For Those Who’ve Had Enough:
What do we know about women with an intent to limit?

Lynn Bakamjian, EngenderHealth Consultant
Patricia MacDonald, USAID
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  - Futures Institute
The proportion of women who want no more children is a strong predictor of CPR and TFR (Westoff & Bankole, 2000)

Fertility intention (for both spacing and limiting) is an important predictor of reproductive behavior (Islam et al, 2003; Roy et al, 2003)

Increasing contraceptive use among limiters reduces high-parity births and maternal mortality (Stover & Ross, 2009)
Secondary DHS Analysis

- 15 African countries with DHS surveys after 2000
- Part of larger global secondary analysis of 37 countries
- Countries excluded if LA or PM method use was >25
- All women 15-49 included—analysis done using STATA & SPSS

<table>
<thead>
<tr>
<th>Country</th>
<th>Survey Year</th>
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<tbody>
<tr>
<td>Benin</td>
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<td>Zimbabwe</td>
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Unmet need for limiting versus spacing

Married women of reproductive age with unmet need

- Benin 2006
- Cameroon 2004
- Ghana 2008
- Kenya 2003
- Lesotho 2004
- Madagascar 2008/09
- Malawi 2004
- Namibia 2006/07
- Rwanda 2005
- Senegal 2005
- Swaziland 2006/07
- Tanzania 2004/05
- Uganda 2006
- Zambia 2007
- Zimbabwe 2005/06

Unmet need to space  Unmet need to limit

From the American People
Unmet need for limiting among postpartum women

- Benin
- Cameroon
- Ghana
- Kenya
- Lesotho
- Madagascar
- Malawi
- Namibia
- Rwanda
- Senegal
- Swaziland
- Tanzania
- Uganda
- Zambia
- Zimbabwe

Unmet need to limit
Many assume Africa has low demand for limiting—data suggest otherwise

- 20.4% women in Anglophone Africa wanted no more children at last birth
- Despite generally high fertility desires, data suggest many women do indeed have need to limit

Demand for limiting has remained **strong** or **increased** in nearly all analysis countries over past 20 years.
Increasing Trends in Demand for Limiting Desire to limit births

- Benin
- Cameroon
- Ghana
- Kenya
- Madagascar
- Malawi
- Namibia
- Rwanda
- Senegal
- Tanzania
- Uganda
- Zambia
- Zimbabwe
Younger African Women Want to Limit

- As age increases, demand to limit begins to exceed demand to space.
- Demand to limit “crossover” begins at:
  - 31.3 years in AA
  - 34.3 in FA
- Demand for limiting often associated with older women, however, demand to limit exists among younger women:
  - Namibia: 31.7% of MWRA 15-29 have a demand for limiting
  - Lesotho: 26.37%
  - Kenya: 14.43%
  - Malawi: 12.77%
  - Pattern not limited Southern Africa
- Counters claim that only older high-parity MWRA have demand for limiting.
“Crossover Age” decreases as CPR increases

Age at which demand for limiting meets or exceeds demand for spacing

Modern CPR

Age
Limiters using traditional and short-acting methods

Family planning use and non-use among women with a demand to limit births

MWRA

Senegal  Cameroon  Tanzania  Benin  Rwanda  Zambia  Ghana  Malawi  Uganda  Madagascar  Kenya  Zimbabwe  Lesotho  Namibia  Swaziland

Permanent  Long-acting  Short-acting  Traditional  Unmet need for limiting
African Women Exceeding Desired Parity

Mean and ideal parity among permanent method users

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Conclusions: Profile of Limiters in Africa

- Unmet need for limiting exists in Africa
- Demand for limiting exists in Africa
- Younger cohorts desire to limit future childbearing
- Large # exceed desired fertility
- Remember….spacers eventually become limiters

How will FP programs respond to their needs?
Impediments to Meeting Reproductive Intentions to Limit in Africa: 
Client Perspectives & the Role of Behavior Change Communication

Lynn M. Van Lith
JHU·CCP

Managing Partner: EngenderHealth; Associated Partners: FHI 360; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council
Rose’s Story

Photo by B. Jones / EngenderHealth

[Image of a man holding a baby in a hospital setting]
Secondary DHS Analysis

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Reasons for Non-Use: Findings from 15 African Countries

- MWRA with unmet need for limiting cited:
  - **Fear of side effects** top reason for lack of intention to use FP in future [22%]
  - **Health concerns** [14%]
  - **Infrequent sex** [14%]
  - **Opposed to FP** [10%]

- Spacers cite ambivalence, limiters may do so less*

- Pervasive fear of contraceptives and perceived side effects

- Driven by misinformation which inhibits use resulting in unintended births

*Bhushan I. Understanding unmet need. JHU-CCP, 1997 (Working Paper No. 4)
Knowledge of FP Methods

- Informed choice requires access to wide range of FP methods & one must understand complete, accurate, and up-to-date information

- Measuring knowledge is critical

- Knowledge of SAMs nearly universal; LA or PMs considerably lower

- Almost 1 in 2 non-users cannot name an LA or PM

- Nearly 1 in 4 TM users cannot name an LA or PM

- True knowledge extends much deeper
  - Understanding how methods work
  - Associated side effects
  - Whether they best suit one’s reproductive intentions (which vary over time)
Barriers to FP Use

