



International Journal of Advanced Academic Studies

E-ISSN: 2706-8927

P-ISSN: 2706-8919

www.allstudyjournal.com

IJAAS 2022; 4(4): 26-29

Received: 05-07-2022

Accepted: 07-08-2022

Hana Alsumri

Assistant Professor,
Department of Family
Medicine and Public Health,
College of Medicine and Health
Sciences, Sultan Qaboos
University, Oman

Corresponding Author:

Hana Alsumri

Assistant Professor,
Department of Family
Medicine and Public Health,
College of Medicine and Health
Sciences, Sultan Qaboos
University, Oman

Contraception utilization in the developing world and the role of women autonomy

Hana Alsumri

DOI: <https://doi.org/10.33545/27068919.2022.v4.i4a.862>

Abstract

Modern contraceptive methods are considered an effective way to achieve family planning. It is also an efficient way to improve the overall health of both mothers and their children. This is achieved by helping women plan their pregnancies and reduce the number of unwanted pregnancies and through having a spacing gap between born children. It is also an essential mean to reduce the country's fertility rate and thus help in its economic growth. The scientific evidence supports that the risks from using modern contraception methods are much less compared to the risks of pregnancy and delivery especially if they are high risk and unplanned. However, the utilization of these modern family planning methods is unsatisfactorily slow particularly among women in countries of the developing world. Although provision of family planning services and allowing an easy access should be encouraged, more attention should be directed towards the role of women's autonomy in their likelihood to utilize these services.

Keywords: Modern, contraception, developing world, women, autonomy

Introductions

In the late 20th century, maternal health gained international attention as a public health issue. The 'Safe Motherhood Initiative', launched in 1987, at the International Conference on Safe Motherhood, in Nairobi ^[1], has helped draw more attention on this issue. In 1994, women's right to safe pregnancy and childbirth were recognized at the United Nation's International Conference on Population and Development, and was formally included within its program of action ^[2]. Since the year of 2000, global attention has turned to the Millennium Development Goals (MDGs), which were developed after the Millennium Summit in 2000, and included 189 nations. The main focus of the MDGs was to address socio-economic and health-related inequities in many areas such as; poverty, education, gender equality, child mortality, maternal health, and infectious diseases, by the end of 2015 ^[3]. The fifth of the eight MDGs was incorporated specifically to enhance maternal health as previous international initiatives did not yield expected rewards in women's reproductive health issues, especially, in developing countries ^[3].

Prior to 1980, utilization of modern contraceptive methods was very limited in Sub-Saharan Africa (SSA), partially because African government did not fully support family planning initiatives and programs ^[4]. Therefore, postpartum abstinence was the only method of family planning utilized in many African countries ^[5]. However, in the early 1980s, the occurrence of major political and economic crises led many African governments and policymakers to reconsider their beliefs regarding the effect of population growth on socioeconomic development. Thus, African leaders started endorsing the family planning methods and the necessity to incorporate them into maternal and child health programs at national levels ^[6]. Therefore, postpartum abstinence declined in Sub-Saharan African (SSA) countries and women started replacing it with modern contraceptive methods as a more effective method of achieving the desired birth interval between children ^[5]. Despite that, different recent studies indicate that use of effective modern contraception methods is still substantially lower in SSA countries compared to most other regions of the world ^[7].

The number of women in need of effective contraception to avoid unplanned pregnancy has increased substantially, from 716 million (54%) of 1321 million in 2003, to 827 million (57%) of 1448 million in 2008, to 867 million (57%) of 1520 million in 2012 ^[8]. Most of the increase (108 million) was related to population growth.

The use of modern contraceptive methods also increased, and the overall proportion of women with unmet need for modern methods among those wanting to avoid pregnancy decreased from 29% (210 million) in 2003, to 26% (222 million) in 2012. However, unmet need for modern contraceptives was still very high in 2012, especially in sub-Saharan Africa (53 million [60%] of 89 million), south Asia (83 million [34%] of 246 million), and western Asia (14 million [50%] of 27 million)^[8]. The short-acting methods, such as the pill, injectable and male condom, constitute more than half of all contraceptive methods used in countries of sub-Saharan Africa^[9].

