



# Family Planning Needs during the First Two Years Postpartum in the Ethiopia

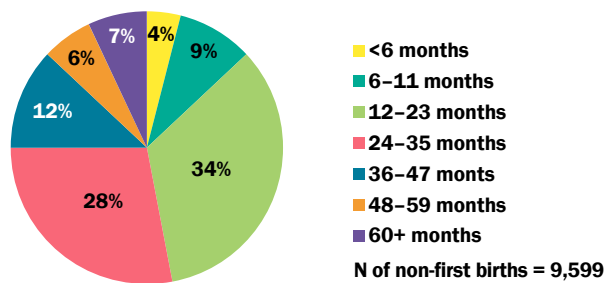
This analysis is based on the 2011 Demographic and Health Survey (DHS) data from Ethiopia. It summarizes key findings related to birth and pregnancy spacing, fertility return, unmet need for and use of family planning (FP), and contact with key services for women during the period from the last birth 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* (birth-to-pregnancy interval) in order to reduce the risk of adverse maternal, perinatal and infant outcomes.<sup>1</sup> In addition, an analysis of DHS data from 52 developing countries, which studied over one million births, found that birth-to-pregnancy intervals that are too short are associated with adverse pregnancy outcomes, increased morbidity in pregnancy, and increased infant and child mortality.<sup>2</sup>

## PREGNANCY SPACING IN THE ETHIOPIA

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, 4% of pregnancies occur within very short intervals of less than six months following the preceding birth, 9% occur within short intervals of less than 12 months, and another 34% occur within intervals of 12–23 months. Thus, almost half (47%) of all pregnancies in Ethiopia occur within short intervals of less than 24 months after the preceding birth.

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



It is noteworthy that the 2011 Ethiopia DHS data demonstrate a sharp decrease in infant and childhood mortality rates as the length of the birth-to-pregnancy interval increases. Infant mortality decreases by more than half, from 122/1,000 for infants born at birth-to-pregnancy intervals <15 months, to 49/1,000 for infants born at birth-to-pregnancy intervals between 27 and 38 months. Similarly, higher rates of under-five mortality are evidenced for children born at birth-to-pregnancy intervals of less than 15 months (179/1,000) compared with children born at birth-to-pregnancy intervals between 27 and 38 months (72/1,000).

<sup>1</sup> Report of a WHO Technical Consultation on Birth Spacing, Geneva, Switzerland, 13–15 June 2005.

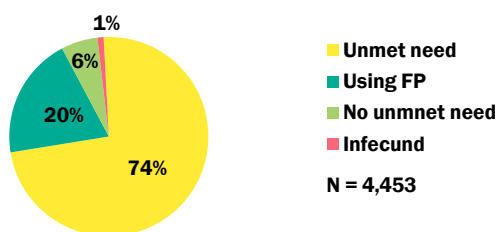
<sup>2</sup> Rutstein SO. 2008. Further evidence of the effects of preceding birth intervals on neonatal, infant, and under-five-years mortality and nutritional status in developing countries: Evidence from the Demographic and Health Surveys. *DHS Working Papers, Demographic and Health Research* (41).

## PROSPECTIVE UNMET NEED FOR FAMILY PLANNING

Data from 4,453 women within two years of a birth were used to examine unmet need, as illustrated below in **Figure 2**. In this analysis, unmet need for FP is defined prospectively<sup>3</sup> regarding the woman’s desired timing for her next pregnancy and her current use of a method of contraception. Prospective unmet need is based on fertility preferences looking forward because it is most likely to predict a woman’s need for FP in the extended postpartum period.

Among women within two years postpartum, 74% have an unmet need for FP; 20% are using a method of FP; and only 6% of women desire another pregnancy within two years.

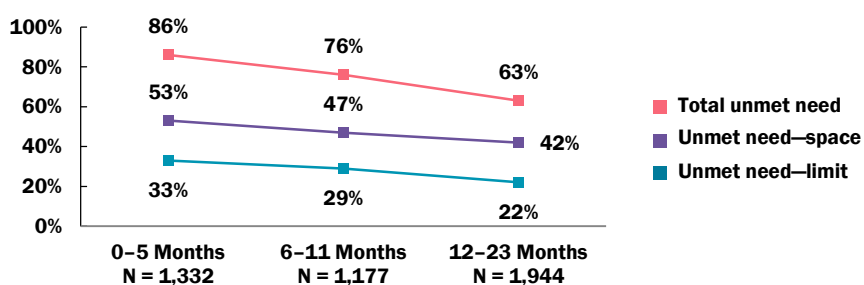
**Figure 2: Prospective unmet need for FP among women within 0–23 months postpartum**



## UNMET NEED FOR SPACING AND LIMITING

**Figure 3** demonstrates the prospective unmet need for 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 86%. Overall unmet need decreases to 76% among women 6–11 months postpartum, and then decreases further to 63% among women 12–23 months postpartum. With regard to women’s fertility desires among the total unmet need, the levels of unmet need for spacing decrease throughout the two-year postpartum period, from 53% (0–5 months) to 47% (6–11 months) to 42% (12–23 months). Similarly, the unmet need for limiting decreases over this same period, going from 33% (0–5 months) to 29% (6–11 months) to 22% (12–23 months).

