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Original Research Article

Determinants of postpartum family planning uptake among women in the union of the Comores: the role of socio-demographic characteristics, partner support, and contraceptive awareness

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ABSTRACT

Background: The postpartum period is an important opportunity to prevent unintended pregnancies through family planning (FP). Despite high contraceptive awareness, postpartum FP (PPFP) uptake remains low in many low- and middle-income countries (LMICs), including Comoros. This study assessed factors associated with postpartum contraceptive uptake among women in the Union of the Comoros.
Methods: A cross-sectional study was conducted among 251 pregnant and postpartum women aged 15 -49 years attending health facilities across the three islands of Comoros from July to December 2024. Data were collected using a structured questionnaire, and associations with PPFP uptake were assessed using chi-square tests. Ethical approval was obtained (UI/EC/24/0302 and N°24002/CNESS/PR).
Results: Among the participants, 78.9% had knowledge of FP, while 65.0% reported current contraceptive use. Injectable contraceptives were the most commonly used method (43%), followed by implants (23%) and oral contraceptive pills (12%). PPFP uptake was significantly associated with island of residence (p=0.0005), educational level (p=0.042), and number of living children (p=0.013). Women from Anjouan had the highest proportion of contraceptive use (25.0%), followed by Ngazidja (23.0%) and Mohéli (16.0%). Higher contraceptive uptake was observed among women with secondary and tertiary education compared with those without formal education. Women with three or more living children had the highest proportion of contraceptive use (46.1%). Age, marital status, employment status, income sufficiency, and desire for another child were not significantly associated with PPFP uptake.
Conclusions: PPFP uptake in Comoros is influenced by geographic location, education, and parity. Improving access to quality PPFP services and targeted interventions may enhance contraceptive use and maternal health outcomes.

Keywords: Postpartum family planning, Contraceptive uptake, Reproductive health, Socio-demographic factors, Comoros

INTRODUCTION

The postpartum period is a high-risk period for unwanted pregnancies. A short interval between pregnancies can lead to a series of complications for both the mother and the fetus. Therefore, FP during this period is essential for the well-being and safety of maternal and child health, as it offers protection against closely spaced and unintended pregnancies during the critical time following childbirth.[1,2] Postpartum is also an opportune moment to address the unmet need for FP and to reduce the risk of short birth intervals.[3] Nevertheless, contraceptive prevalence during

the postpartum period remains low in developing regions. Increasing the uptake of contraception is therefore key in preventing maternal, neonatal, and child morbidity and mortality during this stage. Since 2010, requests have increased for recommendations to establish or strengthen voluntary FP programs for women in the postpartum year within national health systems, according to the World Health Organization (WHO).[4]

The WHO and other international organizations recommend that individuals and couples wait at least 2 to 3 years between births to minimize complications for both mother and child. Recent studies supported by the United States Agency for International Development (USAID) suggest that waiting 3 to 5 years could further reduce these risks.[5] Globally, access to and use of modern contraceptives has contributed significantly to the decline in maternal and infant mortality. However, in LMICs, including Comoros, contraceptive use remains inadequate.

For over three decades, the slogan "FP saves lives" has been used to highlight and communicate the well-established scientific evidence that contraceptive use improves survival rates for women before and during the childbearing years, and enhances the health of their babies. Universal access to contraception has been prioritized in the Sustainable Development Goals (SDGs) as a critical means for women and their partners to exercise their rights to freely and responsibly decide on the number and spacing of their children.[6]

Maternal mortality defined as the death of a woman during pregnancy, childbirth/within postpartum period remains a major global health challenge. Each day, more than 700 women die from preventable causes related to pregnancy and childbirth, with the vast majority of these deaths occurring in LMICs.[7,8] Maternal and new-born health, and FP, are recognized as essential and interrelated elements of sexual and reproductive health and rights. However, services for protecting maternal and new-born health and those for contraception are often delivered through separate providers, locations, budgets, and programs. Sustained progress in reducing maternal and new-born deaths requires much greater integration of these services into health systems' policies, financing, implementation, monitoring, and accountability mechanisms. Against this backdrop, this study examines the influence of socio-demographic characteristics on postpartum contraceptive uptake in the Comoros, providing evidence to guide policy and programmatic interventions aimed at reducing inequalities and improving maternal and infant health outcomes.

