New Strategic directions: four suggestions

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Outline

Section 1: Post-partum and post-abortion contraception

Section 2: Method Discontinuation and Switching

Section 3: Condoms and Young People

Section 4: Method- Choice

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Section 1: Post-partum & Post-abortion contraception

Post-partum & Post-abortion contraception

- Public health rationale

- Traditional spacing mechanism weakening

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- Contraception in ensuring long birth intervals is becoming important
  - Contraceptive prevalence & birth interval lengths positively correlated

- Unmet need for family planning
  - High among women with births within 2 years postpartum (**Table 1b)**.

Table 1a: Median number of months of postpartum amenorrhea, abstinence, and insusceptibility, for births in the three years preceding the survey

Regions	Amenorrheic		Abstaining		Insusceptible	
	1990-97	2000-07	1990-97	2000-07	1990-97	2000-07
East/Southern Africa	12.8	11.4	3.3	3.6	13.8	13.0
West Africa	13.9	11.4	10.6	6.3	16.3	14.4
Latin America	8.3	8.6	2.4	2.5	9.5	9.8
North Africa/E.Europe/Asia	4.0	3.5	1.8	1.8	4.1	3.8
South/S.East Asia	7.3	6.8	2.3	2.4	8.1	7.5

West Africa based on Benin, Burkina Faso, Cameron, Chad, Ghana, Guinea, Mali, Niger, Nigeria, Senegal

East/Southern Africa includes Ethiopia, Eritrea, Kenya, Madagascar, Malawi, Mozambique, Namibia, Rwanda, Tanzania, Uganda, Zambia, Zimbabwe

Latin America includes Bolivia, Colombia, Haiti, Peru, Guatemala, Dominican Republic, Nicaragua

South/SE Asia Bangladesh, Indonesia, Nepal, Phillipines, Pakistan

North Africa/Asia includes Egypt, Morocco, Jordan, Turkey , Yemen

Motivation for Post-partum contraception

Table 1b. Percentage distribution of UNMET need among currently married women with a birth in the last 5 years by months since last birth (DHS 2000+)

Region	0-11 m	12-23 m	24-35 m	36-47 m	48-60 m	Total
East/Southern Africa	37.3	32.2	15.7	8.9	5.9	100
West Africa	32.9	33.9	17.9	9.6	5.7	100
Latin America	36.4	25.4	15.7	12.3	10.2	100
North Africa/Asia	33.5	25.4	16.9	13.5	10.7	100

West Africa (Benin, Burkina Faso, Cameron, Chad, Ghana, Guinea, Mali, Niger, Nigeria, Senegal).
East/Southern Africa (Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Namibia, Rwanda, Tanzania, Uganda, Zambia, Zimbabwe).
Latin America (Colombia, Haiti, Nicaragua, Peru).
North Africa/Asia(Egypt, Morocco, Jordan, Nepal).

Identifying gaps in post-partum protection

- Examine the incidence of contraceptive uptake or conception
  - Following live births & pregnancy terminations,
    - cumulative incidence of contraceptive adoption by month 12 is 55% in 19 developing countries (Table 1c).

Table 1c: 12-month cumulative incidence rates of first event after birth or pregnancy termination, by country

		Contraceptive uptake		Conceptions	
Country		Rate	SE	Rate	SE
Bangladesh		35.7	0.76	7.7	0.5
Bolivia		41.8	1.28	11.6	0.8
Brazil		65.0	0.56	13.6	0.7
Colombia		73.9	0.78	7.5	0.4
Egypt		51.8	0.34	15.5	0.4
Indonesia		57.5	0.39	7.5	0.3
Jordan		54.0	0.40	24.4	0.8
Kenya		34.6	0.84	10.7	0.9
Morocco		43.8	0.96	12.0	0.9
Peru		59.0	0.62	7.3	0.3
Zimbabwe		68.1	0.82	5.5	0.5
Total	**Pooled**	**54.0**	**0.16**	**11.8**	**0.13**
	Median	**55.2**		**13.3**	

Postpartum contraceptive adoption

- A distinctive feature of the period surrounding childbirth is
  - the high intensity of contact between
    - women and health care providers

- How well are these opportunities being exploited for post-partum contraception?

- When is the optimal timing of postpartum contraceptive adoption?

