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Married young women and girls' family planning and maternal health preferences and use in Ethiopia

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TECHNICAL BRIEF

Married Young Women and Girls' Family Planning and Maternal Health Preferences and Use in Ethiopia

Approximately one-third of Ethiopia's population is between the ages of 10-24 (Central Statistical Agency 2014). These young people have unique sexual and reproductive health (SRH) needs, and often face barriers accessing SRH services. To inform programmatic efforts to improve young people's access to SRH and other health services, the Evidence Project/Population Council recently conducted a study to determine young people's awareness and perceptions of available SRH services, as well as their service use and experiences.

Many Ethiopian women marry at a young age and become sexually active soon after. Though child marriage is declining in Ethiopia, it remains prevalent,

with two out of five (41%) women ages 20-24 married before the age of 18 (the legal age of marriage) (Central Statistical Agency and ICF International 2012). Negative outcomes associated with child marriage include maternal mortality, infant mortality and morbidity, risk of HIV infection, violence and exploitation, and isolation from friends (UNICEF 2008). Given their increased risk for negative health outcomes, it is crucial to meet the SRH and other health needs of this population. Yet few programs target married young women and girls, and little is known about their preferences for care. This brief focuses on married young women and girls' use, demand, and preferences for SRH services, and potential strategies for better meeting their SRH needs.

METHODS

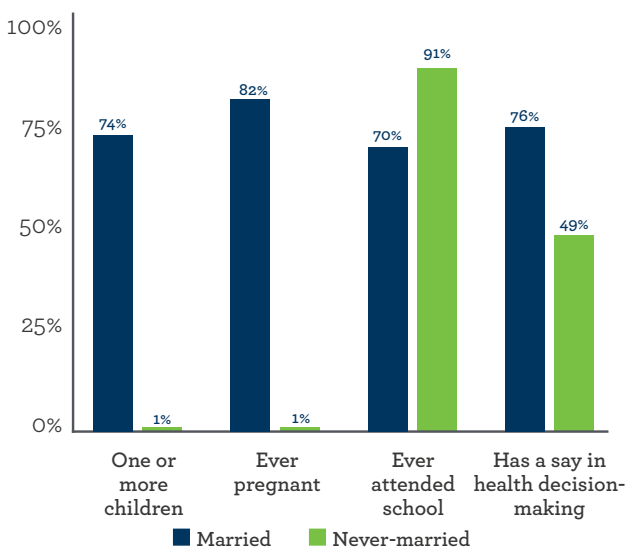
The Evidence Project/Population Council conducted a cross-sectional, quantitative study among young males and females, ages 12-24, in rural and peri-urban areas of Amhara, Oromia, Tigray, Benishangul-Gumuz, and Southern Nations, Nationalities, and Peoples' Region (SNNPR) from January to July 2016 (Jain et al. 2017). The final sample size was 3,611 (1,823 females and 1,788 males).

RESULTS

BACKGROUND CHARACTERISTICS

The mean age of married young women and girls was 21.2 years, with five percent between the ages of 15-17, while the mean age of never-married respondents was 15.9. Sixty percent of married respondents reported being married before the age of 18, and the mean age at marriage was 17. When compared to never-married 15-24 year-olds (Figure 1), married young women and girls are much more likely to have one or more children (74%) and to report ever being pregnant (82%, currently or in the past). Married young women and girls are also less likely to have ever attended school (70%) compared to unmarried women and girls (91%). Among married young women and girls, 76% reported having sole or partial say in their health decision-making, compared to 48% of those who were never-married.

