

The need for family planning

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Abstract The purpose of this paper is to examine the evidence on the need for family planning. The available evidence on current levels of unmet need for contraceptives, fertility preferences, and the non-contraceptive benefits of family planning is reviewed. I argue that expansion of family planning programs is still needed. These programs provide couples with tools to reach their desired family size; can significantly impact maternal and child mortality by decreasing fertility and optimizing child spacing; and by decreasing fertility, slow population growth. It is therefore imperative to continue to expand the provision of family planning services.

Keywords Family planning · Unmet need · Contraception · Maternal mortality · Abortion · Access to services · Barriers to family planning · Fertility · Population growth

Introduction

Family planning is an effective way of controlling fertility. Low fertility leads to a slower population growth. It has long been acknowledged as an effective public health intervention, highly cost-effective in decreasing maternal and child health burden of disease (World Bank, 1993). Globally, the use of modern contraceptive methods and the desire for smaller families has been increasing. However, large disparities between rich and poor still exist in access to services, resulting in disproportionately high unmet need for the poor (PRB, 2004). The causes of unmet need are mainly related to poor access to services, lack of correct information, social opposition to use, and concerns (whether warranted or not) about side effects (Casterline & Sinding, 2000).

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The purpose of this paper is to examine the evidence on the need for family planning. The available evidence on current levels of unmet need for contraceptives, fertility preferences, and the non-contraceptive benefits of family planning is reviewed. I argue that expansion of family planning programs is still needed. These programs provide couples with tools to reach their desired family size; can significantly impact maternal and child mortality by decreasing fertility and optimizing child spacing; and by decreasing fertility, slow population growth.

Data and methods

A literature review of published data was conducted using electronic data sources (i.e. Pubmed, JSTOR, Google Scholar) with the following keywords: unmet need; contraception; maternal mortality; abortion; family planning; access to services; barriers to family planning; fertility; HIV; population growth. Relevant indicators used are published data in the World Health Organization (WHO); United Nations Population Fund (UNFPA); United Nations Population Division; and Population Reference Bureau (PRB) population reports, data sheets, and thematic reports. Where relevant, analysis of available Demographic and Health Surveys (DHS) were performed using Statcompiler from the Measure DHS website. Data from country specific DHS final reports were also used.

Findings

Contraceptive use

Worldwide, since the 1960's the percent of married women using contraception has steadily increased (PRB, 2006; UN Population Division, 2005). Since the early 1990s more than half of all married women in the world were using some form of contraception (Fig. 1).

Despite overall progress, enormous differences exist between the world regions. Contraceptive use is higher in middle and high-income countries, and is lowest in the least developed countries. With the exception of the countries in Southern Africa