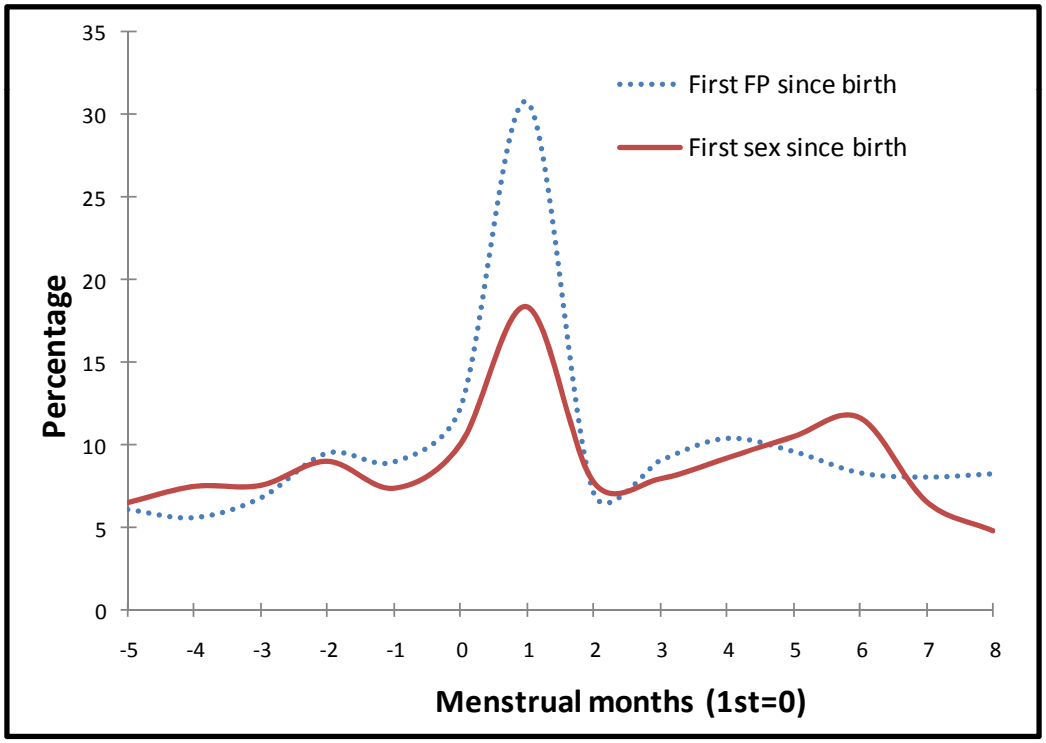
Table 1d: *Continued* (Percent distribution according to timing of contraceptive uptake during 12-month post-partum)

Country		N	Non-hormonal methods[2]		
			Relative to insusceptibility		
			Before	Same time	After
Bangladesh		729	21.2	4.2	74.6
Bolivia		631	63.8	6.8	29.4
Brazil		1,511	41.7	15.4	42.9
Colombia		3,688	40.7	14.5	44.8
Egypt		6,152	22.3	5.3	72.4
Indonesia		3,400	51.4	12.3	36.3
Jordan		3,052	27.0	7.3	65.7
Kenya		218	51.8	9.6	38.6
Peru		5,328	46.7	9.1	44.2
Philippines		2,088	44.3	9.6	46.1
Zimbabwe		506	68.6	7.7	23.7
Total	**Pooled**	**37,131**	**36.4**	**9.5**	**54.1**
	Median		**41.7**	**9.1**	**44.8**

, [2] Non-hormonal methods include: IUD Diaphragm/Foam/Jelly, Male or Female Condom, Male or Female Sterilization, Withdrawal, Abstinence, Herbs, Massage, vaginal douche

