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# Accelerating uptake of voluntary, rights-based family planning in developing countries

Kazuyo Machiyama

Francis Obare  
*Population Council*

Venkatraman Chandra-Mouli

Doris Chou

Mario Festin

*See next page for additional authors*

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**Authors**

Kazuyo Machiyama, Francis Obare, Venkatraman Chandra-Mouli, Doris Chou, Mario Festin, Rajat Khosla, James Kiarie, Lale Say, and Nandita Thatte

# EVIDENCE BRIEF

## Accelerating uptake of voluntary, rights-based family planning in developing countries

→ A woman's ability to choose whether and when to become pregnant directly affects her health and well-being. Voluntary family planning saves lives and accelerates sustainable human and economic development (1). It leads to the realization of human rights and promotes the empowerment of women and adolescent girls, enabling them to complete their education, seize better economic opportunities, and fulfil their capabilities. Enabling women and adolescent girls to make decisions about their health and future is one of the most cost-effective ways of creating more sustainable and thriving societies around the world.

To meet the FP2020 and Sustainable Development Goals, significant investments are required by countries and donors in the following priority areas: sustainable financing, reaching all adolescents, expanding availability of services to the poorest and hard-to-reach populations, improving the quality of services, increasing the range of methods available, strengthening procurement procedures and supply chains, broadening social and behaviour change communication interventions, and sustaining research and development investments in contraceptive methods and their delivery.

The Sustainable Development Goals (SDGs) make specific references to family planning in regard to health and well-being, gender equality, and women's empowerment. Ensuring that all women and adolescent girls have access to high-quality, rights-based family planning services contributes towards achieving these goals and realizing targets related to other SDGs. Accelerated fertility decline through effective family planning programmes slows rapid population growth, contributing to the SDGs related to the economy, environment, and development (2).



**To meet the FP2020 and Sustainable Development Goals, significant investments are required by countries and donors in the following priority areas:**

- Sustainable financing
- Reaching all adolescents
- Expanding availability of services to the poorest and hard-to-reach populations
- Improving the quality of services
- Increasing the range of methods available
- Strengthening procurement procedures and supply chains
- Broadening social and behaviour change communication interventions
- Sustaining R&D investments in contraceptive methods and their delivery

This brief summarises evidence on the benefits of family planning for girls and women, their children, families, and societies. It also provides evidence on the cost-effectiveness of family planning programmes; discusses reasons for unmet need for contraception and identifies ways to reduce unmet need and discontinuation; and describes progress in meeting FP2020 and the Sustainable Development Goals.

## HUMAN RIGHTS-BASED APPROACH TO FAMILY PLANNING

International and regional human rights treaties and national constitutions and laws provide legally binding obligations for states to ensure timely and affordable access to quality family planning information, services, and contraceptive commodities for all. The human right to the highest attainable standard of health, which includes access to health services and health-related information, cannot be fulfilled without promotion and protection of the rights to education and information.

Human rights standards for family planning information and service delivery include nondiscrimination; availability, accessibility, acceptability, and quality of family planning information and services; informed decisionmaking; privacy and confidentiality; participation; and accountability.

→ Access to quality family planning services is both a right and a smart investment for governments, communities, and families. Fulfilling and protecting this right is critical for achieving the SDGs, including gender equality, as well as more inclusive economic development.

## BENEFITS OF FAMILY PLANNING

### Health benefits

Family planning has clear health benefits, principally the prevention of unintended pregnancies and reductions in maternal and infant mortality and morbidity. **An estimated 214 million women in the developing world want to delay or prevent pregnancy but are not using a modern method of contraception (3).** Providing access to these women would prevent 67 million unintended pregnancies and reduce induced abortions from 48 million to 13 million. It would reduce maternal deaths by 76,000 per year, newborn deaths from 2.9 million to 660,000 per year and HIV infections in newborns from 130,000 to 9,000 (3).