FIGURE 1. MARRIED AND NEVER-MARRIED YOUNG WOMEN AND GIRLS CHARACTERISTICS



SERVICE USE

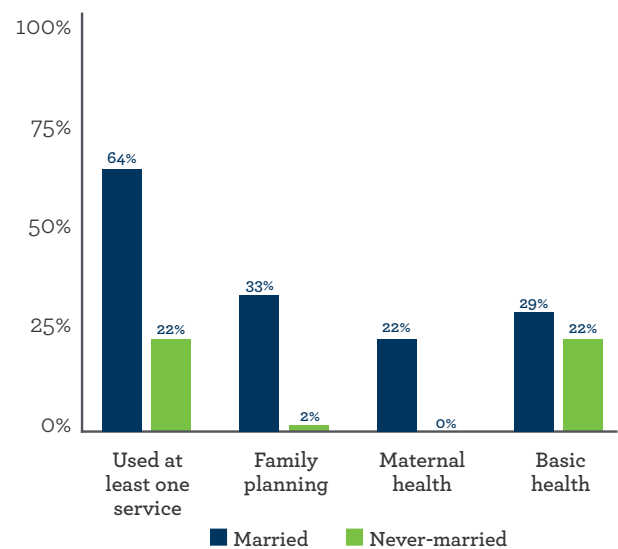
In the six months preceding the survey, approximately two-thirds (64%) of married young women and girls had used family planning, maternal, and/or basic health services (Figure 2, multiple responses were possible). One-third of married respondents (33%) had used family planning services; of those, most (58%) had gone for method re-supply, though about one in four (27%) were first-time contraceptive users. Twenty-two percent of married respondents had used maternal health services; of those, most had sought prenatal care (62%), followed by labor and delivery (19%), and postnatal care (15%). General health services were used by 29% of married young women and girls, for a variety of basic health concerns.

As seen in Figure 2, compared to never-married 15-24 year-olds, married young women and girls are much more likely to use family planning and maternal health services. Thus, the remainder of this brief describes preferences of married young women and girls, ages 15-24 (n=516), since they are the ones who are accessing health services.

FAMILY PLANNING

Demand, current use, and intention to use in the future: Among married respondents, 32% had an unmet need for family planning. This means that 32% of married young women and girls want to stop

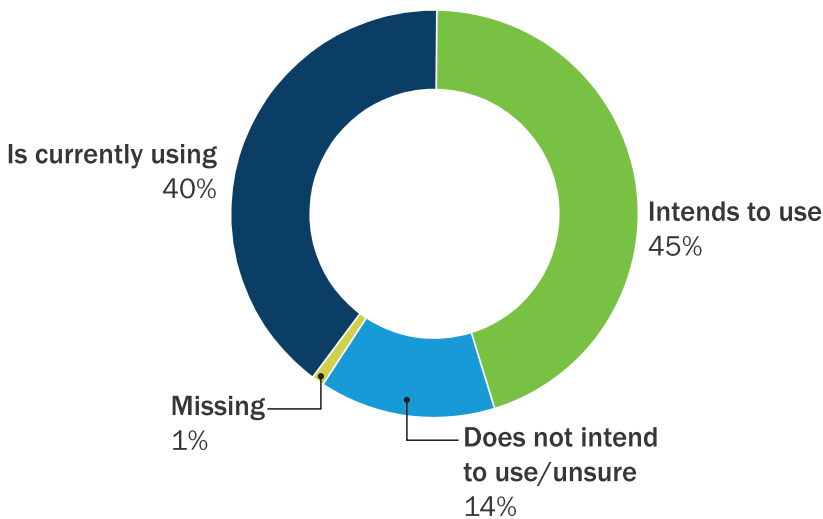
FIGURE 2. PERCENT OF MARRIED AND NEVER-MARRIED YOUNG WOMEN AND GIRLS WHO USED HEALTH SERVICE IN THE 6 MONTHS PRECEDING THE SURVEY



or delay childbearing by at least two years but are not using any form of contraception. As most (95%) of the respondents want children in the future, this unmet need represents a demand for reversible contraception.

Overall, 40% of respondents were using a form of contraception (Figure 3). Injectables were the most commonly used method (66% of users), followed by implants (22%) and the pill (8%). An additional 45% of respondents were not using contraception but reported an intention to use a method in the future. The number of married young women and girls who are currently using or intend to use contraception in the future, taken with the substantial proportion with an unmet need for FP, emphasizes that ensuring accessible and available FP services for married young women and girls is paramount.

FIGURE 3. CURRENT USE AND FUTURE INTENTION TO USE CONTRACEPTIVE METHODS AMONG MARRIED YOUNG WOMEN AND GIRLS



Preferences: When asked where they would prefer to get FP services, almost two-thirds of married young women and girls named health centers as their top preference (64%), followed by health posts (21%). Respondents listed the facility's proximity to their home, school, or work (55%), low-cost or free services (34%), and friendly staff (22%) as reasons for their preference. These responses indicate the importance of accounting for geographic, economic, and social accessibility when designing programs and



interventions to increase access to and subsequent use of FP services in this population.

