African Population and Health Research Center

Policy Brief
May 2018

What it takes: Meeting unmet need for family planning in East Africa

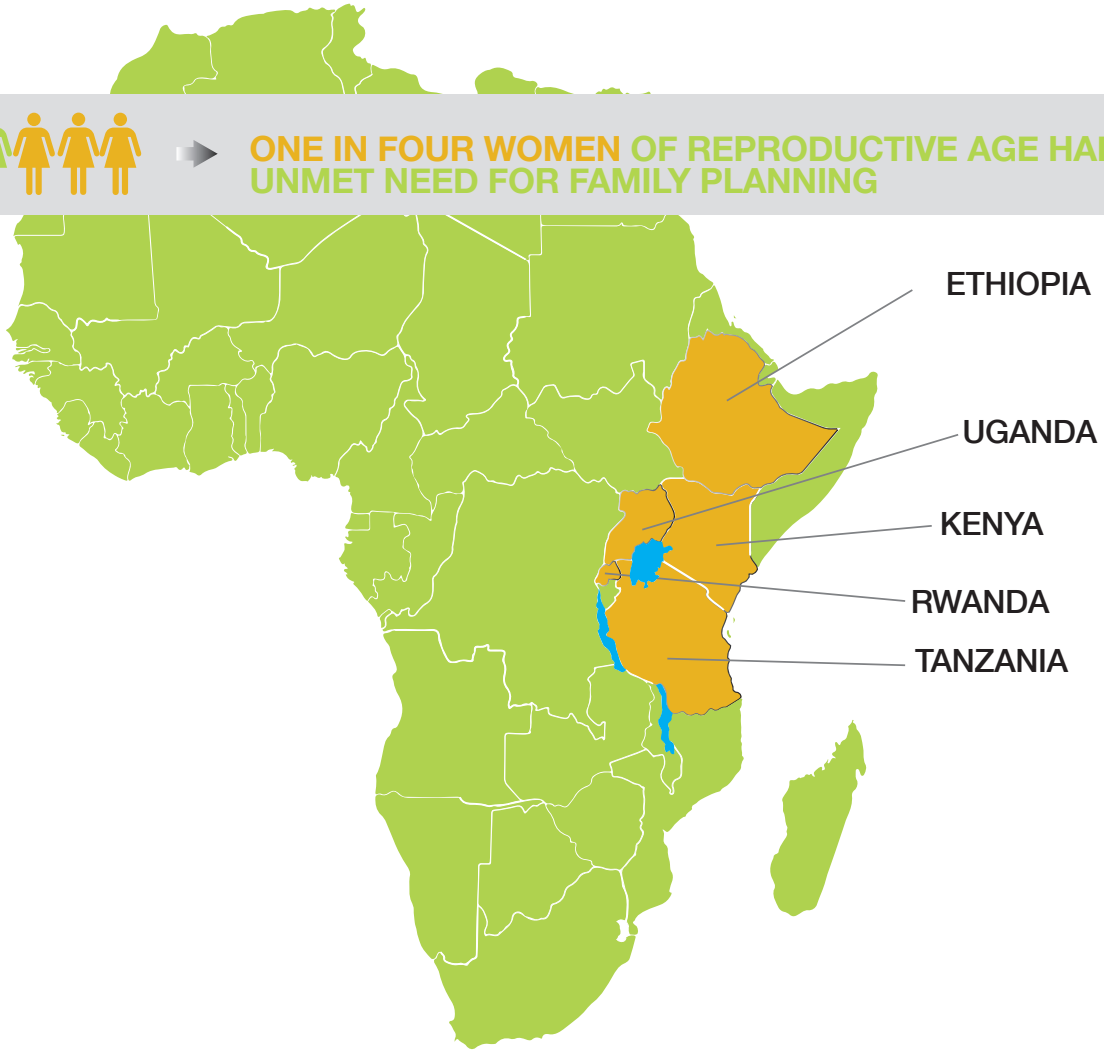
Unmet need for family planning (FP) exists when a woman who wants to postpone pregnancy or stop having children altogether is not using modern contraception [1]. Sub-Saharan Africa (SSA) has the highest number of women who have an unmet need for contraception. SSA also has the highest global burden of unintended pregnancy, unsafe abortion and maternal mortality. In this brief, we take a closer look at the realities of FP for women in five countries of East Africa—Ethiopia, Kenya, Rwanda, Tanzania, and Uganda. One in four of women of reproductive age in the sub-region had an unmet need for FP.

