



## **Return to Fertility & Pregnancy Risk After Delivery**

Global Online Discussion Forum

September 24-October 5, 2012

Summary Report

### **Background**

The Maternal and Child Health Integrated Program (MCHIP) hosted a two week online discussion forum on “Return to Fertility and Pregnancy Risk After Delivery” from September 24 to October 5, 2012 through the Postpartum Family Planning Community of Practice (PPFP COP). The PPFP COP was established in 2007 to encourage global dialogue and exchange information around essential postpartum family planning (PPFP) technical and programmatic issues.

Misconceptions around timing and conditions for return to fertility and pregnancy risk, and stigma related to postpartum return to sexual activity often act as barriers to healthy timing and spacing of pregnancies and timely postpartum family planning uptake. The Online Forum featured research findings and program learning around postpartum return to fertility and strategies for strengthening knowledge of pregnancy risk and timely uptake of family planning services.

### **Objectives**

The objectives of the forum were four-fold:

1. To discuss perceptions held by women, their partners and health providers around fertility return and return to sexual activity during the postpartum period.
2. To discuss barriers to timely uptake of family planning services during the postpartum period.
3. To share strategies for strengthening understanding of postpartum return to fertility and enabling women to access family planning services.
4. To obtain feedback from participants based on field implementation experiences.

Limited program experience and research on this topic has been documented from low resource settings, so it was hoped that this forum would provide a valuable opportunity for sharing and discussion.

### **Expert Facilitators**

A group of experts served as forum facilitators and shared their practical experiences, lessons learned, and challenges:

- Catharine McKaig, MCHIP South Sudan Integrated Service Delivery Program
- Trinity Zan, FHI 360
- Salahuddin Ahmed, MCHIP Bangladesh
- Chelsea Cooper, MCHIP/Jhpiego
- Marcos Arevalo, Pathfinder International
- Anne Pfitzer, MCHIP/Jhpiego

Discussion posts were circulated to approximately 1,087 PFP COP members from 82 countries. The daily postings and resources shared over the course of the online forum can be accessed by visiting the PFP COP library at: <http://my.ibpinitiative.org/pfp>.

### Top Take Home Messages from the Discussion

Key themes that were addressed during the forum included the following:

- Postpartum women’s misconceptions around fertility return and pregnancy risk often act as a barrier preventing them from accessing FP services after delivery, placing them at increased risk of unintended and closely spaced pregnancies. Postpartum women often think that they are not at risk of pregnancy until menses return or for as long as they are breastfeeding, and/or that past birth intervals are a predictor of likely timing of future pregnancies.
- Women’s decisions to use family planning after delivery are complex and rely on other factors beyond just having sufficient information about timing of fertility return and importance of timely contraceptive uptake. More research is needed to better understand the individual and social factors that affect behaviors in this area.
- Provider attitudes and behaviors often act as a barrier to women’s timely uptake of family planning after delivery. Providers often do not systematically or proactively communicate information about postpartum pregnancy risk to clients, and in some places providers rely on direct observation of menses (e.g. seeing blood on a pad or cotton) to rule out pregnancy, and therefore deny methods to non-menstruating women. In many cases, providers assume that postpartum women have not yet returned to sexual activity, and thus may feel it is not necessary to proactively discuss or offer family planning to postpartum women.
- Utilize LAM as an introduction strategy or ‘gateway method’ to PFP. One of the goals of LAM is the timely transition to another method, *prior* to return to fertility. Research indicates that women using LAM are more likely to use a modern contraceptive method at 12 months postpartum<sup>1</sup>. IEC materials, counseling, follow-up schedules, referral systems, commodity distribution, etc. are designed to help LAM users switch to another FP method before LAM ends. Mothers can and should be encouraged to continue breastfeeding their baby, offer complementary foods if he is at least six months AND start another modern method of FP as soon as possible.

---

<sup>1</sup> Bongiovanni, A. et al. 2005. Promoting the Lactational Amenorrhea Method (LAM) in Jordan Increases Modern Contraceptive Use in the Extended Postpartum Period. The LINKAGES Project, Academy for Educational Development.

- Attitudes and behaviors around return to fertility and postpartum contraceptive use can change. Experience from the Healthy Fertility Study indicates that perceptions around return to fertility can be shifted, and contraceptive uptake during the postpartum period can be improved, through community-based programming with sufficient running time to observe such changes.
- More work needs to be done to equip women with the knowledge and tools to adequately space births and improve health outcomes both for themselves and their children. It will require addressing social norms and creating an enabling environment for women to act on the knowledge by ensuring that health providers, partners and families understand the return to fertility postpartum and support timely contraceptive uptake.

