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Postpartum family planning in East Africa: Uptake, unmet need, and the role of couple communication: A Synthesis of recent evidence

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Abstract
Postpartum Family Planning (PPFP) is crucial for preventing closely spaced pregnancies that pose health risks to mothers and infants. In East Africa, modern contraceptive use remains suboptimal and unmet need is high, particularly in the first year after childbirth. This article synthesizes recent evidence on PPFP uptake, unmet need, and the influence of couple communication in East Africa. Researcher reviewed recent studies examining PPFP outcomes in East African contexts, including multi-country analyses, country-specific surveys, and qualitative research. Key indicators (contraceptive prevalence, unmet need) and determinants (socio-demographic factors, service delivery, spousal involvement) were extracted and compared. PPFP uptake in East Africa has improved in some settings but remains low overall. For example, only about 40% of postpartum women in Tanzania use contraception, and immediate postpartum uptake in facilities can be as low as 4%. Unmet need for contraception among married women ranges from 20% to 33% in several East African countries, with postpartum women experiencing unmet need as high as 81% in the first 6 months after birth. Socio-economic disadvantages (younger age, low education, poverty) are associated with higher unmet need, while adequate counseling and awareness during antenatal/postnatal care favor PPFP uptake. Notably, couple communication and male partner support emerge as pivotal: Women who discuss family planning with their partners are significantly more likely to adopt and continue postpartum contraceptive use. Conversely, lack of spousal approval remains a major barrier (cited by 70% of women not using family planning). Strengthening PPFP in East Africa requires addressing both service delivery gaps and socio-cultural barriers. Integrating contraceptive counseling into maternity care, engaging community health workers, and fostering open spousal communication can substantially increase postpartum contraceptive uptake and reduce unmet need. Policies that involve male partners and tailor interventions to young mothers will be critical to improving PPFP outcomes and accelerating progress toward national and global family planning targets.

Keywords: East Africa, postpartum family planning, contraceptive uptake, unmet need, couple communication, male involvement

1. Introduction
Family planning during the postpartum period the first year following childbirth is an essential strategy for reducing maternal and infant morbidity and mortality. Short birth intervals (< 24 months, especially < 15 months) greatly increase risks of adverse outcomes, including pregnancy complications, preterm births, neonatal mortality, and maternal depletion syndrome [1]. By preventing unplanned and closely spaced pregnancies, effective postpartum contraception can avert nearly 30-40% of maternal deaths and a significant portion of infant deaths [2]. The postpartum period offers a critical window to provide family planning services, as women are in frequent contact with healthcare systems (antenatal, delivery, immunization, and postnatal care). Meeting contraceptive needs at this stage helps women achieve healthy spacing of pregnancies and avoid unintended pregnancies that jeopardize health and well-being.

Despite its recognized importance, postpartum family planning (PPFP) remains suboptimal in many low-resource settings. Globally between 2015 and 2019, about 48% of pregnancies were unintended, with sub-Saharan Africa bearing a disproportionate burden (approximately 91 unintended pregnancies per 1000 women) [3]. East African countries in particular continue to exhibit high fertility and low contraceptive prevalence relative to global averages [4].

Only about 25-30% of married women in East Africa use a modern contraceptive method, compared to 58% globally [5]. Recent multi-country analyses confirm that modern family planning use in East Africa, while rising, remains well below the levels needed to achieve Sustainable Development Goal targets [4].

A 2021 analysis of Demographic and Health Survey data found an average modern contraceptive prevalence of around 20.7% (range 9%-61%) among women in East African countries [4]. Conversely, the unmet need for family planning the proportion of women who want to avoid or delay childbearing but are not using contraception remains high. In four East African countries (Burundi, Rwanda, Uganda, Tanzania), an estimated 20-33% of married women have an unmet need for family planning[6]. This gap signals that a large segment of women, including many postpartum women, are not being reached by family planning services.

Importantly, progress is not uniform across the region. Kenya, for example, has achieved relatively high contraceptive uptake (58% of married women) and a lower unmet need (18%), reflecting successful family planning programs and perhaps greater engagement of men and communities in reproductive health [6]. Rwanda, through strong political commitment and health system integration, tripled its contraceptive use rate from 17% to 53% between 2005 and 2015 [7]. These success stories underscore the potential of concerted efforts. However, neighboring countries like Burundi, Uganda, and Tanzania still report that roughly one-quarter to one-third of women have unmet family planning needs [6].