There is a lot of evidence around the benefits of FP including reduction of unintended pregnancies and induced abortions, as well as fewer maternal deaths annually [2]. It also gives women increased agency over their FP decisions on when or if to have children. Investment in FP not only benefits an individual or family, but also a nation. It opens up a window of opportunity for countries to harness a demographic dividend and can help an economy thrive when infants and children survive into adulthood, average lifespans increase [3, 4] and there are improved investments in helping people thrive by providing quality educational opportunities and jobs.

> “Family planning reduces unintended pregnancies, induced abortions, and leads to fewer maternal deaths.”

For these reasons, FP should be a budgetary and policy priority for government decision-makers. This brief uses data from secondary sources including Demographic and Health Surveys (DHSs) to examine the dynamics of unmet need for FP in the five countries. The brief also identifies policy implications for meeting women’s need for FP.

ONE IN FOUR WOMEN OF REPRODUCTIVE AGE HAD AN UNMET NEED FOR FAMILY PLANNING



Key Findings

- Unmet need for family planning is highest in Uganda (28%) and Tanzania (22%) and lowest in Kenya (18%) and Rwanda (19%).
- Unmet need is related to socio-economic factors: place of residence, age, educational attainment and wealth status are among the drivers of inequalities in the level of unmet need for family planning. In all five countries, FP use is higher among urban, educated and wealthier women while unmet need is higher among rural, uneducated and poorest women.
- The most common contraceptives used in the study countries are short-term methods such as injectables, which offer a maximum of three months of protection from pregnancy when compared to long-acting methods such as implants that offer three or more years of protection.
- Method related concerns, specifically fear of contraceptive side effects and health risks, is the major reason for not using contraception among married women with unmet need in study countries.
- In countries such as Rwanda and Ethiopia, a large proportion of women with unmet need reported they do not need or should not use contraception because they are breastfeeding or they haven't resumed menstruation after a birth or both (labeled as fertility related).
- A growing number of women also continue to cite opposition to use (partner or religious prohibition) and a lack of knowledge of available methods as reasons for non-use of contraceptives.
- The desire for more children is declining in the sub-region, and the intention to space or limit childbearing is increasing.

BETWEEN 1990 AND 2017, THE DECLINE IN UNMET NEED FOR FP WAS FASTEST IN KENYA, RWANDA AND ETHIOPIA, SLOWEST IN TANZANIA AND UGANDA. UGANDA STILL HAS THE HIGHEST LEVEL OF UNMET NEED FOR FP