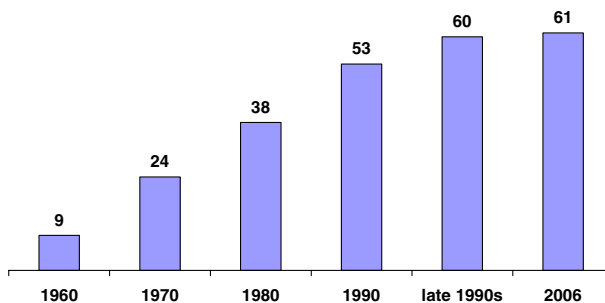


Fig. 1 Percent of married women using contraception, 1960 to the late 1990s

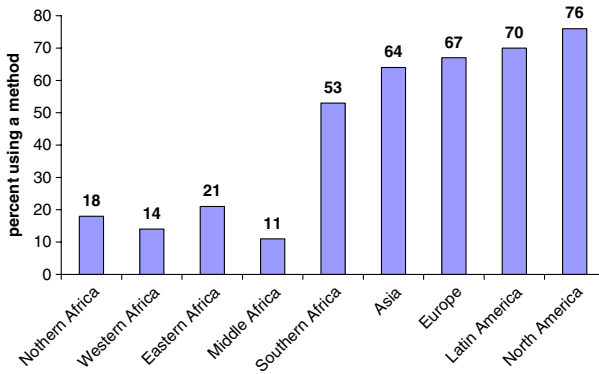


Fig. 2 Current contraceptive use by region

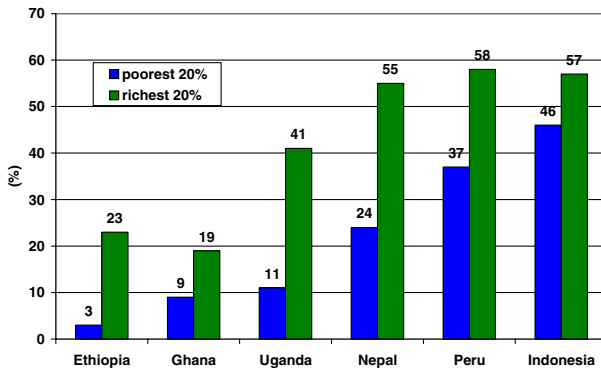


Fig. 3 Percent married women ages 15–49 using modern contraception according to wealth

(i.e. South Africa, Swaziland, Lesotho, Botswana, and Namibia), sub-Saharan Africa (all African regions except North Africa) presents the lowest levels of contraceptive use globally (Fig. 2).

Within countries, wide gaps between rich and poor women exist. Women from the richest segments of the population have contraceptive prevalence rates two to seven times higher than their poorest counterparts, a reflection of the existing inequalities in access to contraception (Fig. 3). Nevertheless, socio-economic differences in contraceptive use seem to be smaller in countries where contraceptive methods are widely available and accessible.

When comparing Bangladesh and the Philippines, for example, we found that in Bangladesh contraceptive use does not significantly vary according to level of education (Bangladesh 1999–2000 DHS). In contrast, contraceptive use increases with level of education in the Philippines (Philippines DHS 1998) (Fig. 4). It is important to note that these two countries differ significantly in their approach to family planning provision. In Bangladesh, rural women live and work within the

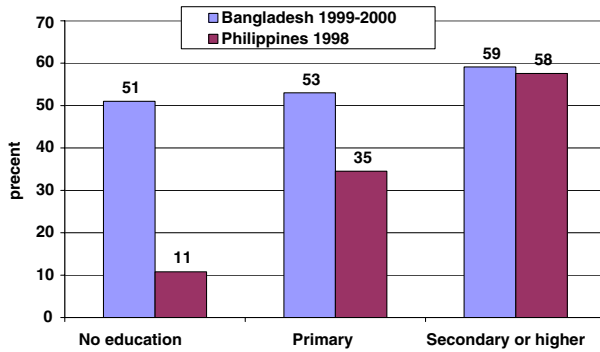


Fig. 4 Contraceptive use by level of education

confines of the extended family home and compound. Many women have no independent sources of income, little or no education, and few marketable skills. Reproductive decision-making has been influenced by expectations of traditional female roles and women’s dependence on men. The family planning program in Bangladesh has taken into account women’s isolation and dependence. It employs a vast force of female field workers to visit women in their homes and provides highly subsidized contraceptives (Shuler, Hashemi, Cullum, & Hassan, 1996). In the Philippines however, low-income women experience great difficulty accessing modern family planning methods. In addition to cultural and religious barriers, family planning program planners also face formidable legal barriers due to the country’s own policies (Mello, Powlowski, Nanagas, & Bossert, 2006).

