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Reducing unmet need for family planning: Evidence-based strategies and approaches

Today, 63% of women in developing countries use a method of family planning.[1] In 1960, that number was just 10%.[2] Despite this dramatic increase, about one in six married women still has an unmet need for family planning: that is, she wants to postpone her next pregnancy or stop having children altogether but, for whatever reason, is not using contraception.[3] As a consequence, 76 million women in developing countries still experience unintended pregnancies each year,[4] and 19 million resort to unsafe abortions.[5]

Family planning, maternal health, and the MDGs

Current circumstances present a critical opportunity to reconsider the importance of family planning and to revisit and update program strategies. In recent years, new political, financial, and health-system challenges have emerged that complicate addressing women's unmet need. At the same time, in 2006, unmet need for family planning was added to the fifth Millennium Development Goal (MDG) as an indicator for tracking progress on improving maternal health[6] (see box, page 2). A recent analysis concluded that family planning is among a handful of feasible, cost-effective interventions that can make an immediate impact on maternal mortality in low-resource settings.[7]

Family planning can reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of births at high risk.[3,8] As contraceptive use increases in a population, maternal mortality decreases (see Figure 1, page 2). It has been estimated that meeting women's need for modern contraceptives would prevent about one-quarter to one-third of all maternal deaths, saving 140,000 to 150,000 lives a year.[4,9] It would also prevent a similar proportion of the injuries, infections, and long-term disabilities that result from pregnancy, childbirth, and abortion and affect an estimated 15 million women annually.[10]

Family planning offers a host of additional health, social, and economic benefits: it can help reduce infant mortality, slow the spread of HIV/AIDS, promote gender equality, reduce poverty, accelerate socioeconomic development, and protect the environment (see box on "Making the case for family planning," page 5). For example, a recent analysis in sub-Saharan Africa found that investing in family planning services would prevent 29% more births of children with HIV than spending the same amount on prevention of mother-to-child-transmission (PMTCT) programs that offer antiretroviral drugs to pregnant women with HIV.[11]

Investing in family planning takes on additional urgency because it can help to reduce global inequities in health—a fundamental element of the MDG agenda. Some individuals are far more likely than others to suffer unwanted pregnancies and their consequences, which range from possible death and disability to the personal and financial burdens of raising more children than a family wants or can afford.[12] Unmet need for family planning is twice as common in sub-Saharan Africa as in Latin America.[13] Within Latin America, it is twice as high in the poorest fifth of the population as in the wealthiest fifth.[2] Disparities in unmet need contribute to

Millennium Development Goal (MDG) 5: Improve maternal health

Target 5a: Reduce by three-quarters the maternal mortality ratio

Indicators: 5.1 Maternal mortality ratio
5.2 Proportion of births attended by skilled health personnel

Target 5b: Achieve universal access to reproductive health

Indicators: 5.3 Contraceptive prevalence rate
5.4 Adolescent birth rate
5.5 Antenatal care coverage
5.6 Unmet need for family planning

even wider gaps in maternal mortality rates.[12,14] They also violate women's and men's fundamental human right to control their own fertility and choose the number and timing of their children, a right endorsed by 179 countries at the International Conference on Population and Development (ICPD) in 1994.[15] Reducing these inequities is as important a goal for health systems as effectiveness, efficiency, or quality care.

The first half of this report reviews the concept of unmet need and the major challenges in developing countries where unmet need for family planning is growing or remains high. The second half offers suggestions on how public-sector program managers can take steps—both independently and in collaboration with the private sector—to address unmet need in the current environment.