Of particular concern is the extended postpartum period, when many women are amenorrheic or breastfeeding and may mistakenly perceive themselves to be at low risk of pregnancy. Studies show that unmet need during the first postpartum year is extraordinarily high if no method is used: For example, in Tanzania an estimated 81% of women 0-5 months postpartum and 61% at 6-11 months postpartum have an unmet need for family planning [8]. Similar patterns have been reported elsewhere, indicating that the postpartum interval is a time of elevated risk for unintended pregnancy if contraceptive services are not accessed.

Multiple factors contribute to low PPFP uptake and high unmet need in East Africa. Socio-demographic disadvantages such as young maternal age, limited education, and low household wealth are consistently associated with lower contraceptive use and higher unmet need [4, 6]. Health system and informational factors are also critical: Inadequate counseling during antenatal and postnatal visits, poor integration of family planning into routine maternal-child healthcare, and lack of access to a range of methods all hinder postpartum contraceptive uptake [5, 8]. Cultural and gender dynamics play a defining role as well. In many communities, decisions about contraception are strongly influenced by male partners and social norms. Women frequently cite fear of side effects, partner disapproval, and religious or cultural expectations (e.g. pressure for large families or postpartum sexual abstinence practices) as reasons for not using family planning [2]. Historically, low male engagement in reproductive health has been a barrier men's lack of support or communication about family planning can leave women without the agency or confidence to use contraception. On the other hand, when couples openly communicate and husbands are supportive, contraceptive use tends to be much higher [1, 5].

Given these considerations, this paper aims to synthesize recent evidence on postpartum family planning in East Africa, with a focus on three interrelated aspects: (1) the current uptake of contraception during the postpartum period, (2) the magnitude of unmet need for family planning among postpartum women, and (3) the influence of couple communication and male partner involvement on PPFP outcomes. By examining findings from the latest studies, researcher seek to identify common challenges and highlight promising approaches to improve PPFP. Understanding how spousal communication and community factors impact postpartum contraceptive behavior is especially important for designing interventions that effectively engage both women and men. Ultimately, this evidence synthesis will inform strategies to close the postpartum family planning gap as part of broader efforts to achieve reproductive health goals in East Africa.

2. Materials and Methods

Researcher conducted a narrative synthesis of recent research on postpartum family planning in East Africa. The scope was defined to include studies published from 2017 onward, reflecting "recent evidence" on the topic as per research objective. Both quantitative and qualitative studies were included to capture a comprehensive picture of PPFP uptake, unmet need, and couple dynamics. The geographic focus was East Africa, broadly encompassing countries in the East African Community and surrounding region.

The synthesis draws exclusively on content from a set of studies provided for this analysis. These comprised peer-reviewed journal articles and reports examining family planning in East African contexts. Key sources included: (a) multilevel and pooled analyses of national survey data assessing contraceptive use and unmet need in East Africa [4, 6]; (b) country-specific observational studies of postpartum women (such as a district-level survey in Tanzania [8] and a facility-based study in Uganda[1]); (c) a large scoping review of male involvement in reproductive health in East Africa [5] and (d) qualitative research on barriers to family planning use [2]. The provided studies covered multiple countries and methodologies, allowing triangulation of findings.

From each source, researcher recorded relevant results and themes. For quantitative studies, key indicators were extracted (e.g. percentage of women using contraception postpartum, percentage with unmet need, odds ratios for factors associated with family planning use or non-use). For qualitative studies, researcher noted reported barriers, facilitators, and themes related to couple communication or service delivery. Researcher paid particular attention to findings concerning the postpartum period (typically defined as up to 12 months after birth) and any gender or household dynamics affecting family planning use. The results were then grouped into thematic categories corresponding to study areas of interest: (1) PPFP uptake/prevalence, (2) unmet need for contraception (general and postpartum-specific), and (3) role of couple communication/male involvement. Within each theme, findings from different studies were compared and contrasted to identify consistencies or discrepancies. Researcher presents summary statistics and representative findings and embed two tables to consolidate key quantitative data from the region.

Because this is a targeted review of provided studies rather than a systematic review of all literature, the findings are

necessarily limited to those sources. However, the included studies represent a range of contexts in East Africa and recent data, lending confidence that major trends have been captured. Caution is warranted in interpreting associations as causal, given most data are cross-sectional. Nonetheless, the triangulation of survey data with qualitative insights and multi-country analyses strengthens the robustness of the conclusions.

3. Results

3.1 Contraceptive Uptake in the Postpartum Period

Overall uptake of modern contraception during the postpartum period remains modest in many East African settings, though there are signs of improvement in some countries. National surveys indicate that by one year postpartum, only a minority of women are using any family planning method if specific postpartum programs are not in place. In Tanzania, for instance, the extended postpartum family planning (EPPFP) utilization rate is about 40% according to the 2015-2016 Demographic and Health Survey [8]. A cross-sectional study in one district of Tanzania (Mvomero, Morogoro region) found that 46% of women who had given birth in the past year were using family planning method at the time of the survey [8]. While this represents nearly half of recent mothers, it also underscores that more than half were not protected from pregnancy despite recent childbirth.

