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Contraceptive Use in Sub-Saharan Africa: The Sociocultural Context

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Abstract

Background: This paper presents information on needs, barriers, and approaches to access and use of contraception by adolescents in low and middle income countries (LMIC). Despite the various strategies and policies, total fertility rate still remains high at 4.6 percent, while CPR and unmet need for family planning are estimated at 46 percent and 24 percent, respectively. These are aimed at increasing contraceptive prevalence rate (CPR), reduction in both total fertility rate (TFR) and unmet need for family planning services. *Methods:* An electronic search of the published literature was conducted using the search terms contraceptive use", "contraception", "family planning", and "Sub-Saharan Africa". This was supplemented by including search terms for the various types of contraceptive methods, e.g., Dual Contraception, Hormonal contraception, Female Sterilization, and Barrier methods, in combination with "Sub-Saharan Africa", "Socio-cultural", "Socio-Economic" and then comparing the results with the main search to identify articles that may have been missed. PubMed, Google Scholar, Cochrane, Sage Journal's, PLoS Medicine, and all indexed journals on Contraception, Family Planning, Reproductive Health, and Obstetrics and Gynecology that specifically addressed contraceptive issues in Sub-Saharan Africa were searched. The search was restricted to English language articles. Results: Contraception is one of the four important proximate determinant factors of fertility identified by Bongaarts (1978). The role of contraceptive use in population reduction and reproductive health cannot be over emphasised. However, in many countries, particularly sub-Saharan Africa, modern contraceptive use and prevalence is especially low and fertility is very high resulting in rapid population growth and high maternal and child mortality and morbidity. It is estimated that over 215 million women in the developing world have an unmet needs for modern contraceptives. *Conclusions:* In summary, we have shown that there is abundant information that contraceptive knowledge and awareness is high among the Sub-Saharan Africa population, but this awareness has not translated into increased contraceptive use, with the end result being very low contraceptive prevalence. This low contraceptive prevalence correlates with high levels of unplanned pregnancies and abortions, leading to increases in the maternal mortality ratios especially in the rural areas. The changes observed in some countries over the past decade indicate that selected parts of Africa have joined other regions of the developing world in a contraceptive revolution.

Keywords

Contraception, Family Planning, Sub-Saharan Africa

1. Introduction

Contraceptive use in sub-Saharan Africa remains low despite the high level of unmet needs and fertility rates. This paper focuses on identifying the key determinants of contraceptive use and approaches that can be adopted to improve contraceptive use in sub-Saharan Africa particularly those that empower individuals and communities.

Family planning is an important strategy in promoting maternal and child health as highlighted in MDG 5: a UN Goal with 2 targets and 6 indicators since the ICPD in Cairo, Egypt in 1994(UN, 1994). MDG goal 5 seeks to improve maternal health and its targets are to reduce by three quarters, between 1990 and 2015 and achieve, by the year 2015, universal access to reproductive health.

Goal 5: Improve maternal health

- Target 5.A:

Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

- Target 5.B:

Achieve, by 2015, universal access to reproductive health

The benefits of Family Planning include Preventing pregnancy-related health risks in women, reducing Infant mortality, prevention of HIV and AIDS, Empowering people and enhancing education, reducing adolescent pregnancies and slowing down population (Sonfield, Hasstedt, Kavanaugh, & Anderson, 2013).

In sub-Saharan Africa Family Planning Characterized by a paradox of High fertility rates especially among adolescents, low contraceptive use across all ages and high unmet need for family planning. A situation suggestive of both provider-side and user –side barriers are constraints that need to be overcome.

Sub-Saharan Africa has the highest average fertility rate in the world at 5 compared to 2 for Europe and 2-3 for Asia, Latin America and the Caribbean. Fertility rates have converged or are converging towards 2 by the year 2050 for all regions of the world except for Africa probably due to sub-Saharan Africa (UN, 2013).

The Kenya Demographic Health Survey(KDHS 2008-9) data indicate that declined during the Fertility rate in the 1980s and 1990s, changed from a high of 8.1 children per woman in the late 1970s to 6.7 in the late 1980s, and dropping to 4.7 during the last half of the 1990s(KNBS, 2012).

The Kenyan family planning program was started in the 1950s and launched as the 1st national family planning program in Africa in 1967 integrated into the maternal and child health division of the Ministry of Health. The HIV/AIDS epidemic has impacted fertility levels in Sub-Saharan Africa-causing either stagnation or accelerated decline in fertility.

Under this plan, family planning was integrated into the maternal and child health division of the Ministry of Health. In 1984, the Government ratified a set of population policy guidelines to assist in the implementation of the program. Reflecting the 1994 International Conference on Population and Development (ICPD), these guidelines were further revised in the population policy for sustainable development, issued in 2000 (UN, 1994).

