



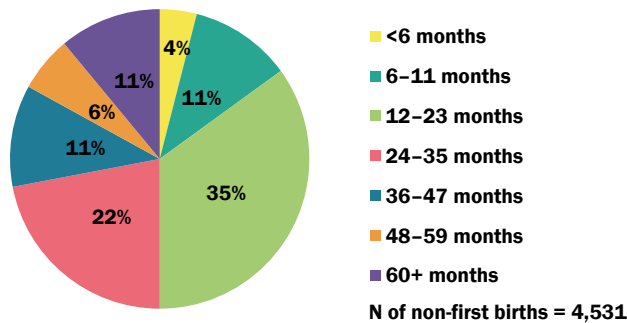
Family Planning Needs during the First Two Years Postpartum in Kenya

This analysis is based on the 2008–09 Demographic and Health Survey (DHS) data from Kenya. It summarizes key findings related to pregnancy spacing, fertility return, family planning (FP) use and contact with key services for women during the period from the last birth through two years postpartum.

PREGNANCY SPACING IN KENYA

Figure 1 presents data from women experiencing births in the past five years. In this analysis, the pregnancy duration is calculated at nine months and only women with pregnancies that resulted in a live birth are included. Half (50%) of all pregnancies in Kenya occur within short intervals of less than 24 months after the preceding birth. Of these pregnancies, 15% occur within very short intervals of less than 12 months, and another 35% occur within intervals of 12–23 months.

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



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.¹ 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.²

It is noteworthy that the 2008–09 Kenya 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 91/1,000 (for infants born at intervals <15 months) to 31/1,000 (for infants born at intervals between 27 and 38 months). Similarly, higher rates of under-five mortality are evidenced for children born at intervals of less than 15 months (130/1,000) compared with children born at intervals between 27 and 38 months (53/1,000).

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

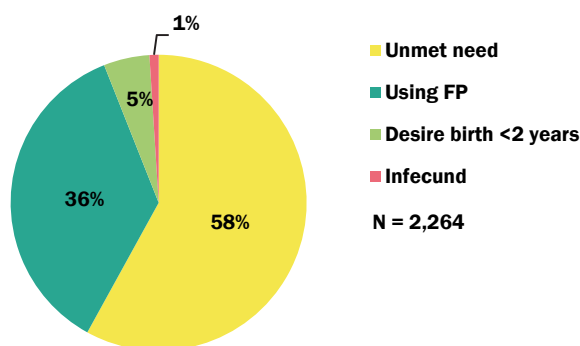
² Rutstein SO. 2008. Further evidence of the effects of preceding birth intervals on neonatal, infant, and under-five-years mortality and nutritional status in developing countries: Evidence from the Demographic and Health Surveys. *DHS Working Papers, Demographic and Health Research* (41).

PROSPECTIVE UNMET NEED FOR FAMILY PLANNING AMONG WOMEN 0–24 MONTHS POSTPARTUM

Data from 2,264 women within two years of a birth were used to examine unmet need, as illustrated below in **Figure 2**. In this analysis, unmet need is defined prospectively³ regarding the woman’s desired timing for her next pregnancy. Prospective unmet need is based on fertility preferences looking forward because it is most likely to predict a woman’s need for family planning in the extended postpartum period.

Among women within two years postpartum, 58% have an unmet need; 36% are using a method of FP; and only 5% of women during this 24-month postpartum period desire another pregnancy within two years.

