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Helpdesk Report: Contraceptive Prevalence Rate Increases

Date: 14 January 2011

Query: Which countries if any (in the last 20 years) achieved increases in contraceptive prevalence rates for women of reproductive age of (a) over 3% and (b) over 5% per year? Can conclusions be drawn about private sector service provision as an enabling factor for these increases?

Enquirer: DFID Uganda

Content

1. Overview

Question 1

Yearly contraceptive prevalence rate change data is rarely available. Most data are collected from household surveys conducted every 3-5 years. Based on UN MDG data for married women, countries that achieved a 3% or 5% increase in a year or a similar average over more years include:

- The Gambia (8 percentage point increase in 1 year)
- Malawi (8.5 point increase over 2 years)
- Rwanda (19 point increase 3 years)
- Uganda (4 point increase in 1 year)
- Zambia (12.2 point increase in 3 years)

Statistics from other sources include:

- 15.75 percentage point increase in Ethiopia over 4 years (2005-9)
- 27.2 point increase over 6 years in contraceptive prevalence among unmarried women in Mozambique (1997-2003)
- 10 point increase over 2 years in Afghanistan

Question 2

It is difficult to draw conclusions about private sector service provision as an enabling factor. There was little evidence of private sector impact found within the scope of this study. It was noted at a recent DFID meeting discussing the private sector that, by its nature, publishing research and evidence is not a priority for the sector. Ashford & Makinson (1999) also highlight the difficulty in tracking spending by private individuals, while government expenditures are usually published annually.

Private sector seems to be encouraged where there are supply problems and not specifically to increase use. It is mentioned alongside other providers where countries have seen improvements in contraceptive prevalence but its contribution is not clear.

Case studies of increased use of contraceptives often report that injectables and sterilisation are the most successful. How this is provided is not always outlined.

Ashford (2002) and Tarmann (2001) both note that distribution of products is a key strength of the private sector. The ability of clients in developing countries to pay for services is questioned.

2. UN data

Indicators for Monitoring the Millennium Development Goals--Definitions, Rationale, Concepts and Sources
http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/Handbook.htm

This publication contains complete and authoritative information on the concepts, definitions, implementation and sources of data for the 48 official MDG indicators. Some details are listed below for contraceptive prevalence rate.

Contraceptive prevalence rate is defined as the percentage of women who are practising, or whose sexual partners are practising, any form of contraception. It is usually reported for women ages 15–49 in marital or consensual unions.

Contraceptive methods include condoms, female and male sterilisation, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and natural family planning, as well as lactational amenorrhoea (lack of menstruation during breastfeeding) where it is cited as a method.

It is computed by taking the number of women ages 15–49 in marital or consensual unions who report that they are practising (or whose sexual partners are practising) contraception and dividing by the total number of women ages 15–49 (and same marital status, if applicable) in the survey.

Contraceptive prevalence data are obtained mainly from household surveys, notably the Demographic and Health Surveys, Multiple Indicator Cluster Surveys and contraceptive prevalence surveys. Surveys are generally conducted every three to five years.

A limitation is that data are generally collected for women in unions and in a particular age range, while the population of concern includes all women of reproductive age, irrespective of marital status.

It is noted that contraceptive methods may include traditional methods that are largely ineffective. It is important, to the extent possible, to at least distinguish between traditional and modern methods. Also, underreporting can occur when the interviewer does not mention specific methods, such as contraceptive surgical sterilisation.

Current Contraceptive Use Among Married Women 15-49 Years Old, Any Method
http://unstats.un.org/unsd/mdg/Data.aspx

The following table is compiled from the official United Nations site for the Millennium Development Goal indicators. It includes available contraceptive prevalence rate data for sub-Saharan Africa from 1990-2009.

Yearly rate changes are not often found. As noted in the handbook, most data are collected from household surveys conducted every 3-5 years.