METHODS

Study area

The study was done in Comoros, an archipelago in the Indian Ocean. It lies to the north of the Mozambique Channel, in south-east Africa, between the northern coast of Mozambique and the northern tip of Madagascar.

This group of islands consists mainly of separate landmasses: Ngazidja: PMI, ASCOBEF, Mbeni Hospital, Anjouan: CMU, Ndomoni, and Ouani district (high birth rate area) and Mohéli: CMU Fomboni, Ndrondroni and Wanani health post.

The population of the Comoros in 2024 was estimated to be 852,075 people at mid-year.

Study design

This study adopts a quantitative approach, using a cross-sectional survey to examine factors associated with FP uptake among pregnant and postpartum women in Comoros.

Study population and sampling

The survey was carried out between 10 July and 15 December 2024 among 251 pregnant and post-partum women in health facilities on the three islands. Pregnant and postpartum women aged 15 to 49 living on the three islands were eligible to take part in the study. An informed consent form was signed by the participants to show their willingness and consent to take part in the survey.

Data collection tool

Data were collected using a questionnaire designed to assess knowledge, attitudes and practices related to FP, as well as factors such as socio-cultural, economic and interpersonal factors that influence the use of FP services.

Before each interview, clear and precise explanations of the subject and objectives were given to the participants, and no personal information was recorded on paper. The consent and assent of participants and/or parents, as appropriate, were obtained before the survey was administered. Participants were given the opportunity to refuse or not participate in the procedure.

Trained data collectors administered the questionnaire during face-to-face interviews in health facilities. Responses were recorded on paper and then digitised for analysis. Ethical approval UI/EC/24/0302 and N°24002/CNESS/PR was obtained from the relevant authorities and participants were assured of confidentiality and voluntary participation.

Variables

Dependent variable was contraceptive method uptake.

Independent variables were education level, income, employment status, island of residence, discussion/ communication with others.

RESULTS

Socio-demographic characteristics and patterns of FP awareness and utilization among participants

The main socio-demographic characteristics of the respondents are shown in Table 1. The majority of participants (78.90%) reported being aware of FP; however, despite this high level of knowledge, only 65% were using contraception. Regarding age distribution, 104 participants (41.4%) were aged between 25 and 30 years, 97 (38.6%) were over 30 years old, and 49 (19.5%) were between 18 and 24 years.

In terms of educational level, the majority of participants had some level of formal education: 27.5% had primary education, 28.7% had secondary education, and 27.5% had tertiary education, while only 16.3% had no formal education.

Most of the women were married (213; 84.9%). Concerning parity, 101 participants (40.2%) had more than three living children. Despite this, 111 women (44.2%) expressed a desire to have another child.More than half of the participants (136; 54.2%) were unemployed, and A high proportion of participants (164; 65.3%) had never discussed PPFP with their partners. However, 179 women (71.3%) approved of the use of FP, and 147 (58.6%) reported that their partners also approved of FP use.

FP methods used

A total of 161 respondents reported current contraceptive use. Table 2 presents distribution of contraceptive methods among these participants. Injectable contraceptives were the most frequently used method (43%), followed by implants (23%) and oral contraceptive pills (12%).

Condoms accounted for 5% of contraceptive use, while IUDs and natural methods each represented 6%. Withdrawal was reported by 4% of users, and tubal ligation was the least commonly used method (1%). These findings suggest that injectable contraceptives remain the preferred FP method among participants, with relatively low utilization of permanent and traditional methods.

Association between socio-demographic and reproductive characteristics and postpartum FP uptake

Table 3 presents the association between socio-demographic and reproductive characteristics and PPFP uptake among study participants.