Organized family planning programs are a great contributor to increases in contraceptive prevalence (Allman, Vu, Nguyen, Pham, & Vu, 1991). An analysis of 73 less developed countries for the period 1977–1983 showed that even though socio-economic changes were associated with the variance in contraceptive prevalence, provision of family planning programs significantly strengthened the association (Lapman & Mauldin, 1985). There is a strong inverse relationship

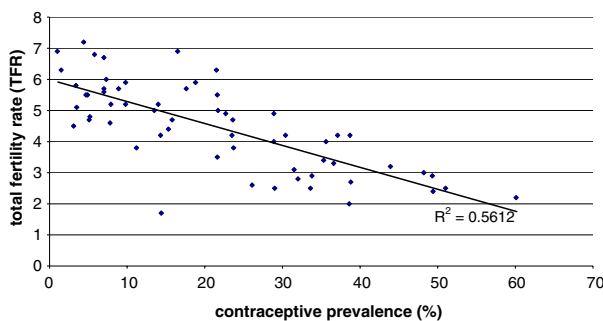


Fig. 5 Relationship between fertility and modern contraceptive use. Countries with at one (latest) DHS

between the total fertility rate (TFR) and contraceptive prevalence (Fig. 5). Thus, family planning contributes to fertility decline.

In Indonesia, for example, Gertler and Molineaux found that contraceptive use contributed to 75% of the fertility decline (Gertler & Molineaux, 1994). The authors concluded that changes in Indonesia's education and economic development that increased contraceptive use and subsequent fertility decline were only possible because an organized supply delivery system of contraceptives existed. Furthermore, this result demonstrates the significant role family planning plays during fertility transition. Unlike the fertility transition effects in many Asian countries (i.e., Indonesia, Thailand, South Korea, Vietnam, and others), fertility decline in sub-Saharan African countries has not been accompanied with rapid changes in socio-economic development—the exceptions being South Africa, Botswana and Namibia (ECA, 2003). Thus, for the remaining countries that have initiated a fertility transition, access to family planning could play an even more significant role in contributing to that transition. Similarly, family planning could contribute to the onset of fertility decline in pre-transition societies. Recent evidence from Ethiopia, where the majority of the population live in rural areas, indicates that the country's contraceptive prevalence rate could double if the current community-based reproductive health program were expanded to include provision of family planning (Tawye, Jotie, Shigu, Ngom, & Maggwa, 2005).

Unmet need for family planning

An estimated 150 million married women in the developing world want to delay or stop childbearing and are not using contraception (Shane, 1996). Among married women, unmet need for family planning is highest in sub-Saharan Africa, where contraceptive use is the lowest in the world. Measuring the unmet need for family planning can be a way of evaluating how effective family planning is in responding to unwanted fertility. Some critics to this measure point out that many women considered with unmet need will not use contraceptives due to their low risk perception of pregnancy, or for social, cultural, and health reasons (Pritchett, 1994).

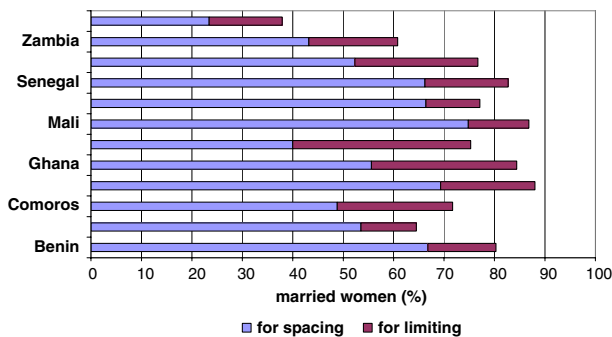


Fig. 6 Unmet need for family planning among married women for selected countries in sub-Saharan Africa

This assumes that changes in fertility preferences need to occur first in order to achieve increases in contraceptive use. However, a review by Casterline and Sinding on unmet need for family planning in developing countries found that substantial increases in contraceptive prevalence can be achieved in the absence of changes in the demand for children by meeting the existing unmet need (Casterline & Sinding, 2000).

Most of the unmet need in sub-Saharan Africa seems to be for spacing births (Fig. 6). Assuming that unmet need represents latent demand for family planning, analysis of satisfaction of unmet need indicates that contraceptive prevalence targets could be attained by most countries. Even with the conservative assumption that unmet need represents only a portion of the latent demand for family planning that can be converted into contraceptive use, substantial demographic impact would follow (Westoff & Bankole, 1996).