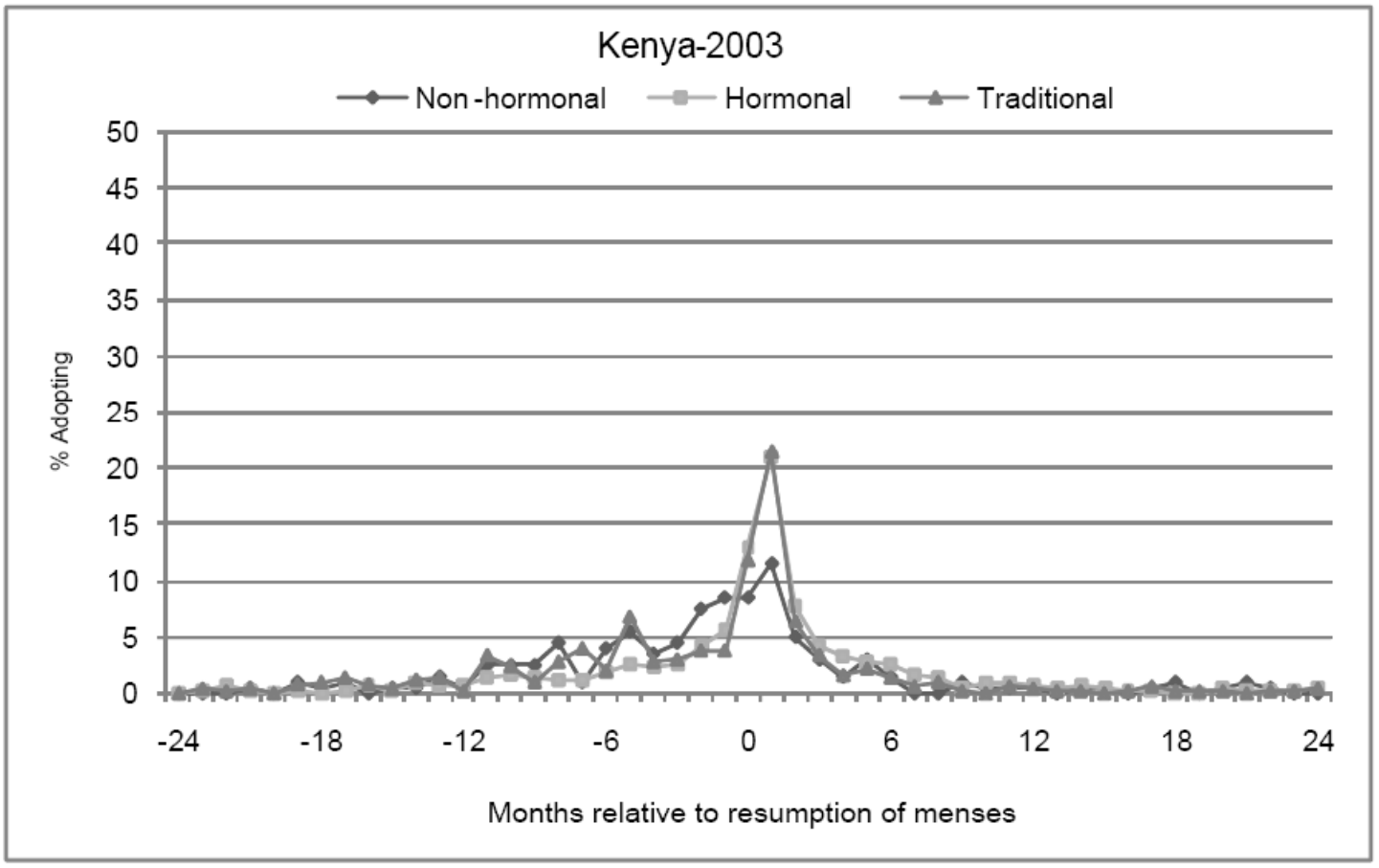
Post-partum Contraceptive adoption & Menses

Figure 1a-1: Percentage of mothers who initiated contraceptive use relative to resumption of menses and sexual intercourse in Nairobi urban slums



A spike in the monthly probability of contraceptive adoption is apparent at the time of menses resumption

Figure 1a-2: Percentage of mothers who initiated contraceptive use relative to resumption of menses and sexual intercourse in Kenya, by methods



Source (DHS Analytical studies No. 14)

Section summary

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• Integrating family planning into routine obstetric and child care services offers
  - ➢great scope for reducing the postpartum unmet needs.

•Considerable scope exists for improving immediate postpartum family planning provision.
  - ➢With few exceptions (e.g. Brazil) immediate post-delivery contraceptive provision appears to be uncommon.
  - ➢Institutional deliveries are steadily increasing but private sector hospitals and maternity homes may account for much of this increase (e.g. India).
  - ➢Little attempt has been made to incorporate family planning services into these private-sector facilities.

Summary cont'd

•Strict adherence to LAM is very rare.

- An appealing case can be made for a post-amenorrheic strategy (i.e. delay contraceptive adoption until the return of menses),
  - Ideal for countries where safe abortion services are available.

- This makes most use of lactational protection and accords with existing customs;
  - in most countries contraception peaks in the month that menses resumes.

• Family planning providers dealing with pre and post-abortion cases

- can emphasize the benefits of family planning
- women are more receptive to the contraceptive messages at this time

- Evidence shows that IUDs,
  - less likely to be discontinued than hormonal methods,
  - can be easily inserted following termination
  - there are no significant differences in risk of complications
    - for immediate vs delayed post-abortion IUD insertions.

- Major practical constraint on post-abortion provision is
  - being illegal and thus practised clandestinely
  - training and encouraging providers of post-abortion contraception difficult.