Other East African countries show a range of postpartum contraceptive uptake, partly reflecting the strength of their family planning programs. In Rwanda, which has invested heavily in family planning, overall modern contraceptive prevalence among married women reached 53% by 2015, and integrating family planning into postpartum and child health services is standard practice [7]. This suggests Rwanda's postpartum contraception rates are likely comparatively high. In Uganda and Kenya, national data specifically on PPFP uptake are not always disaggregated, but general contraceptive prevalence among postpartum-age women has been on the rise. For example, across East African countries in a pooled analysis (not specific to postpartum status), about 21% of women were using modern contraception as of 2016, with substantial country variation[4]. High-performer Kenya stands out with a majority of married women using contraception, whereas others like Uganda and Tanzania are closer to 30-40% range [6, 8].

One critical gap is the low immediate postpartum uptake of contraception (i.e. initiation of a method before hospital discharge or during the six-week postnatal check). Even when women deliver in health facilities, many do not receive a contraceptive method prior to going home with the newborn. In the Mvomero, Tanzania study, health facility records showed that out of all women who delivered in facilities over a 4-year period, only about 4% accepted family planning method before discharge [8]. This ranged annually from as low as 1.8% to about 5.2%, never exceeding one in twenty new mothers. Table 1 summarizes unmet need levels in East African countries and highlights Tanzania's case, where despite most deliveries now occurring in facilities, postpartum contraceptive provision has been strikingly low [8]. This missed opportunity contributes to a high incidence of short-interval pregnancies.

By contrast, settings that proactively offer postpartum contraception show better uptake. Several projects in Africa focusing on immediate postpartum intrauterine device or implant insertion have demonstrated higher acceptance rates, though such data in East Africa were not directly provided in the reviewed studies. Nonetheless, the principle is evident: Strengthening postpartum counseling and same-day method provision (especially for long-acting reversible contraceptives) can significantly raise PPFP uptake. In Rwanda's coordinated system, for example, postpartum family planning counseling is used routinely "as an opportunity to plan for returning to a facility for postnatal care" and contraception, and community health workers follow up to ensure continuity of care[9]. Reaching women during infant immunization visits with family planning services is another effective approach; modeling suggests that integrating family planning into routine immunization clinics could reduce overall unmet need by an estimated 3.8-8.9% in sub-Saharan Africa [9]. These integrated service models leverage the postpartum period as a key touchpoint to initiate contraception.

Table 1: Unmet need for family planning among married women in East Africa

Country	Unmet Need for Family Planning (%)
Burundi	33%
Rwanda	28%
Uganda	22%
Tanzania	20%
Kenya	18%

As Table 1 shows, about one-fifth to one-third of married women across five East African countries have an unmet need for contraception. These figures include postpartum women and reflect general gaps in family planning use. Notably, Kenya's unmet need is lowest (18%), consistent with its higher contraceptive uptake, whereas Burundi's is highest (33%). Tanzania, Uganda, and Rwanda fall in between. This variation indicates that while East Africa as a region faces challenges in meeting family planning demand, some countries have made more progress than others. It also underscores a regional average unmet need that remains unacceptably high, around 25% or more, signaling that millions of women many of them recently postpartum-are not achieving their fertility desires in terms of spacing or limiting births.

3.2 Unmet need for contraception in the postpartum context

The postpartum period is recognized as a time of especially high unmet need for family planning. Immediately after childbirth, most women do not wish to become pregnant again soon, yet many are not using contraception for various reasons (breastfeeding amenorrhea, cultural practices, lack of counseling, etc.). The data from Tanzania illustrate this clearly. Despite the moderate uptake of family planning by one year postpartum (40% as noted above), the unmet need during the early postpartum months is extremely high. According to prior analyses cited in the Mvomero study, 81% of women 0-5 months postpartum had an unmet need for family planning, and 61% at 6-11 months postpartum [8].

In other words, the vast majority of Tanzanian women in the first half-year after delivery who did not want an immediate pregnancy were not using contraception. By one year postpartum the situation improves somewhat, but still over half of those women desiring to avoid pregnancy lacked contraception. This pattern likely holds in many other East

African countries, given similarities in breastfeeding practices and service challenges. It points to a crucial gap: Postpartum women, who might feel "safe" from pregnancy while not menstruating, actually account for a large share of unmet need and subsequent unplanned pregnancies.