The region has the highest prevalence of HIV/AIDS and the largest number of people living with HIV/AIDS in the world. Stagnation in fertility decline over the past 10 years has been related to the increase in HIV prevalence.

In Kenya according to the Kenya Aids Indicator Survey 2014 (KAIS, 2104) persons aged 15-64 years, 5.6% were living with HIV infection in 2012, presenting a statistically significant decline from 2007, when HIV prevalence was estimated to be 7.1% (National AIDS and STI Control Programme, 2013).

There was wide regional variation in HIV prevalence among adults and adolescents aged 15-64 years, ranging from 15.1% in Nyanza region to 2.1% in Eastern North region. HIV prevalence was significantly higher among widowed men (19.2%) and women (20.3%) than men (1.4%) and women (3.5%) who had never married or cohabited. HIV prevalence was higher among women (6.9%) than among men (4.4%). In particular, young women aged 20-24 years were over three times more likely to be infected (4.6%) than young men of the same age group (1.3%). HIV prevalence among uncircumcised men aged 15-64 years (16.9%) was at least five times greater than circumcised men 3.1% (ibid).

The modern contraceptive prevalence rate varies widely across the region among women of reproductive age, CPRs for modern methods ranged from 1.2 percent in Somalia to 60.3 percent in South Africa. Geographic variations in family planning use were apparent, with countries in Southern Africa reporting the highest levels of contraceptive use followed by countries in East Africa.

With a few exceptions, West and Central African countries report very low rates of contraceptive use. Some of the lowest contraceptive prevalence rates in the world exist in these two sub regions of Africa of West and Central Africa (WBG, 2012).

The use of traditional methods tends to be higher in settings where acceptance of family planning is low and use of family planning programs is weak. The use of modern methods has increased most markedly in countries that had the greatest increases in CPR (Madagascar, Malawi, Namibia, Zambia, and Zimbabwe).

Use of traditional methods in these countries has either remained stagnant or has decreased. Ghana, Kenya, Tanzania, and Uganda showed increases in use of modern methods while maintaining use of traditional methods. In West African countries such as Benin, Burkina Faso, Cameroon, Senegal, and Togo, traditional method use declined and relatively modest gains in modern method use were observed (Sharan et al., 2010)

Estimated 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. In Africa, 53% of women of reproductive age have an unmet need for modern contraception compared to 21% and 22%, in Asia, and Latin America and the Caribbean respectively regions with relatively high contraceptive prevalence(WHO, 2013)

The contraceptive prevalence and fertility in Kenya have leveled off in the recent past. Between 1993 and 1998 total unmet need declined, but then remained constant between 1998 and 2003, at about 25% (Ojakaa, 2008).

John Bongaarts (1978) analysed and indicated that variations in four factors-marriage, contraception, lactation, and induced abortion-are the primary proximate causes of fertility differences among populations**.** Some of the reasons affecting contraceptive use include supply-side and demand-side barriers these are things like poor quality of available services, limited choice of methods, limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people, fear or experience of side-effects, cultural or religious opposition and Gender-based barriers(Bongaarts, 1978).

The determinants of contraceptive use are divided as follows

- Behavioural (demand or user-side)factors:
- Biological(provider or supply-side) factors:

- Socio- cultural factors

Several socioeconomic factors are shown to be associated with high fertility rates, low levels of female education and income per capita, rural residence, and high infant and child mortality. Other barriers to sustained contraceptive use include medically inaccurate notions about how conception occurs and fears about the effects of contraception on fertility and menstruation, which were not taken seriously by care provider. Many contraceptives are encumbered with potentially unnecessary restrictions on their use. Indeed, fear of side effects, fostered by alarmist labeling, is a leading reason that women do not use contraceptives.

Christian teachings vary depending upon the denomination Roman Catholics are therefore forbidden to use medical or physical contraceptive methods. Natural contraceptive methods such as abstinence and the rhythm method remain permissible. Among Protestants, no specific forms of contraception are forbidden. Hindu doctrine prefers sons and no prohibitions against contraception. Buddhist religious dogma allows contraception may be used (Srikanthan & Reid, 2008).

Chinese religious traditions, such as Confucianism and Taoism, do not prohibit birth control. Cultural views that associate certain contraceptive methods with promiscuous behaviour, a lack of information about the safety of contraceptive methods, and lack of access because of the expense or availability of contraceptives may limit their effective utilization (ibid).

Intervention programs aimed at increasing contraceptive use may need to involve different approaches The Biopsychosocial Approach:

- Behavioural (demand or user-side)Approaches:
- Biological(provider or supply-side) Approaches:
- Socio - cultural Approaches

Including promoting couple's discussion of fertility preferences and family planning, improving women's self-efficacy in negotiating sexual activity and increasing their economic independence.