Encouraging results include:

- a 3.2 percentage point increase in 2 years in Cameroon, from 26-29.2 in 2004-2006
- an increase of 8 in 1 year in the Gambia, 9.5-17.5 in 2000-2001
- rates in Lesotho appear to increase by 10.2 in 1 year then falls again slightly in later years. 30.4 in 2000 to 40.6 in 2001, then 38 in 2002 and 37.3 in 2005
- a 12.8 increase in Madagascar over 5 years, 27.1-39.9 in 2004-2009
- an 8.5 increase in Malawi in 2 years, 32.5 in 2004 to 41 in 2006
- an increase of 19 in 3 years in Rwanda, 17.4 in 2005 to 36.4 in 2008
- an increase of 4 in 1 year in Uganda, 19.7-23.7 in 2005-2006
- an increase of 7 in 3 years in Tanzania, 18.4-25.4 in 1996-1999
- a 12.2 increase in 3 years in Zambia, 22-34.2 in 1999-2002

Current contraceptive use among married women 15-49 years old, any method, percentage

Country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Angola							8.1					6.2								
Benin							16.4					18.6					17			
Botswana							47.6				44.4									
Burkina Faso				7.9						11.9				13.8			17.4			
Burundi											15.7		19.7				9.1			
Cameroon		16.1							19.3		25.6				26		29.2			
Cape Verde									52.9							61.3				
CAR						14.8					27.9						19			
Chad								4.1			7.9				2.8					
Comoros							21				25.7									
Congo																44.3				
Cote d'Ivoire					11.4					15							12.9			
DRC		7.7										31.4						20.6		
Equatorial Guinea											10.1									
Eritrea						8							8							
Ethiopia	4.8							3.3			8.1					14.7				
Gabon											32.7									
Gambia	11.8										9.5	17.5								
Ghana				20.3						22				25.2			16.7		23.5	
Guinea				1.7						6.2						9.1				
Guinea-Bissau											7.6						10.3			
Kenya				32.7					39					39.3						45.5
Lesotho			23.2								30.4	40.6	38			37.3				
Liberia																		11.4		
Madagascar			16.7					19.4		25	18.8				27.1					39.9
Malawi			13				21.9				30.6				32.5		41			
Mali							6.7					8.1					8.2			
Mauritius		74.6											75.8							
Mozambique								5.6							16.5					
Namibia			28.9								43.7							55.1		
Niger			4.4						8.2		14						11.2			
Nigeria	6				13.4					15.3				12.6				14.7	14.6	
Rwanda			21.2				13.7				13.2					17.4			36.4	
ST&P											29.3									
Senegal				7.4				12.9		10.5						11.8				
Sierra Leone			2.6								4.3					5.3			8.2	
Somalia										7.9							14.6			
South Africa									56.3					60.3						
Swaziland											27.7		46					50.6		
Togo									23.5		25.7						16.8			
Uganda						14.8						22.8				19.7	23.7			
UR of Tanzania			10.4		20.4		18.4			25.4					28.2	26.4				
Zambia			15.2				25.9			22			34.2					40.8		
Zimbabwe					48.1					53.5							60.2			

3. Data on contraception use for unmarried women

Contraception Use Among Unmarried Sexually Active Women
http://www.statcompiler.com/tablebuilderController.cfm?userid=334226&usertabid=359543

STATcompiler contains data from Demographic and Health Surveys (DHS). These are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition.

Current use of contraception, unmarried sexually active

Country	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Benin					50.1					38.2					54.9			
Burkina Faso		34.9					52.1					58						
Cameroon							62.9						68.5					
Chad					14.4								10.6					
Cote d'Ivoire			49.1					56										
Eritrea				52.9							26.6							
Ethiopia									40.7					54.9				
Ghana		38.5					37					43.4					50.4	
Guinea								50.5						45.2				
Kenya		46.5										54.4						50.3
Madagascar	20.9					26.3							37.7					43.2
Malawi									26.9				26.4					
Mali					42.2					32					27.2			
Mozambique						17.8						45						
Namibia	35.1								58							78.2		
Niger	40						50.8								42.1			
Nigeria								58.6				49.9					61	
Rwanda	29.3								22.3					11.8				
Senegal		41.4				52.4								43.3				
Tanzania	17.5				26.2			33						41.8				
Uganda				35.6						48.4					54			
Zambia	13.7				24						32.6					47.3		
Zimbabwe			56					55.3										

The available data on contraception use among unmarried women in sub-Saharan Africa show improvements in some countries. In others the use rate falls and in some countries it rises and falls. Patterns are often unclear.

Some positive observations include:

- an increase in Benin from 38.2 in 2001 to 54.9 in 2006
- in Ethiopia an increase from 40.7-54.9, in 2000-2005
- an increase in Mozambique from 17.8-45 in 1997-2003
- an increase from 58-78.2 in Namibia 2000-2007
- in Zambia an increase from 32.6 in 2002 to 47.3 in 2007

4. Country studies on contraceptive prevalence

The Cost of Family Planning in Ethiopia
Health Policy Initiative, USAID, 2010
http://www.healthpolicyinitiative.com/Publications/Documents/1091_1_Ethiopia_Brief_FINAL_7_12_10_acc.pdf

This brief presents the main findings of a multi-country study conducted in support of USAID's efforts to help national governments increase modern contraceptive prevalence. The study's main objective is to promote understanding of the aggregate costs of increasing the use of family planning (FP). The USAID, Health Policy Initiative, Task Order 1 analysed the costs of actual FP service provision, identified key barriers to increased uptake of family planning, and estimated the cost of reducing these barriers.