Recent evidence suggests that unintended pregnancies in the postpartum period are a significant driver of high fertility and pose unique challenges. A multi-country analysis (including East African nations) examined women's "motivational readiness" for postpartum contraceptive use in relation to their pregnancy intentions [3]. The findings indicate that experiencing an unintended (mistimed or unwanted) pregnancy can motivate women to adopt contraception postpartum. For example, in several countries, women whose recent pregnancy was mistimed had significantly higher odds of being in contemplation or action stages for postpartum family planning use than women who had intended pregnancies [3]. In Côte d'Ivoire and Nigeria, mistimed births were associated with moving to the contemplation stage of family planning adoption, and in Ethiopia an unwanted birth was associated with greater odds of family planning contemplation [3].

Furthermore, women with mistimed births in certain settings (Burkina Faso, Côte d'Ivoire, Nigeria) were more likely to be in the post-action stage (already using contraception postpartum) [3]. These results imply that a recent surprise or unwanted birth often serves as a wake-up call, prompting women to seek family planning to prevent another rapid pregnancy. However, this increased motivation does not uniformly translate into uptake without support; context matters, as the country-by-country differences show. It underscores the need for health systems to capitalize on the postpartum period-especially for women with an indicated desire to prevent another pregnancy by providing timely information and services. If unmet need in the first postpartum year can be reduced, it will directly lower the incidence of unintended pregnancies.

One positive trend is that unmet need for limiting (i.e. wanting no more children) has begun to decline slightly in East Africa, as contraceptive use for stopping childbearing increases. For instance, in Tanzania from 1999 to 2016, the proportion of married women with unmet need for limiting fell from 9.5% to 6.6%[10]. This likely reflects better availability of permanent or long-acting methods for women who have achieved desired family size. By contrast, unmet need for spacing births showed no significant change over the same period a stagnant trend that is particularly relevant to postpartum women, who mainly represent spacing needs [10]. This stagnation suggests that the challenges around short-term birth spacing (which is essentially the PPFP domain) have not been fully addressed over decades, and innovative approaches are needed to finally move the needle.

Table 2: Postpartum family planning utilization and unmet need in Tanzania

Indicator (Tanzania)	Value (%)
Contraceptive prevalence among women in first year postpartum (Extended PPFP, national)	40%
Unmet need for FP, 0-5 months postpartum	81%
Unmet need for FP, 6-11 months postpartum	61%
Immediate postpartum FP uptake in health facilities (within delivery stay, Mvomero District)	4%

Table 2 highlights the stark contrast between high postpartum unmet need and low immediate uptake in Tanzania. While around 81% of women in the first five (5) months postpartum want to avoid pregnancy but are not using contraception, only about 4% actually received a method before leaving the facility after delivery. This discrepancy underscores a systemic gap in service delivery during the maternity-to-postnatal continuum. The drop in unmet need by 6-11 months (to 61%) indicates that some women eventually adopt family planning as menses return or at infant immunization visits, but many others remain unprotected. Bridging this gap earlier would significantly reduce unintended pregnancies. Interventions such as immediate postpartum contraceptive counseling and provision (within maternity wards) have been recommended as high-impact practices to close this window of risk [9, 11]. Indeed, the World Health Organization and partners promote postpartum family planning as a key component of childbirth and postnatal care[11]. The Tanzanian data make a compelling case that implementing such practices (e.g. offering the contraceptive implant or intrauterine device within 10 minutes of placental delivery, or before discharge) could dramatically lower the 81% unmet need figure.

It is worth noting that postpartum contraceptive choice should be broadened beyond short-acting methods; expanding access to Long-Acting Reversible Contraceptives (LARCs) can reduce reliance on methods with high discontinuation. Studies show that when women are given a wider method mix, many are interested in intrauterine devices or implants postpartum, which they can use for extended intervals [5]. Moreover, increasing LARC uptake may help reduce unmet need arising from discontinuation of short-acting methods, since LARCs have much lower failure and discontinuation rates [5]. Thus, strengthening PPFP is not only about coverage but also about method choice and continuity.

3.3 Factors Associated with PPFP uptake and unmet need

Recent evidence from East Africa consistently points to a set of individual, community, and health system factors that influence whether a woman uses family planning in the postpartum period. These factors can be broadly categorized into socio-demographic characteristics, knowledge/access factors, and gender/couple dynamics.