Understanding unmet need

Unmet need for family planning is a statistical measure that calculates how many sexually active women say they want to stop childbearing or delay their next birth by at least two years but are not using any method of contraception, either modern or traditional. To be included in the standard definition of unmet need, a woman must be sexually active and able to conceive (that is, not pregnant, amenorrheic, or infertile). Pregnant or amenorrheic women are also considered to have an unmet need if their current or most recent pregnancy was unwanted or mistimed and they were not using a method of family planning.[16,17]

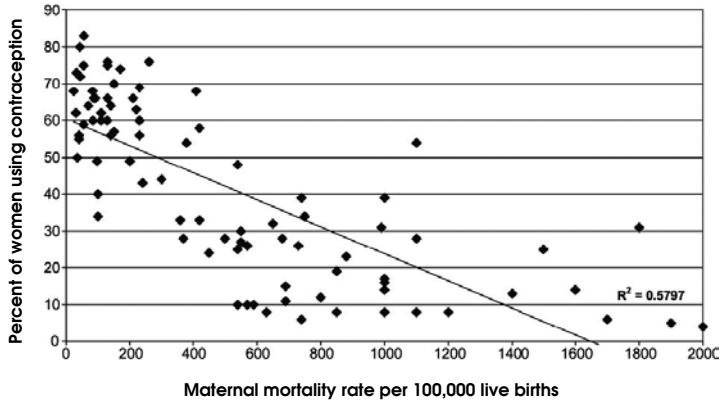
Unmet need is a valuable indicator for national family planning programs because it shows how well they are achieving a key mission: meeting the population's felt need for family planning.[2] Data on unmet need can also help family planning programs target activities by identifying women who are at greatest risk of unintended pregnancy and more likely to adopt a method than other nonusers. In addition, the concept of unmet need places women's personal reproductive preferences, rather than numerical targets for fertility and population growth, at the center of family planning services.[18]

Levels of unmet need rise and fall in response to two factors: demand for family planning and contraceptive use. It is important to remember that low levels of unmet need may reflect the fact that women want large families—not that contraception is widely available or used. Program managers also need to look at desired family size and contraceptive prevalence to gauge whether they need to raise awareness of the benefits of small, well-spaced families. MDG 5 employs both unmet need and contraceptive prevalence as indicators of progress (see box).

Statistics on unmet need may also understate the true demand for family planning. They often exclude unmarried women because it is difficult to collect reliable information.[18,19] Yet unmarried young people face great barriers to services and may have higher levels of unmet need than married women.[6] The standard definition of unmet need also fails to consider women who are using contraception but need a method that is more effective, safer, or a better fit with their personal circumstances.[20]

Even when women want to avoid pregnancy, they may have diverse reasons for not using contraception that can explain their unmet need—including concerns about side effects, religious strictures against family planning, the belief that they are unlikely to become pregnant, or issues related to cost or access.[13] Where unmet need remains high, it is important to understand women's and men's personal decisions regarding family planning.

Figure 1. The relationship between contraceptive use and maternal mortality



Data are from countries with a Demographic and Health Survey in the last five years.

Source: Prata N, Sreenivas A, Vahidnia F, Potts M.[7]

Patterns of unmet need

Unmet need for family planning remains low in some countries, notably in sub-Saharan Africa, because many couples still want relatively large families and thus do not use contraception. They are classified as having no need for family planning. By contrast, unmet need is greatest—more than 20% of married women—in 24 countries of sub-Saharan Africa and in Bolivia, Cambodia, Guatemala, Haiti, Nepal, and Yemen.[21] In these countries, changes in fertility preferences have outpaced the expansion of family planning services, especially among poor, less educated, and rural women.[13,22] In other developing countries, contraceptive use has become widespread, and the level of unmet need has fallen. Unmet need is now 10–12%, on average, in developing regions outside sub-Saharan Africa. As unmet need declines, disparities in use of family planning between rural and urban areas, less and more educated women, and the poor and non-poor tend to shrink.[19] However, pockets of unmet need may remain among marginalized groups with limited access to services, such as adolescents, indigenous peoples, and people living with HIV.

