

Family Planning Needs during the First Two Years Postpartum in Tanzania

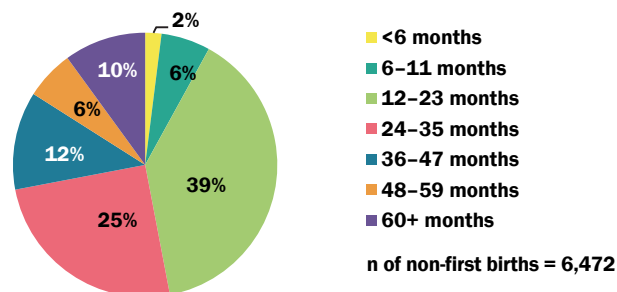
This analysis is based on the 2010 Demographic and Health Survey (DHS) data from Tanzania. It summarizes key findings related to birth and pregnancy spacing, fertility return, unmet need for and use of family planning (FP), and contact with key services for women during the period from the last birth through two years postpartum.

Because research findings demonstrate improved perinatal outcomes for infants born 36–59 months after a preceding birth, experts made recommendations to a World Health Organization (WHO) Technical Committee to advise *an interval of at least 24 months before couples attempt to become pregnant* in order to reduce the risk of adverse maternal, perinatal and infant outcomes.¹ In addition, rigorous analyses have found that interpregnancy (birth-to-pregnancy) intervals that are too short are associated with adverse pregnancy outcomes, increased morbidity in pregnancy, and increased infant and child mortality.^{2,3}

PREGNANCY SPACING IN TANZANIA

Figure 1 presents data from women experiencing births in the past five years. In this analysis, only women with pregnancies that resulted in a live birth are included, and the pregnancy duration is calculated at nine months. Of these pregnancies, 2% occur within very short intervals of less than six months, 6% within short intervals of less than 12 months, and another 39% within intervals of 12–23 months. Thus, almost half (47%) of all pregnancies in Tanzania occur before the recommended interpregnancy interval of at least 24 months.

Figure 1: Interpregnancy spacing among all women aged 15–49, all non-first births in the last five years



Strikingly, the 2010 Tanzania DHS data demonstrate a sharp decrease in infant and childhood mortality rates as the length of the interpregnancy interval increases. Infant mortality decreases by over half, from 86/1,000 for infants born with interpregnancy intervals <15 months, to 48/1,000 for infants born with interpregnancy intervals between 27 and 38 months. Similarly, higher rates of under-five mortality are evidenced for children born with interpregnancy intervals of less than 15 months (136/1,000) compared with children born with interpregnancy intervals between 27 and 38 months (74/1,000).

¹ World Health Organization. Report of a WHO Technical Consultation on Birth Spacing, Geneva, Switzerland, 13–15 June 2005.

² Rutstein SO. Further evidence of the effects of preceding birth intervals on neonatal, infant, and under-five-years mortality and nutritional status in developing countries: Evidence from the Demographic and Health Surveys. *DHS Working Papers, Demographic and Health Research* (41). September 2008.

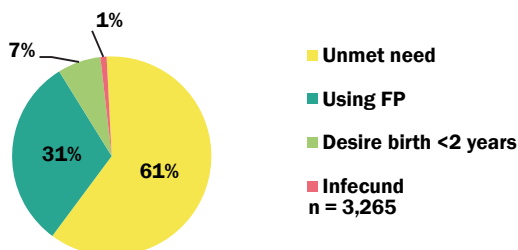
³ Kozuki N, Lee AC, Silveira MF, et al. The associations of birth intervals with small-for-gestational-age, preterm, and neonatal and infant mortality: A meta-analysis. *BMC Public Health*. 2013 ; 13(Suppl 3):S3.

PROSPECTIVE UNMET NEED FOR FAMILY PLANNING

Data from 3,265 women within two years of having given birth were used to examine unmet need, as illustrated below in **Figure 2**. In this analysis, unmet need for FP is defined prospectively⁴ based on the woman's desired timing for her next pregnancy, if any, and her current use of contraception. Prospective unmet need based on fertility preferences looking forward is most likely to predict a woman's need for FP in the extended postpartum period.