In short, meeting the unmet need fulfills individual fertility aspirations and is a sensible reason for continuing the expansion of family planning programs. Eliminating the unmet need would increase contraceptive use, decrease fertility, and serve national population policy goals (Sinding, Ross, & Rosenfield, 1994).

Factors contributing to the existence of an unmet need for family planning

An essential first step in planning to eliminate unmet need is to understand its underlying causes. Using data from DHS I, Bongaarts and Bruce (1995) identified lack of knowledge, fear of side effects, and husband's disapproval of family planning as the primary reasons for non-use of contraception. Using DHS II, Westoff and Bankole (1995) identified lack of information about contraception, opposition to family planning and ambivalence about future childbearing as the main underlying causes for unmet need. A recent review of the literature on the barriers for fertility regulation from a consumer perspective identifies limited method choice, financial costs, women's status, medical and legal restrictions, provider bias and misinformation as reasons for non-use of contraception (Campbell, Sahin-Hodoglugil, Potts, 2006). Affordability of contraceptives is a very important barrier to use. When contraceptive cost amounts to more than 1% of the household income, a decline in use is observed (Harvey, 1999). Based on the 1% income rule, Green (2002) estimated ability to pay for contraceptives by region. Results show that in sub-Saharan Africa the majority of the population cannot afford family planning. Thus, in poor countries some subsidy is needed.

The degree to which the aforementioned reasons for non-use of contraception affect the ability to control fertility varies among countries. Further, knowledge of these variations is important in determining the pace of contraceptive uptake. An effective family planning program should go beyond service provision and address barriers to contraceptive use (Bongaarts & Bruce, 1995).

Fertility preferences

Available data from recent DHS surveys from sub-Saharan African countries show that the wanted total fertility rate (WTFR) is almost always lower than the actual

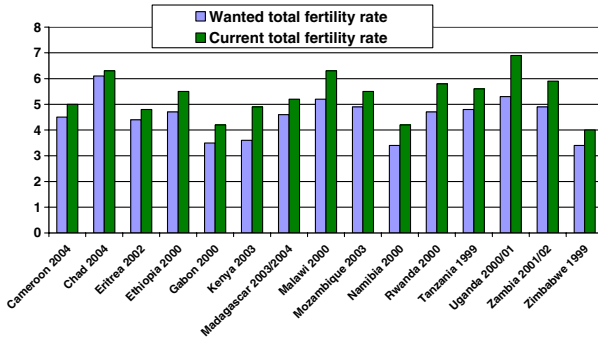


Fig. 7 Current and wanted TFR in sub-Saharan Africa

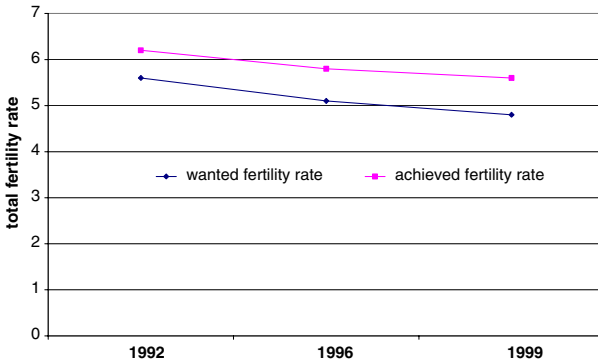


Fig. 8 Trends in wanted and achieved total fertility rates. Tanzania 1992–1999

TFR (Fig. 7). WTFR is an indication of fertility preferences, and the difference between wanted and actual fertility can amount to two children, as in the case of Uganda.

A closer look at the trends in wanted and actual fertility in Tanzania indicates that WTFR is a moving target (Fig. 8); as actual fertility declines so does wanted fertility.

In the case of Tanzania, using current and wanted fertility from the 1999 DHS, we estimate a decline in fertility of approximately 17% if the unmet need for family planning and couples’ fertility aspirations were met. This potential reduction would occur in the absence of any current changes in the demand for children.