The key finding reported is that contraceptive prevalence doubles in 4 years, from 14.7–29.8 in 2005-2009. (It should be noted that the two figures are from different data sources.) The survey found that virtually all of the increased contraceptive use came from injectables, which are now provided by community health extension workers.

Based on the 2005 Ethiopia Demographic and Health Survey, 80 percent of current FP users obtained their methods from the public sector, 17 percent from the private medical sector, and 3 percent from other sources. The most important sources of contraceptives in the public sector were government health centres and health posts/clinics, which provided FP methods to 37 and 35 percent of current users, respectively. Government facilities were the leading providers of injectables (85% of total users) and pills (71% of total). Almost three quarters of condom users obtained their supplies from other sources, predominantly commercial shops.

The Cost of Family Planning in Kenya
Health Policy Initiative, USAID, 2010
http://www.healthpolicyinitiative.com/Publications/Documents/1189_1_Kenya_Brief_FINAL_7_12_10_acc.pdf

Kenya has made impressive progress in family planning over the last three decades. Data show that increased use of modern methods of family planning drove the overall increase in contraceptive prevalence rates between 1989 and 2008. According to the 2003 Kenya Demographic and Health Survey, 53 percent of family planning users obtained contraceptives through public facilities, while 41 percent and 5 percent of FP users obtained contraceptives through private medical and other sources, respectively. Only 1 percent of users obtained their contraceptives through community-based distribution.

The Cost of Family Planning in Mali
Health Policy Initiative, USAID, 2010
http://www.healthpolicyinitiative.com/Publications/Documents/1190_1_Mali_Brief_FINAL_7_12_10_acc.pdf

Mali is a pronatalist society; people marry at a young age, especially women, and both men and women prefer large families. Contraceptive use has seen little increase in the last 20 years.

Government facilities today serve about 52 percent of current modern method users (down from almost 80 percent 20 years ago). The private sector has increased its role in FP provision and now serves a 37 percent share of modern method users. The major public service providers are community health centres, dispensaries, maternity clinics, and referral centres. Almost three quarters of the contraceptives provided by the private sector are sold by pharmacies and street vendors. Other sources include shops and friends and family. Community-based distribution, which accounted for almost 6 percent of FP service provision during the mid-1990s, today accounts for just 1 percent.

A 2006 survey suggests 31 percent of married women in Mali have an unmet need for family planning—21 percent for spacing pregnancies at least two years apart and 10 percent for limiting them.

Achieving success with family planning in rural Afghanistan
Huber D, Saeedi N & Samadi MK, Bulletin of the World Health Organization, 2008
http://www.who.int/bulletin/volumes/88/3/08-059410/en/

A small Accelerating Contraceptive Use (ACU) project achieved an increase of contraceptive use from 16% to 26%, over a period of 2 years.

Key lessons:

- Traditional rural communities will rapidly accept modern contraceptives, particularly injectables, introduced by community health workers when people are educated about common non-harmful side-effects and correct use.
- Medical misconceptions were more important than cultural and religious barriers.
- Men's involvement was vital in supporting their wives' use of birth spacing. Once educated, men demonstrated positive practices about birth spacing for maternal and child health.

Family Planning Success Stories in Sub-Saharan Africa
Malarcher S, USAID, 2007
http://www.maqweb.org/techbriefs/tb21reposition.pdf

Evidence from Malawi, Zambia, and Ghana demonstrate that rapid uptake and sustained use of modern family planning methods can occur in even the most poor, resource-strapped, and largely rural countries.

The report notes that mobilisation of partnerships with the private sector and civil society can be an effective complement to the public sector health system for method supply and promotion.

5. Private sector and family planning provision

Creating Options in Family Planning for the Private Sector in Latin America
Sharma S, Gribble JN, Menotti EP, 2005, Rev Panam Salud Publica

The countries of Latin America and the Caribbean are facing the gradual phase-out of international donor support of contraceptive commodities and technical and management assistance, as well as an increased reliance on limited public sector resources and a limited private sector role in providing contraceptives to the public. Therefore, those nations must develop multi-sectoral strategies to achieve contraceptive security. The countries need to consider information about the market for family planning commodities and services in order to define and promote complementary roles for the public sector, the commercial sector, and the non-governmental organisation sector, as well as to better identify which segments of the population each of those sectors should serve.