A review of family planning programs indicates a clear link between program implementation and contraceptive use. In Botswana, Kenya, and Zimbabwe, political commitment and the development of population policies supportive of family planning have created environments for the successful implementation of programs. In particular, the sustained improvements in, and resulting low levels of, mortality in these countries are unique within Africa (NRC, 1993)

In the examination of the factors affecting modern contraceptive use, female education emerges as an important determinant of prevalence at the individual, regional, and national levels.

Education will help achieve reproductive behavioural change in face of challenging socio-cultural, gender and economic circumstances (Schultz, 1993).The World Bank defines empowerment as the "expansion of freedom of choice and action to shape one's life. This definition encompasses two features of women's empowerment: process of change (through which a woman gains power in making decisions) and agency (Do & Kurimoto, 2012).

A multi-sectorial approach is imperative to improve women's health in Africa; these are some of the approaches and the way forward beyond 2015:

1. Girl child /Women Education
2. Access to quality Reproductive Health Care, (Maternal, FP, PMTCT Strategy)
3. Protecting women's rights and Empowerment

2. Methods

An electronic search of the published literature was conducted using the search terms contraceptive use", "contraception", "family planning", and "Sub-Saharan Africa". This was supplemented by including search terms for the various types of contraceptive methods, e.g., Dual Contraception, Hormonal contraception, Female Sterilization, and Barrier methods, in combination with "Sub-Saharan Africa", "Socio-cultural", "Socio-Economic" and then comparing the results with the main search to identify articles that may have been missed. PubMed, Google Scholar, Cochrane, Sage Journal's, PLoS Medicine, Guttmacher institute and all indexed journals on Contraception, Family Planning, Reproductive Health, and Obstetrics and Gynaecology that specifically addressed contraceptive issues in Sub-Saharan Africa were searched. The search was restricted to English language articles.

3. Results

Contraception is one of the four important proximate determinant factors of fertility identified by Bongaarts (1978). The role of contraceptive use in population reduction and reproductive health cannot be over emphasised. However, in many countries, particularly sub-Saharan Africa, modern contraceptive use and prevalence is especially low and fertility is very high resulting in rapid population growth and high maternal and child mortality and morbidity (Asamoah et al., 2013). It is estimated that over 215 million women in the developing world have an unmet needs for modern contraceptives.

As one of the first countries in Africa to develop a Population Policy and establish a Family Planning Programme as the main policy lever to reduce the population growth rate, Kenya has been well placed to initiate a fertility transition through government-led actions (Ian, Alex, Bongaarts, & Townsend, 2009; Okech, Wawire, & Mburu, 2011).

4. Conclusion

In summary, we have shown that there is abundant information that contraceptive knowledge and awareness is high among the Sub-Saharan Africa population, but this awareness has not translated into increased contraceptive use, with the end result being very low contraceptive prevalence.

This low contraceptive prevalence correlates with high levels of unplanned pregnancies and abortions, leading to increases in

the maternal mortality ratios especially in the rural areas.

Although there is considerable uncertainty about Africa as a whole, the evidence on balance points to an undeniable trend in Zimbabwe, Botswana, and Kenya. The changes observed in these three countries over the past decade indicate that selected parts of Africa have joined other regions of the developing world in a contraceptive revolution.

However, in the vast majority of countries within Africa,1 the prevalence of use of modern methods of contraception is less than 6 percent, placing them squarely in the "emergent" category with regard to family planning programs (NRC, 1993) . In these countries, postpartum non susceptibility due to lactational amenorrhea and sexual abstinence is more dominant than modern contraception in restraining fertility.

Recommendations

Formation of lobby groups to enhance cultural change, awareness creation and counselling and integrating family planning services with HIV/AIDS are recommended.

Significant investments are needed in Sub-Saharan Africa in order to meet the need for modern family planning. That investment will actually reduce overall health care costs, while also providing substantial public health and economic benefits to families and governments (Kieny & Evans, 2013).

Key interventions needed to fully meet family planning needs include integrating family planning services into the provision of other health care services; ensuring continuous supplies of a broad range of contraceptive methods; building service provision capacity, including strong community-driven service delivery; improving provider competency in counseling, education and method provision; and educating women and their partners to overcome unfounded fears about side effects.

Expanded efforts and culturally appropriate approaches are needed to meet the contraceptive needs of women and couples, especially those who face the greatest barriers in obtaining and effectively using modern contraceptives: individuals who are poor, less educated, unmarried or living in rural areas with little access to services.

Interventions are needed to address social factors that inhibit the use of modern contraceptives. Such barriers include women's low level of decision-making power within families, differences in fertility preferences between partners, and the stigma attached sexual activity and the use of contraceptive services among unmarried women. Addressing these types of barriers requires commitment to providing comprehensive sex education, improving school attendance for girls, launching large-scale public education efforts about the benefits of using contraceptives to avoid unintended pregnancies and eliminating child marriage.

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