Respondents reported on the types of provider they would like to see for FP services (with multiple responses possible, see **Figure 4**). The majority of respondents (86%) would like to see a physician, nurse, or midwife in a health facility. More than one in four (28%) would like to have a HEW visit them in their home, and a small proportion (5%) listed a pharmacist.

Respondents were also asked about their preferences regarding the age and sex of FP providers (**Figure 5**). It was important to them to have a female provider: three out of four (74%) said they would prefer providers who were close to their age and the same sex, while three out of five (61%) would prefer providers who were older and the same sex (multiple responses were possible).

Overall, reported preferences for FP facilities and providers suggest that married young women and girls are looking for convenient and affordable care from female providers of any age. As recommended by Family Planning High Impact Practices (HIP), expanding the role that HEWs, a primarily female workforce, play in offering services to married young women and girls is a strategy that may effectively and efficiently meet

their needs (HIP 2015). Task-shifting FP to pharmacists and drug owners, a promising intervention according to HIP, may also be a mechanism to improve access among those who need services (HIP 2013).

Perceptions: Lastly, respondents who had ever used a contraceptive method (66%) were asked about their perceptions of FP services and providers. Results were largely positive, but also point to areas where current services can be improved. Nearly all (96%) respondents agreed with the statement “the time in the day that contraceptive and family planning services are available is convenient to me,” indicating that hours of operation are not a major barrier for these women and girls. Thirteen percent of respondents agreed or strongly agreed with the statement “contraceptive and family planning service providers are unfriendly.” It is promising that this number is so low, given the importance respondents assigned to friendly staff. Finally, 82% of respondents agreed with the statement “available contraceptive and family planning services are affordable for me.” As low-cost or free services were an important factor in facility preference for one-third of respondents, affordability should continue to be ensured and prioritized by FP programs and providers.

FIGURE 4. PROVIDER TYPE PREFERENCES FOR FAMILY PLANNING SERVICES, REPORTED BY MARRIED YOUNG WOMEN AND GIRLS

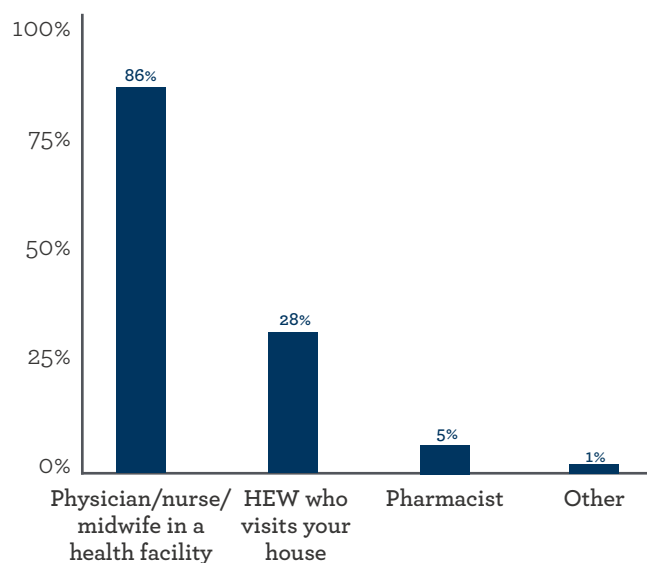
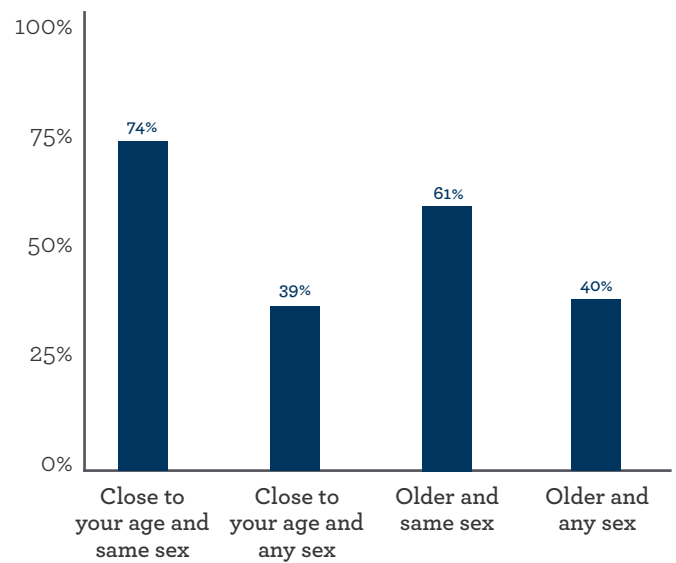