In a recent population-based cross-sectional study (2019) using data on contraceptive use from the Demographic and Health Surveys (DHS) of 17 Sub-Saharan African countries (Angola, Benin, Burkina Faso, Burundi, Cameroon, Congo, Gambia, Ghana, Guinea, Ivory Coast, Liberia, Mali, Niger, Nigeria, Senegal, Togo, and Uganda), the overall prevalence of current contraceptive use among women of reproductive age was only 17%, with rates ranging from 7% in Gambia to 29% in Uganda^[10]. Findings indicated that the use of contraception was highly associated with both personal and socioeconomic factors^[10].

Challenges of The Un-met Needs of Contraception Among Developing Countries

In the recent years, the desire of having small families and achieving a healthy spacing of birth in the developing countries have steadily increased^[11, 12]. The Millennium Development Goal (MDG) 5, calls for universal access to the contraceptive services that women and couples need, to have the desired number of births, when they want them^[13]. Measuring and documenting the levels and trends in contraceptive use and unmet need for contraceptive services among the developing countries is crucial in informing the decisions of healthcare providers, program planners, and those in charge of resource allocation^[14].

The available information about unmet need for contraception has allowed health promoters, professionals, policymakers and funding bodies to identify the potential needed investments in family planning programs in these developing countries^[15]. Women are considered to have an unmet need if they are sexually active and want to avoid becoming pregnant but are not using any contraception method to achieve that goal^[16]. When women get health-guidance in preventing unintended pregnancies, it will help reduce unwanted births and unsafe abortions, and ultimately improve both maternal and child health^[17].

As of 2014, an estimated 225 million women in developing regions had an unmet need for modern contraception^[18, 19]. Annually, an estimated 74 million unintended pregnancies occur in developing regions, the great majority of which are among women not using any contraception or traditional method for birth spacing^[20]. If all unmet need for modern contraception methods were met, 52 million of these unintended pregnancies could be avoided, thereby preventing the deaths of 70,000 women from pregnancy-related complications^[21].

Review of DHS data from 1995 to 2005 showed that women's lack of knowledge about contraception had declined substantially compared with that reported in the 1980^[22]. On the other hand, concerns about side effects and health risks associated with the different modern contraceptive methods had increased substantially

throughout the developing world^[23, 24]. In West and Middle Africa only around 10% of women with unmet need for contraception reported that they are unaware of contraception, that they do not have access to a contraception source of supply, or that they cannot afford its cost^[25]. Twenty-six percent of these women mentioned concerns about contraceptive side effects and health risks; 24% say that they have intercourse infrequently or not at all; 23% say that they or others related to them are against contraception; and 20% report that they are breast-feeding and/or have not resumed menstruation after a birth^[26].

DHS data have been useful in revealing the various reasons why women might not utilize contraceptive services. However, because the reasons for non-use are collected on the basis of a single question, the responses might not clearly capture the potentially complex interplay of challenges that contribute to nonuse. Therefore, studies following qualitative methods have also examined the barriers to contraceptive use, uncovering issues similar to those found in the quantitative data, but with more explanatory detail. A review of studies among young women, primarily unmarried women in Sub-Saharan Africa, identified a theme of a lack of family planning education and information on how these contraceptive methods work^[27]. The review has also found that young women were concerned about possible side effects and health risks related to contraception use, such as menstrual disruption and future infertility, while unmarried women were also unwilling to risk the social disapproval associated with seeking these services^[28]. Studies that explored why women stopped using their methods have revealed the importance of health concerns and side effects (such as changes in bleeding patterns, weight gain and headaches) in women's decision making about methods^[29, 30]. Other studies have shown that men as well as women have concerns, real or falsely anticipated, about the effects of contraceptive methods on women's bodies-their weight, menstrual cycles, libido, sexual desirability and pleasure. Moreover, these studies revealed that both men's and women's opposition to family planning could be related to traditional gender norms or to misconceptions that outsiders (Westerners) aim to control women's fertility in a negative way in these countries^[31, 32].

Role of women's autonomy in their decision to use contraception

It is important to note that many of the studies assessing the individual-level factors affecting contraceptive use are often grounded in the assumption that individuals have control over their contraceptive behavior^[33]. However, a woman's capacity to act upon her intention or willingness to use contraception may be pertinent to the wishes and actions of her partner or other family or community members^[34].

Reproductive autonomy is defined as the power to control and decide about matters concerning contraceptive use, pregnancy and childbearing^[35]. Together with other demographic, social and cognitive constraints to contraceptive use, women's autonomy is believed to be a crucial determinant of a woman's capacity and ability to use contraception^[36].