Island of residence was significantly associated with PPFP uptake (p=0.0005). Women from Anjouan had the highest proportion of postpartum contraceptive use 63 (25.0%), followed by Ngazidja 58 (23.0%) and the Mohéli 40 (16.0%).

Educational level was also significantly associated with PPFP uptake (p=0.042), with higher contraceptive use observed among women with secondary 51 (20.3%) and tertiary education (50, 19.9%) compared with those without formal education 23 (9.1%).

The number of living children showed a significant association with PPFP uptake (p=0.013). Women with three or more living children had the highest proportion of contraceptive use 116 (46.1%), whereas women without living children had the lowest uptake 2 (0.8%).

Other characteristics, including age (p=0.323), marital status (p=0.203), employment status (p=0.111), income sufficiency (p=0.834), and desire for another child (p=0.060), were not significantly associated with PPFP uptake.

Relationship between spousal support factors and FP utilization

Regarding communication with partners, among women who were currently using FP methods, 27.2% reported discussing FP with their partners, while 37.1% reported not having discussed FP with their partners. Among women who had never used FP, only 7.2% had discussed FP with their partners, whereas 27.5% had not discussed FP with their partners. A small proportion of women who were not currently using FP and had never used it reported partner discussion (0.4% and 0.8%, respectively).

Concerning partner approval of FP, women who reported that their partners approved FP use represented a higher proportion among current FP users (44.3%) compared with those who had never used FP (13.9%). Conversely, among participants whose partners did not approve FP use, 20.0% were current users, while 20.7% had never used FP.

Overall, the findings suggest that partner support and approval may play an important role in FP uptake. Women who reported partner approval had a higher proportion of current contraceptive use compared with those who reported lack of approval. However, partner discussion was less frequent, with nearly two-thirds of participants (65.4%) indicating that they had not discussed FP with their partners.

Table 1: Socio-demographic characteristics, FP knowledge, attitudes, and uptake among study participants.

Attribute	Response	N	Percentage (%)
Knowledge of FP	Yes	198	78.9
	No	53	21.1
FP uptake	Yes	163	65.0
	No	87	35.0

Continued.

Attribute	Response	N	Percentage (%)
Age (in years)	18-24	49	19.5
	25-30	104	41.4
	>30	97	38,6
Level of education	No formal education	41	16.3
	Primary	69	27.5
	Secondary	72	28.7
	Tertiary	69	27.5
Marital status	Married	213	84.9
	Separated or divorced	13	5.2
	Unmarried	23	9.2
	Widowed	2	0.8
Employment status	Salaried employment	43	17.1
	Self-employed	72	28.7
	Not employed	136	54.2
Discuss with partner	Yes	87	34.7
	No	164	65.3
Woman approves FP	Yes	179	71.3
	No	72	28.7
Partner approves FP	Yes	147	58.6
	No	104	41.4
Importance of FP	Yes	190	75.7
	No	61	24.3

Table 2: Distribution of FP methods used among participants currently using the contraception, (n=161).

Items	Response	N	Percentage (%)
Method use	Condom	9	5
	Implant	37	23
	Injectable	69	43
	Intra-uterine device (IUD)	10	6
	Natural method	10	6
	Oral contraception pills	19	12
	Tubal ligation	1	1
	Withdrawal (Coitus interruptus)	6	4
Total		161	100

Table 3: Distribution of PPFP use according to participants' geographic location, socio-demographic and reproductive characteristics.

Variables	PPFP use		P value
	Yes N (%)	No N (%)	
Island			
Ngazidja	58 (23)	50 (20)	0.0005
Anjouan	63 (25)	20 (8)	
Moheli	40 (16)	20 (8)	
Age (in years)			
18-24	21 (8.30)	29 (11.4)	0.323
25-30	67 (26.70)	37 (14.7)	
>30	73 (29.20)	23 (9,2)	
Level of education			
No formal education	23 (9.10)	18 (7.2)	0.042
Primary	40 (15.90)	29 (11.6)	
Secondary	51 (20.30)	21 (8.4)	
Tertiary	50 (19.90)	19 (7.6)	
Marital status			
Married	144 (57.40)	68 (27.5)	0.203
Separated/divorced	8 (3.20)	5 (2)	
Unmarried	10 (4)	13 (5.2)	
Widowed	2 (0.80)	0 (0.0)	

Continued.