FIGURE 5. AGE AND SEX PREFERENCES FOR FAMILY PLANNING PROVIDERS, REPORTED BY MARRIED YOUNG WOMEN AND GIRLS



* The term “doctor” is often used by this population to refer to any medical professional, which may have resulted in some overreporting of the number of births attended by a doctor.

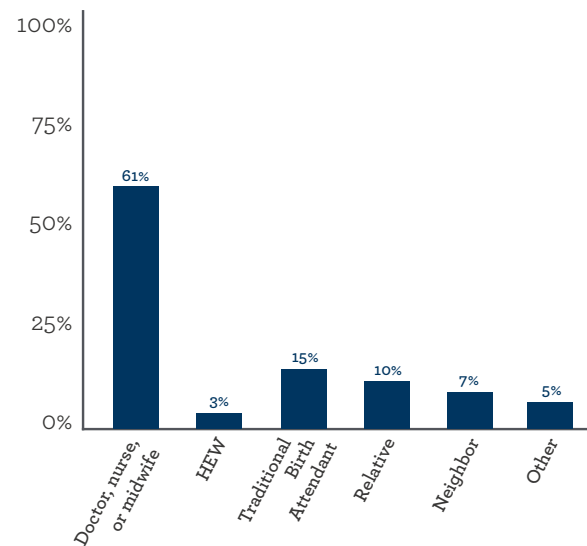


MATERNAL HEALTH

Among respondents with children (74%), most had delivered their youngest child in a health facility (66%), though about one-third (34%) had delivered at home. Over half (61%) reported being attended to by a doctor, nurse, or midwife at their last birth, while 3% were attended to by a health extension worker (HEW), and 15% were attended to by a traditional birth attendant (Figure 6).^{*} More than one in five (21%) had their youngest child delivered by a relative, neighbor, or other person, including a small number who delivered alone.

The considerable proportions of respondents who delivered their last child at home and who delivered without a health care professional highlight a gap in maternity care and services for these young women and girls. This is particularly concerning, given that almost three-quarters (72%) of the mothers in our sample gave birth at or before age 19, placing them at increased risk of maternal mortality compared to those who give birth in their 20s (Nove et al. 2014).

FIGURE 6. TYPE OF BIRTH ATTENDANT PRESENT DURING DELIVERY, REPORTED BY MARRIED YOUNG WOMEN AND GIRLS WITH CHILDREN



CONCLUSIONS

This brief highlights both successes and gaps in the provision of SRH services to married young women and girls in Ethiopia. Reported health-seeking behaviors of the respondents were largely promising. Most married young women and girls had some contact with the health care system in the last six months, visiting a facility for family planning, maternal, or basic health services. The majority of those who had ever given birth delivered their youngest child in a health facility and in the presence of a skilled birth attendant. Forty percent of respondents were using contraception, and an additional 45% intended to use in the future. Most married young women and girls who had used contraception found FP providers friendly and services convenient.

However, gaps in care were identified as well. One-third of those who had given birth delivered their youngest

child at home. One-third of the total sample had an unmet need for contraception. One-fifth of those who had ever used contraception reported that services were unaffordable.

The following recommendations provide solutions to help close service gaps, while meeting the reported preferences and needs of married young women and girls.

RECOMMENDATIONS

Target SRH services to married young women and girls at health facilities: Married young women and girls in this study population are largely sexually active, and the vast majority have already experienced a pregnancy. When compared to unmarried girls, married young women and girls are more likely to have used FP, and the majority indicated that they would like to receive FP services from facility-based service



providers. A focus on “youth-friendly services” may miss this population, since young women and girls – regardless of age – are no longer viewed as youth after marriage and may avoid services labeled as such. Therefore, specific SRH services should be designed that meet the needs of married young women and girls, outside the umbrella of “youth friendly services.”

