

OCTOBER 2018

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FERTILITY INTENTIONS: GETTING THE RIGHT INSIGHTS BY ASKING THE RIGHT QUESTIONS

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Women worldwide wish to avoid or delay pregnancy.

Strategies for identifying and retaining contraceptive users to reduce unintended pregnancies must engage both women and men.

Fertility intentions vary by age, sex, and other factors and can change fluidly over the life course.

Additional enhanced and interactive information accompanies this brief and is available online at:

thepaceproject.org/fertility-intentions/

Over the last 50 years, family planning (FP) has created opportunities for women and girls to increase schooling, labor force participation, occupational choice, and wages, so they can build better lives for themselves and their families. For these reasons, FP has often been called the key to sustainable development.¹

In 1965, less than 10 percent of women in the developing world (excluding China) were using a modern contraceptive method, and the average family had more than six children. Today, in the 31 countries where the United States Agency for International Development (USAID) focuses its support, modern contraceptive prevalence has increased to 30 percent, and average family size has dropped to 4.4 children. Almost 885 million women worldwide wish to avoid or delay pregnancy, and about three-quarters are currently using a modern contraceptive method. Yet, more than 214 million women still have an unmet need for FP—they want to limit or space their pregnancies but are not using modern contraceptives.²

Measuring and understanding women's and men's fertility intentions—ideal family size and desire for additional children—are key to addressing

unmet need and expanding access to voluntary FP for all women and couples. Data on fertility intentions, however, are only a starting point. To better address women's and men's needs and preferences, policymakers and program planners also need to understand ambivalence about future fertility intentions and possibly divergent fertility preferences within a couple. These differences could encompass women's and men's knowledge of, attitudes toward, or fears about modern contraceptive methods. Understanding these dynamics will support sustained contraceptive use during critical periods when women and men need it.

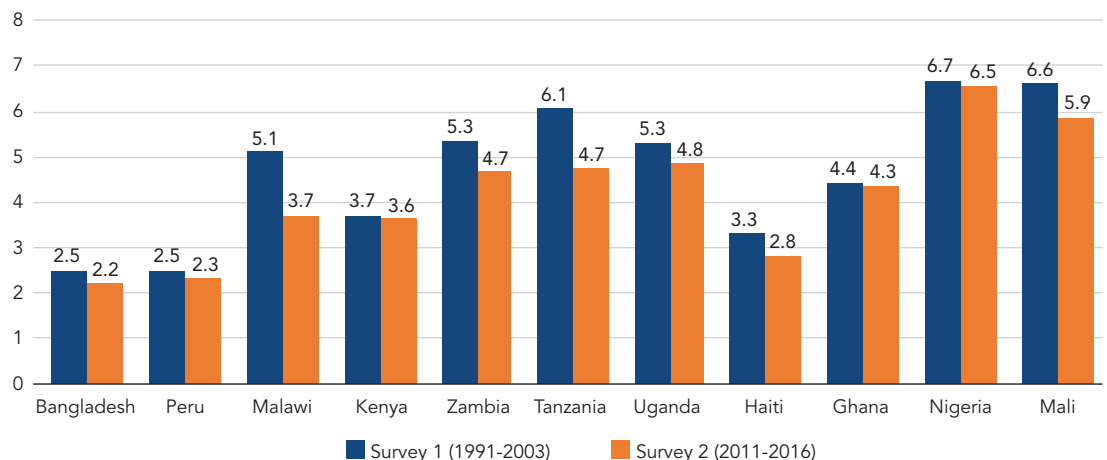
Sound Data Are the Building Blocks of Good Policy and Program Design

More data are now available to track fertility preferences and contraceptive use, including the standard Demographic and Health Surveys (DHS) quantitative and qualitative data sources.³ DHS data provide insights into changes in fertility intentions over

FIGURE 1

Ideal Family Size Has Decreased Over Time

Mean Ideal Number of Children Among All Women



Note: Data for Bangladesh in all figures refer to ever-married women.

Source: Demographic and Health Surveys, various years.

time, both in the total number of children that women and men say is ideal and whether they would like to have another child soon or in the future. To collect data on fertility preferences, DHS asks women a series of questions about their ideal number of children, their desire to have another child, and the length of time they prefer to wait before having another child.