Section 2:
Method Discontinuation & Switching

Figure 2a: Twelve month cumulative probabilities of method-related discontinuation Per 100 episodes: Women's education Primary or no education (left hand box) vs. Secondary or higher (right hand box)

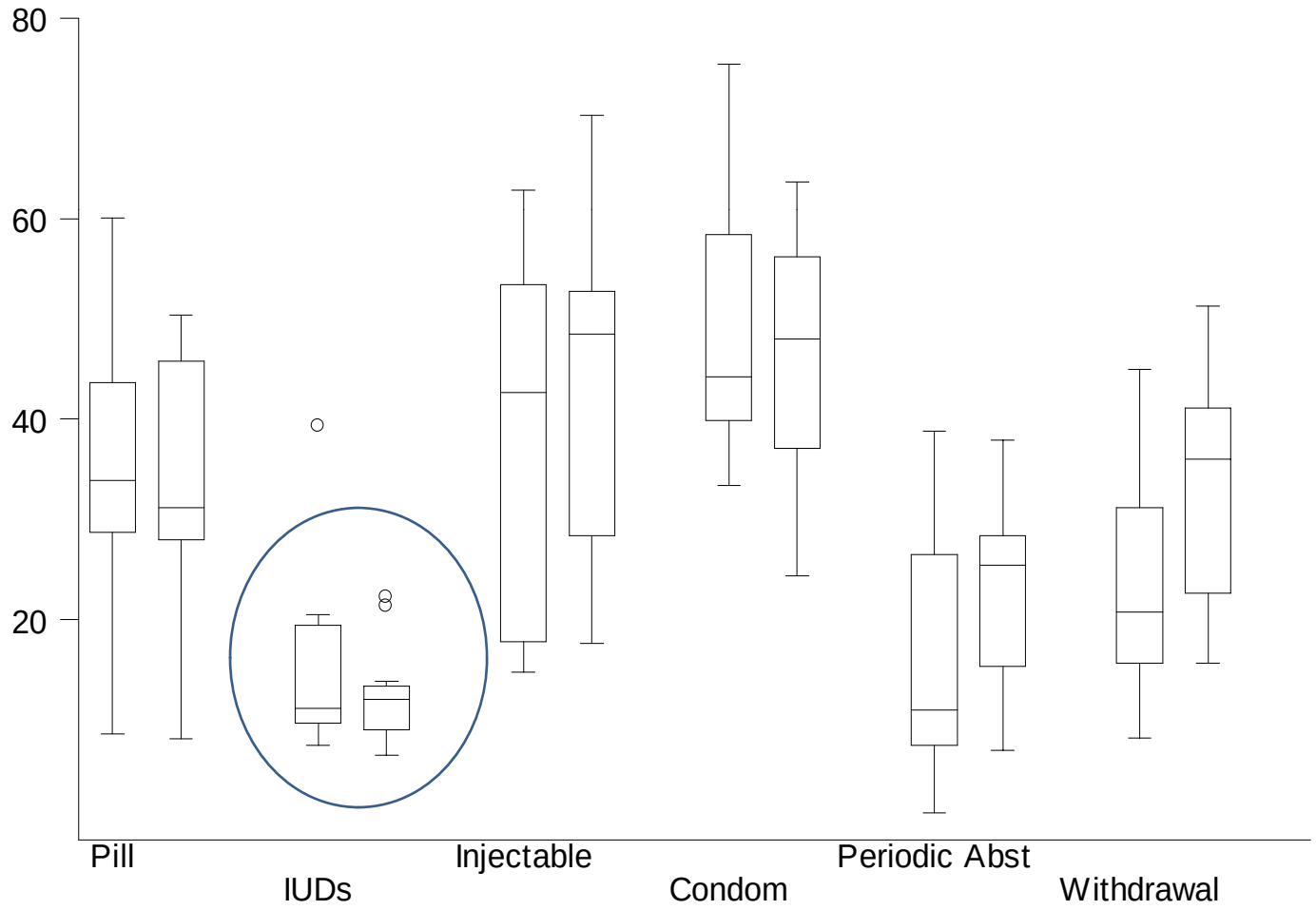


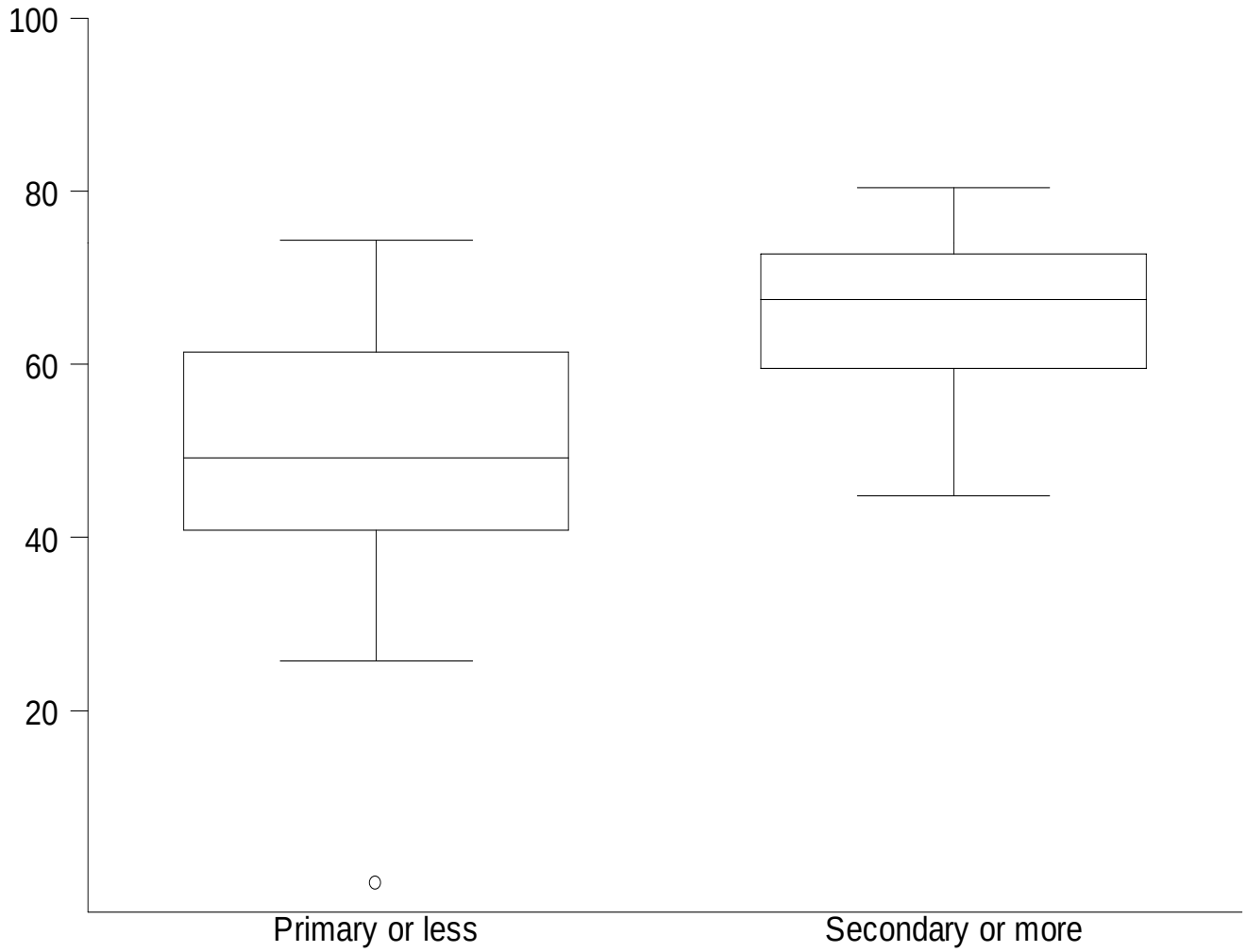
Table 2a-1: Method-switching: Status at three month after discontinuation for method-related reason per 100 discontinuations

	Discontinued Modern Method				
	Still at risk	Switched to:		Became Pregnant	Total
		Modern	Traditional		
Latin America					
Bolivia	31.4	25.1	30.5	13.0	100.0
Brazil	23.5	44.4	21.7	10.4	100.0
Colombia	16.7	51.0	20.8	11.5	100.0
Dominican Republic	35.3	27.8	13.2	23.8	100.0
Peru	25.4	52.1	15.6	6.9	100.0
North Africa/Central & Western Asia					
Egypt	34.9	49.3	1.5	14.4	100.0
Jordan	23.3	35.9	23.2	17.6	100.0
Morocco	35.7	27.1	17.8	19.4	100.0
Turkey	19.5	36.3	29.6	14.7	100.0
South/South East Asia					
Bangladesh	31.1	45.2	11.9	11.8	100.0
Indonesia	30.8	61.3	4.1	3.9	100.0
Philippines	39.0	23.3	25.6	12.1	100.0
Sub-Saharan Africa					
Kenya	50.8	28.3	3.8	17.1	100.0
Zimbabwe	46.6	33.1	2.3	17.9	100.0
Median	**31.0**	**38.8**	**16.7**	**13.5**	**100.0**