### **Summary of Discussion by Topic**

The two-week discussion was organized around four key topics, each led by one of the forum experts. Various members from the COP contributed their valuable experiences and insights to the dialogue. Discussion points highlighted below are derived from facilitators' and participants' personal and program experiences, as well as published research.

A summary of the discussion, organized by each discussion topic, can be found below.

#### **1. Overview of key considerations for return to fertility after delivery**

This session was facilitated by Catharine McKaig. Key areas of discussion included:

- A key barrier that programs face, particularly during the extended postpartum period (after six weeks through the first year postpartum) is an abundance of misconceptions about fertility return (in particular, menses return) and pregnancy risk after delivery. These misconceptions often prevent women from seeking timely initiation of contraception, and can put them at risk for another pregnancy too soon.
- From experience with MCHIP and ACCESS-FP, misconceptions may affect programs in two ways: 1) Women believe that they are not at risk for pregnancy until menstruation returns, and 2) Women believe that they are not at risk for pregnancy for a specific period, either based on their previous experience or that of other women in their families. Many health providers hold these same beliefs, and simply assume that amenorrheic women are not at risk for pregnancy, so they do not proactively offer FP to them.
- Beliefs around fertility return are often deeply held, and are difficult to change, requiring more personalized counseling. Individual counseling had been relatively successful at increasing early initiation of contraception and providing protection against unintended pregnancies, but it requires specialized messages, concentrated attention and multiple contacts.
- In response to Dr. McKaig's post, Yongmei Huang from Population Council cited findings from a study on Chinese rural-to-urban migrant women, which revealed that misconceptions about the return to fertility after childbirth were the main reasons for the delay of contraception

initiation<sup>2</sup>. Most interviewees believed that they would not become pregnant soon after delivery without the return of menses or if they were lactating when their menses resumed. They felt that “the maternal body was not ready for another pregnancy.” Another study<sup>3</sup> that they conducted involved providing intensive contraception counseling and free contraceptive methods for rural-to-urban migrant women and their partners, who came to a hospital for hospitalized delivery, prior to discharge. Data from this intervention study indicated that early contraceptive counseling and free postpartum contraceptive services can promote early use of contraception, and reduce the occurrence of unintended pregnancy among migrant women.

- Other forum participants cited specific misconceptions around fertility return that they have acted as barriers to postpartum contraceptive uptake, such as:
  - The belief that women cannot get pregnant for at least a year after delivery
  - The belief that women will not become pregnant as long as they are breastfeeding
  - The belief that when women reach a certain age, even if they are still actively menstruating, they cannot get pregnant
  - The belief that sperm spoils the breast milk so women are restricted from resuming sexual intercourse until the baby stops breastfeeding
  - The belief that contraceptives may cause cancer and so are not advisable to use especially when you are still thinking of having another child
- One participant emphasized the importance of finding a way to reconcile local knowledge and public health/medical knowledge. She mentioned that asking women to believe that they are fertile before their menses returns may be counter-intuitive and requires that a woman disregard what her own body and experiences are telling her. It is important for health workers to realize that what they are asking a woman to do may not seem consistent with what her own body tells her, highlight the benefits of timely contraceptive uptake, and explain the consequences of not taking the recommended actions.
- Specific strategies to raise awareness about postpartum fertility return and timely family planning uptake after delivery suggested by forum participants included:
  - Midwives and family planning providers should be able to give health education at ANC and other service contacts on FP. Health education should also be given at the out-patient department waiting area to the clients who come for consultation.
  - Mobile clinics should be organized in areas where trained FP providers are not present.

---

<sup>2</sup> Huang YM, Merkatz R, Kang JZ, Roberts K, Hu XY, Di Donato F, Sitruk-Ware R, Cheng LN. Postpartum unintended pregnancy and contraception practice among rural-to-urban migrant women in Shanghai. *Contraception*. 2012 Jun 13. [Epub ahead of print] PubMed PMID: 22703950

<sup>3</sup> Publication pending.

- Nurses and other health worker cadres should be trained to provide counseling and method at the different communities.
- IEC materials with messages around return to fertility and pregnancy risk are needed at the health center and for the community.
- Include religious gatekeepers in sensitization efforts.
- Conduct rigorous follow up of postpartum women by field staff.

