Education for contraceptive use by women after childbirth

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An updated version of this systematic review has been published and can be found online at www.cochrane.org. We will soon update the below RHL summary to reflect the updated findings of the systematic review.

Overall, available evidence suggests that postpartum contraceptive education may increase contraceptive use and decrease unplanned pregnancies. However, the results cannot be generalized to all women in under-resourced settings.

RHL Commentary by Dadhwal V

1. INTRODUCTION

The provision of contraceptive education is now considered a standard component of postpartum care. Postpartum contraception counselling is often limited to one encounter which is unlikely to affect behaviour. Decisions about contraception use made right after counselling may differ considerably from actual contraceptive use postpartum (1). Though postpartum contraceptive education has become common, research on evaluation of such interventions is still limited. Surveys from 27 countries indicate that two-thirds of postpartum women had an unmet need for contraception (2). A 1966 project sponsored by the Population Council on family planning, focusing primarily on developing countries, was considered a success given its ability to reach a large number of women. This project was based on the assumptions that women are more receptive to family planning education during the postpartum period, and that they will not return to the health centre for contraception after discharge (3). It should pointed out, however, that randomized controlled trials (RCTs) were not used to assess the effectiveness of the Population Council project.

This Cochrane review (4) combines data from RCTs on the effectiveness of postpartum interventions to educate women about contraceptive choices. The primary objective of the review was to evaluate the effectiveness of postpartum interventions on preventing unplanned pregnancies, improving contraceptive knowledge, attitudes and practices, increasing or improving breast-feeding and improved satisfaction with care. Secondary objectives were to determine the effectiveness of interventions according to: mode of delivery of the intervention (written material, video/audio recording, one-to-one or group counselling); type of health-care professional providing the intervention (midwife/nurse, physician or specially trained lay person); and timing (immediately postpartum, postpartum visit in a health-care facility or at home, or another occasion).
2. METHODS OF REVIEW

The authors thoroughly searched relevant databases. RCTs were included in the review if they had evaluated postpartum education with the aim of influencing the uptake of contraception, including lactational amenorrhoea. Trials that had focussed on needs of women with alcohol or drug problems and those with chronic health conditions were excluded. Education interventions included written material, video or audio recordings, or individual or group counselling. In the included trials, the intervention commenced postpartum and was applied during the first month after delivery. The review authors evaluated the included trials for methodological quality: they considered randomization method, blinding and loss to follow-up and early discontinuation.

3. RESULTS OF THE REVIEW

Eight trials with 3017 women met the inclusion criteria. The studies had been conducted in Australia, Nepal, Pakistan, Syria and the USA. Three trials had focussed on adolescents. There was heterogeneity in the trials in terms of content and format of education. Three trials had focussed solely on contraception while five had addressed additional health education or parenting issues as well as contraception. In most trials clinicians were used to provide education and in most cases providers had received some intervention-related training.

3.1 Short-term counselling (one or two contacts)

Data from two studies were suitable for analysis. In one study from Pakistan (n=648), at 8–12 weeks postpartum all of the woman in counselling group planned to use a modern contraceptive method compared with a third in the control group. More importantly, women in the counselling group were more likely to be using contraception at 8–12 weeks [odds ratio (OR) 19.56, 95% confidence interval (CI) 11.65–32.83]. The intervention involved a 20-minute counselling session for contraception immediately after birth and a pamphlet.

In the second study from Nepal (n= 540), women were randomized into four groups: (i) counselling immediately after birth and at 3 months; (ii) counselling immediately after birth; (iii) counselling at 3 months; and (iv) no counselling. The outcomes studied were duration of exclusive breast-feeding and uptake of family planning. At 6 months, groups with immediate postpartum counselling were more likely to use contraception than others (OR 1.62, 95% CI 1.06–2.50). The group with two sessions was similar to the group with one immediate session at 6 months. The group with immediate session did not differ much from group with no education. Family planning was not emphasized in immediate session; it was part of other health counselling. Exclusive breast-feeding was emphasized in the immediate counselling, but the study arms did not differ in breast-feeding in any comparisons.

One study did not provide data regarding contraceptive choice, but data on satisfaction were reported. Women who had counselling by a physician were more satisfied than those who had watched a video (OR 0.27, 95% CI 0.07–0.98). Satisfaction was the same in groups that had watched video or received a pamphlet.

3.2 Multiple contacts (home or clinic based)

Three out of four studies reported a positive effect on pregnancy or contraceptive use. The two that had focussed on adolescents showed fewer repeat pregnancies or births in the experimental group (OR 0.41, 95% CI 0.17–1.00 and 0.35, 95% CI 0.17–0.70 at 24 and 18 months, respectively). The experimental group had multiple contact with health-care professions throughout the period of study. In the third study women in the experimental group were more likely to use contraception at 6 months (OR 3.24, 95% CI 1.35–7.79).
4. DISCUSSION

4.1 Applicability of the results

Of the eight included trials data from six could be used for analysis. Results from five studies showed positive effects; two of these studies had been conducted in the USA and one each in Australia, Nepal and Pakistan. The studies from Nepal and Pakistan were large and primarily hospital-based and there was heterogeneity in the study designs. Overall, the evidence favours that postpartum contraceptive education may increase contraceptive use and decrease unplanned pregnancies.

The results cannot be broadly generalized to women in all developing countries. The studies which evaluated longer-term interventions with positive results are from developed countries and involved multiple visits and considerable amount of time being spent on each subject. This may not be possible in most under-resourced settings. Also, in under-resourced settings, owing to the shortage of trained physicians and nurses, such interventions are likely to be carried out by mid-level health-care providers and it is not known whether those providers will be able to achieve the same results as seen in the studies with physician and nurses.

4.2 Implementation of the intervention

Postpartum counselling should be planned to be initiated for postpartum women. Before implementation on a large scale, the health-care providers will need to test in their own countries or regions the type of intervention that would be most appropriate for their population, keeping in mind the available resources (e.g. single contact or multiple contacts, type of health-care professional providing the intervention, timing of the intervention and method of delivering it). Moreover, the interventions selected may vary from region to region within the same country.

4.3 Implications for research

For short-term interventions, studies with longer follow-up periods need to be done to test the effectiveness of the interventions. Research also needs to focus on postpartum contraception counselling by mid-level health-care providers in developing countries.

REFERENCES