Table 2b: Pill switching: Status at three months after discontinuation of pill because of dissatisfaction, per 100 discontinuations

	No of episodes	At risk	Became pregnant	Switched to				Total
				Pill	Reversible Modern	Traditional	Sterilization	
Bangladesh	1,709	24.4	7.9	0.5	48.2	18.6	0.4	100
Brazil	757	35.0	14.4	3.5	21.1	19.6	6.5	100
Colombia	1,991	23.3	19.1	0.9	35.2	13.2	8.4	100
Egypt	1,201	30.7	11.3	0.5	55.1	2.4	0.0	100
Indonesia	975	32.6	4.4	0.0	60.0	2.6	0.4	100
Jordan	486	25.0	14.5	0.1	35.6	24.5	0.5	100
Kenya	315	44.9	14.7	0.0	34.7	5.3	0.5	100
Morocco	957	21.1	8.2	1.3	38.0	30.3	1.2	100
Peru	1,384	21.8	10.2	1.1	49.1	15.7	2.2	100
Viet Nam	145	11.0	11.2	0.0	42.7	30.6	4.6	100
Zimbabwe	323	44.4	15.8	0.31	34.9	4.1	0.5	100
Median	**582**	**30.7**	**13.5**	**0.4**	**34.9**	**15.7**	**0.5**	100

Figure 2c: Percentages of women who switched to any reversible modern method with three months of discontinuation: women's education: primary or no schooling (left hand box) vs secondary or higher (right hand box)



Section conclusions

•In all countries (rich or poor), adopters of contraception have a high probability of stopping use of their chosen method within 12 months

- for reasons that imply dissatisfaction with the method.

•Discontinuation is more likely for methods that require no provider-involvement with cessation of use

- (e.g. pills, injectables, condoms).

•Little convincing evidence exists that improvements of service quality, such as more intensive counselling, improves continuation of use.

- Family planning providers need to anticipate that 30-40% of women will not persist with their method.

Section conclusions

•Following discontinuation of a modern method in low and middle-income countries,

- ➢only 30-40% switch promptly to another modern method
- ➢ the remainder are at moderate or high risk of an unintended pregnancy.

•Switching is lower among less privileged strata

- ➢(e.g poorly educated women).

•Switching is less common in settings where alternative methods are not commonly used;

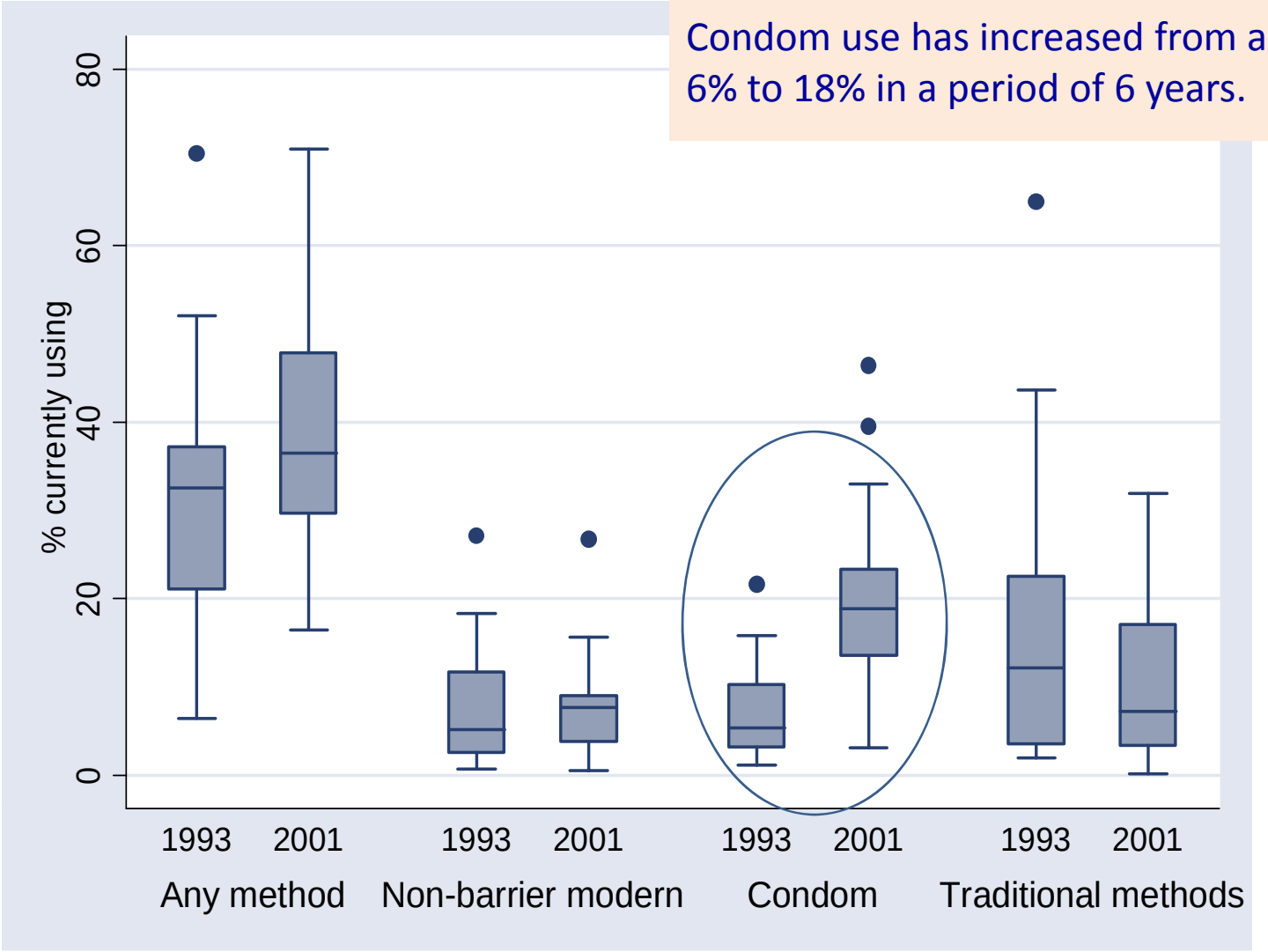
- ➢thus method-mix is an important consideration in identifying countries where poor switching is likely to be a severe problem.