**Family planning allows spacing of pregnancies and can delay pregnancies in young women.** Current use of modern contraceptives prevents an estimated 307 million unintended pregnancies annually among adolescent girls and women in developing regions. Access to family planning is especially critical for adolescents with unmet need. Meeting the unmet need for modern contraception among adolescents aged 15–19 would reduce unintended



pregnancies in this age group by 6 million annually, thereby averting 2.1 million unintended births, 3.2 million abortions, and 5,600 maternal deaths (4).

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**When women and couples use family planning to delay, space and limit their pregnancies, their children also benefit.** Pregnancies spaced 18 months apart or less produce poorer health outcomes for newborns due to prematurity, low birth weight, or early neonatal mortality (5,6). Babies born less than two years after the preceding birth are 60% more likely to die in the first year than those born after an interval of 2–3 years (7). One of the reasons for the improved survival among better-spaced children is breastfeeding. Longer birth spacing gives infants and young children the chance to derive the maximum benefits from breastfeeding, including better nutrition, protection from childhood diseases, and opportunities for mother-and-child bonding. And women are protected from the risk of pregnancy if they exclusively breastfeed immediately after the birth and up to 6 months postpartum (8).

**Pregnant adolescents face maternal health challenges related to their physical and psychological immaturity and limited autonomy.** They are more likely to have a repeat pregnancy within a year of giving birth, which can place them and their children at risk for poor health outcomes (9). Additionally, legal systems in some

countries deny adolescents access to family planning and safe abortion services. As a result, they may be forced to seek unsafe and clandestine procedures or, if unavailable, may resort to suicide rather than reveal their pregnancy status (10).

### Social, economic, and environmental benefits

One of the key social benefits of family planning is improvements in education for all children and in gender equality. **Having smaller families allows parents to invest more in each child and enables children to stay in school longer than children with many siblings (7). Early and unintended pregnancy is one of the major reasons for dropping out of school in some countries (11), and preventing early pregnancies will help girls remain in school.** Girls' and women's education is a major driver of fertility decline and facilitates human and economic development (12).

Young people (aged 15–24 years) constitute about one-third of the working-age population across Africa, but 50% of them are either unemployed or economically inactive (13). Investments in youth through education, skill development, and employment opportunities are essential for seizing the window of opportunity provided by the demographic dividend (14). **Rapid fertility decline through strong rights-based family planning programmes is a crucial prerequisite for attaining the dividend.** In 2017, the African Union launched the policy “Harnessing the Demographic Dividend Through Investments in Youth”. This political commitment in African Union countries has led to greater investments in family planning programmes.

**The relationship between population growth, human and economic development, and the environment is multi-faceted. The United Nations estimates that by 2050 the world's population will increase by 2.4 billion people, with over 90% of the growth in developing countries (15).**

Rapid population growth exerts considerable pressure on individuals, communities, and the planet. Environmental changes, such as global warming, changes in water availability, soil degradation, deforestation, and land-use change, may directly affect levels of agricultural production (16). These changes would have a large impact on sub-Saharan Africa, where two-thirds of employment is derived from agriculture. Widespread weather anomalies increase the vulnerability of the population and trigger internal and international migration in sub-Saharan Africa and elsewhere (17).

→ Prevention of unintended pregnancy in both the developed and developing world is one of the most cost-effective ways of mitigating negative environmental impacts (18).

### A cost-saving investment

The estimated annual cost of modern contraceptive services in developing regions, covering 671 million women who use modern methods, is \$6.3 billion, including direct and indirect costs. This is less than one dollar (\$1.01) per person in developing regions (3). **Meeting the needs of all women**



**for modern contraception in developing regions—including current users and women with unmet need—would cost around \$12 billion annually, or \$1.93 per person (3). Preventing unintended pregnancies through use of modern contraception is much cheaper than the cost of care for unintended births.** Spending one additional dollar for contraceptive services above the current level reduces the resources needed for pregnancy-related care by \$2.2 (3).

## UNMET NEED FOR FAMILY PLANNING, NON-USE, AND DISCONTINUATION

The figure of 214 million women in developing countries with an unmet need for family planning (3) includes women who have never used contraception and those who have discontinued use of a method. As overall contraceptive use increases, addressing reasons for discontinuation and failure to switch to an alternative method becomes more important. Levels of contraceptive discontinuation vary by duration of use and method. More than one in three (38%) women in 19 developing countries discontinue a method within 12 months, 55% within 24 months, and 64% within 36 months (19).