Understanding how desired family size, contraceptive use, and levels of unmet need change over time can help countries set service priorities. For example, in the early phase of family planning programs, communicating the benefits of smaller, well-spaced families and creating legitimacy is crucial. Moving forward, extending family planning services and supplies throughout the population and improving the quality of services become priorities, along with special efforts to reach underserved groups.[2,22]

The changing environment for family planning

Changes in the political environment, funding mechanisms, and organization of health systems have created new challenges for meeting the need for family planning. In part, family planning has been a victim of its own success. Highly effective family planning programs, together with profound social and economic changes, have dramatically boosted contraceptive use in developing countries and cut fertility in half since 1960.[2] This led to the mistaken belief that public investments in family planning were no longer needed.[23]

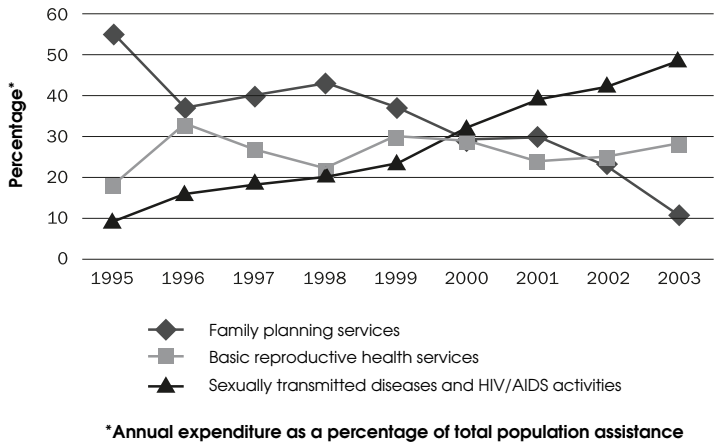
Then, national and global attention shifted to other pressing issues, including the alleviation of poverty and the AIDS pandemic.[2] In Zambia, for example, the Ministry of Health, nongovernmental organizations (NGOs), and donors reallocated time, money, and staff to fighting HIV/AIDS. Former champions of family planning also shifted priorities. Family planning was considered yesterday's problem, rather than an essential way to combat the epidemic.[24] Global trends also show funds for family planning have been increasingly reallocated to HIV/AIDS activities (see Figure 2).[25]

Another funding challenge has been fulfilling the ambitious and much broader agenda for reproductive health, including family planning, established at the 1994 ICPD.[2,23] Women have benefited from the wider array of services, but resources have been stretched in the process as governments have fallen far short of their ICPD commitments. Pressure will only intensify as the largest cohort of adolescents in history enters their reproductive years and demands services.[26]

There have also been significant changes in how public health systems are funded and organized and who makes decisions about resource allocations and service delivery. Sector-wide approaches (SWAps), for example, pool donor funding so that governments can coordinate planning and spending across the health sector. This gives national governments greater say in setting health priorities—but also leaves specific activities, such as family planning, more vulnerable to competing priorities, political conservatism, or leadership changes. At the same time, health sector reforms aim to increase the efficiency, quality, and sustainability of health systems, including by decentralizing decision-making and service provision. In the process, the delivery of family planning may be disrupted.[25,27] After responsibility for health services was decentralized in Tanzania, for example, persistent staff shortages at the district level weakened service delivery. In addition, District Health Management Teams did not consider family planning to be a top priority and budgeted their funds accordingly.[28]

Some programs must work to overcome additional, persistent local problems that reduce demand for

Figure 2. Changes in family planning donor assistance compared with HIV/AIDS assistance over time



*Annual expenditure as a percentage of total population assistance

Source: Adapted from UNFPA.[29]

family planning or complicate supply and service delivery. Unmet need for family planning is closely linked with gender equity and socioeconomic development. Where poverty is widespread, the status of women is low, and girls receive little schooling, changes in social norms regarding fertility come slowly, and women find it difficult to take control of their own fertility.[30,31]

Increasing access to services is also more difficult when infrastructure is weak. There may not be enough health facilities to serve the entire population or a functioning logistics system to keep them stocked with contraceptives. Shortages of qualified providers, supervisors, and managers are pervasive in developing countries.[27,28,32,33] Natural disasters or armed conflicts have disrupted service delivery systems in some places.[25]

The way forward

No matter the setting, it is possible for countries to reduce unmet need for family planning with carefully chosen and well implemented interventions. Rigorous experiments conducted in Matlab, Bangladesh, and Navrongo, Ghana, have demonstrated how redesigning service delivery systems can increase contraceptive use and reduce unmet need, even in areas with widespread poverty, low literacy, and largely rural populations.[34,35]

Along with tried and tested interventions, planners should consider new and innovative strategies that may be better adapted to current political priorities and funding realities. Successful programs employ a combination of interventions that address both demand for and supply of family planning services.[36,37] In the current environment, the way forward may include a mix of the following approaches.