•Low continuation and low switching is a neglected issue in family planning services.

- ➢It needs a higher profile and perhaps operations research to identify effective ways of improving the situation.

Section 3
Condoms and Young People

Figure 3a: Trend (1993-2001) in current contraceptive use among single women aged 15-24 who were sexually active in the last 3 months: 18 African countries



Condom use has increased from a median of 6% to 18% in a period of 6 years.

Table 3a: Median percent with 95%CI of condom use at last sex by residence and wealth combined

	Survey round						Annual Change	
	1997			2003				
	n	Median	95%CI	n	Median	95%CI	Median	95%CI
Residence & Wealth								
Rural poor	1315	9.1	(4.5 18.9)	1059	15.9	(7.8 23.9)	0.96	(-0.23 1.51)
Rural rich	1361	17.8	(9.2 25.4)	1128	26.5	(16.5 36.5)	0.94	(-0.75 3.28)
Urban poor	1116	20.7	(11.4 35.3)	1319	36.7	(20.0 52.3)	2.96	(0.84 3.77)
Urban rich	1123	30.2	(20.4 50.3)	1415	47.9	(33.3 62.9)	3.41	(-0.60 4.71)

Section conclusions

- Condoms as a method of contraception among young unmarried people has increased.
  - ➢ Condom are now the most commonly used method in this sector of the population.
  - ➢ They have higher failure rate than, e.g. oral contraceptives, but offer dual protection.
  - ➢ Also well suited for many young people for whom sex is a relatively infrequent event.
  - ➢ The availability of the method at commercial outlets is a bonus.
    - ➢ Purchase can be quick and anonymous.
- Promotion of condoms as pregnancy vs. disease-prevention might be more effective
  - ➢ easier to negotiate use with a partner for pregnancy prevention than for disease
  - ➢ the latter strategy implies that the partner might be infected whereas the former one carries no such imputation.
- A greater sense of 'ownership' of condoms by the FP movement is desirable.
- Trends in condom use show much steeper increases in urban vs. rural areas.
  - ➢ Need to assess the extent to which limited access to condoms in rural areas is impeding increased uptake.