## **2. Return of menses following childbirth and family planning use: Findings from Ghana, India, Rwanda, and Zambia**

This session was facilitated by Trinity Zan. Key areas of discussion included:

- The PROGRESS Project recently presented findings related to return of menses following childbirth and use of modern family planning from six studies conducted in four countries: Ghana, India, Rwanda and Zambia. While none of the studies was designed specifically to explore postpartum return to fertility, the return of menses following childbirth emerged as an important theme in all six studies. Key findings include:
  - Postpartum contraceptive use: Self-reported data from these studies confirm the relationship between resumption of menses and use of family planning among postpartum women that has been seen primarily in aggregate DHS data, namely that modern contraceptive use is higher among women whose menses have returned following childbirth than among amenorrheic women.
  - Understanding of pregnancy risk: Among women, analysis of the data indicated substantial and persistent gaps in understanding of pregnancy risk vis-à-vis amenorrhea in the postpartum period.
  - Provider barriers to FP initiation: Findings suggested that providers do not systematically communicate information about postpartum pregnancy risk to clients. Some providers relied on direct observation of menses (e.g. seeing blood on a pad or cotton) to rule out pregnancy, and denied methods to non-menstruating women.
- According to the FHI 360/PROGRESS data, a provider may deny a postpartum woman an FP method either because she does not think the client is at risk or because s/he thinks the client may already be pregnant—both based on her amenorrheic status. There have already been trainings, and protocols and tools created—like the pregnancy checklist—to decrease the likelihood that a woman is denied an FP method because she is not menstruating.
- PROGRESS documented evidence that providing pregnancy tests to FP clinics may help decrease the number of women turned away for same-day FP method provision due to menstrual status. Based on positive results in one study context where provision of free pregnancy tests led to increased access to same-day provision of FP, PROGRESS suggested that offering pregnancy tests could be a nice complement to use of the checklist when the checklist cannot rule out pregnancy. Pregnancy tests may also have other benefits—including attracting clients to health centers, serving as a tool to support continuation of progestin-only methods, and being socially marketed/sold by CHWs or clinics for a small profit. PROGRESS also pointed out that pregnancy

tests are not, in fact, as expensive as previously thought, costing as little as \$0.09 per test strip. It was estimated that the cost per client not turned away for FP was only US \$0.57 with provision of the pregnancy tests<sup>4</sup>.

- Although a woman may understand or acknowledge an abstract risk of pregnancy prior to return of menses, she may not personalize that risk and instead believe in her own personal history of not getting pregnant for a specific period of time (e.g. 2 years and/or until her menses return).
- Women’s decision-making may be influenced by provider attitudes and behaviors, specifically provider requirements that women must be menstruating in order to start an FP method. Although a woman may understand the pregnancy risk prior to return of menses, she may still wait for menses before she goes to seek a method because she knows the provider will require this. This may be especially true if her personal “aversion” to pregnancy is weak or moderate. In this instance, the “hoops” she may have to jump through to get a method may outweigh the perceived benefit of obtaining services.
- This an area that deserves more exploration, documentation, and research -- why women who understand pregnancy risk prior to return of menses still choose to wait for menses before beginning a method.
- In response to Ms. Zan’s post, Anne Pfitzer raised a number of questions around whether there is need for clinicians to use stronger persuasion at time of birth (especially with high parity women or those with serious health concerns). Where is the line between provision of information and persuasion? Is some form of persuasion acceptable? She also raised questions around client rights and discussing family planning in the immediate postpartum period. For example, as women’s rights advocates, many of us strongly belief in putting emphasis on client rights. Are clinicians who assist women in childbirth made reluctant to actively engage in deeper discussions of contraception in the immediate postpartum out of respect for client rights? Or is it more a matter of thinking the timing seems wrong (even though we have seen again and again that some women hunger for that information exactly at that time)?

### **3. Perceptions around postpartum fertility return & programmatic implications in Bangladesh**

This session was facilitated by Salahuddin Ahmed and Chelsea Cooper. Key areas of discussion included:

- A Return to Fertility Assessment, conducted in July-September of this year, aimed to examine views of women, husbands, and mothers/ mothers-in-law in the MCHIP-supported Healthy Fertility Study sites regarding postpartum return to fertility. Key findings included:
  - Knowledge of risk of pregnancy before menses return: Women with infants under one year generally were aware that women can become pregnant before menses resumes. A number of respondents mentioned that these views have been changing over time, and

---

<sup>4</sup> Stanback J, Diabaté F, Dieng T, Duarte de Morales T, Cummings S, Traore M. Ruling out Pregnancy Among Family Planning Clients: The Impact of a Checklist in Three Countries. *Studies in Family Planning*. 2005;36(4):311-5.

that there is growing understanding in their communities that women can indeed become pregnant before menses resumes.

