

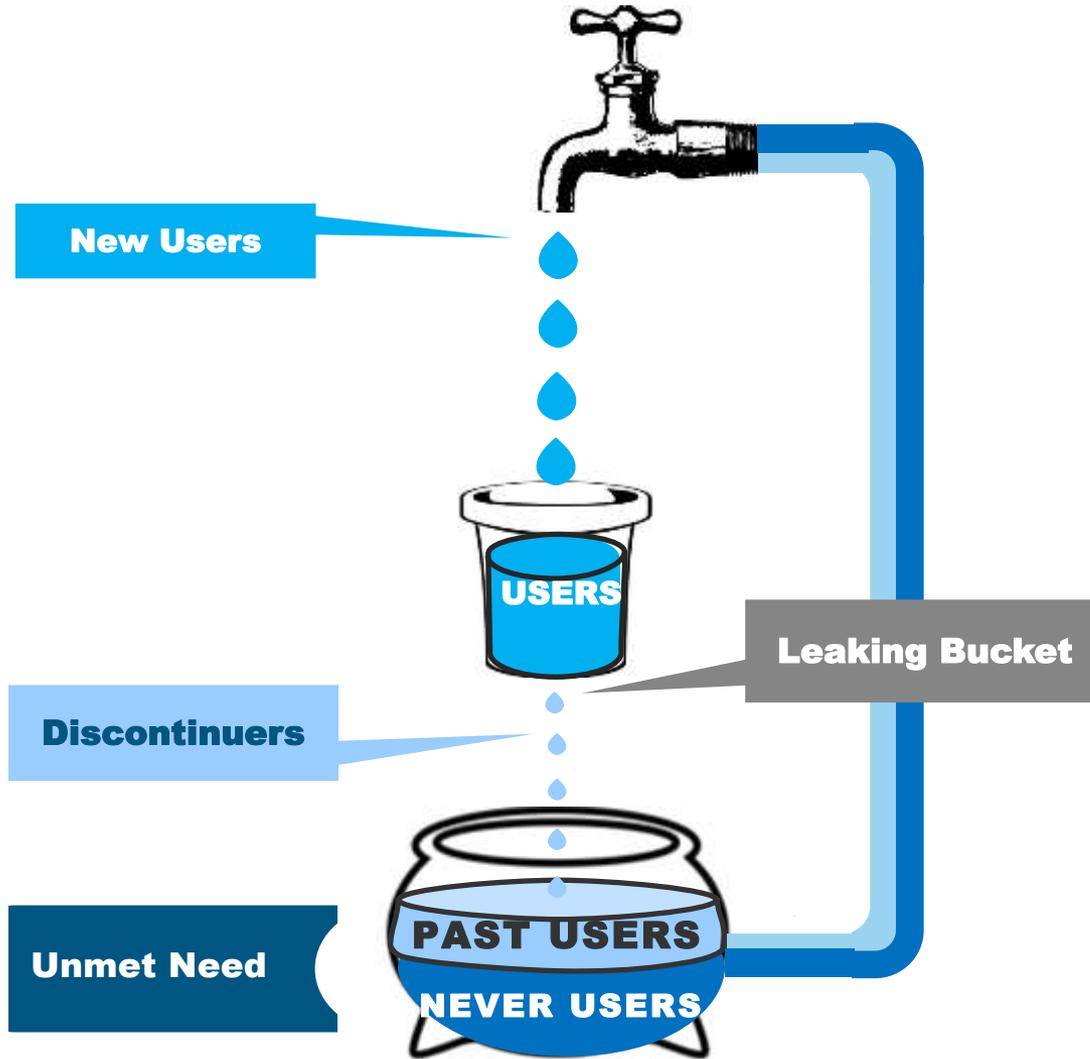
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# HEALTHY TIMING AND SPACING OF PREGNANCIES FOR ALL POPULATIONS: THE CHALLENGE OF DISCONTINUATION

Ian Askew and Sarah Castle

**Accelerating Access to Postpartum Family Planning,  
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# Why is discontinuation important?



# How big a problem is discontinuation?

Method	Average	12 months	24 months
<u>All methods</u>	20 months	38%	64%
<u>Modern</u>			
IUD	40 months	13%	37%
Condom	16 months	50%	74%
Pill	15 months	44%	65%
Injectable	12 months	41%	63%
<u>Traditional</u>			
Period abstinence	18 months	40%	62%
Withdrawal	15 months	40%	62%

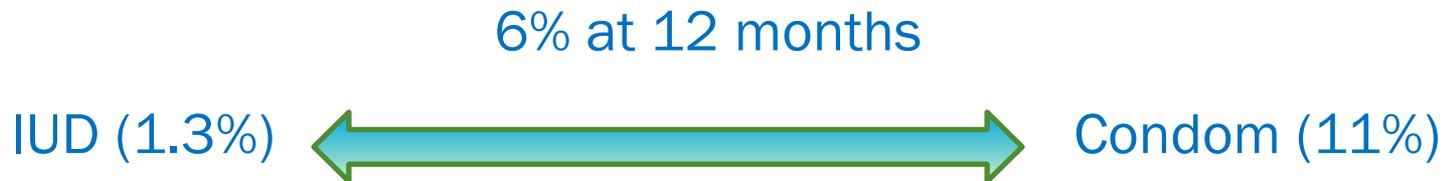
Source : Ali, Cleland and Shah (2012)