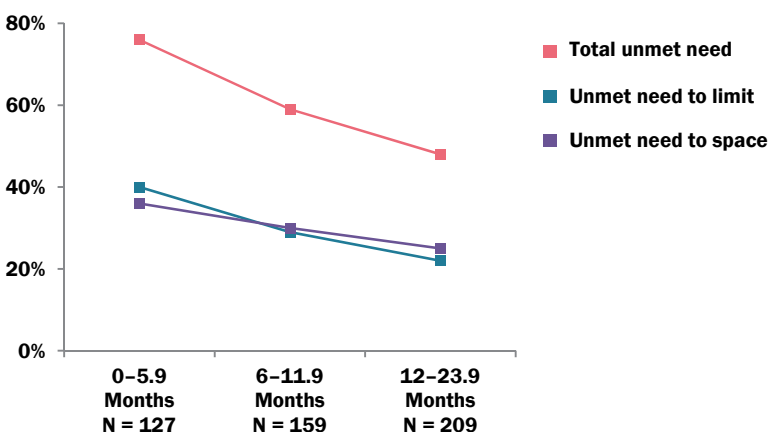
Figure 2: Prospective unmet need for FP among women within 0–24 months postpartum



UNMET NEED FOR SPACING AND LIMITING

Figure 3 demonstrates the prospective unmet need for spacing and limiting births compared to FP use during this period. Total unmet need decreases steadily as the number of months post-delivery increases. From 0–5.9 months postpartum, overall unmet need is 76%. At the end of one year postpartum, overall unmet need has decreased to 59%, and then to 48% by the end of the second year. With regard to components of overall unmet need, the levels of unmet need for limiting and spacing are very similar throughout the period. During the first six months, 36% have an unmet need for spacing and 40% have an unmet need for limiting; from 12–24 months, one-quarter (25%) have an unmet need to space compared with 22% who have an unmet need to limit.

Figure 3: Prospective unmet need across postpartum periods

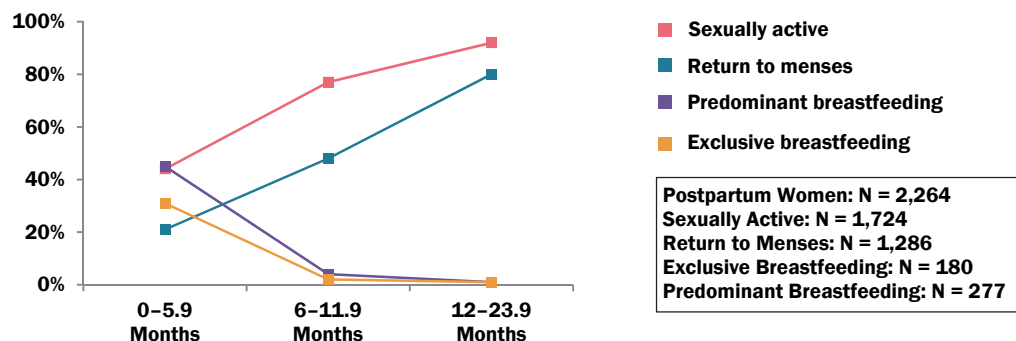


³ The definition for *prospective unmet need* is based on the DHS question “Would you like your next child within the next two years or would you like no more children?”

RETURN TO FERTILITY AND RISK OF PREGNANCY

Figure 4 illustrates key factors related to return to fertility and the risk of pregnancy among women during the first two years postpartum. Forty-four percent of women are sexually active during the first six months postpartum and more than 21% of women have experienced menses return during the same period. From 12–24 months postpartum, 92% of postpartum women are sexually active and 80% have menses return, yet only 44% are using FP.

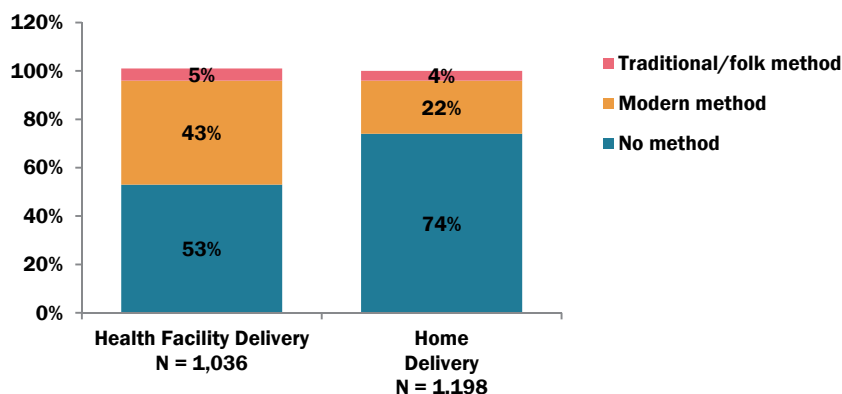
Figure 4: Factors related to return to fertility and risk of pregnancy in the first 0–24 months after birth