- Social constructs & accepted norms about sex, family size, and composition impact decision making

- Factors include:
  - Pressures from extended family, community influences, & gender dimensions
  - Spousal communication (or lack thereof)
  - Family, friends, & neighbors key in providing support & influencing contraceptive decision-making
  - FP services distinct from many other health services
    > ignite judgmental attitudes
    > social disapproval
    > moralistic beliefs

- Knowledge & attitudinal factors pose significant constraints
Demand: an essential element

- Exposure to BCC messages has positive effects
  - Increases knowledge of methods
  - Increases spousal communication
  - Increases favorable attitudes on use & intention to use
  - Increases use of FP

- Mass media, social mktg, IPC, mHealth, EE, community engagement & others are promising approaches

- Multiple channels reinforce & support dose effect = increased FP use

- Meets RH needs of limiters & a country’s health goals
Conclusions

- Many barriers to use
- Informed choice compromised due to low awareness and misinformation
- Appreciation needed for why couples don’t use contraceptives
- Requires greater emphasis on demand generation and SBCC
- Must address women with intention to limit as a unique audience
- Demand aspects most often overlooked in budgeting and planning
Meeting needs of women with intention to end childbearing

- Address key barriers: fears of side effects & health concerns
- Don’t shy away from sensitivities
- Expand method choice to wide range of options
- Address policy & supply barriers
- Greater awareness raising of LA/PMs
- Context-specific responses needed
- Demand generation with limiters as unique audience
- Address social norms through creative means
From choice, a world of possibilities

Achieving the Goal of Universal Access to FP/RH using Strategic Approaches

Ilka Rondinelli
Senior Adviser-Access
## Performance and Results Framework

### Critical Issues and Result Areas

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<th>Performance and Results Framework</th>
<th>Result Area</th>
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<tr>
<td>Advocate, influence and challenge</td>
<td>Increase access to information, education and quality services</td>
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<tr>
<td>Build MA capacity and support national capacity</td>
<td>Improve performance, effectiveness and accountability</td>
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### MTR Critical Issue

| Advocacy and communication | SRHR for poor and vulnerable populations, especially youth | Capacity Building | Performance Culture |
Barriers to Access FP/RH

- Living in a remote/rural area

- Services provider’s lack of up-to-date knowledge and skills (mainly for LARCs)

- Lack of strong linkages between MCH, HIV and Family Planning

- Lack of public, political and financial commitment to guarantee contraceptives commodities
IPPF Contributes to Universal Access to Sexual Reproductive Health and Rights

152 Member Associations (MAs) worldwide meet the needs of women, men, and young people in delaying, spacing, or limiting births as they desire and choose throughout direct provision of services, and via multiplier effects at national and global levels in the domains of policy, advocacy, capacity building and health systems strengthening.
Expanding the focus of services

- Acknowledge that addressing women & girls’ need is strengthened by a gender and rights-based approach.
- Men, boys, women and girls independently of their sexual orientation are all part of the solution.
- Needs of SRHR of the individual - best addressed when the needs of the collective are effectively addressed and managed.

Addressing Adolescents need

- Refine our approaches in dealing with Young People.
- They are not a homogenous group (differing needs among age groups).
- Consider the evolving capacities of youth.

Providing Responsive services

- Recognise that peoples’ sexual identities are context driven and are not static.
- Services have to be responsive to needs and not to identities.
TA and Support to MAs

- Increase access to vulnerable and underserved populations

- Increase access to post-partum and post-abortion family planning for women in particular adolescents

- Improve partnerships to strengthen the capacity of local health systems to provide FP/RH services

- Influence policy change for contraceptives security
Innovative health financing approaches to remove financial barriers to access services especially for PMSUs

- Provide guidance to ROs and MAs on (vouchers, removal of user fee for selected services and selected populations).

- Support pilot projects, to enhance performance culture, using different approaches of health financing schemes, disseminate best practices and plan for scaling up.
Massive effort in collaboration with MOH

Tends and health posts staffed with auxiliary nurses and community educators

In 2010, 360,000 contraceptives were provided, mostly in communities displaced by the earthquake.

Haiti - PROFAMIL

"Task sharing for expanded access to essential FP/RH services"
High levels of unmet need for family planning among women at one year postpartum

Globally 65%
NOW- No Opportunity Wasted! in delivering universal access to Family Planning and Reproductive Health Services
Strengthening linkages...12 countries

- Quality provision of LARCs through post-partum and post-abortion programs, targeting women, who desire to space or limit their births. Key features of the strategy are:

- A focus on the development of strong linkages between pre-natal care, delivery, post-partum and post-abortion FP, focusing on LARCs;

- The use modern Quality Improvement model (QI) to strengthen the linkages to FP services.
Trained 1,156 Health Extension Workers (HEWs) in implants insertion and removal.

Cascade training to 5,000 other HEWs

Implants insertions doubled from 2009 to 2010.

Work is proceeding to scale-up to 14,000 HEWs

Ethiopia - Family Guidance Association (FGAE)-Partnership with Government to achieve equitable access to LARCs
Advocacy to the Ghana Drugs Administration to include eight recommended contraceptives on the National Essential Drugs list

PPAG provision of contraceptives increased from 2,272,574 in 2009 to 6,508,850 in 2010

IUD insertion more than doubling.

Ghana- The Planned Parenthood Association of Ghana (PPAG)