- Firsthand experiences with closely spaced pregnancies: A couple of respondents cited that their perspectives on fertility return and importance of timely FP uptake had shifted as a result of firsthand experience with closely spaced pregnancies.
- Barriers to timely FP uptake after delivery: Although respondents report increased levels of knowledge and shifting community beliefs around postpartum fertility return and importance of timely FP uptake, many women still face barriers to timely FP uptake after delivery. Several women cited knowing that they are currently at risk of pregnancy, but still not using a modern FP method. Barriers cited by respondents included: a desire to have more children before using an FP method, opposition from partner and mother-in-law, and infrequent sexual activity/husband working abroad.
- In response to the post, Adrienne Alison reported that in World Vision's experience, CHWs do household level counseling for all pregnant women and women with children under two in our integrated MNCHN program. Mothers-in-law and occasionally fathers are in the house at the time, and everyone is counseled together. She emphasized the importance of counseling couples, because when male CHWs counsel men, and female CHWs counsel women separately, the messages may not be consistent but conflicting. Conflicting messages cause discord, and rather than facing this difficulty, couples stop talking about FP use altogether. She also emphasized the importance of community mobilization (including reaching out to religious leaders) as necessary for building an enabling environment.

#### **4. Return to Fertility, Lactational Amenorrhea Method (LAM), and timely transition to other modern methods**

This session was facilitated by Marcos Arevalo. Key areas of discussion included:

- Some providers and breastfeeding mothers think that if the mother is still breastfeeding and amenorrheic she is protected against pregnancy even when the mother introduces complementary foods. Indeed, some providers will not initiate family planning to lactating women because they think that these women are not fertile.
- Some providers assume that breastfeeding women are not sexually active since this may not be culturally acceptable. On the other hand, some providers may be concerned that the timing of the return of fertility is not predictable among breastfeeding mothers and could happen before six months especially if the baby starts receiving more liquids and/or food.
- Utilize LAM as an introduction or 'Gateway' strategy to PFP. Under this approach, the goal of LAM is the timely transition to another method, PRIOR to return to fertility. IEC and BCC materials, counseling, follow-up schedules, referral system, commodity distribution, etc. are designed to help LAM users change to another FP method before LAM ends. Mothers can and should be encouraged to continue breastfeeding their baby, offer complementary foods if he is at least six months AND start another modern method of FP as soon as possible.
- John Stanback from FHI 360 responded to this post by suggesting that where pregnancy tests are not easily available, it's crucial that providers also trust LAM as a means to rule out pregnancy

when a woman comes for that new method. Otherwise, if the woman is still amenorrheic, the provider may worry that she is pregnant and refuse to provide a method until the woman presents with menses. It would be a sad irony if LAM users who want to transition are being sent home from the clinic empty handed because providers don't trust client histories (such as the pregnancy checklist) and don't have free pregnancy tests available.

### **Summary and Closing**

In the concluding post, Anne Pfitzer provided a summary of key points raised during the online forum and thanked participants for their contributions.

The forum highlighted research findings and program experiences around return to fertility. Salahuddin Ahmed and Chelsea Cooper shared preliminary findings from a Return to Fertility Assessment as part of the Bangladesh Healthy Fertility Study and Trinity Zan analyzed questions around return to fertility from six FHI360 studies in 4 countries. Yongmei Huang of Population Council shared an interesting study of contraceptive practices and unintended pregnancies among recently migrated women in Shanghai, China. Overall however, there does not appear to be much research in this area from low resource settings.

In addition to research findings, participants also shared their observations and program learning, including Manjuh Florence from Cameroon, Adrienne Allison and Minal Mehta about programs in India, and from Marcos Arevelo about work in Angola. The issue of timing of pregnancy risk and strategies to minimize the risk is perhaps not a topic that surfaces as often as it should in our work. Dr. Arevelo suggests that more programming and education about the Lactational Amenorrhea Method and the transition to other modern contraceptive methods offers a conduit for changing perceptions, and indeed, the Healthy Fertility Study assessment suggests that perceptions can change and awareness evolves, for example through the use of storytelling.

This discussion does highlight that more work needs to be done to equip women with the knowledge and tools to adequately space births and improve their own and their children's health outcomes. It will require addressing social norms and creating an enabling environment for women to act on the knowledge by ensuring that health providers, partners and families understand the return to fertility postpartum and support timely contraceptive uptake.