Fertility rates have been declining in Ethiopia and its capital city, Addis Ababa, has reached below replacement level fertility (Fig. 9). In 2000, Addis Ababa had a contraceptive prevalence rate of 45% (Ethiopian 2005 DHS, preliminary report), and abortion service provision is more accessible and safer (IPAS, 2005).

Despite the recent decline in fertility, the Ethiopian population continues to grow and is projected to reach close to 100 million by 2015 (Fig. 10). In Fig. 10, the United Nation’s population projections for Ethiopia are based upon actual TFR

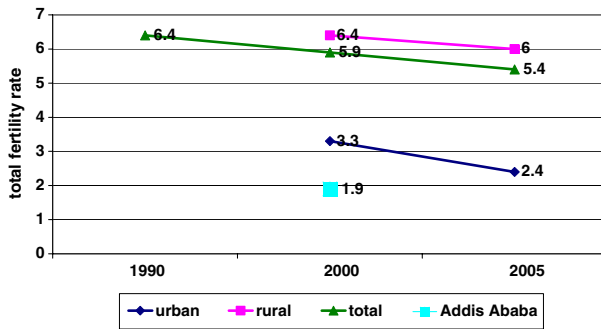


Fig. 9 Trends in total fertility rate. Ethiopia 1990–2005

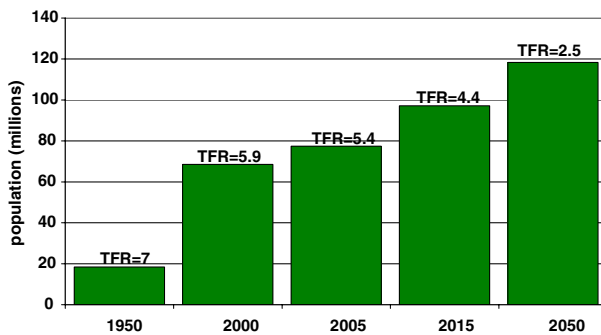


Fig. 10 Total population of Ethiopia 1950–2025

through 2005 and projections of the TFR thereafter. However, the Ethiopian 2000 DHS reports a WTFR of 4.7, a 1.2 children difference to the actual TFR for the same period. Ethiopia therefore has a choice: follow the course of events and achieve the projected dramatic increase in population size, or provide services to help couples achieve their desired fertility aspirations thus reducing fertility more rapidly. Even small reductions in fertility rates have great implications for future population growth.

Family planning does not limit people’s rights; it gives people choices. Couples are able to control their fertility and therefore achieve desired family size and timing of the birth of their children.

Non-contraceptive benefits of family planning

There is a strong negative correlation between maternal mortality and contraceptive prevalence (Fig. 11). Contraceptive use decreases the risk of maternal death by decreasing the odds of being pregnant (WHO/UNFPA/UNICEF, 1999). Therefore, the use of family planning could potentially play a protective role among women at high risk for maternal mortality such as during adolescence, older age, high-parity, and short birth intervals (Marston & Cleland, 2004).

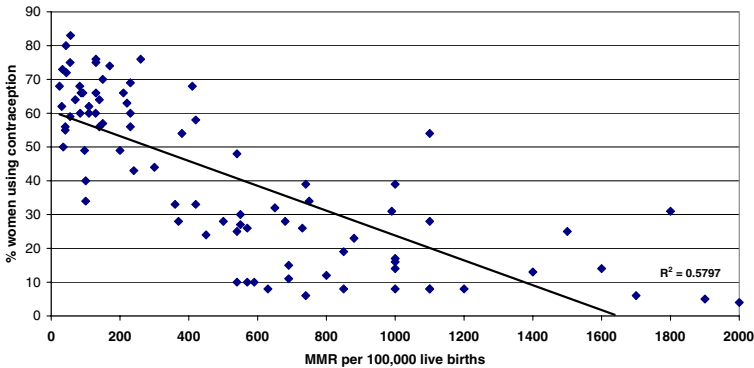


Fig. 11 Maternal mortality and contraceptive prevalence for countries with a DHS in the last 5 years