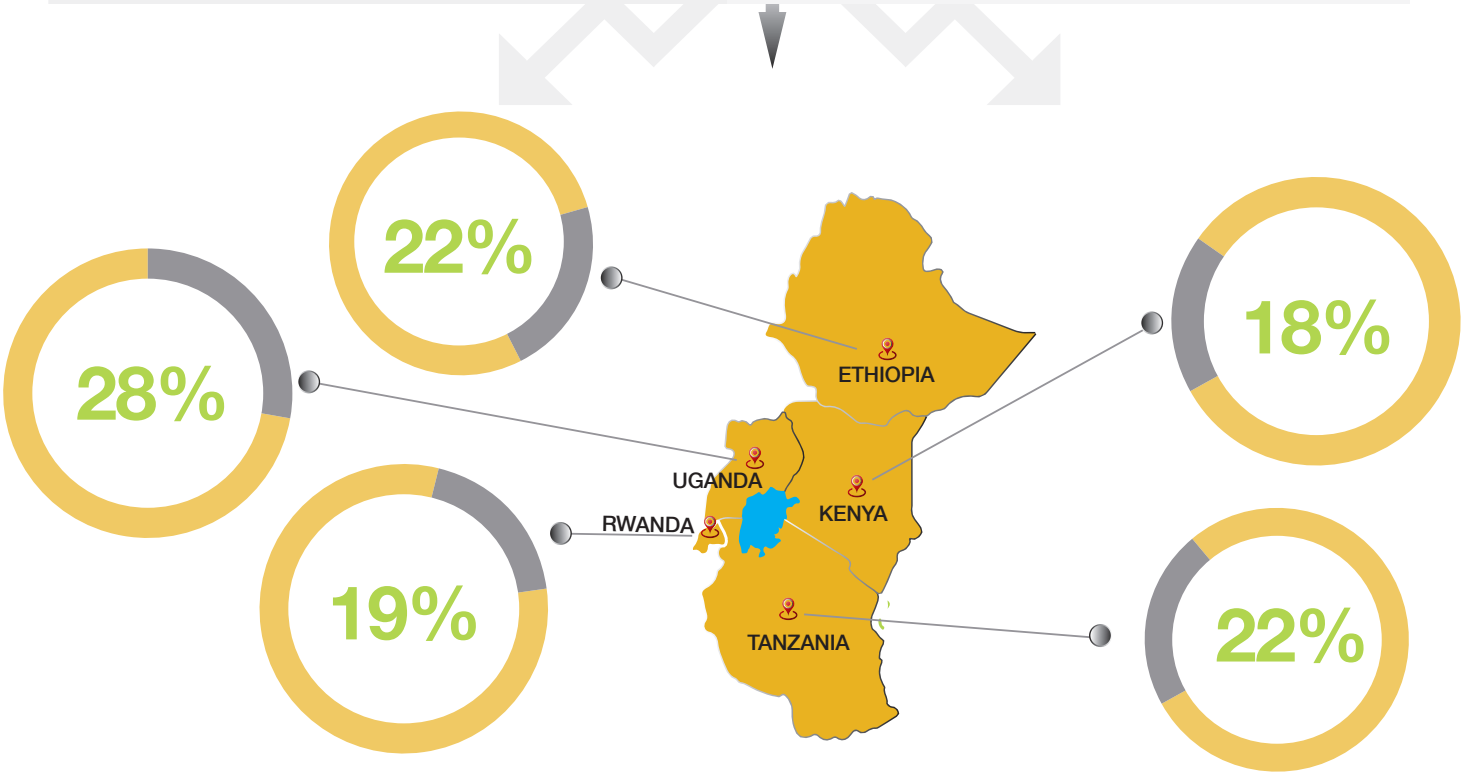
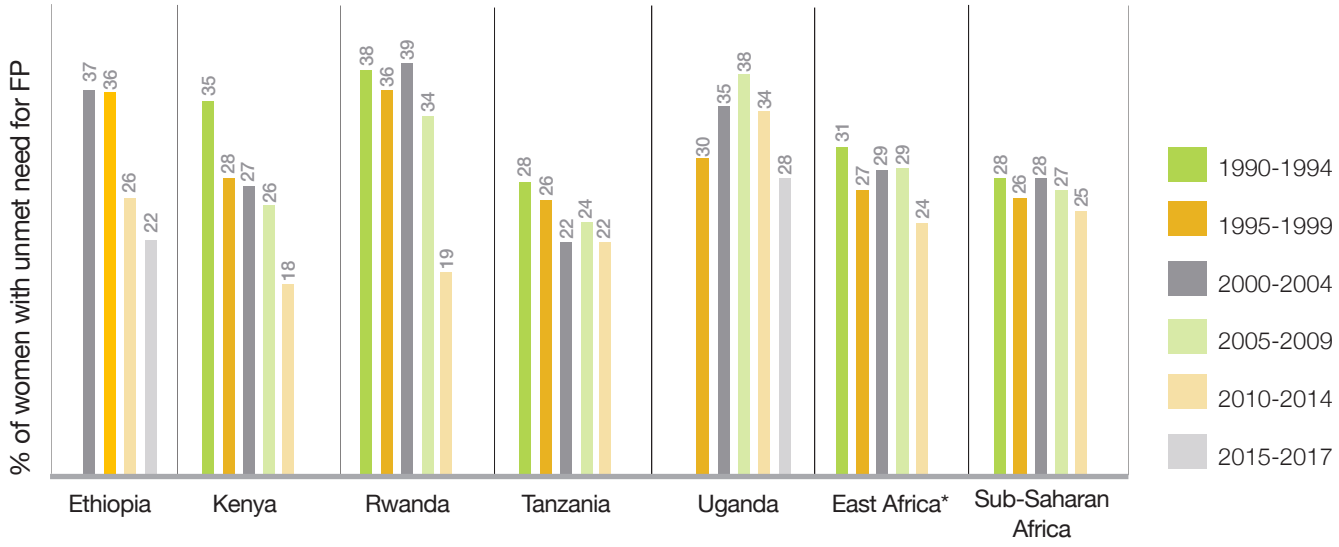


Figure : Unmet need for family planning in East Africa, 1990-2017



*East Africa here refers to all countries in the region, not only the five study countries.