Among Tanzanian women within two years postpartum, 61% have an unmet need for FP; 31% are using a method of FP; and only 7% of women desire another pregnancy within two years. Contraceptive use is higher among urban postpartum women (33%) than rural ones (22%).

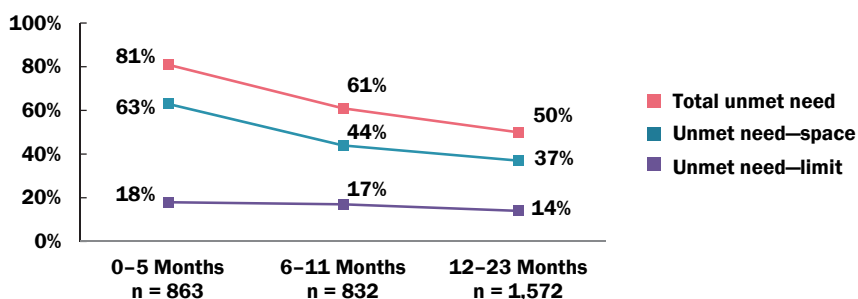
Figure 2: Prospective unmet need for FP among women within 0–23 months postpartum



UNMET NEED FOR SPACING AND LIMITING

Figure 3 demonstrates the prospective unmet need for FP by women's desires for spacing and limiting births through two years postpartum. Total unmet need decreases as the number of months post-delivery increases. Among women 0–5 months postpartum, overall unmet need is 81%. Overall unmet need decreases to 61% among women 6–11 months postpartum, and then decreases further to 50% among women 12–23 months postpartum. With regard to women's fertility desires within total unmet need, the levels of unmet need for limiting decrease slightly throughout the two-year postpartum period, from 18% (0–5 months) to 17% (6–11 months) to 14% (12–23 months). The unmet need for spacing decreases sharply over this same period, going from 63% (0–5 months) to 44% (6–11 months) to 37% (12–23 months).

Figure 3: Prospective unmet need across postpartum periods



RETURN TO FERTILITY AND RISK OF PREGNANCY

The figures on the following page illustrate key factors related to return to fertility and risk of pregnancy. **Figure 4** shows that among all women 0–23 months postpartum, 39% of women are sexually active during the first six months postpartum and 15% have experienced menses return during the same period. By the second year postpartum, 88% of women are sexually active and 77% have seen menses return.

⁴ The definition for prospective unmet need is based on the DHS question: "Would you like your next child within the next two years or would you like no more children?"

Figure 5 looks at the subset of sexually active women during the same period and illustrates how risk of pregnancy increases over time during the two years postpartum. While 47% of sexually active women are at risk of pregnancy during the first six months postpartum, this risk increases to 68% of women 6–11 months postpartum, and then decreases slightly to 65% of women 12–23 months postpartum.⁵

Figure 4: Factors influencing return to fertility among all women 0–23 months postpartum

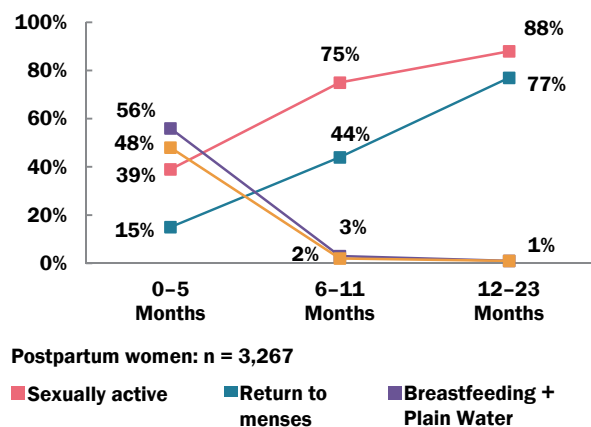
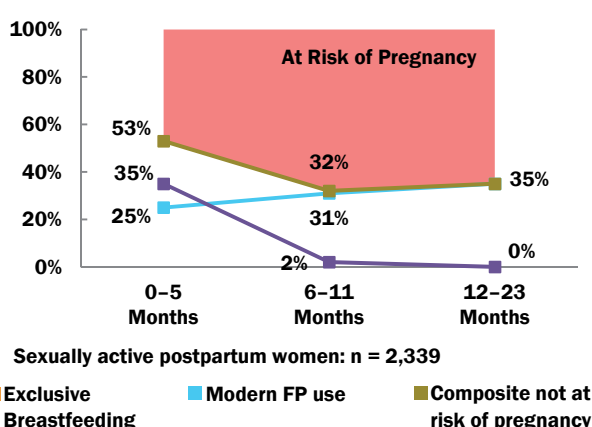