In parts of South Asia, and elsewhere in the developing world, women have a considerably lower social status and autonomy than men^[37] and their low status and autonomy seems to be associated with lower fertility control^[38, 39].

Several reports have also showed a positive association between women's autonomy and contraception use^[40-42]. A woman who feels that she does not have much control over basic aspects of her life matters may be less likely to feel she can make and carry out decisions about her fertility^[43]. Women may also feel the need to choose methods that are less obvious or that do not depend on her husband's cooperation^[44]. In addition, women's educational level and paid employment are important determinants that directly or indirectly enhance the autonomy status of women in the household and community and significantly decrease the wide spread of the unmet need for family planning in these countries^[45].

Investing in family planning is one of the crucial investments for development, as population dynamics have a fundamental influence on the pillars of sustainable development. Most importantly, the utilization of modern contraceptives is believed to be highly cost-effective in enhancing the socioeconomic status of nations and thus reducing poverty, as demonstrated in earlier studies. Modern contraceptives also assist couples in their personal decisions to achieve their desired family size in their preferred time scale which will most likely lead to a better health of mother and children.

References

- Hounton S, *et al.* Patterns and trends of contraceptive use among sexually active adolescents in Burkina Faso, Ethiopia, and Nigeria: evidence from cross-sectional studies. *Global Health Action*. 2015;8(1):29737.
- Report of the International Conference on Population and Development. United Nation: New York; c1994. P. 1-149.
- Millennium Development Goals (midses). [Cited 2022 January 18th]; Available from: who.int/news-room/fact-sheets/detail/millennium-development-goals (mugs); c2018.
- Africa Potpdoss, National Research Council (Us) Working Group on Factors Affecting Contraceptive Use. *Factors Affecting Contraceptive Use in Sub-Saharan Africa*. National Academies Press (US), Washington (DC); c1993.
- Van balen h, and Ntabomvura v. methods of birth spacing, maternal lactation and post-partum Abstinence in Relation to Traditional African Culture. *Journal of Tropical Pediatrics*. 1976;22(2):50-52.
- Africa UNECF. Kilimanjaro programme of action on population. Programme d' action de Kilimanjaro concern ant la population, in Second African Population Conference, [Addis Ababa, Ethiopia], ECA, [1984]. Arusha, United Republic of Tanzania; c1984. p. 9-13.
- Tsui AO, Brown W, and Li Q. Contraceptive Practice in sub-Saharan Africa. *Population and Development Review*. 2017;43(S1):166-191.
- Darroch, JE. And Singh S. Trends in contraceptive need and use in developing countries in 2003, 2008, and 2012: an analysis of national surveys. *The Lancet*, 2013;381(9879):1756-1762.
- United Nations Does. *Contraceptive use by method*: United Nations; c2019.
- Ba DM, *et al.* Prevalence and predictors of contraceptive use among women of reproductive age in 17 sub-Saharan African countries: A large population-based study. *Sexual & Reproductive Healthcare*. 2019;21:26-32.
- Ahinkorah B, *et al.* Drivers of desire for more children among childbearing women in sub-Saharan Africa: implications for fertility control. *BMC Pregnancy and Childbirth*. 2020 Dec;20(1):1-1.
- Darroch JE. Trends in contraceptive use. *Contraception*, 2013;87(3):259-263.
- Organization WH. *The Mellennium Development Goals report*; c2015.
- Cleland J. *et al.* Family planning: the unfinished agenda. *Lancet*, 2006;368(9549):1810-27.
- Sedgh G, Ashford LS and Hussain R. *Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method*. Guttmacher Institute: New York. 2016. p. 1-93.
- Westoff CF. The concept of unmet need. *Plan Parent Chall*. 1994;(1):5-8.
- Baschieri A, jc s, Floyd a, Dube a, Msona and jrg A. *et al.* French, reproductive preferences and contraceptive use: a comparison of monogamous and polygamous couples in northern malawi. *J Biosoc. Sci*. 2013 Mar;45(2):145-66.
- United Nations DoE and PD. *Social Affairs, Trends in contraceptive use worldwide 2015*. ST/ESA/SER. A/349; c2015.
- Nations U. *The millennium development goals report*. New York: United Nations; c2015.
- Organization WH. *Family planning: a global handbook for providers: 2011 update: evidence-based guidance developed through worldwide collaboration*; c2011.
- Bradley SE, *Revising unmet need for family planning*. ICF International; c2012.
- AI SGe. *Women with an Unmet Need for Contraception in Developing Countries and Their Reasons for Not Using a Method*. New York: Guttmacher Institute. 2007 Jun;37:5-40.
- Casterline JB, Perez AE, Biddlecom AE. Factors underlying unmet need for family planning in the Philippines. *Studies in family planning*. 1997;28(3): 173-191.
- Westoff CF. *Unmet Need for Modern Contraceptive Methods*, in DHS Analytical Studies 28. Office of Population Reserach, Princeton University; c2012.
- Cleland J, Ali MM, Shah I. Trends in protective behaviour among single vs. Married young women in sub-Saharan Africa: the big picture. *Reproductive health matters*. 2006;14(28):17-22.
- Gilda Sedgh LSA, Rubina Hussain, *Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method*. Guttmacher Institute: New York; c2016.
- Williamson LM, Parkes A, Wight D, Petticrew M, Hart GJ. Limits to modern contraceptive use among young women in developing countries: A systematic review of qualitative research. *Reproductive health matters*. 2009 Dec;6(1):1-2.
- Machiyama KC. *J Insights into Unmet Need in Ghana*. London School of Hygiene and Tropical Medicine; c2013.
- Machiyama K, *et al.* Women's attitudes and beliefs towards specific contraceptive methods in Bangladesh and Kenya. *Reproductive Health*. 2018;15(1):75.
- Rademacher KH, *et al.* *Menstrual Bleeding Changes Are NORMAL: Proposed Counseling Tool to Address*