**Figure 3: Prospective unmet need across postpartum periods**



## RETURN TO FERTILITY AND RISK OF PREGNANCY

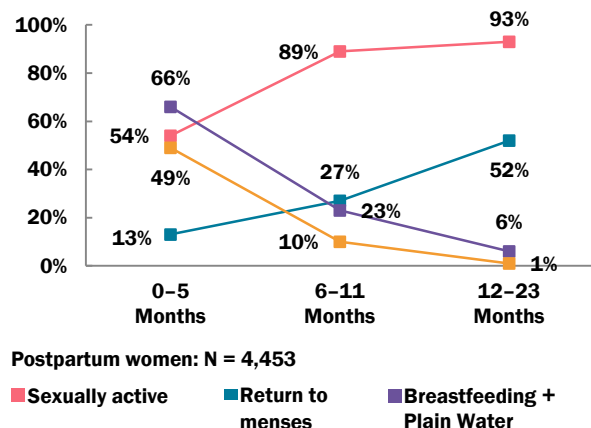
The figures on the following page illustrate key factors related to return to fertility and risk of pregnancy. **Figure 4** shows that among all women 0–23 months postpartum, 54% of women are sexually active during the first six months postpartum and 13% have experienced menses return during the same period. Among women 12–23 months postpartum, 93% are sexually active and 52% have menses return.

**Figure 5** looks at sexually active women during the same period and illustrates how risk of pregnancy increases over time during the two years postpartum. While only 37% of sexually

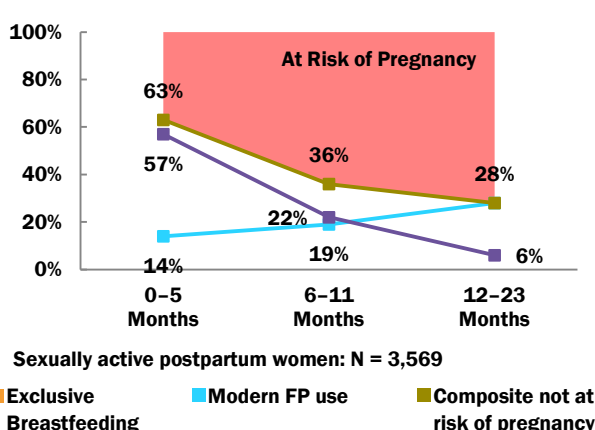
<sup>3</sup> The definition for *prospective unmet need* is based on the DHS question: “Would you like your next child within the next two years or would you like no more children?”

active women are at risk of pregnancy during the first six months postpartum, this risk increases to 64% among women 6–11 months postpartum, and then to 72% among women 12–23 months postpartum.<sup>4</sup>

**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 869 postpartum women who are using a FP method, 77% are using injectables, 10% are using an implant, 7% are using pills, 1% are using an IUD, 1% are using female sterilization, 1% are using condoms and 4% are using traditional methods (withdrawal and periodic abstinence).

**Figure 6** shows the method mix among postpartum women by their reproductive intentions. Among women who are using FP to limit, 82% are using short-acting or traditional methods, while only 18% are using long-acting or permanent methods, such as implants (14%), female sterilization (3%) and IUDs (1%). For women intending to space, the mix is dominated by short-acting methods. Of note is the use of injectables by the majority (78%) of the women who are using FP to space.

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



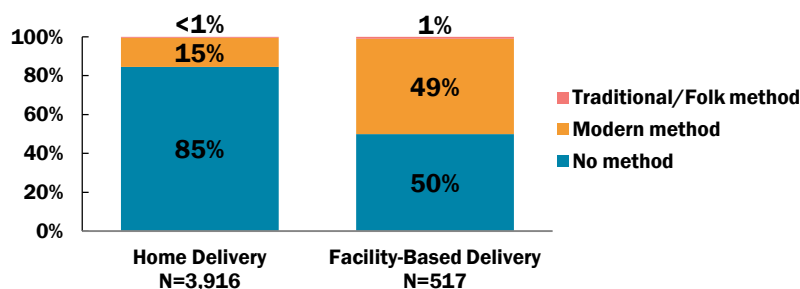
## CONTRACEPTIVE USE BY PLACE OF DELIVERY

According to the 2011 DHS, only 10% of all births in Ethiopia occur at a health facility, while 90% occur at home. **Figure 7** shows that overall, 49% of postpartum women who delivered at a health

<sup>4</sup> 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.

facility are using a modern method of FP, compared with only 15% of women who delivered at home.

Figure 7: Uptake of family planning during the 0–23 months postpartum period by place of delivery



## CONCLUSION

Almost half (47%) of all non-first births in Ethiopia are spaced at less than the recommended 24-month birth-to-pregnancy interval, putting women and their infants at increased risk for poor maternal and perinatal outcomes. This analysis demonstrates that women in Ethiopia have a significant unmet need for FP during the two years after a birth. Even though total unmet need decreases during this period (from 86% to 63%), the overall unmet need is still very high.

In Ethiopia, risk of pregnancy increases over time during the two years postpartum. While only 37% of sexually active women are at risk of pregnancy during the first six months postpartum, this risk increases to 64% among women 6–11 months postpartum, and then to 72% among women 12–23 months postpartum. Method mix in Ethiopia relies heavily on short-acting methods, with the majority of women relying on injectables (77%) and only 12% using long-acting or permanent methods (implants, IUDs and female sterilization). However, the unmet need to limit is still high for postpartum women (33% among women 0–5 months postpartum and 22% among women 12–23 months), demonstrating the need for increased access to long-acting and permanent methods of FP, which are highly effective methods for women to achieve their desired pregnancy spacing/limiting needs.

While only 10% of Ethiopian women deliver at a facility, this analysis reveals a striking difference in postpartum family planning (PPFP) use among women who choose a facility birth, suggesting that encouraging greater utilization of health services overall might be appropriate. Program evidence indicates that offering 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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