3.3.1 Socio-Demographic Factors

Young age is a significant correlate of unmet need in the region. An analysis of four East African countries found that younger women (e.g. age < 25) had a higher probability of unmet need for contraception than older women [6]. This may be because younger, newly married or first-time mothers often have less autonomy and confidence to seek contraception, or they face greater opposition from partners or elders. They may also be under pronatalist pressure to have another child soon. On the flip side, older women (especially those who have achieved desired family size) may be more motivated to use family planning to stop childbearing. Education emerges as a protective factor: women with at least secondary education are significantly more likely to use contraception postpartum than those with no formal schooling [4, 6].

In a pooled East African analysis, having secondary or higher education increased the odds of modern

contraceptive use by about 1.6-2.9 times [4]. Educated women may have better awareness of family planning options and more decision-making power in the household. Similarly, household wealth status is linked to family planning uptake-wealthier women have higher contraceptive prevalence, while those in the poorest strata have higher unmet need [6]. For example, the poorest women in the East African study had significantly greater odds of unmet need than the richest, reflecting inequalities in access and perhaps differences in fertility ideals [6]. Parity also plays a role: Evidence from Tanzania shows that women with multiple children (parity 5+) were more likely to have unmet need for limiting (desiring no more children but not using family planning), whereas very low parity (e.g. first-time mothers) often corresponds with spacing needs that may or may not be met [10]. Interestingly, one district study found women with a history of a previous pregnancy (i.e. not first-timers) were more likely to be using PPFP [8]. This suggests that experience might matter-after their first childbirth, women could be more open or exposed to family messages, whereas first-time mothers may be more hesitant or less informed.

3.3.2 Knowledge and Access to services

Awareness and counseling are crucial determinants of PPFP uptake. The Mvomero, Tanzania study identified multiple knowledge-related variables significantly associated with postpartum contraceptive use. Women who were aware of the reasons to use family planning in the postpartum period, aware of PPFP methods, and aware of possible side effects had significantly higher utilization of extended PPFP [8]. This underscores that simply educating women on why and how to use contraception after childbirth can translate into greater uptake. Likewise, exposure to family planning information through media or health workers is important-in East Africa, women with exposure to family planning messages (e.g. via radio, community outreach) tend to have lower unmet need [6]. Formal health system contact also provides opportunities: One study noted that women who had visited a health facility in the past year were more likely to be using family planning, hinting that integrating family planning counseling into routine visits helps [10].

A standout factor is the provision of counseling sessions specifically on family planning during antenatal and postnatal care. In Tanzania, attending family planning counseling during maternal care was strongly associated with postpartum contraceptive uptake (p<0.001) [8]. However, many women do not receive adequate counseling-a gap highlighted in the same study, which noted that even though health facility delivery rates have increased, providers often miss the chance to educate postpartum mothers about family planning [8]. Health system issues like stock outs and convenience also affect uptake. If contraceptives are unavailable or if clinics have long wait times and other barriers, women may not initiate or continue a method.

In the Iringa, Tanzania a mixed-method study indicates that long waiting times at clinics were the most commonly reported barrier to family planning use (75.5% of women), followed by lack of method availability and other facility obstacles [2]. Women in focus groups described spending many hours at health facilities only to sometimes find the family planning provider absent or the desired method out of stock [2]. Such experiences discourage postpartum mothers, who often have to bring infants to appointments, making lengthy waits difficult. The implication is that improving clinic efficiency and ensuring consistent contraceptive supplies (Including a range of methods) are tangible steps to increase PPFP uptake.

3.3.3 Gender or Couple Dynamics

Community and cultural norms shape postpartum family planning use by influencing perceptions and acceptability. In societies where large families are valued or myths about contraception prevail, women face pressure against using family planning. The Iringa study's qualitative findings revealed that in some communities a woman who uses family planning might be stigmatized for supposedly limiting family size against cultural expectations [2]. Some participants mentioned that certain clans still encourage having many children, and that a woman could face criticism or opposition if she tries to space or limit births. Religious beliefs also came up as impediments, with some women citing that their faith or religious leaders disapprove of contraception [2]. These socio-cultural barriers can be particularly salient in the postpartum period as family and community members often have close involvement around the time of childbirth (e.g. advising on postpartum practices). The practice of postpartum sexual abstinence in some cultures may lead couples to assume contraception is unnecessary until abstinence ends, but if abstinence durations shorten or are not strictly observed, pregnancies can occur earlier than expected. While none of the recent studies detailed abstinence practices, it remains an underlying factor in how couples approach postpartum fertility management.

3.4 The role of couple communication and male involvement

Perhaps the most striking findings from recent evidence relate to the influence of male partners-their communication, approval, and involvement in family planning-on postpartum contraceptive behavior. Across East Africa, studies are converging on the conclusion that when couples jointly discuss and decide on family planning, contraceptive uptake improves markedly. Conversely, poor spousal communication and male disapproval are major contributors to unmet need in the postpartum period.