Figure 5: Risk of pregnancy among sexually active women 0–23 months postpartum

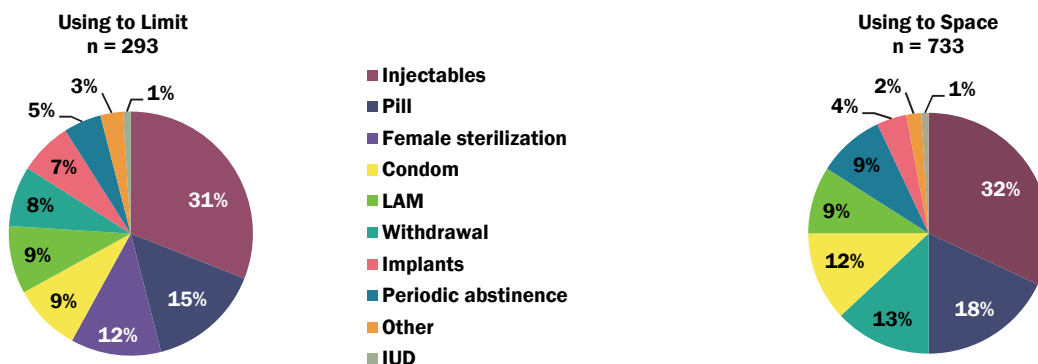


METHOD MIX FOR POSTPARTUM FAMILY PLANNING USERS

Among the 1,024 postpartum family planning users, the largest proportion use injectables (32%), followed by pills (17%), condoms (11%), the lactational amenorrhea method (9%), implants (5%), female sterilization (4%), IUDs (1%), or other methods (2%). The remaining 20% use traditional methods (12% withdrawal and 8% periodic abstinence).

Figure 6 shows the method mix among postpartum women by their reproductive intentions. Among women who are using FP to limit, 80% are using short-acting or traditional methods, while 20% are using long-acting or permanent methods, such as implants (7%), female sterilization (12%) and IUDs (1%). For women intending to space, the mix is also dominated by short-acting methods. Of note is the use of injectables by 32% of postpartum women using FP to space and 31% of those intending to limit.

Figure 6: FP method use among women 0–23 months postpartum according to their intention to limit or space



⁵ The composite not-at-risk calculation includes: (1) women 0-5 months postpartum who are exclusively breastfeeding, or providing breastmilk and plain water only, or are using a modern FP method; (2) women 6-11 months postpartum who are exclusively breastfeeding and menses have not returned, or providing breastmilk and plain water only and menses have not returned, or are using a modern FP method; (3) women 12-23 months postpartum who are using a modern FP method.

INTERPREGNANCY INTERVALS AND CONTRACEPTIVE USE BY AGE

According to the 2010 DHS data, more than three-quarters (78%) of non-first births to young women age 15–19 occur within an interpregnancy interval of less than 24 months, with over half of births (51%) occurring in the second year postpartum. **Figure 7** shows a tendency toward longer, healthier intervals with age. **Figure 8** shows that the youngest and most vulnerable mothers are also the least likely to use postpartum contraception.