Creating a broad base of support

Historically, family planning programs have had their greatest success in countries that forged a broad base of support across many sectors of society, including politicians, government bureaucrats, academics, health professionals, and people at large.[38] Building a national consensus in support of family planning has become even more important as attention and funding have dwindled. Advocates need to convince officials to adopt supportive policies and allocate funds to family planning by appealing to current development priorities[25] (see box, page 5).

Kenya's national family planning program became a top government priority in the 1980s. A rapid expansion of service delivery, combined with extensive communication campaigns, led to a remarkable increase in the use of modern contraception from 6% of married women in 1977–1978 to 32% in 1998. Progress then stalled, in part because of a shift in attention and resources to HIV/AIDS. The supply of contraceptives was interrupted, the number of clinics offering family planning dwindled, and unmet need increased.[39,40]

Data from the 2003 Demographic and Health Survey in Kenya documented the deteriorating situation and gave family planning champions the evidence they needed to advocate for a renewed commitment to contraceptive services. Advocates reframed family planning as an important issue for the nation's economic growth and social development, using the slogan "Planning our families is planning for our nation's development." They also linked family planning to the MDGs and promoted integration with HIV/AIDS and other reproductive health issues. Finally, they worked to demonstrate that family planning was not just a "women's issue," but had benefits for men, children, and the nation at large.[40] Their efforts ultimately led to government funds being allocated to contraceptive commodities in the 2005 national budget, a first for Kenya. This accomplishment was especially important because Kenya's earlier successes relied heavily on external funding.

While advocacy at the national level remains important, in many countries decision-making and resource allocation are being decentralized to the district and even local levels. Advocates need to redirect their efforts accordingly. A series of public- and private-sector projects in Ethiopia, Ghana, and India have demonstrated how advocacy at the community level can increase the reach and impact of service delivery efforts. Each project began by identifying which community members could contribute to the success of family planning services, given the local setting. Project staff explained the benefits of family planning to these influentials and recruited them to join committees supporting service delivery in their communities. Committee members contributed to the success of the projects by promoting family planning, recruiting and supporting frontline providers, and raising money and other essential resources.[35,41,42]

Overcoming barriers to family planning uptake

Family planning programs in many countries have successfully used mass media communication campaigns to raise awareness of the benefits of family planning, legitimize small families, and change reproductive preferences.[43] Programs can use these same communication channels to address many of the reasons why women with an unmet need do not use a family planning method and encourage them to change their behavior. Effectively crafted, evidence-based messages can explain the true risk of pregnancy for women who are breastfeeding or have sex infrequently, address concerns about contraceptive side effects and health risks, publicize sources of supply, and address religious or other opposition to modern contraceptives.

The coordination or integration of services as part of health sector reform offers another, complementary way to reach women and reduce missed opportunities to provide family planning services. Any time people seek health care represents an opportunity to identify their unmet need. In a study in Turkey, for example, providers interviewed clients about their need for

family planning after offering routine services, such as children's vaccinations and checkups. They found that 43% of clients had an unmet need for a modern contraceptive method. Referrals to the family planning unit led about two-fifths of them to adopt a method that same day.[44] Even more effective than referrals is having providers offer family planning at the same time and place as other services.[45] In Haiti, a voluntary counseling and testing (VCT) center integrated family planning along with other primary care services. All clients seeking an HIV test were screened for contraceptive and other health needs. This approach led 19% of new VCT clients to adopt a contraceptive method and to return for at least three family planning visits.[46]

Health clients may be especially receptive to and in need of family planning information and services when they are seeking an abortion, have just delivered a baby, or are diagnosed with HIV.[25] Offering integrated services at these moments is convenient for clients and can also address other health problems. For example, offering family planning as part of postabortion care can reduce the rate of repeat abortions. When offered contraceptive counseling and services, 90% of women in Tanzania seeking an induced abortion or care for complications of an unsafe abortion adopted a method.[47] Most were still using it a year later.[48] Similarly, making contraceptive methods available immediately after delivery or during visits for postnatal and well-baby care encourages new mothers to adopt a method and helps them space children at healthier intervals.[49] However, coercive policies that target family planning to marginalized groups, including people living with HIV/AIDS, are a violation of human rights and can invite a backlash against family planning services.