Variables	PPFP use		P value
	Yes N (%)	No N (%)	
Employment status			
Salaried employment	33 (13.10)	10 (4.0)	0.111
Self-employed	49 (19.50)	23 (9.2)	
Not employed	79 (31.50)	57 (22.7)	
Income			
Sufficient	53 (21.20)	33 (13.1)	0.834
Not sufficient	108 (43.00)	57 (22.7)	
Number of living children			
0	2 (0.80)	13 (5.2)	0.013
1	18 (7.10)	21 (8.4)	
2	25 (9.90)	10 (4)	
≥3	116 (46.10)	46 (18.4)	
Desire for another child			
Yes	55 (21.90)	56 (22.3)	0.060
No	56 (22.30)	27 (10.8)	
Not yet	50 (19.90)	7 (2.8)	

Table 4: Partner communication and support for FP use.

FP uptake	Discuss with partner		Partner approves FP	
	Yes (%)	No (%)	Yes (%)	No (%)
Current use	68 (27.20)	93 (37.10)	111 (44.30)	50 (20.00)
Never use	18 (7.20)	69 (27.50)	35 (13.90)	51 (20.70)
No use	1 (0.40)	2 (0.80)	0 (0.00)	1.20
Total	87 (34.80)	164 (65.40)	146 (58.20)	105 (41.90)

DISCUSSION

The present study assessed FP awareness, utilization, PPFP use, contraceptive method preferences, and the influence of socio-demographic and spousal factors among women in the Union of the Comoros. The findings revealed a high level of awareness of FP (78.9%) among participants; however, actual contraceptive utilization was lower, with 65.0% reporting current use. This gap between knowledge and practice suggests that awareness alone may not be sufficient to increase contraceptive uptake, as other factors such as socio-cultural norms, partner influence, access to services, and individual reproductive intentions may play important roles.

The high level of FP awareness observed in this study is consistent with findings from several African settings, where knowledge of contraception is generally widespread, although utilization continues to be constrained by social, cultural, and structural barriers. However, the level of awareness observed in the present study (78.9%) was lower than that reported by Sulemana, Iddrisu et al who found that 91.9% of women were aware of FP methods.[9]

The socio-demographic characteristics of participants showed that most women were aged 25 years and above, married (84.9%), and had at least some formal education. The predominance of married women in this study reflects the importance of marital and reproductive contexts in FP decisions in Comoros. Similar patterns have been reported in other African countries, where shown an association between being married and increased FP uptake, Marriage may facilitate communication between partners; however, it can also reinforce traditional norms that influence reproductive decisions.[10,11] Other studies have highlighted the relationship between socio-demographic factors, including marital status and wealth status, and contraceptive use.[11,12]

Education appeared to influence postpartum FP utilization, with higher proportions of PPFP users among women with secondary (20.3%) and tertiary education (19.9%) compared with women without formal education (9.1%). This finding supports evidence that education improves women's knowledge, autonomy, confidence in decision-making, and ability to access reproductive health services. Educated women may also have better understanding of birth spacing benefits and greater ability to negotiate contraceptive decisions with their partners. However, the relatively high proportion of users among women with lower education levels indicates that other factors beyond education, such as contact with healthcare services and previous reproductive experiences, also influence PPFP uptake. The significant association between women's level of education and contraceptive uptake aligns with previous research conducted across sub-Saharan Africa, which consistently shows that education enhances awareness, decision-making autonomy, and health-seeking behaviour among women, Similar trends have been reported in Ethiopia and Tanzania, where education facilitates access to information and promotes confidence in using modern contraceptives.[13-15]

Employment status were also strong determinants of contraceptive use. Women who were self-employed or salaried had higher rates of modern contraceptive use, reflecting both economic empowerment and better access to healthcare services. Those reporting sufficient income were more likely to choose long-acting reversible contraceptives (LARCs), suggesting that financial stability reduces economic barriers to method uptake. This finding corroborates previous evidence. For instance, a study conducted in Sukoharjo, Central Java, reported that employment status, family income, and contraceptive availability significantly influenced the use of long-term contraceptive methods, further emphasizing the role of economic factors in FP.[16] Conversely, unemployed or low-income women were overrepresented among non-users, highlighting persistent economic and structural inequalities that hinder access to FP.