Figure 7: Interpregnancy intervals according to women's age

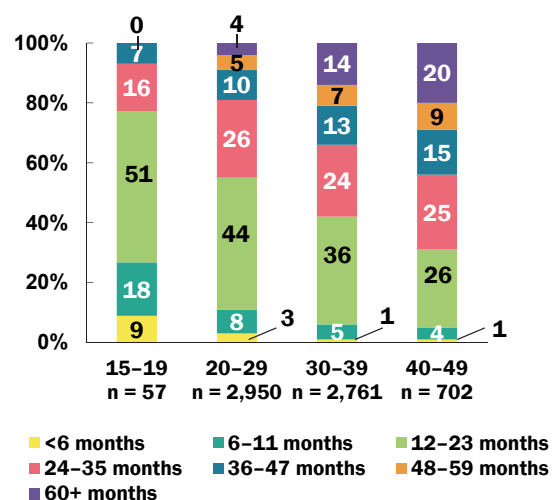
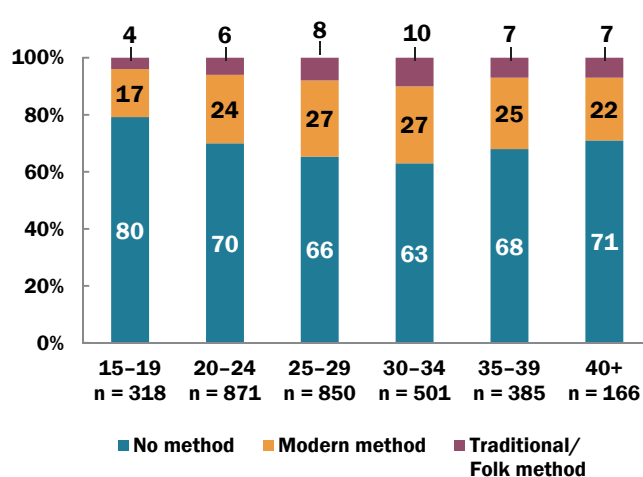


Figure 8: Uptake of FP during the postpartum period by women's age



CONCLUSION

Almost half (47%) of all non-first births in Tanzania are spaced at less than the recommended 24-month interpregnancy interval, putting women and their infants at increased risk for poor maternal and perinatal outcomes. In developing countries, if all women waited 24 months after a birth before having another child, infant deaths (<1 year) would decrease by 10%, and child deaths (ages 1–4 years) would fall by 21%.⁶ This analysis demonstrates that women in Tanzania have a significant unmet need for FP during the two years after a birth. Total unmet need decreases during this period (from 81% to 50%), in part due to the higher proportion of women starting contraception as time elapses after a birth.

In Tanzania, risk of pregnancy peaks in the second half of the first year postpartum. While 47% of sexually active women are at risk of pregnancy during the first six months postpartum, this risk increases to 68% among women 6–11 months postpartum, and then decreases slightly to 65% among women 12–23 months postpartum. While sexual activity is low in the first six months after birth, by the second year postpartum the large majority (88%) of women are sexually active, amplifying the number of women at risk of pregnancy during this period.

Method mix in Tanzania relies heavily on traditional and short-term methods, with the majority of women relying on injectables (32%) and only 10% using long-acting or permanent methods (implants, IUDs, and female sterilization). However, the desire to space is high among women 0–5 months postpartum (63%). Increased use of long-acting methods of FP would improve postpartum women's ability to achieve both spacing and limiting fertility desires.

Young women, especially those less than 20 years of age, have the greatest proportion of births occurring with short interpregnancy intervals of less than 24 months and the least postpartum contraceptive use. With more than three-quarters (78%) of non-first births to women 15–19 occurring with an interpregnancy interval of 0–23 months, these findings suggest that special

⁶ Cleland J, Conde-Agudelo A, Peterson H, Ross J, Tsui A. Contraception and health. *The Lancet*. 2012; 380(9837):149-156.

attention is needed to help the youngest mothers make decisions with respect to healthy child-bearing. **Program evidence indicates that offering postpartum family planning (PPFP) counseling during antenatal care and offering PPFP services during all maternal and child health contacts, can be effective for increasing awareness of, demand for and use of FP in this critical period.**

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