# Why do 38% discontinue at 12 months?

## 1. No need:



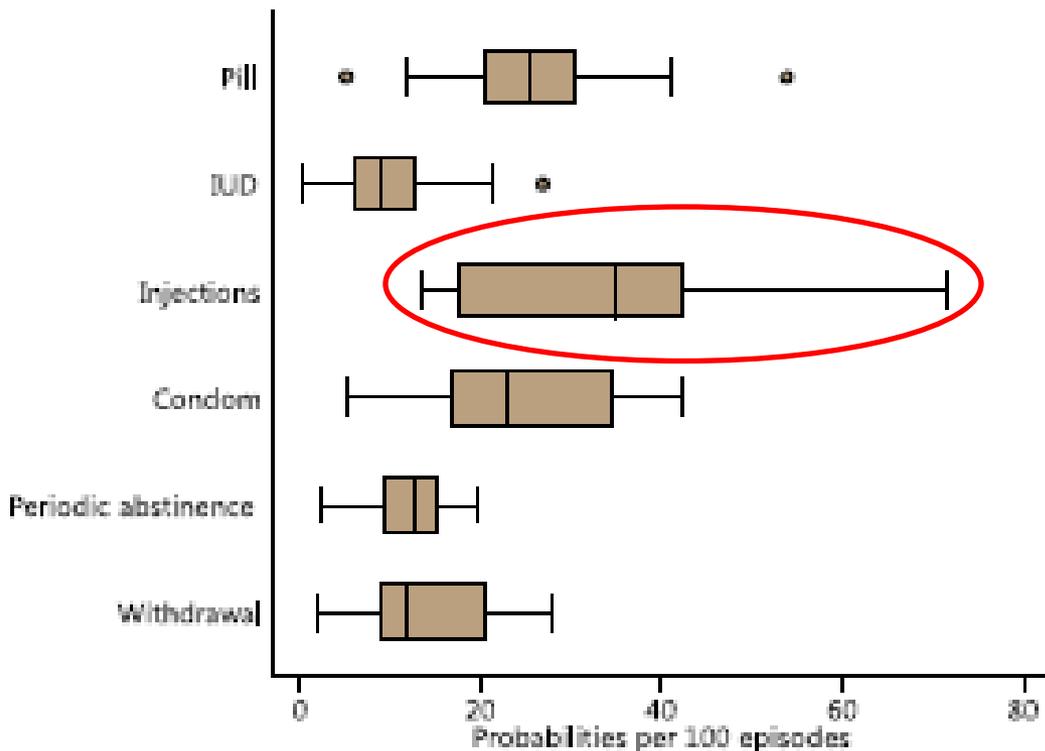
## 2. Want pregnancy:



## 3. Failure:



# Over half discontinue for method-related reasons... But reason varies by method



Injectable, pill, IUD:

- Side effects
- Health concerns

Condom, withdrawal, periodic abstinence:

- Low effectiveness
- Husband's concerns

Source : Ali, Cleland and Shah (2012)

# And what happens afterwards?

## May switch to another method:

- Wide range across countries
  - 92% in Turkey; 14% in Malawi
- Most do so within 3 months
- Majority switch to a modern reversible method
  - But up one quarter may switch to traditional or condom
- Switching is lowest in sub-Saharan Africa

## Consequences of not switching:

- Became pregnant:
  - 3 months: 3 - 20%
  - 12 months: 7 - 38%
- At risk:
  - 3 months: 12 - 56%
  - 12 months: 8 - 42%
- At risk is highest in sub-Saharan Africa

# What do we know about discontinuation among postpartum women?

- Very little actually, but some evidence emerging...
  - In northern Tanzania:
    - Condom use before menses, switch to hormonal afterwards
    - Relatively low levels of discontinuation
  - In urban Kenya:
    - High discontinuation rates for all methods, including LARCs
    - Method-related reasons
    - Highest among non-married
- Community-level postpartum services with male engagement appear to enhance PFP (India, Egypt)

# What works to reduce discontinuation?

**Very little rigorous evidence;**

**However, if a program did just 3 things:**

1. Improve provider counseling skills to:
  - Help women choose the method best suited to their needs
  - Understand how it works and what side effects are likely
  - What to do if they have a problem
2. Increase availability of a full range of methods to facilitate preferred choice and immediate switching by:
  - Improving referral mechanisms
  - Eliminating stockouts
  - Introducing methods not currently available
3. Increase range of service delivery points, contacts and providers to:
  - Increase timely access to more methods
  - Enable clients to engage with empathetic providers

# Closing words of wisdom:

“The issue is not only about adding methods to the contraceptive mix in a country or improving the quality of counseling *per se*. Rather it is about meeting women’s reproductive health needs, their right to have a choice among contraceptive methods, their right to make informed choices, and their right to receive accurate information from service providers about the method they select and about switching methods whenever the initial one is no longer suitable.”

Anrudh Jain, 2014