Multiple data points illustrate this dynamic, A scoping review of male partner involvement in East Africa identified family planning as one of the domains significantly affected by partner communication and support. In that review, several studies showed that women with partners involved in discussions about contraception were far more likely to use family planning postpartum and to do so consistently [12]. For example, one finding was that women who had discussed contraceptive use with their partner were more likely to initiate postpartum contraceptive use on time, to utilize family planning services, and to continue using contraceptives since childbirth, and were less likely to discontinue use, compared to those who never discussed family planning with their partner [12]. The effect sizes reported are striking: in one Ugandan study, simply having a spousal discussion about family planning was associated with a 58-fold higher odds of the man's involvement in PPFP (crude OR 58.5) [1]. Men who actively encouraged their spouse to use family planning had even higher odds of participation (OR 79) [1]. These enormous ratios reflect that nearly all couples who communicate and agree on family

planning ended up using it, whereas those who never communicate almost never use-indicating communication is nearly a prerequisite for uptake in that context.

Even after adjusting for other factors, male approval of contraception was the strongest predictor of postpartum family planning involvement in the Kampala, Uganda study, men who approved of family planning use were about 15.5 times more likely to be involved in PPFP services (adjusted OR 16) than those who disapproved[1]. Additionally, men's knowledge about family planning (knowing methods and benefits) significantly increased their participation, highlighting that educating men can translate into better support for their partners [1].

The high male involvement in the Kampala study is noteworthy by itself-80% of surveyed men reported participating in postpartum family planning with their partners [1]. "Participation" in this context included actions like accompanying the wife to postpartum visits, discussing and jointly deciding on contraception, or at minimum approving the use of family planning at home [1]. This 80% figure is higher than Uganda's national average of male involvement (around 73% reported in 2018), likely because the study was in an urban setting with relatively educated respondents [1]. It suggests that in conducive environments, a large majority of men are willing to engage in PPFP, contradicting stereotypes that African men uniformly oppose contraception. In fact, in some communities male involvement is becoming normalized: the Ugandan men in the study had high education levels, and nearly half had only 2-4 children (indicating an openness to smaller families) [1]. This profile may not generalize to rural areas or more traditional settings, but it points to a positive shift among certain groups of men. For example, outside East Africa, nearly universal male participation (94%) was observed in Sweden's postpartum care per one cited study-while East Africa is far from that, urban Ugandan men's 80% involvement shows substantial progress in an African context [1]. However, the other side of the coin is that lack of male support remains a major barrier for many women, particularly in rural or conservative areas. The Iringa, Tanzania study found that 69.6% of women who were not using contraception cited their husbands' disapproval as a barrier-it was the second most common barrier after long waits at clinics [2]. Qualitative interviews reinforced this: women expressed that if a husband is against family planning, the wife will not use it or only use it secretly with anxiety. In some cases, women feared conflict or even violence if they pursued contraception against their partner's wishes[2]. Such situations often lead to unmet need, as the woman may desire to space births but cannot act on it. Intimate partner violence and gender inequities further exacerbate the issue, though not detailed in our provided studies, broader literature suggests women in unequal relationships have lower contraceptive use. The scoping review of male partners' involvement did note that partner attitudes like opposition to family planning and presence of intimate partner violence had impacts on reproductive outcomes including condom use and prevention of mother to child transmission adherence, which analogously would affect family planning usage [12].

In addition to direct spousal approval, joint decision-making is a key element. When both partners feel they have a say and come to an agreement on contraception, uptake is higher. The scoping review reported that male involvement defined by joint decision-making and support led to better outcomes such as timely postpartum contraceptive initiation and lower discontinuation [12]. In contrast, if the decision is one-sided (either entirely the woman's or, commonly, the man's without consulting the wife), there may be less commitment and higher chance of discontinuing use. An interesting finding from a study of HIV-positive women was that a partner's fertility desires can influence the woman's intentions: If the male partner desired more children, even an HIV-positive woman was more likely to intend to have another child [12]. This underlines how powerful partner influence is on reproductive plans in general.

Collectively, these findings emphasize that couple communication is a linchpin in postpartum family planning success. Interventions that promote spousal communication (For instance, couples counseling during antenatal care or community dialogues that include men) are likely to yield significant dividends. In Uganda, a trial of involving men in antenatal counseling on PPFP showed promise in improving uptake (This was alluded to in the literature, though not detailed in the provided sources). The notion of "male champions" or incorporating men as partners in maternal health has gained traction. Indeed, the evidence suggests that when men are positively engaged-by improving their knowledge, addressing their concerns (such as about side effects), and fostering supportive attitudes-the couple is much more likely to use contraception after a birth.