Section 4:
Method - Choice

Method choice

•A reasonably wide and free choice of contraceptive methods is firmly entrenched as a key ingredient of overall quality of family planning services

- Also has been re-emphasised under the Rights approach

•Evidence also exists to show that the introduction of a new method tends to increase overall use or that widened access to a range of methods has the same effect

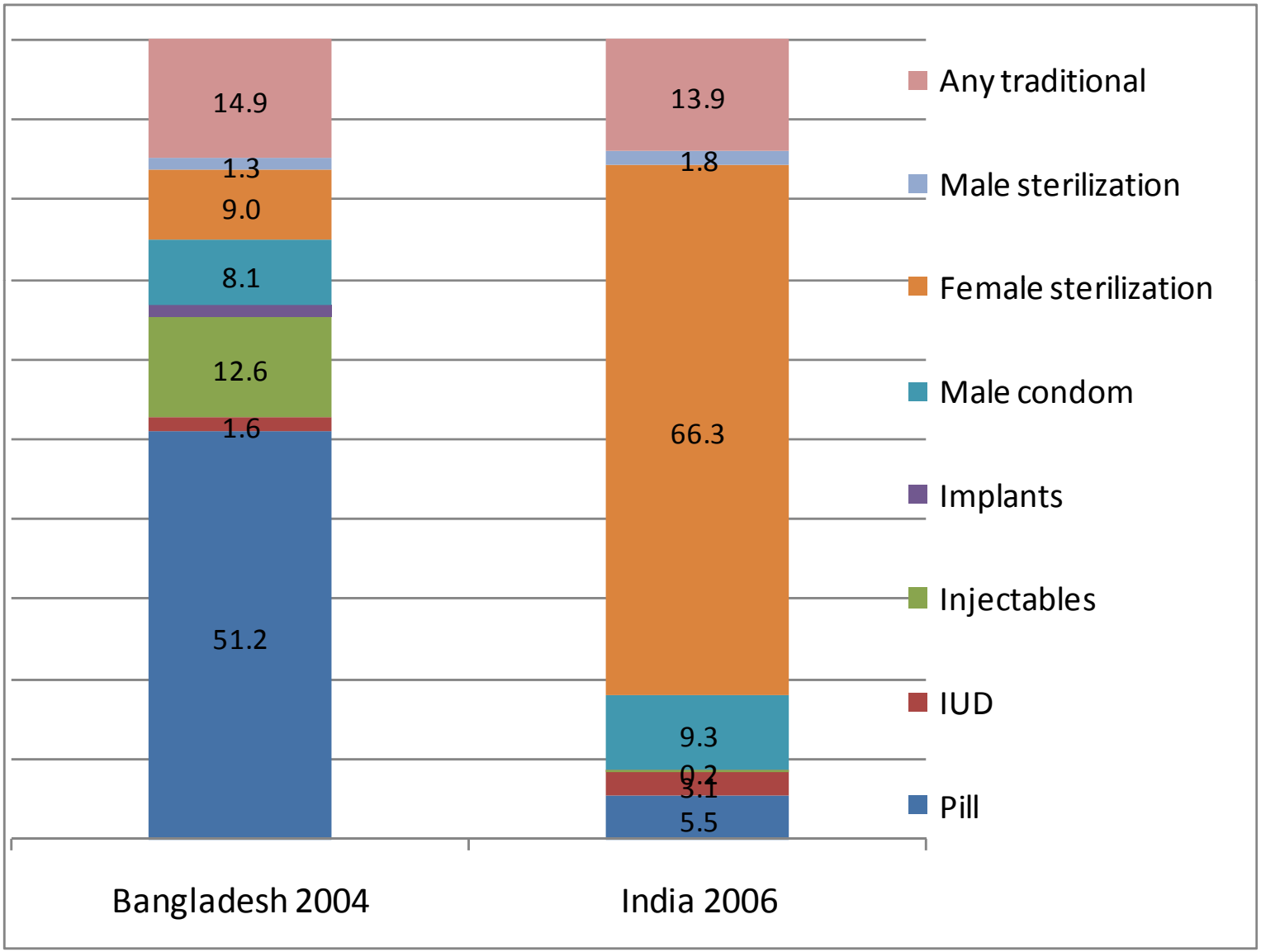
•Severe method skewness is common in

- rich, poor, highly educated countries, poorer countries etc.
- the conclusion might be that it is a matter of no concern

•Forces underlying limited contraceptive choices operate in both poor and rich country settings

- Consider India vs. Bangladesh (Figure 4a)

Figure 4a: Percentage distribution of currently married women by contraceptive method currently used in Bangladesh and India



Key conclusions

- Method choice is an important component of the quality of a family planning service
  - For some countries (rich and poor) one single method accounts for over half of all contraceptive protection
  - In many more countries two methods account for most protection.
- This very partial realisation of the full potential of contraception
  - in meeting the diverse needs of women and couples should be more widely recognised as a shortcoming
- New strategic direction for international FP might be
  - to broaden effective method choice in selected countries where skewness is particularly severe.