→ Contraceptive discontinuation is higher for short-acting methods (e.g., injectables, pills and condoms) than for long-acting reversible contraceptives (LARCs) (e.g., implants, IUDs), with discontinuation rates of 50% for condoms, 44% for pills, 41% for injectables, and 13% for IUDs within 12 months of use (19).

Women who are young, less educated, from poorer households, or from rural areas are more likely to have unmet need for contraception and a higher likelihood of

discontinuation (20,21). Sexually active unmarried women have high levels of unmet need, contributing to more than one-third of total unmet need in East, Middle and Southern Africa (22). This proportion will tend to rise as age at marriage and/or levels of premarital sex increase.

The high levels of unmet need and contraceptive discontinuation indicate that women and girls need greater support to newly adopt or switch to appropriate and suitable methods based on their fertility preferences, sexual behaviour, and health.

### Reasons for non-use or discontinuation

Lack of knowledge, sociocultural obstacles, and barriers to obtaining services are major reasons for non-use in populations with low contraceptive prevalence.

→ As modern contraceptive prevalence (mCPR) increases, reasons for non-use shift to health concerns and side effects of specific, primarily hormonal, methods and a lack of perceived risk of unintended pregnancy (22). The dominant reason for discontinuation is method-related, particularly fear of side effects and health concerns.

- **Health and method-related reasons.** Side effects and health concerns are frequently cited as reasons for non-use and discontinuation. Menstrual irregularities, weight gain, nausea, and fear of other health risks are major causes of concern. Concerns about side effects in settings with high contraceptive prevalence are mostly derived from experience rather than perception (20). Fear that contraception causes infertility is also commonly reported. Infertility is often highly stigmatized, resulting in worry about potential harm to future childbearing (20).

Lack of knowledge about contraception overall is a less significant barrier to use; however, inadequate information about specific methods remains a barrier. Lack of awareness of certain methods and supply sources appears more important than previously claimed (23). Improving knowledge among populations with low mCPR is essential—for example, in remote rural areas and in West and Middle Africa (20).

Low perceived risk of pregnancy as a result of infrequent sex is often cited as a reason for non-use, particularly in areas where labour migration is common (20,24). Amenorrhoea or breastfeeding is sometimes cited as a reason for non-use in the postpartum period.

- **Socio-cultural barriers.** Opposition to contraception can include women's own opposition to contraception or to specific methods or broader cultural opposition to contraception. Lack of support from partner or family and adherence to social norms prevent some women from adopting and continuing contraception, and being advised not to use or knowing dissatisfied



users through social networks may also discourage uptake and continuation of contraception (25).

Low levels of motivation to avoid pregnancy and ambivalence or uncertainty about pregnancy intentions, which may partly derive from cultural or religious beliefs or from norms about ideal family size, also prevent women from using a contraceptive method.

- **Barriers to obtaining services.** Stockouts of contraceptive commodities are another reason for non-use and/or discontinuation. When a preferred method is not available, women are more likely to discontinue use (26).

Provider biases about contraceptive use in general—and about provision of specific methods—are common, especially within services for young people. Some healthcare workers are hesitant to provide contraceptive methods to unmarried women and adolescents, and are particularly reluctant to provide long-acting reversible contraceptives (LARCs) to nulliparous women, despite clear evidence that their use is safe and effective, regardless of parity (27,28,29,30). Because of biases among some providers, women and adolescents may be unable to receive counselling about certain methods or to obtain the methods themselves.

Distance to services and cost of obtaining contraceptives, even when they are provided free, are frequently barriers for women, and especially

adolescents, living in remote rural areas (31). In settings where contraceptive services are not free, their cost can be a barrier, particularly for LARCs and sterilisation and for all methods among young people.

## HOW CAN COUNTRIES REDUCE UNMET NEED AND DISCONTINUATION?

No single intervention by itself will be effective in reducing unmet need for family planning and method discontinuation. Most successful programmes have created political and social support for family planning throughout the population and ensured that a wide range of methods is accessible and affordable through a variety of delivery systems.