Source: Demographic and Health Surveys; Izugbara et al (2017) *Family planning in East Africa: trends, patterns, and dynamics*, African Population and Health Research Center, 2017

How well are countries meeting the demand for family planning?

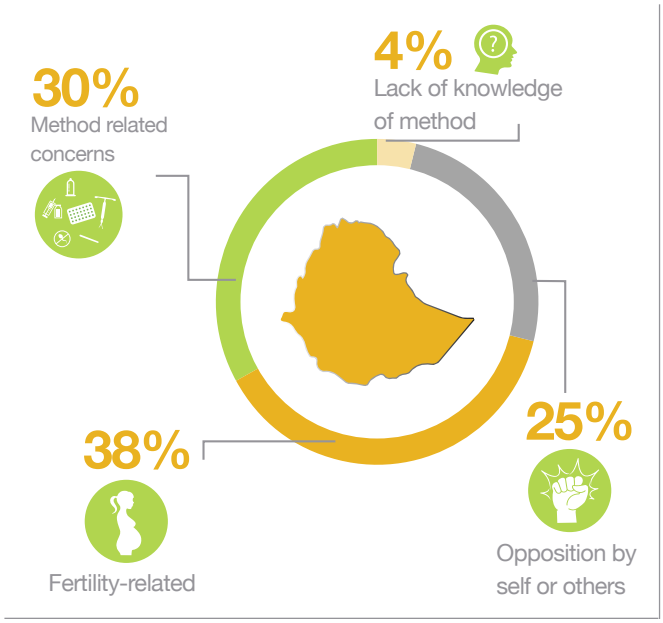
Ethiopia

Ethiopia experienced a rapid rise in contraceptive use since 2003 largely due to its community-based Health Extension Program (HEP),where trained female community health workers provide short-term methods such as pills and injectables at village health posts and door-to-door to women in the communities. In addition, there was rapid expansion of health centres, a primary health care unit staffed with mid-level providers to provide comprehensive and basic preventive and curative services including long acting and reversible contraception such as implants.

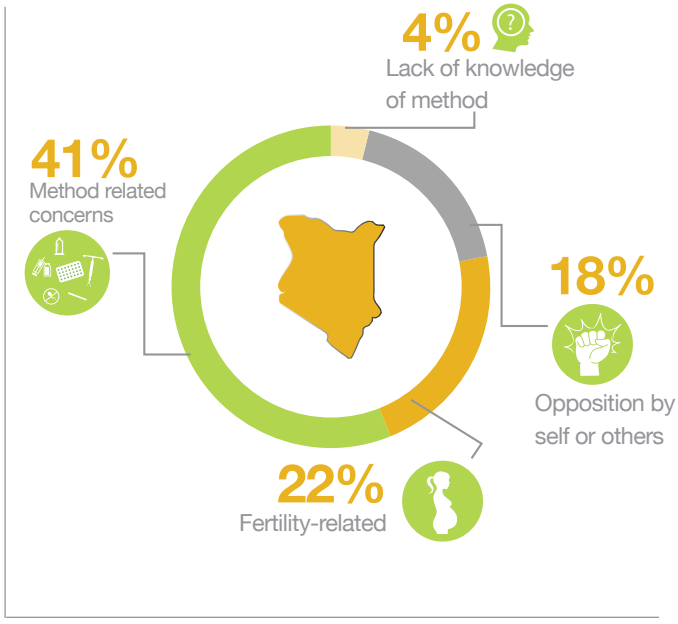
Kenya

Kenya experienced a stall in fertility decline in the 2000s, in part due to a huge shift in focus to fighting HIV/AIDS as a singular priority which took resources away from family planning. The revitalization of the national family planning program brought attention back to family planning as a central pillar of a reproductive health strategy initiated as part of the second National Health Sector Strategic Plan (2005-2010) and the Population and Development Policy (2012). Since then, FP services—together with HIV/AIDS treatment, care, and prevention --are widely provided through public and private facilities in Kenya including mobile clinics targeting hard-to-reach populations.

