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Original article

Who Meets the Contraceptive Needs of Young Women in Sub-Saharan Africa?

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A B S T R A C T

Purpose: Despite efforts to expand contraceptive access for young people, few studies have considered where young women (age 15–24) in low- and middle-income countries obtain modern contraceptives and how the capacity and content of care of sources used compares with older users.
Methods: We examined the first source of respondents' current modern contraceptive method using the most recent Demographic and Health Survey since 2000 for 33 sub-Saharan African countries. We classified providers according to sector (public/private) and capacity to provide a range of short- and long-term methods (limited/comprehensive). We also compared the content of care obtained from different providers.
Results: Although the public and private sectors were both important sources of family planning (FP), young women (15–24) used more short-term methods obtained from limited-capacity, private providers, compared with older women. The use of long-term methods among young women was low, but among those users, more than 85% reported a public sector source. Older women (25+) were significantly more likely to utilize a comprehensive provider in either sector compared with younger women. Although FP users of all ages reported poor content of care across all providers, young women had even lower content of care.
Conclusions: The results suggest that method and provider choice are strongly linked, and recent efforts to increase access to long-term methods among young women may be restricted by where they seek care. Interventions to increase adolescents' access to a range of FP methods and quality counseling should target providers frequently used by young people, including limited-capacity providers in the private sector.

IMPLICATIONS AND CONTRIBUTION

Using nationally representative data from 33 sub-Saharan African countries, this study comprehensively describes where young women obtain modern contraception and how their use of providers and care received compared with older women. Results suggest that efforts to improve quality and method choice should target limited-capacity private providers frequently used by youth.

Conflicts of Interest: The authors have no conflicts of interest to disclose.
Disclaimer: Selected findings from this study have previously been presented as an oral presentation at the International Health Policy Conference in London, United Kingdom (February 2017) and the IUSSP International Population Conference in Cape Town, South Africa (November 2017), and as a poster presentation at the Global Women's (GLOW) Research Society Conference in Manchester, United Kingdom (November 2016), and the Population Association of America annual meeting in Chicago, USA (April 2017).
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It is critical to address unwanted pregnancy among young women in sub-Saharan Africa, a region with one of the highest adolescent pregnancy rates and the lowest rates of family planning (FP) use [1]. Amidst increasing calls to prioritize adolescents' contraceptive needs, understanding current patterns of adolescent FP service use is vital to achieving universal access to sexual and reproductive health services [2–4].

High-quality FP care is crucial to preventing unwanted pregnancy, particularly among young people. In a study of 40 countries with Demographic and Health Surveys (DHS), adolescent contraceptive practice was characterized by inconsistent use, with more method failure and discontinuation compared with older women; the authors suggest young women face more obstacles to use or abandon a method if experiencing side effects [5]. Health concerns and side effects are frequently cited as reasons for not using a method [4,6], and youth often have misconceptions about how contraception works [3,7]. Appropriate counseling, particularly when initiating contraceptive use or switching methods, is important to addressing knowledge gaps around pregnancy prevention and consistent contraceptive use [8,9] and is one of the six elements in the Bruce framework for quality FP care [10].

However, young people encounter significant barriers to accessing quality health care [11–13], including provider bias, age restrictions or stigmatization when seeking FP services, and concerns about confidentiality [7,14–16]. World Health Organization 2012 guidelines emphasized the improvement of young people's health services [11], and efforts to make services "youth friendly" have appeared in several small-scale initiatives, primarily led by nongovernmental organizations (NGOs) and, to some extent, government-run health facilities [11,17]. Some evidence suggests that these efforts have increased health service utilization, including FP use [3,17,18].

Yet the evidence base for where adolescents seek FP care in low- and middle-income countries is limited. Much of the evidence on young people's FP use and provider preferences in sub-Saharan Africa comes from small-scale, often qualitative, studies not nationally representative [14,15,19], focused on a limited number of countries [16,20,21] or studies that do not consider quality of FP counseling across provider types [22]. The private sector is an important source of FP care in the region for women of all ages [23], suggesting that public-sector efforts expanding youth-friendly services may miss a significant proportion of young people accessing private providers. Young people frequently utilize different FP methods compared with older users. As method and source can be linked, there is a need to consider how youth FP care seeking compares with older women.

Within global efforts to improve FP access and quality of care, particularly for youth, it is essential to understand where young people obtain contraception to inform points of intervention and cross-country learning. This paper aims to compare how FP sources and the content of FP care received differs between adolescent (aged 15–19), young (aged 20–24), and older women (aged 25+) using nationally representative surveys from multiple sub-Saharan African countries.

Methods

DHS are nationally representative, cross-sectional household surveys of women of reproductive age (15–49 years) with multistage cluster sampling designs. We utilized the most recent DHS as of June 2016 for every country in sub-Saharan Africa with a survey since 2000 and data available for the first source of respondents' current contraceptive method. We examined first source of the user's current method as DHS content of care questions refer to the provider where respondents initiated use of the method.

Results are presented for each country, adjusted for survey design and survey-specific weighting. We calculated regional statistics for sub-Saharan Africa by weighting country-specific estimates by the country's population based on United Nations population estimates for the median survey year 2012 [24]. We present 95% confidence intervals; adjusted Wald tests were performed to compare proportions. Analyses were conducted using Stata/SE v14 (StataCorp, College Station, TX).

Definitions and population

We examined two populations of women exposed to pregnancy risk [25]: (1) those currently using a modern FP method and (2) a subsample of modern method users starting use in the 5 years before the survey. We included intrauterine device (IUD), implant, injection, pill, and male condom as modern methods, according to Hubacher and Trussell's definition [26]. We excluded lactational amenorrhea and standard days method—methods sometimes considered modern in other studies—as unlike other contraceptive commodities and medical procedures, they do not always require a source or provider. We excluded the 1.2% of respondents reporting their method as "other modern" in DHS response options as these respondents were not asked about the method's source. We further excluded female/male sterilization, female condom, emergency contraception, diaphragm/foam/jelly, and contraceptive patch users as these methods combined account for less than 6% of modern method users, including less than 1% of users aged 15–19 or 20–24. We considered IUD and implant to be long-term methods. Because of the small sample size of IUD users among those aged 15–19 and 20–24 years, IUD and implant users were combined. Modern method mix estimates included the first population of respondents, who started their current method at any point before the survey.

Women were grouped by their age at the time of the survey: 15–19, 20–24, and 25 + years. We used DHS classifications for current marital/cohabitation status, grouping currently married and formerly married respondents as "ever married."

Categorization of source and sector of provision

DHS respondents were asked for the first source of their current method only if starting continuous use of the method within 5 years of the survey. Continuous use of the method was based on the month and the year since the respondent reported using the method "without stopping" [27]. The median length of use was less than 1 year for modern method users aged 15–24 and 1.5 years for users aged 25+; 99%, 97%, and 87% of users aged 15–19, 20–24, and 25+, respectively, started current use less than 5 years before the interview.

Across all 33 countries, we classified response options for the first source of the user's current method according to the sector and the theoretical capacity to provide both short- and long-term methods, calling FP providers "comprehensive" or "limited." Respondents with missing or unclassifiable sector/capacity of first source (i.e., "other") accounted for <3% of modern method users and were excluded. We created six classifications of FP providers: (1) public—comprehensive, (2) public—limited, (3)