Explore the potential for expanding maternal health and FP access and use through HEWs:

- **Continue to expand the reach of HEWs in family planning counseling, provision, and referrals for married girls and young women:** HEWs are widespread in Ethiopia, and a substantial proportion of respondents were open to seeing HEWs for FP. Since most married young women and girls preferred female providers and services that are low-cost and located nearby, HEWs – who provide services in clients’ homes and are usually women – are well-positioned to expand access to FP services for this young married population.
- **Continue to train HEWs in the provision of injectables and implants:** The most popular methods among contraceptive users in this group were the injectable and the implant. The World Health Organization has recommended that HEWs, with appropriate training and monitoring and evaluation, can administer injectables, (WHO, USAID and FHI 2009 and WHO 2012) and

a pilot study in Ethiopia subsequently confirmed the feasibility of this provision (Prata et al. 2011). HEWs began inserting implants in 2009 (though removals are done at health centers) and use of implants has risen dramatically (USAID Africa Bureau 2012).

- **Ensure HEWs are trained in maternal and child health and antenatal care and delivery:** WHO has recommended that HEWs support a variety of interventions for pregnant women, administer misoprostol to prevent postpartum hemorrhage, and provide continuous support during labor in the presence of a skilled birth attendant (WHO 2012). Given the proportion of deliveries at home and without the presence of skilled care, HEWs could help to improve care during the antenatal period and delivery.

Promote and provide referrals for facility-based delivery: Health care providers, including HEWs, who interact with married young women and girls should counsel them and their families about the importance of delivering in health facilities, and offer referrals to health centers.

Counsel young women and girls who have recently given birth on post-partum family planning: There is a high unmet need for FP among this population, especially for birth spacing. Delivery – whether at a health facility or with a HEW or skilled birth attendant – presents a key window of opportunity for counseling and providing post-partum FP.

REFERENCES

- Central Statistical Agency. 2014. 2014 Ethiopia Mini Demographic and Health Survey. Addis Ababa, Ethiopia.
- Central Statistical Agency [Ethiopia] and ICF International. 2012. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA.
- High-Impact Practices in Family Planning (HIP). 2013. Drug Shops and Pharmacies: Sources for family planning commodities and information. USAID. Washington, DC. Available from <http://www.fphighimpactpractices.org/briefs/drug-shops-and-pharmacies>
- High-Impact Practices in Family Planning (HIP). 2015. Community health workers: bringing family planning services to where people live and work. USAID. Washington, DC. Available from: <http://www.fphighimpactpractices.org/briefs/community-health-workers/>
- Jain, A., Ismail, H., Tobey, E., and Erulkar, A. 2017. "Understanding Adolescent and Youth Sexual and Reproductive Health-seeking Behaviors in Ethiopia: Implications for Youth Friendly Service Programming," Research Report. Washington, DC: Population Council, The Evidence Project.
- Nove, A., Matthews, Z., Neal, S., & Camacho, A. V. 2014. Maternal mortality in adolescents compared with women of other ages: Evidence from 144 countries. *The Lancet Global Health*, 2(3), 155–164.
- Prata, N., Gessesew, A., Cartwright, A. and Fraser, A. 2011. Provision of injectable contraceptives in Ethiopia through community-based reproductive health agents. *Bulletin of the World Health Organization*, 89(8), pp.556-564.
- United Nations Children's Fund. 2008. *The State of the World's Children 2009: Maternal and Newborn Health*. New York.
- USAID/Africa Bureau, USAID/Population and Reproductive Health, Ethiopia Federal Ministry of Health, Malawi Ministry of Health, Rwanda Ministry of Health. 2012. *Three Successful Sub-Saharan Africa Family Planning Programs: Lessons for Meeting the MDGs*. Washington, DC.
- World Health Organization. 2012. *WHO recommendations: Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting*. OptimizeMNH. Geneva.
- World Health Organization, U.S. Agency for International Development, Family Health International (FHI). 2009. *Community-Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives: Conclusions from a Technical Consultation*. Research Triangle Park, North Carolina, USA.

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The Evidence Project uses implementation science—the strategic generation, translation, and use of evidence—to strengthen and scale up family planning and reproductive health programs to reduce unintended pregnancies worldwide. The Evidence Project is led by the Population Council in partnership with INDEPTH Network, International Planned Parenthood Federation, PATH, Population Reference Bureau, and a University Research Network.

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