Reasons Married Women Give for Not Using Contraception - Ethiopia, 2011



Reasons Married Women Give for Not Using Contraception - Kenya, 2014



Source: Demographic and Health Surveys: Sedgh, G. Ashford, L. and Hussain, R. Unmet need for contraception in Developing Countries: Examining women's reasons for not using a method, June 2016.

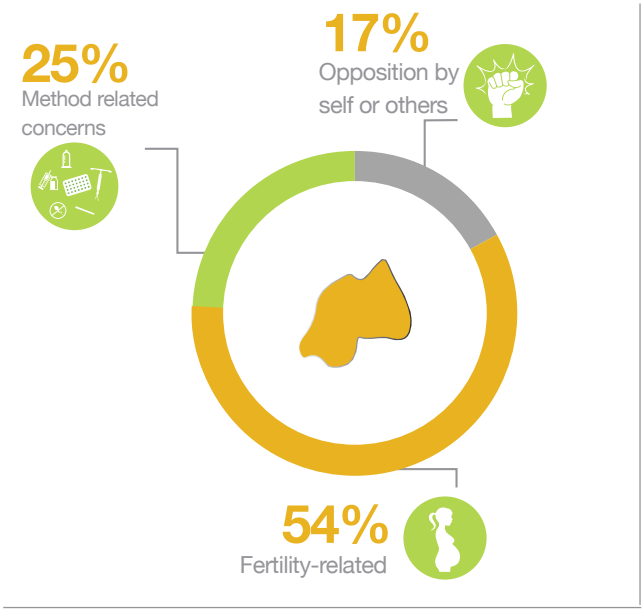
Rwanda

Rwanda is a clear leader in contraceptive prevalence and use by improving awareness and demand creation on FP, as well as improving access to FP services. The government has made a strong commitment to create an enabling environment for family planning, to meet and mitigate challenges of rapid population growth.

Rwanda has also implemented effective strategies including performance-based financing, decentralization of services, and community based health insurance.

Taken together, these health system improvement plus steady financing of supplies, brought about increased demand for family planning services. Since 2010, Rwanda has pursued an ambitious plan involving the training and recruitment of Community Health Workers (CHWs) in family planning and preventive services.

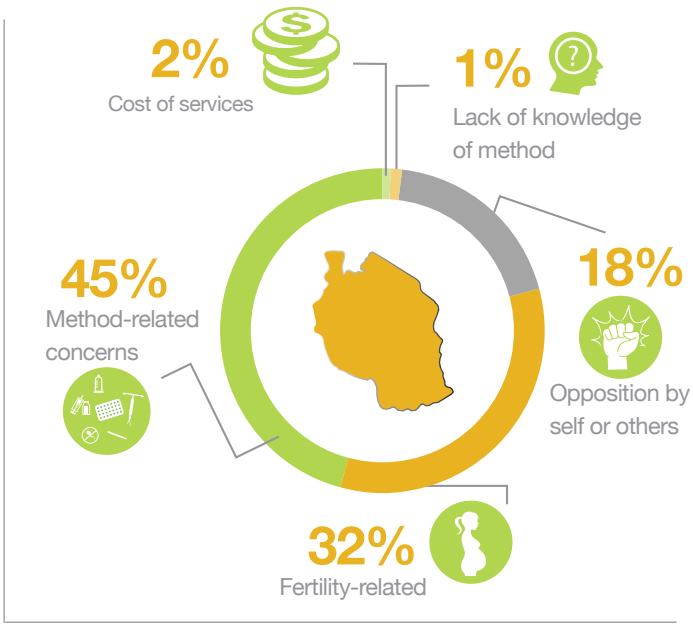
Reasons Married Women Give for Not Using Contraception - Rwanda, 2010



Tanzania

Evidence shows that the level of unmet need for contraception has hardly changed in Tanzania despite growth of modern contraceptive use in recent years. The Ministry of Health and Social Welfare's 2015-2020 strategic plan states that reproductive health services such as family planning are not performing as hoped, despite continued investment. The government recognizes the need to address rapid population growth. However, shortages in funding and human resources remain a challenge. With support from the private sector and international agencies, there has been an increase in quality of services and greater contraceptive use, especially in rural areas.