- Common Reasons for Non-Use and Discontinuation of Contraception. *Global health, science and practice*. 2018;6(3):603-610.
31. John NA, Babalola S, Chipeta E, Sexual Pleasure, Partner Dynamics and Contraceptive Use in Malawi. *International Perspectives on Sexual and Reproductive Health*. 2015;41(2):99-107.
 32. Slaymaker E. *et al.* Trends in sexual activity and demand for and use of modern contraceptive methods in 74 countries: A retrospective analysis of nationally representative surveys. *The Lancet Global Health*. 2020;8(4):E567-e579.
 33. Nguyen N, *et al.* Reproductive autonomy and contraceptive use among women in Hanoi, Vietnam. *Contracept X*. 2019;1:100011.
 34. Upadhyay UD. *et al.* Development and Validation of a Reproductive Autonomy Scale. *Studies in Family Planning*. 2014;45(1):19-41.
 35. Alsumri HH. A National Study: the Effect of Egyptian Married Women's Decision-Making Autonomy on the use of Modern Family Planning Methods. *Afr J Reprod Health*. 2015;19(4):p68-77.
 36. Rahman M. Women's Autonomy and Unintended Pregnancy among Currently Pregnant Women in Bangladesh. *Maternal and Child Health Journal*. 2012; 16(6):1206-1214.
 37. Saleem Sm, Bobak M. Women's autonomy, education and contraception use in Pakistan: a national study. *Reproductive Health*. 2005;2(1):1-8.
 38. Jejeebhoy SJ. Women's education, autonomy, and reproductive behaviour: experience from developing countries. Oxford: Clarendon Press; New York: Oxford University Press; c1995.
 39. Rabbi AMF. Transition to Second Parity: Role of Employment and Household Decision-Making Autonomy in Bangladesh. *American Journal of Public Health and Reserach*. 1(6), 140-145.
 40. Dhak B, Saggurti N, Ram F. Contraceptive use and its effect on Indian women's empowerment: evidence from the National Family Health Survey-4. *Journal of Biosocial Science*. 2020;52(4):523-533.
 41. Saleem S, Bobak M. Women's autonomy, education and contraception use in Pakistan: A national study. *Reproductive health*. 2005 Dec;2(1):1-8.
 42. Derose L, Ezeh A. Decision-Making Patterns and Contraceptive Use: Evidence from Uganda. *Population Research and Policy Review*. 2009;29(3):423-439.
 43. Mason KO, Taj AM. Differences between Women's and Men's Reproductive Goals in Developing Countries. *Population and Development Review*. 1987;13(4):611-638.
 44. Das B, Tarai D. Decision-making and Fertility Behaviour:A Comparative Analysis of Scheduled Caste and Scheduled Tribe Women in Odisha. *Social Change*, 2011;41(2):233-249.
 45. Jejeebhoy SJ. Women's education, autonomy, and reproductive behaviour: experience from developing countries. Oxford; New York: Clarendon Press; Oxford University Press; c1998.