That said, it's important to tailor approaches to context. In some extremely patriarchal settings, women may not have the ability to negotiate family planning use at all; there, community and religious leader involvement might be needed to gradually shift norms. In others, men might already be supportive in principle but simply uninvolved due to traditional service structures (e.g. clinics not welcoming men). Simple changes like encouraging husbands to accompany wives for postnatal visits can open the door for discussions with health providers.

4. Discussion

This synthesis of recent evidence reveals a multifaceted but consistent picture: Postpartum family planning in East Africa, while improving incrementally, is still characterized by substantial unmet need, suboptimal uptake and significant opportunities for intervention-especially through engaging couples. Several key findings emerge. First, the postpartum period remains a weak link in the continuum of care, with far too many women leaving childbirth services without a plan or method to prevent an immediate repeat pregnancy. The data from Tanzania and similar contexts show that a large majority of women want to avoid pregnancy for at least two years postpartum, yet contraception is often not initiated until many months after delivery, if at all [8]. This delay can be perilous; it is precisely in these early months that closely spaced pregnancies can occur, contributing to the high rates of unintended pregnancies in the region [3]. The persistently high unmet need for spacing (as opposed to limiting) in East Africa underscores that young women and new mothers are not getting the support they need to achieve healthy intervals between births [10].

Second, socio-economic disparities clearly play a role in who accesses postpartum family planning. Recent studies reinforce longstanding observations that education and wealth empower women to practice contraception, while

poverty and low literacy correlate with higher unmet need [4, 6]. What is notable in the newest evidence is the emphasis on information and counseling as a mediating factor. Even among poorer, rural populations, those who received dedicated PPFP counseling or had exposure to family planning messages were significantly more likely to use a method [8]. This suggests that bridging the knowledge gap can mitigate some inequities. Of course, deeper structural issues like shortages of healthcare staff and commodities in remote or low-resource areas must be addressed in parallel-women cannot adopt methods that are unavailable or overly difficult to obtain. Supply-side improvements (ensuring method mix, reducing clinic wait times, and integrating services) are as crucial as demand-side education. The finding that three-quarters of women cited long clinic wait times as a barrier indicates a need for health system strengthening: More efficient service delivery, possibly expanding community-based distribution to decongest facilities, and client-centered approaches that save time for postpartum mothers who typically have newborn care duties [2]. Third, and most prominently, the role of couple communication and male involvement stand out as a game-changer in postpartum family planning outcomes. The contrast between scenarios of high male support versus high male opposition could not be starker. In supportive environments, as seen in an urban Ugandan clinic, male involvement can reach 80% and correspond with most couples using postpartum contraception [1]. Here, men approving and discussing family planning leads to timely uptake and sustained use [12]. On the other hand, in environments where male disapproval prevails, women's hands are effectively tied-evidenced by nearly 70% of non-users in one Tanzanian study attributing their status to a husband's opposition [2].

This dichotomy highlights that family planning is not just a health service issue, but a social and relational one. Interpersonal dynamics within the couple can either facilitate or inhibit contraceptive use. Our synthesis aligns with earlier studies which found that spousal concordance on fertility preferences greatly reduces unmet need [13]. What the recent evidence adds is quantification of the benefit-such as the enormous odds ratios for family planning use when couples communicate-and the demonstration that male involvement interventions are feasible in East African contexts [1]. It is encouraging that male participation in maternal and child health is gaining acceptance, at least among certain segments of the population. The challenge moving forward will be to normalize this across broader society. Traditional gender norms that frame contraception as solely a woman's concern are increasingly outdated and counterproductive. Engaging men as equal partners in the reproductive journey, from pregnancy to postpartum, can lead to better outcomes for both. Programs might include targeted male-focused education (through workplaces, male community groups, or media campaigns featuring male family planning champions) to dispel myths and emphasize the benefits of healthy spacing for the whole family. Furthermore, couple-based counseling sessions during antenatal care could preemptively address fears or disagreements about postpartum contraception before the baby arrives-potentially increasing the likelihood that a plan is in place by the time of delivery [9].