→ Explicitly addressing social norms concerning family planning, method-related concerns about specific methods, and barriers to access can reduce unmet need for contraception.

### Addressing lack of knowledge, myths, and misconceptions

Information, education, and communication (IEC) efforts, including a **combination of mass media and interpersonal communication**, can improve knowledge about contraception and where to obtain services, thereby increasing uptake of methods (32,33).

Promoting **communication between couples and among friends and with health professionals** about method characteristics, especially side effects, can support continued use through method switching if problems are experienced. Engaging male community and religious leaders can also enhance support for use of contraception broadly within communities (34,35).

**Improved counselling**, including how to manage side effects, can reduce discontinuation, enhance switching if problems occur and improve client satisfaction with contraceptive use (36). Providers must anticipate some level of discontinuation among all of their clients and inform women and adolescents about the option of switching to alternatives when first counselling about starting a new method.

### Improving access to services

Social marketing makes contraceptive commodities more accessible and affordable through private-sector outlets such as pharmacies and shops. Incorporation of **social marketing to complement public sector clinic outlets increases clients' knowledge of and access to contraceptive methods**, particularly pills and condoms (37). The reduced international funding for social marketing needs to be replaced by domestic resources.

Mobile outreach services have increased contraceptive use, particularly in areas where access through health facilities and community-based programmes is limited or health



worker shortages limit the provision of certain methods, and when the services are higher quality than those available in health facilities or from community workers. **Mobile outreach services can also expand method choices** by providing long-acting and permanent methods in hard-to-reach areas (38).

→ **Task-sharing between different cadres or shifting certain service delivery tasks to lower-level healthcare workers improves the availability of some methods (39).**

**Community health worker (CHW) programmes increase contraceptive use** in places where access to clinic-based services is limited (40), and engaging drug shops and pharmacies in the provision of contraception has led to increased use, particularly among young people and in urban areas (41).

**Integrating family planning with other reproductive, maternal, and newborn health services** such as immunization, antenatal and immediate post-delivery care, and HIV services contributes to increased use of methods. The impact depends, however, on the overall service structure, quality of counselling, volume of clients, and other considerations (42); consequently, integrated models need to be carefully developed and pilot-tested before being implemented at scale.

Contraceptive commodity procurement and supply systems need to be strengthened and better integrated with broader health commodity systems to reduce stockouts and ensure that a wide range of methods is consistently available. Although no single method mix is right for all countries, and indeed many countries have reached



low fertility with a method mix skewed towards a small number of methods, ensuring **availability of a range of contraceptives allows women to use their preferred method and to switch if a chosen method proves to be unacceptable** (43).

**LARCs have lower discontinuation rates and for many women can be more effective than short-acting methods.** Increasing the availability of LARCs, especially to postpartum women at public-sector maternal and child health facilities or through mobile outreach services to geographically dispersed populations, can lead to greater use among previously underserved populations and higher rates of continuation (8,38). **Vouchers** that reduce the cost of obtaining these methods from quality-accredited facilities can also increase use by reducing multiple barriers (44).

## PROGRESS IN FAMILY PLANNING USE SINCE 2012

In July 2012, more than 20 countries made commitments and \$2.6 billion was pledged in increased resources to enable 120 million more women and girls to use contraceptives by 2020. Three years later the 2030 Sustainable Development Goals were launched and include targets to ensure universal access to sexual and reproductive healthcare services and rights, including family planning (45). **As countries move towards achieving these ambitious goals, it is important to assess the evidence of what has worked, what has not worked, and to identify areas for further investment.** The number of women who want to avoid a pregnancy but are not using an effective contraceptive method decreased from 225 million in 2014 to 214 million in 2017 (46).