Improving the quality of services

The quality of family planning services can be judged on six key dimensions: the choice of contraceptive methods,

Making the case for family planning

Modern-day family planning advocates need to marshal an array of arguments that appeal to current health and development priorities, including the MDGs. Key messages include:

- **MDG 1**: ***Family planning alleviates poverty and accelerates socioeconomic development.*** With fewer, healthier children to provide for, families are less likely to become poor. They are also better able to feed and provide health care for their children, which creates a healthier and more productive workforce that can contribute to the economic growth of the nation as a whole.[4] On the national level, rapid population growth resulting from high levels of unmet need often outstrips economic growth and undermines a country's ability to offer adequate educational, health, and other social services to its people.[50,51]
- **MDG 2**: ***Family planning can help ensure that all children go to school.*** Families are more likely to be able to educate their children if they have smaller families.[4] For example, some girls are forced to drop out of school early to care for younger siblings. Girls and young women may also be forced to leave school early if they get pregnant.
- **MDG 3**: ***Family planning promotes gender equality.*** Women have greater opportunities for education, training, and employment when they can control their fertility. This can increase their financial security, decision-making power in the household, and status in the community.[4] Because so much of women's work consists of unpaid household labor and poorly paid work in the informal economy, their increased productivity may go unnoticed and unmeasured. Yet it is still of enormous importance for moving families out of poverty.[52]
- **MDG 4**: ***Family planning can reduce infant mortality*** by one-fifth to one-third or even more in some settings.[3] Spacing births 36 to 60 months apart reduces malnutrition as well as neonatal and infant mortality.[53]
- **MDG 5**: ***Family planning reduces maternal mortality*** in three ways. It decreases the total number of pregnancies, each of which places a woman at risk.[3] It prevents pregnancies that are unwanted and hence more likely to end in unsafe abortions, which contribute to one in eight maternal deaths.[8] Finally, it reduces the proportion of births that are at greater risk of complications because of the mother's age, parity, or birth spacing.[3]
- **MDG 6**: ***Family planning can slow the spread of HIV/AIDS.*** Condoms simultaneously prevent HIV transmission and unwanted pregnancy. Contraceptives also enable HIV-positive women to prevent unwanted pregnancies. This is as cost-effective as antiretroviral drugs in reducing mother-to-child transmission of HIV.[54]
- **MDG 7**: ***Family planning can help protect the environment*** by reducing population growth and the pressures it places on natural resources, such as arable land, fresh water, timber, and fuel.[55,56]

For more information on making the case for family planning, see *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*[4]*; Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*[25]*; Why Family Planning Matters*[57]; and "Repositioning Family Planning in Sub-Saharan Africa."[58]

information given to clients, the technical competence of providers, interpersonal relations between providers and clients, follow-up and continuity of services, and the constellation of services offered.[59] Good-quality services not only attract new clients but can also help prevent contraceptive discontinuation.[60]

A proven approach to improving quality of care is reassessing the method mix in a given setting—based on the capacity of the service delivery system and the needs of the population—and encouraging clients to make an informed choice of methods. This approach does not necessarily involve introducing new methods; raising the awareness and availability of underused methods, overcoming provider biases for and against certain methods, and strengthening providers' counseling skills may be more important.[37,61]

Given current funding challenges, public-sector health systems should also consider partnering with the private sector to increase women's choices and improve the quality of services. Non-public-sector outlets—which include pharmacies and other retailers, doctor's offices, and NGO clinics—may offer clients more convenient hours and locations as well as greater anonymity than a clinic waiting room. By segmenting the population and encouraging clients who can afford to pay to use private-sector services, the public sector can reduce its financial burden and focus its resources on quality care for poor and underserved groups.[22,43,62] The public sector can promote and strengthen private-sector services by setting and enforcing standards for service delivery, reducing regulatory barriers to private services, referring clients to private practitioners, or even subsidizing initiatives such as the social marketing of condoms and oral contraceptives.[62]