There are an estimated 80 million unwanted pregnancies and more than 19 million unsafe abortions annually (WHO, 2004). Maternal mortality has not been improving. Sub-Saharan Africa presents the worst situation (AbouZahr, 2001). It has the highest fertility, the highest unmet need for family planning and the lowest contraceptive prevalence rates. Improved access to family planning could avert perhaps 100,000 maternal deaths worldwide. Therefore, meeting the unmet need for family planning should also be part of the strategies to reduce maternal mortality.

Abortion is common, and according to current abortion rates a lifetime average of one abortion per woman is estimated for both developed and developing countries (AGI, 1999). Abortions result mostly from unwanted pregnancies, and in the absence of effective contraception can be used to control fertility. However, evidence shows that given the option most societies would prefer contraception to abortion (Casterline & Sinding, 2000). Unsafe abortion is the second largest cause of maternal death. They can be prevented by preventing unwanted pregnancies (Rosenfield & Schwartz, 2005). In short, by preventing unwanted pregnancies, deaths related to unsafe abortion could also be averted. In addition family planning can help reduce abortions over time (Marston & Cleland, 2003).

In 2005, 17.5 million women were estimated to be living with HIV (UNAIDS, 2005). Of those, 25% have an unmet need for family planning. Family planning is also a cost effective way to prevent mother to child transmission (PMTCT) of HIV. It reduces program cost and averts HIV positive births by decreasing the unwanted pregnancies of HIV positive mothers (Reynolds, Janowitz, Homan, & Johnson, 2006).

By providing the ability to space pregnancies, family planning can also have a positive impact in increasing birth spacing, one of the risk factors for child mortality (Fig. 12), and therefore impact child mortality (Rutesteyn, 2005). Effective use of family planning methods can contribute to improved maternal and newborn health by helping women avoid pregnancy when the risks are high.

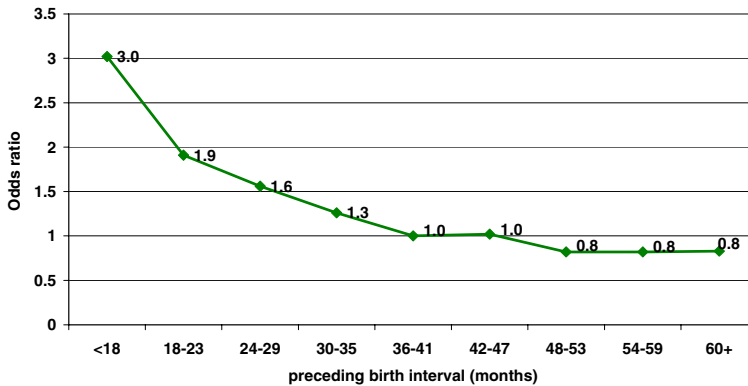


Fig. 12 Adjusted odds ratio for mortality under for the age of five

Conclusion

Family planning is an effective public health intervention with multiple individual and societal benefits. It lowers fertility rates therefore paying a demographic dividend. It helps couples achieve their desired family size and can help lower maternal and child mortality—critical Millennium Development Goals. Family planning does not limit rights; it gives people choices by providing them the tools to control the timing and number of children to have. Meeting the fertility preferences of individual families is undoubtedly a desirable objective on reproductive rights grounds and in many countries would at the same time address the objective to reduce population growth rates (Casterline, Perez, & Biddlecom, 1997). The need for family planning is clear. The direct impact of making family planning available includes decreasing both maternal and child mortality, decreasing unsafe abortion, reducing population growth, and meeting the desires of men and women worldwide for smaller families with larger spacing between their children. It is therefore imperative to continue to expand the provision of family planning services.

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