CONTRACEPTIVE USE BY PLACE OF DELIVERY

It is also useful to examine contraceptive use during the postpartum period by place of delivery. According to the 2008–09 Kenya DHS, 43% of all births occur at a health facility, while more than half (56%) occur at home. **Figure 5** shows that overall, 43% of postpartum women who deliver at a health facility are using a modern FP method, compared with 22% of women who delivered at home; it is notable that over 50% of women in both groups are not using any FP method.

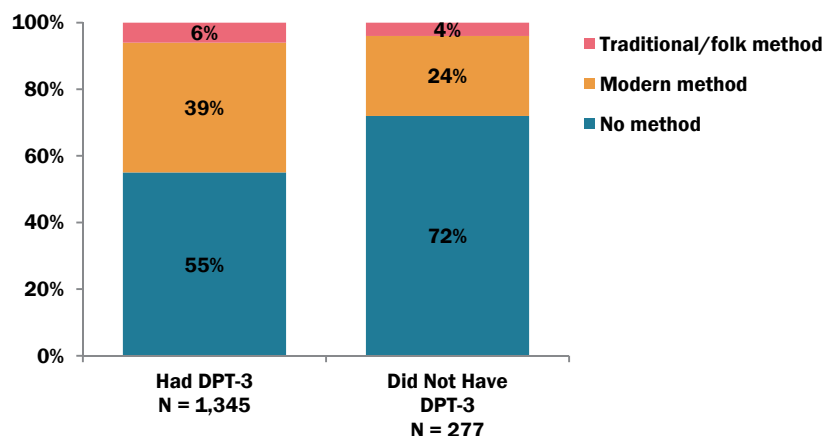
Figure 5: Uptake of family planning during the postpartum period by place of delivery



CONTRACEPTIVE USE BY INFANT VACCINATION STATUS

As new mothers and their infants have multiple contacts with health services during the first two years postpartum, it is worthwhile to examine contraceptive use by immunization status. **Figure 6** shows that mothers of children who received a DPT-3 vaccine are much more likely to use a modern FP method in the postpartum period (39%) compared with mothers of children who did not receive a DPT-3 vaccine (24%). In Kenya, more than eight in 10 children 6–24 months (83%) have received their third dose of DPT-3 vaccine, highlighting the potential for increased FP and immunization service integration.

Figure 6: Uptake of family planning by DPT-3 vaccination status



CONCLUSION

This analysis demonstrates that women in Kenya have a significant unmet need for FP during the two years after a birth. This unmet need is for both spacing and limiting, supporting the need to ensure availability of a wide range of FP methods. In addition, 50% of all non-first births in Kenya are spaced less than 24 months apart, putting women and their infants at increased risk for poor maternal and perinatal outcomes. At 12–24 months postpartum, 92% of postpartum women are sexually active, 80% have experienced menses return, and yet, only 44% are using FP. Ensuring that women with infants and small children have access to high-quality FP services through existing maternal and child health services, both in the community and at the facility level, is an important strategy for reducing both maternal and childhood mortality.

Program evidence indicates that offering postpartum family planning (PPFP) services that begin during antenatal care and are offered during all maternal and child health contacts can be effective for increasing awareness of, demand for and use of FP in this critical period. The high levels of unmet need and characteristics among FP users outlined in this brief further suggest opportunities to integrate FP with existing programs that are reaching this target group.

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