Findings of this study also underscore a need for integrative strategies. No single intervention will solve postpartum family planning gaps; rather, a combination of health system integration, community engagement, and couple-focused communication is required. The Rwandan experience provides a blueprint: by integrating family planning services at all levels (community health workers, postpartum check-ups, immunization visits) and ensuring coordination between providers, Rwanda achieved a rapid increase in contraceptive use [7]. Integration should particularly target the postpartum period, making every contact (e.g. postnatal or infant vaccination visit) an opportunity to either initiate or reinforce family planning use. This approach is being echoed by global high-impact practice recommendations, such as postpartum family planning counseling as part of routine care and family planning-immunization integration, which were reflected in some of the literature reviewed [9, 11]. The evidence suggests that such practices have not been uniformly implemented in East Africa-there is plenty of room to scale them up.

In discussing these results, it is important to acknowledge that increasing postpartum contraception must be culturally sensitive and respect women's and couples' informed choices. The goal is not to pressure every postpartum woman into using family planning, but rather to remove the barriers that currently prevent those who do want to space or limit from acting on that intention. A substantial proportion of unmet need is due to concerns about side effects or health impacts of contraception [2]. This calls for better counseling to address misconceptions and for method options that cater to different needs (for example, non-hormonal methods for those who cannot or will not use hormones, long-acting methods for those who want a "fit and forget" solution, etc.). Also, postpartum women have unique needs-some methods may be contraindicated immediately after birth (Like combined oral contraceptives for breastfeeding women) and others are ideally provided before discharge (Like intrauterine device or implant insertion). Health providers must be trained and equipped to guide women through these options at the appropriate times, providing the method of choice unless medically inadvisable.

The interplay between partner dynamics and service delivery can be complex. For instance, a woman may intend to get an intrauterine device postpartum, but if her husband is against it, she might cancel her appointment. Conversely, even if a husband is supportive, if the clinic experience is poor (Long waits or stock out), the couple's plan may fall through. Therefore, effective interventions will likely need to operate on multiple levels: Individual (knowledge and motivation), couple (Communication and joint decision-making), community (Norms and support networks), and health system (Access and quality).

In interpreting these findings, a few limitations should be considered. Much of the data on factors associated with PPFP uptake are correlational for instance, while partner communication is linked to higher use, it could be that couples who are already inclined to use family planning are more likely to communicate about it, rather than communication solely causing the use. However, the weight of qualitative evidence (Women's own statements that fear of partner's reaction stops them from using) strongly suggests a causal influence of partner support on uptake. Another limitation is that some countries in East Africa (e.g. South Sudan, Somalia) were not represented in the reviewed studies, so generalization to the entire region should be cautious. The contexts of conflict or very low health

infrastructure might present additional challenges beyond those captured here. Nonetheless, the themes of unmet need and male involvement are likely relevant across diverse settings.

5. Conclusion

Postpartum family planning in East Africa remains an area of high need and high impact. Our synthesis of recent evidence reveals that despite some progress, a large proportion of women in the region still navigate the first year after childbirth without effective contraception even though they wish to avoid an immediate pregnancy. Uptake of postpartum contraception is improving gradually-with countries like Rwanda and Kenya leading the way-but overall coverage is insufficient. Consequently, unmet need for family planning persists at elevated levels, especially in the postpartum window when fertility can return quickly and unplanned pregnancies have heightened health risks. Younger, less-educated, and lower-income women are disproportionately affected, indicating an equity gap in access to postpartum family planning services. The health systems in many East African countries have not yet institutionalized postpartum contraceptive delivery as a routine part of maternity care, leading to missed opportunities to counsel and serve women when they are already in contact with healthcare facilities.

Critically, this review highlights the transformative role that couple communication and male involvement can play in improving postpartum family planning outcomes. When men and women make joint decisions about contraception-supported by accurate information and quality services-the likelihood of uptake and continued use of postpartum family planning rises dramatically. In settings where husbands are engaged and supportive, women are far more empowered to initiate contraception early after childbirth, resulting in better spacing of pregnancies and lower unmet need. In contrast, where spousal opposition or lack of discussion prevails, women often remain without contraception, even if they personally desire to use it. Engaging men is therefore not a peripheral option but a central strategy for closing the postpartum family planning gap in East Africa. Programs that foster open spousal communication, address men's questions or misconceptions, and emphasize the shared benefits of healthy timing and spacing of children can create an enabling environment for postpartum family planning use. Likewise, integrating family planning into postpartum and infant care services-so that women receive counseling and methods as a seamless part of the care continuum-is a proven high-impact practice that needs wider implementation in the region. By combining community education, couple-focused counseling, and health system integration, East African countries can substantially increase postpartum contraceptive uptake, reduce unmet need, and ultimately improve maternal and child health outcomes. The evidence is clear that investing in postpartum family planning and involving both partners in the process is a cost-effective step towards achieving national and global reproductive health goals.

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