As an illustration, a social franchise network in the Philippines, the Well-Family Midwife Clinic (WFMC), deliberately sites its clinics to attract middle- and lower-middle-class families who can afford moderate fees.[62] This segment of the market is willing to pay for private providers who offer more convenient hours and locations, shorter waits, and more individualized attention than the public health system. To keep prices affordable, WFMC relies on midwives to provide care and subsidizes some support services while the clinics are getting established. The network offers both clinical and business training so that the midwives not only offer high-quality services but also earn a profit and ultimately become financially sustainable.

Growth in private-sector services is not a signal for the public sector to relax its efforts. Rather, it creates an opportunity for the public sector to adopt pro-poor strategies that will increase the availability, affordability, and quality of services for the poorest segments of the population. The public sector can build facilities and assign providers to urban slums and poor villages, target visits by outreach workers to poor women, and reduce or eliminate client fees and other costs.[22,30,63] An appropriate combination of public- and private-sector services has reduced economic disparities in contraceptive use and unmet need in Indonesia and Morocco.[64]

Increasing access to family planning

Many programs have used community-based distribution (CBD) to increase access to family planning.[43] Contraceptive use rose from an average of 12% at baseline to 33% at one year in a series of six CBD projects in rural and urban areas of Pakistan.[65] A recent study in Uganda found that community-based health workers can be effectively trained to deliver injectable contraceptives, reducing the burden on the clinic-based delivery system.[66]

The CBD approach was originally developed and refined in experiments in Matlab, Bangladesh, in the late 1970s. After a successful pilot test, scaling up this labor-intensive approach required external support from the World Bank and involved a centralized, top-down approach.[35,67]

It is difficult to emulate the Bangladeshi model in an era when outside funding is scarce and health systems are increasingly decentralized. Ghana has developed an alternative approach to community health services that is better adapted to the current environment. It relies on local resources and initiative and takes a decentralized approach to scaling up. This approach, which was first tested in Navrongo, relocates nurses from subdistrict health centers to villages, where they offer family planning and other health services. Influential community members and organizations are mobilized to support the new health services by building a community health compound, recruiting volunteer community health organizers, and promoting family planning. This approach has proven to increase contraceptive use and reduce child mortality—without requiring any additional funding from the health system or outside donors.[34]

Given Ghana's multicultural society and decentralized health system, scaling up proceeds via peer exchanges and local adaptation. District teams learn the approach during a two-week visit to a participating site, after which they adapt it to suit the system of community governance, degree of ethnic diversity, and resources available in their region. The national program provides some technical training, manuals, and protocols, but focuses its training on the broader skills needed to adapt the approach to the local setting and mobilize the community to participate.[35]

Keys to success

There are many potential strategies to reduce unmet need for family planning. Countries that have made progress share a common approach. They follow a systematic and evidence-based process to design and implement interventions,[27,36,68] like the World Health Organization's *Strategic Approach to strengthening sexual and reproductive health policies and programmes*.[69] The first step is generally a strategic assessment to determine whether and why

unmet need is high and to what extent it is concentrated in certain segments of the population. Then planners conduct research to determine which interventions are feasible, acceptable, effective, and sustainable, given the local setting and available resources. Finally, effective strategies are scaled up nationwide. Managers must ensure that improvements cut across economic, regional, and ethnic divides to reach the entire population.[36]

The burden of action cannot rest on public-sector program managers alone, however. Progress will require effective collaborations with the private sector, NGOs, national governments, communities, and major donors, among others. Such partnerships can be built around the immense potential rewards of reassessing and reinvigorating family planning. Addressing unmet need can help tackle some of the most intractable health and development problems facing the world today. As world leaders recently recognized, family planning has an important role to play in achieving the MDGs and ensuring that health is within reach for all people.

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