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Factors influencing use of family planning in women living in crisis affected areas of Sub-Saharan Africa: A review of the literature

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ABSTRACT

Background: far too many women continue to die from pregnancy and childbirth related causes. While rates have decreased in the past two decades, some areas of the world such as sub-Saharan Africa continue to have very high maternal mortality rates. One intervention that has been demonstrated to decrease maternal mortality is use of family planning and modern contraception, yet rates of use in sub-Saharan countries with the highest rates of maternal death remain very low.

Aim: to review available research and summarize the factors that inhibit or promote family planning and contraceptive use among refugee women and women from surrounding areas living in Sub-Saharan Africa.

Design: a review of the literature.

Data sources: Cochrane Library, Cumulative Index to Nursing and Allied Health Literature (CINAHL), OVID, power search, and PubMed databases.

Review methods: studies included were: (1) published in English from 2007 to present; (2) primary research; and (3) focused on family planning and contraceptive use among refugee women and women in surrounding areas. Findings were discussed within the framework of the Interaction Model of Client Health Behavior.

Findings: twelve studies met the inclusion criteria. Utilization of modern contraceptive methods was low. Women were socially influenced to avoid the use of contraceptives by husbands and others in the community. Reasons were a lack of trust in western medicine and the desire to have large families. Low socioeconomic status and proximity of family planning clinics were barriers to access. Women believed that health care providers were unqualified, many described being treated with disrespect in the health clinics. Knowledge and understanding of contraceptives was low; while most women knew different methods were available, there were many misconceptions. Believing that certain contraceptives cause death, infertility and side effects, contributed to fear of use. This lack of knowledge and fear, even with the desire to space and limit births, affected motivation to use contraception.

Conclusions: developing new approaches to educating women, men (husbands), community leaders as well as healthcare providers is needed to address the multi-factorial issues that contribute to underuse of family planning services, thus contraceptive use.

Implications for practice: while lack of access to family planning is a barrier to use, interventions that improve access must be affordable and include education regarding contraceptive methods, preferably from those within the community. However, education and access is not sufficient unless the issue of disrespect by healthcare providers is addressed. Respectful and culturally sensitive care for all women, regardless of socio-economic status or country of origin, must be provided by midwives and other women health providers.

Introduction

Efforts over the past two decades have succeeded in decreasing maternal deaths worldwide from 750,000 per annum in 1990 to 330,000 per annum in 2015 (Alkema et al., 2016; Maternal health, 2016). Unfortunately, these successes are not uniformly distributed across the developing world: maternal death rates are higher in poorer countries and highest for the poorest women within those countries. Since 1990 throughout the world, the gap in maternal mortality rates between countries with the best outcomes and those with the worst has doubled. Sub-Saharan Africa has the highest rate of maternal mortality at 546 deaths per 100,000 (World Health Organization, 2015). In fact,

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all 20 countries with the highest maternal mortality rates are located in sub-Saharan Africa and 65% of all maternal deaths occur in this region of the world (Alkema et al., 2016). In addition, maternal mortality can be viewed as the "tip of the iceberg" with maternal morbidity as the less visible underside of the problem. The WHO defines maternal morbidity as "any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's wellbeing" (Firoz et al., 2013).

Why does pregnancy and childbirth continue to be fraught with risk for women in certain areas of the world? The three leading causes of maternal death globally are complications from abortion, hemorrhage and hypertensive disorders (WHO, 2015). However, the underlying reasons why women die during pregnancy and birth are multifactorial, complex, and inter-related. In low-resourced countries, poverty, malnutrition and disease contribute to the risk of pregnancy-related complications such as anemia, hypertensive disorders, and hemorrhage (WHO, 2009). Women experiencing pregnancy and childbirth-related complications often receive too little care too late (Maternal health, 2016; Miller et al., 2016). Even though births occurring in health facilities have increased, many women still give birth at home without a skilled health worker in attendance. In the event of complications during pregnancy or childbirth, delays of hours or days in arriving at a health facility commonly occur. Many health facilities also lack the required infrastructure, personnel, and supplies to provide timely and adequate care (Maternal health, 2016; Miller et al., 2016). Women report that they do not experience respectful, quality care, which creates reluctance to seek care at health facilities during pregnancy and childbirth (Lieberman, 2016).

