery
Take away points

- Policies in countries often supportive towards family planning, including postpartum family planning
- Limited to very limited funding for postpartum FP
- Monitoring and evaluation systems rarely exist
- Other opportunities exist for delivering services
  - suggest optimizing roles of community health workers
Programmatic questions - proposed

- How can PPFP be integrated into infant and child health services?
- How can PPFP be promoted during antenatal care?
- How can uptake of immediate PP permanent and long-acting reversible contraceptive methods be maximized?
- How can utilization of PPFP by women who do not deliver in the hospital be maximized and promoted?
Next steps

- Your input is very welcome!
- Finalize questions and scope for evidence synthesis
  - Complete review of background evidence
  - Consideration of contextual input
- GDG draft guidance for expert review
- WHO Technical consultation to finalize recommendations (2012)