Comparing these data across surveys demonstrates how fertility preferences have changed. Figure 1, page 1, shows data from 11 countries, ranked by contraceptive prevalence rate (CPR) among all women (with the exception of Bangladesh), comparing women's ideal family size from the earliest to the most recent DHS. The data show that average ideal family size has declined in all countries, with notable variations in the size of the decline. African countries still have relatively high fertility, yet the majority of women say they want another child soon or in the future, signaling ongoing potential for rapid population growth in sub-Saharan Africa. Nigeria is a special case. Since its ideal family size has declined very little and it has a low CPR, Nigeria can expect its population to grow rapidly, from an estimated 196 million in mid-2018 to 411 million by 2050.⁴ Policymakers and planners can use such data to project future fertility trends and population growth.

DATA MAY BE ACCURATE BUT INSUFFICIENT TO GET THE FULL PICTURE

For a number of reasons, data on preferences for additional children and ideal family size do not provide a complete picture of fertility trends and population growth. Fertility intentions can be fluid and change over time. The main DHS question to measure ideal family size asks interviewees to respond hypothetically, starting when they were just entering their childbearing years. Such a snapshot does not account for changes over time: The ideal number of children is usually higher among older age groups, perhaps partly because couples may have already had multiple children and may not feel it is appropriate to report an ideal number lower than the number of children they already have. Age, parity, sex composition of children, and having had a child who died all factor in when responding to this question. Family size norms or economic conditions may also change over time.

Ambivalent fertility intentions that change over the life course also challenge current measurement methods. A study of three sub-Saharan African countries found that at least 25 percent of women who desire to delay or limit childbearing express ambivalence about having children in the future.⁵ Understanding this ambivalence and how it changes over time could shed light on contraceptive use, particularly if it contributes to women discontinuing their contraceptive method of choice or using it inconsistently, both of which contribute to unintended pregnancies.

Another problem is how DHS respondents are asked about current contraceptive use. The questions are suitable for measuring women's ongoing use of contraceptive methods, such as the pill, injectables, implants, and intrauterine devices (IUDs). However, they are less effective at measuring contraceptive use among women who rely on ad hoc methods or for capturing multiple concurrent methods, since certain methods used ad hoc, like emergency contraception, are not always considered

by respondents as "current use".⁶ Information about ad hoc and multiple method use can inform program design.

Additionally, survey data may not capture couple dynamics that can hinder women's ability to achieve her preferences. Women accede to the social norms that play a significant role in shaping fertility preferences and childbearing.⁷ For example, a newly married woman may feel pressure from her in-laws to prove her fertility; she may also face social sanctions that inhibit delaying pregnancy. Qualitative research can help clarify who influences a person's fertility preferences and behavior—in-laws, religious leaders, partners, or social media—and how much.⁸

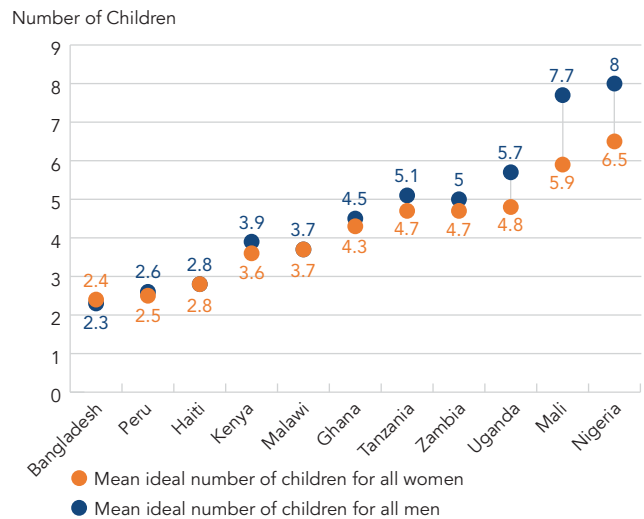
Covert use of contraception is another measurement challenge. Survey respondents may not want to report using FP without their partner's knowledge. Without strong couple communications, a man might not be aware that his partner desires or is using contraception or what method. Age and education gaps can worsen a power imbalance between husband and wife, making it harder for a woman to articulate and act on her fertility preferences. Research on the reasons for, and extent and consequences of, covert contraceptive use would contribute to better programming.