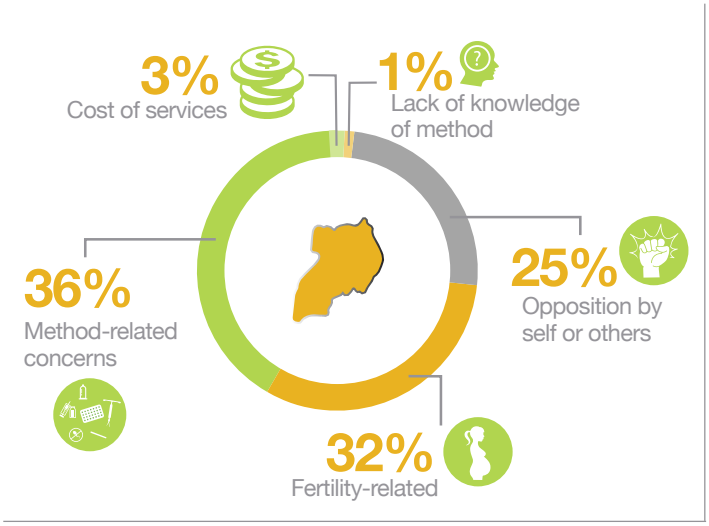
Reasons Married Women Give for Not Using Contraception - Tanzania, 2010



Uganda

Uganda has one of sub-Saharan Africa's highest fertility levels at 5.7 children per women. However, the gap between wanted and actual fertility is widening, indicating growing desire to limit or space childbearing. In 2014, the government developed the Uganda Family Planning Costed Implementation Plan (2015-2020) to reduce unmet need for family planning from 34% to 10% and increase the use of modern contraceptives from 26% to 50% by 2020.

Reasons Married Women Give for Not Using Contraception - Uganda, 2011



Policy Recommendations

1. Increase government investment in sexual and reproductive health services

In most of the countries, FP programs depend on external funding. It is possible for county and national governments to increase budget lines around family planning. A recent example of sub-national investment and leadership comes from two counties in rural Western Kenya (Siaya and Busia) where fertility rates lagged behind decreases realized in the rest of the country.

After seeing positive results – a decreased fertility rates – from a five-year project implemented by APHRC and partners, counties initiated and approved increased allocation of county government resources to support stipends for Community Health Volunteers to distribute family planning information and services [5]. The two counties also set aside funds for continuous provision of FP commodities to meet demand.