Geographical disparities also emerged, with Ngazidja showing the highest adoption of modern contraceptives, particularly implants and injectable, compared to Anjouan and Mohéli. These differences may be attributed to variations in health infrastructure, availability of trained personnel, and exposure to FP campaigns. The lower adoption rates in Anjouan and Mohéli suggest potential gaps in service delivery and awareness that warrant targeted interventions to ensure equitable access across the islands.

This study examined the relationship between partner communication, partner approval, women's approval, and FP uptake. The results provide strong evidence that interpersonal and behavioural factors within couples play a key role in contraceptive behaviour. In general, women who discuss FP with their partner, whose partner approves of FP, and who themselves have a positive perception of contraception have significantly higher levels of use. Conversely, lack of discussion and lack of approval are associated with higher proportions of non-use and lifetime non-use.

These findings are consistent with research conducted in sub-Saharan Africa and other low- and middle-income countries, which highlights the central role of the couple and male involvement in reproductive health decisions.

It has been found that discussing FP within a couple is positively associated with the adoption of contraception. Women who reported discussing FP with their partner had a higher proportion of current users and a significantly lower proportion of women who had never used contraception, compared to those who did not discuss FP with their partner. One study found that discussing FP with one's partner was closely linked to the use of postpartum contraceptive methods. The results showed that women who had discussed FP with their partners were more likely to use these methods than those who had not. These findings are supported by a meta-analysis conducted in low- and middle-income countries. This suggests that men's involvement and support in FP helps women to adopt more practical methods with confidence.[17]

A previous study conducted in Kenya showed that among postpartum women, 69.4% reported having discussed FP with their husband/partner and that of the 108 women using a contraceptive method, and 91.1% reported having discussed contraception with their husband/partner, compared to 58.7% of those who did not use a modern method.[18]

The observed association between discussion patterns and contraceptive use further emphasizes the role of interpersonal communication in shaping reproductive choices. Women who discussed FP with their partners, relatives, or peers were significantly more likely to use modern methods. This aligns with prior studies suggesting that open dialogue enhances spousal agreement, corrects misconceptions, and fosters mutual decision-making. Encouraging community-based dialogues and peer education could therefore strengthen FP acceptance.

Overall, this study demonstrates that while FP awareness is high among women in Comoros, postpartum contraceptive utilization remains influenced by multiple interconnected factors, including age, education, parity, geographic location, reproductive intentions, and partner support. Interventions aiming to improve PPFP uptake should therefore adopt a comprehensive approach that combines quality counselling, improved access to a broad range of contraceptive methods, community engagement, and increased male partner involvement.

Limitations

This study has some limitations that should be acknowledged. Its cross-sectional design restricts the ability to draw causal inferences between socio-demographic factors and contraceptive use. Data were self-reported, which may have introduced recall or social desirability bias, particularly regarding sensitive issues such as reproductive intentions. In addition, the study was conducted among women attending selected health facilities, which may not fully represent those who do not access healthcare services, thereby limiting the generalizability of the findings to the broader population.

CONCLUSION

This study highlights that postpartum contraceptive use in the Comoros is shaped by a combination of socio-demographic, economic, and interpersonal factors. Education level, employment status, income sufficiency, island of residence, and communication with partners or peers significantly influence contraceptive behaviour among women. Financial stability and partner approval emerged as key facilitators of modern contraceptive adoption, while limited education, unemployment, and geographic disparities continue to hinder access. These findings emphasize the need for integrated, equity-focused

strategies to improve postpartum FP uptake and maternal health outcomes.

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