An estimated 222 million women worldwide have an unmet need for contraception (Patel et al., 2016). Since rates of contraception use have an inverse relationship with fertility rates, greater utilization of modern family planning (FP) methods decreases the rate of maternal morbidity and mortality. Conversely, insufficient uptake of FP contributes to morbidity and mortality in women and girls of reproductive age. Higher parity increases the probability that pregnancy will be the cause of death, as well as the risk of complications such as hemorrhage, fetal malposition, and multiple gestation (Graham and Hussein, 2007; Maternal health, 2016). Many of the sub-Saharan countries with high rates of maternal mortality also have some of the highest fertility rates in the world (Table 1). In addition, pregnancy and childbirth at wider age ranges (< 19 and > 35 years of age) carry additional risks. When a young woman who has not reached maturity becomes pregnant, she is more likely to be anemic, have obstructed labor, and have fewer resources for care during pregnancy and birth, all of which contributes to the risk of morbidity and mortality (Cavazos-Rehg et al., 2015). Older women also have a higher risk of pregnancy complications such as spontaneous abortion, hypertensive disorders, and multiple gestation (Cavazos-Rehg et al., 2015). Sub-Saharan Africa has the highest rate of adolescent pregnancy (age 15–19) and the highest rate of pregnancy in very young adolescents, with 10% of adolescents becoming a mother by age 16 (WHO, 2014).

Conflicts and wars afflicting this area of the world contribute to maternal mortality and morbidity by disrupting existing infrastructure, access to health centers, and increasing sexual violence against women. The Fragile State Index uses 12 social, economic and political indicators to provide a measure of the stability and challenges of a country. Countries are ranked on a scale from Very Sustainable to Very High Alert (Table 1). Of the 20 sub-Saharan countries with the highest maternal mortality rates, Lesotho is the only one ranking lower than High Warning (Messner et al., 2015).

An additional consequence of conflicts and wars is migration, which affects the health of those fleeing their homes as well as the population of the area of refuge (Miller et al., 2016). Access to health facilities and FP is often already limited in resource-poor countries; the added burden placed on existing resources by refugee populations taxes the already stretched health care infrastructure (United Nations, 2016a).

Table 1
Maternal mortality, fertility and Fragile State index for Sub Saharan African Countries. Information obtained from Alkema et al. (2016), USAID (2016) and Messner et al. (2015).

Sub Saharan Country	Maternal Mortality Rate (deaths/ 100,000 live births)	Total fertility rate (children born/ woman)	Fragile States Index
1. South Sudan	2054	5.43	114.5
2. Chad	1100	4.68	108.4
3. Somalia	1000	6.08	114.0
4. Sierra Leone	890	4.83	91.9
5. Central African Republic	890	4.46	111.9
6. Burundi	800	6.14	98.1
7. Guinea-Bissau	790	4.3	99.9
8. Liberia	770	4.81	97.3
9. Sudan	730	3.92	110.8
10. Cameroon	690	4.82	94.3
11. Nigeria	630	5.25	102.4
12. Leshotho	620	2.78	79.9
13. Guinea	610	4.93	104.9
14. Niger	590	6.89	97.8
15. Zimbabwe	570	3.56	100.0
16. Republic of the Congo	560	4.73	90.8
17. Democratic Republic of the Congo	540	4.8	109.7
18. Mali	540	6.16	93.1
19. Mauritania	510	4.07	94.9
20. Mozambique	490	5.27	86.9
21. Tanzania	460	4.95	80.8
22. Malawi	460	5.66	86.9
23. Angola	450	5.43	88.1
24. Zambia	440	5.76	85.2
25. Cote d'Ivoire	400	3.63	100.0
26. Senegal	370	4.52	83.0
27. Kenya	360	3.54	97.4
28. Gambia	360	3.85	85.4
29. Ethiopia	350	5.23	97.5
30. Ghana	350	4.09	71.9
31. Benin	350	5.04	78.8
32. Rwanda	340	4.62	90.2
33. Swaziland	320	2.88	86.3
34. Uganda	310	5.97	97.0
35. Burkina Faso	300	5.93	89.2
36. South Africa	300	2.23	67.0
37. Comoros	280	3.76	83.3
38. Eritrea	240	4.14	96.9
39. Madagascar	240	4.28	83.6
40. Gabon	230	4.49	71.3
41. Namibia	200	2.25	70.8
42. Botswana	160	2.37	62.8
43. Cape Verde	79	2.34	73.5
44. Soa Tome and Principe	70	4.67	73.7

Thus, the unique situation of refugee women most likely results in unmet FP needs due to an accumulation of factors such as poverty, instability, and lack of access to contraception (Berryman, 2013).

One of the Millennium Developmental Goals (MDG; United Nations, 2016b) was to improve maternal health (Goal 5). Target 5A was to reduce maternal mortality by 75% between 1990 and 2015 and Target 5B was to increase universal access to reproductive health. Neither target was achieved by the close of the 2015 target date. As the MDGs concluded, the Sustainable Development Goals became the new agenda. Goal 3 is to achieve universal access to reproductive health care, which includes FP, by 2030 (United Nations General Assembly, 2015).

In order to achieve this goal, it is important to understand the reasons for using or not using modern methods of contraception in the areas where use of FP is lowest. While access to modern methods of contraception is a necessary condition for FP use, availability may not