2. Improving quality of care of FP delivery and options

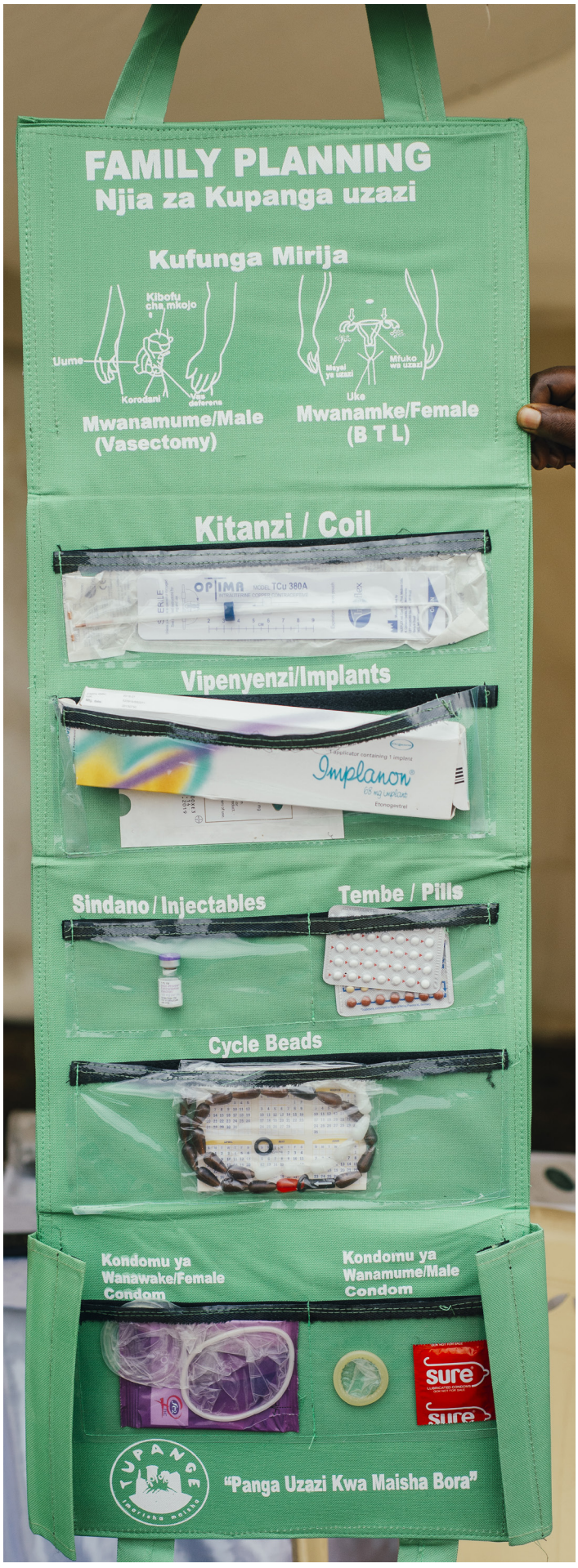
Evidence shows that too many healthcare providers do not inform women about potential side effects of various contraceptive methods or how to manage them. Unanticipated side effects, and the lack of choice of option for those who experience unpleasant side effects, can lead women to stop using contraception, and perpetuate the cycle of unmet need. Quality FP counseling is key to providing accurate information on how contraceptive methods work, the side effects of each method and the benefits associated with them.

CHWs and health service providers need in-service training opportunities to build and refresh their knowledge and skills on the range of available contraceptive methods and their benefits.

3. Raise awareness and empower communities on contraceptive use

Gender inequality and socio-cultural barriers contribute to women's low use of modern contraception. In the long term, East African countries can sustainably increase the use of family planning services by promoting women's empowerment and decision making autonomy, comprehensive sexuality education in schools, and women's participation in the labor force. The Western Kenya project engaged religious leaders from mosques and churches as partners to educate, mobilize and create linkages and referral to health facilities for family planning services.

> "East African countries can sustainably increase the use of family planning services by promoting women's empowerment and decision making autonomy, comprehensive sexuality education in schools, and women's participation in the labor force."



Conclusion

Research can – and should - inform family planning policies and programs, identify barriers to contraceptive use, and develop strategies of improving access in hard to reach areas and underserved populations. Countries in East Africa can learn from each other on how to prioritize FP and reduce unmet need. By making modern FP a higher priority in policies, programs and budgets, national and county governments can avert unintended pregnancies, reduce unsafe abortions and interrupted schooling.

References

1. Westoff, C., *New Estimates of Unmet Need and the Demand for Family Planning*, in DHS *Comparative Reports* 2006, ICF: Calverton, MA,USA.
2. Darroch, J. and S. Singh, *Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2017, fact sheet* https://www.guttmacher.org/fact-sheet., 2017, Guttmacher Institute: New York.
3. Osotimehin, B., *Family planning save lives, yet investments falter.* Lancet, 2012. 380 (9837): p. 82-3.
4. Gribble, J. and J. Bremner, *The challenge of attaining the demographic dividend*, 2012, Population Reference Bureau: Washington DC.
5. African Population and Health Research Center (APHRC). 2016. End of Project Report of the Community Based Family Planning Project in Western Kenya: Expansion Phase, 2012-2015; Nairobi: APHRC.

Authors: Yohannes Dibaba Wado, Tizta Tilahun, Carol Gatura, Danielle Doughman and Chimaraoke Izugbara

For more information go to: http: //bit.ly/2K4ZpIS

African Population and Health Research Center

APHRC Campus, Kitisuru
P.O. Box 10787 - 00100, Nairobi
Kenya +254 20 400 1000
Email: info@aphrc.org
@aphrc