While it is unable to mandate private sector participation, the public sector can create conditions that support and promote a greater role for the private sector in meeting the growing needs of family planning users. Taking steps to actively involve and expand the private sector's market share is a critical strategy for achieving a more equitable distribution of available resources, addressing unmet need, and creating a more sustainable future for family planning commodities and services.

This paper also discusses in detail the experiences of two countries, Paraguay and Peru. Paraguay's family planning market illustrates a vibrant private sector, but with limited access to family planning commodities and services for those who cannot afford private sector prices. In Peru, a 1995 policy change that sought to increase family planning coverage had the effect of restricting access for the poor and leaving the Ministry of Health unable to pay for the growing need for family planning commodities and services.

The Private Sector and Family Planning in Developing Countries: Its Role, Achievements and Potential
http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/1988/09/01/000009265_3960927060804/Rendered/PDF/multi0page.pdf
Levis M A, Kenny G, 1998, World Bank

While a private sector exists in every society, the nature of its involvement in family planning service delivery varies widely across countries. This paper reviews the role of the private sector in family planning and discusses how much more of the demand for contraception can be met through the private sector, thereby reducing government subsidies for contraception.

The report sections discuss the following:

- The characteristics of private sector supply, with a strong emphasis on for-profit producers and distributors of contraceptives.
- The distribution of users across sources and the issue of pricing at public, for-profit and NGO sources of family planning services.
- The experience to date with private sector approaches is outlined to provide a sense of what has been and is currently going on in public and donor efforts to harness and collaborate with the private sector.
- Alternative means for government and donors to promote private sector activity in family planning, and suggests some of the costs of a greater private sector role.

Reproductive Health in Policy & Practice: Case Studies from Brazil, India, Morocco, and Uganda
Ashford L & Makinson C. 1999, Population Reference Bureau
http://www.prb.org/Reports/1999/ReproductiveHealthinPolicyPracticeBrazilIndiaMoroccoandUganda.aspx

Researchers in Brazil, India, Morocco, and Uganda conducted case studies that document changes in reproductive health policies and services, as well as in the political and social environment in which initiatives are carried out. They also analysed how resources have been raised and allocated to support reproductive health programs.

The case studies document some increases in government and donor funding, but not of the magnitude envisioned in Cairo. The studies reveal less about private spending, leaving us with an incomplete picture of resource flows. While government expenditures are usually published annually, health spending by private individuals is only measured periodically in surveys. Moreover, it is difficult to obtain detailed data on either public or private expenditures — for example, breakdowns that would distinguish family planning from other reproductive health services.

Case-study authors note that programme components need stronger linkages, and greater efforts are needed to ensure the quality of care in the private sector, which serves nearly one third of women.

Securing Future Supplies for Family Planning and HIV/AIDS Prevention
Ashford L. 2002, PRB
http://www.prb.org/pdf/SecFutureSupplies_Eng.pdf

While the distribution of products is a key strength of the private sector, the marketing of contraceptives and condoms for HIV/AIDS prevention presents a limited business opportunity because few people can pay market prices for these supplies. The majority of users in the poorest countries, and in poor regions of better-off countries, rely on supplies from local and national governments, which all too often lack sufficient resources and managerial capability to guarantee regular access for all in need.

Contraceptive Shortages Loom in Less Developed Countries
Tarmann A. 2001, Population Today
http://www.prb.org/pdf/PT_augsep01.pdf

Distribution is known to be the private sector's forte. Indeed, the virtually untapped contraceptive markets in countries with fast-growing populations might seem the perfect business opportunities. The reason they are not is that relatively few people can pay for contraceptives at market price. Less than 40 percent of current users of modern contraceptive methods in 87 donor-dependent countries studied by IWG get their contraceptives from the private sector; the majority of current users rely on their local and national governments, which all too often lack sufficient funds to guarantee regular access for all in need. In these countries, although donors continue to push to segment the market so that only those unable to pay receive free or subsidised reproductive health supplies, dependence on donors is still considerable. Many social marketing programmes and non-profit organisations, especially in sub-Saharan Africa, also rely on donors for their contraceptive supplies.