→ **Within the 69 FP2020 focus countries, the number of women using modern contraception increased from 270 million in 2012 to 300 million in 2016 (46). Significant progress has been made in Eastern and Southern Africa, where more than 30% of women and girls are now using a modern method. Notable progress has also been made in West Africa, where the nine Francophone Ouagadougou Partnership countries achieved their collective goal of 1 million additional users between 2011 and 2015 (46).**

### Reasons for observed progress

Between 2012 and 2015 the number of modern contraception users increased significantly more quickly than would have been expected from historical trends (46). Galvanised efforts have improved policies and strengthened services at the country level. **More than 90 partners, including 38 countries, have made commitments to expand access to voluntary, rights-based, high-quality family planning. At the country level, effective partnerships have engaged civil society to support country objectives and address challenges (46).** Improved data tools and resources have led to better country-level and subnational reporting, allowing countries to identify current trends and guide their actions in the coming years (47). There has been a steady increase in donor government and domestic funding for family planning since 2012 (48).

## CHALLENGES TO ACHIEVING FP2020 GOALS

**Despite the progress made, the demand for family planning that is satisfied with modern contraception remains below 50% in many low-income FP2020 countries (3,46).**

Moreover, a limited range of contraceptive methods has prevented women from obtaining their preferred methods, including LARCs that suit their particular needs. **In 37% of the 69 FP2020 focus countries, one method accounts for 50% or more of contraceptive use among women (46).** Stockouts remain a problem, particularly in hard-to-reach areas. In none of the countries with data were at least three methods available in all the primary-level facilities surveyed. Provider biases about contraceptive use for young people and their reluctance to provide LARCs to nulliparous women are common.

Limited counselling about health concerns and side effects and lack of attention to ensuring high quality of services can discourage potential new users and result in rapid discontinuation without switching. Many countries need to improve the quality of counselling to enable more women and girls to exercise informed choice and to change methods when needed. Several countries with low prevalence of modern contraception have large numbers of women and adolescents living in humanitarian settings where the provision of FP services is inadequate.

## CONSIDERATIONS FOR ACCELERATING UPTAKE OF VOLUNTARY, RIGHTS-BASED FAMILY PLANNING IN DEVELOPING COUNTRIES

To improve the proportion of demand for FP that is satisfied through effective contraceptive methods and thereby meet the FP2020 and Sustainable Development Goals, the evidence presented here suggests that significant investments are required by countries and donors in the following priority areas:

- Ensuring sustainable financing, primarily from domestic sources, for services and commodities
- Reaching all adolescents with accurate information and services
- Expanding availability of services to the poorest, especially the urban poor, and other hard-to-reach populations including those in humanitarian settings and rural areas
- Improving the quality of services to reduce discontinuation and increase switching
- Increasing the range of methods available, either at the point of delivery or through referral
- Strengthening procurement procedures and supply chains to prevent stockouts
- Broadening interventions in social and behaviour change communication to reach larger audiences, especially through digital technologies
- Sustaining R&D investments in innovations in contraceptive methods and their delivery.

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Authors: Kazuyo Machiyama (London School of Hygiene and Tropical Medicine); Francis Obare (Population Council); Venkatraman Chandra-Mouli, Doris Chou, Mario Festin, Rajat Khosla, James Kiarie, Lale Say, Nandita Thatte (World Health Organization).

This is one of seven Family Planning Evidence Briefs prepared for the Family Planning Summit held in London on July 11, 2017. The briefs highlight evidence and provide research and programme considerations for improving access to family planning and reducing unintended pregnancy. Programme considerations are based on the expert views of the authors, who undertook desk reviews drawing on existing evidence.

#### Family Planning Evidence Briefs

- Accelerating uptake of voluntary, rights-based family planning in developing countries (*overview*) (Updated October 2018)
- Family Planning Financing (Updated October 2018)
- Reducing early and unintended pregnancies among adolescents (Updated October 2018)
- Improving family planning service delivery in humanitarian crises
- Ensuring contraceptive security through effective supply chains
- Expanding contraceptive choice and method mix (Updated October 2018)
- Partnering with the private sector to strengthen provision of contraception

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For more information, please contact: Department of Reproductive Health and Research, World Health Organization, Avenue Appia 20, CH-1211 Geneva 27, Switzerland  
E-mail: [reproductivehealth@who.int](mailto:reproductivehealth@who.int)  
Website: [www.who.int/reproductivehealth](http://www.who.int/reproductivehealth)  
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