The Potential Market for Expanded Private-Sector Family Planning in the Philippines
Winfrey W et al. 2003, USAID

http://www.psp-one.com/files/935_file_17_Expanded_Family_Planning_in_the_Philippines.pdf

The Philippines, with a population of 80 million and an annual growth rate of 2.36 percent, had 3.2 million women using modern family planning methods in 1998. This number is projected to grow to 5.8 million by 2007. Seventy-two percent of users obtain their contraceptives from the public sector, where the majority of contraceptive supplies have been donated by USAID. Since USAID recently began to phase out its contraceptive donations, and the Philippines Department of Health has yet to demonstrate its willingness to procure contraceptive supplies, the question of how many clients can be served by the private sector is crucial. This study analyses patterns of contraceptive use, makes projections about how the market will grow by method, and defines groups of clients based on their attractiveness to the private sector. The resulting market segments indicate opportunities for private-sector expansion.

6. Examples of increased contraceptive use

Injectable Contraceptive Use Rises in Madagascar
FHI project description
http://www.fhi.org/en/CountryProfiles/Madagascar/res_CBD_DMPA.htm

Injectable contraceptives — primarily in the form of depot medroxyprogesterone acetate (DMPA) — have rapidly become the most popular modern contraceptive in sub-Saharan Africa. They are safe, effective, and convenient, and they can be used discreetly, without a partner's knowledge. For these reasons the potential demand for DMPA is high in Madagascar and elsewhere.

Before the community distribution programme began in 2006, women in Madagascar had to travel to health centres to receive DMPA. For rural women like Razery, that hurdle can effectively rule out method choice. In its pilot phase the programme tested the feasibility of training people in rural communities to dispense DMPA. The programme also evaluated the acceptance of injectable contraception by women who were using other forms of birth control or none at all.

By the end of 2007, 62 local leaders in 13 rural communities had participated in training that refreshed their knowledge about family planning service delivery and taught them how to provide DMPA services.

Within six months, these community health workers provided DMPA to 1,661 women, 41 percent of whom had not been using contraception. One district — Moramanga, in the Alaotra Mangoro region — accounted for 1,392 of the new DMPA users. This shift raised the district's overall percentage of women of childbearing age using contraception from 25 percent to 35 percent.

Given these results, the programme expanded in 2008 from four districts in two regions to 21 districts in 11 regions. By the end of the year, 3,945 women — more than double the number of clients served during the project's pilot phase — were DMPA clients.
This programme's success suggests that the community-based distribution of DMPA is an effective family planning solution not just for Razery but also for many remote communities in Madagascar. Indeed, it should be effective wherever the need for family planning services is great and women live far from health centres that offer modern contraceptive methods.

El Salvador Survey Shows Lower Fertility, Increased Contraceptive Use
Kent MM. 2010, PRB
http://www.prb.org/Articles/2010/elsalvador.aspx

Women of childbearing age in El Salvador are having fewer children and using more family planning, with a recent increase in the use of injectable contraceptives. A 2008 family planning survey by the El Salvador Ministry of Health found that fertility dropped 60 percent in the last 30 years, from 6.3 lifetime births per woman in the mid-1970s to 2.5 in the 2003-2008 period.

Much of this long-term fertility decline resulted from major increases in contraceptive use. The percentage of women of childbearing age using contraception increased from 47 percent in 1988 to 73 percent in 2008, led by large increases in the use of female sterilisation and injectable hormone use.

Fertility Decline and Reproductive Health in Morocco: New DHS Figures
Ayad M & Roudi F. 2006, PRB
http://www.prb.org/Articles/2006/FertilityDeclineandReproductiveHealthinMoroccoNewDHSFigures.aspx

The "fertility transition"—the shift from large to small families that demographers have observed throughout much of the world—has been remarkably rapid in Morocco, according to a recently released demographic and health survey on that country. Among other factors, contraceptive use among married women of reproductive age increased from 19 percent to 63 percent.

Morocco's fertility decline is primarily attributable to increases in women's average age at marriage and in married women's contraceptive use. The proportion of all young Moroccan women ages 15-19 who were married dropped from 21 percent in 1980 to 11 percent in 2004. During the same period, the proportion of women ages 20-24 who were married dropped from 64 percent to 36 percent, and contraceptive use among married women of reproductive age increased from 19 percent to 63 percent.

Although the proportion of private providers for family planning increased from 34 percent in 1992 to 42 percent in 2004, there is still room for improvement—especially considering Morocco’s relatively high levels of economic development and urbanisation.

7. Additional information

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Contributors
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