A Focus on Men and Couples Adds Important Information

Much of the analysis of fertility intentions focuses on women. Yet, without taking men's preferences and couple dynamics into account, FP programming may not be as effective as it could be. Figure 2 illustrates a key point: In many countries, men's ideal family size is larger than women's. In African countries with a relatively high CPR, such as Ghana and Kenya, the gap is

FIGURE 2

Women's and Men's Views on Ideal Family Size Differ



Note: The survey represented is the most recent survey for which data exists for both men and women. The data are only available in earlier surveys for Bangladesh (2004) and Peru (1996)

Source: Demographic and Health Surveys, various years.

narrow. In other countries, like Mali and Nigeria, men express preferences for family size more than one child larger than women. This stronger preference for larger families could be a result of polygamy—prevalent in both countries—or simply a reflection of divergent views on ideal family size.⁹ Data on how women and men view family formation can inform programs to increase demand for FP and services tailored to people’s needs. Research on reasons for non-use of FP among women with unmet need indicates that opposition by partners or others is a challenge, along with more commonly cited reasons: fear of side effects, infrequent sex, and amenorrhea or breastfeeding.¹⁰

Family Planning 2020 (FP2020, a global partnership that supports efforts to enable 120 million more women and girls to use contraceptives by 2020) recently assessed the percentage of women who made their own decision on FP use versus with their husbands/partners. A substantial majority of respondents say the decision was joint, but the data may still obscure the dynamics of the decisionmaking process.¹¹ Decisionmaking in couples is often not equitable: Men exert powerful influences on their partners’ pregnancy and FP intentions. In some contexts, women may not be able to make FP decisions or access FP services without their male partners’ approval or financial support. In addition, providers may not be aware of a couple’s interest in joint decisionmaking. This power imbalance can lead to women using methods that are not the best match for them, increasing the likelihood that they will discontinue use and not achieve their fertility preferences.

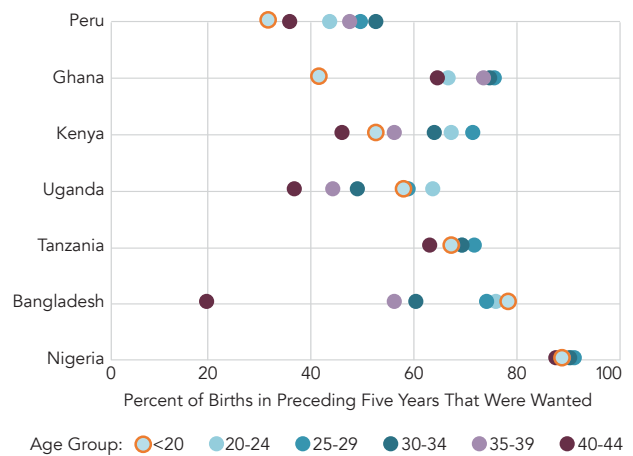
Another challenge is that women and men may not have the same attitudes toward contraceptive use, either overall or related to specific methods. They also may not have the skills to discuss and resolve their differences. A 2014 study in Zambia highlighted that, over time, whether a woman uses contraception covertly or whether the couple decides together may influence psychological and reproductive health (RH) within couples.¹² Some studies show that men know less about the mechanisms of contraceptive methods and may fear the health impacts on their wives.¹³ FP2020 emphasizes use of modern contraceptive methods, but evidence shows that less-effective methods that rely on male involvement can also enhance couple communication and effective fertility regulation if men see themselves as active agents in FP. Male-focused methods—such as condoms, withdrawal, and vasectomy—account for a full one-quarter of global contraceptive use, illustrating why men cannot be ignored.¹⁴

Young People’s Intentions and Needs Are Critical

Young people’s fertility intentions contribute to future population growth. In 2018, the global youth population ages 15 to 29 was nearly 1.8 billion. By 2050, that number is estimated to surpass 2 billion.¹⁵ In sub-Saharan Africa, the rise is far more dramatic: The number will more than double from nearly 290 million in 2018 to more than 580 million by 2050. Understanding and monitoring the fertility intentions of youth, and enhancing their options for achieving their fertility intentions, are crucial for supporting RH goals.

FIGURE 3

Younger Women in Certain Countries Are Less Likely to Report Recent Births as Wanted



Source: Demographic and Health Surveys, various years.

Figure 3 shows that in some countries, like Ghana and Peru, young women under age 20 are less likely than older women to say their births in the previous five years and current pregnancies were wanted. Yet, in countries such as Tanzania and Nigeria, young women do not differ much from older women. Across countries, however, younger women express a smaller ideal family size than older women. These trends were true in 1995 and even more so in 2011.¹⁶ Policymakers and program planners need to work with young people to identify ways to reduce the high percentage of unwanted and mistimed births so that young women can achieve their desired family size.

DHS data also highlight that, like older women and men, young women and men do not necessarily have the same views on ideal family size. Young men often report a higher ideal number of children than young women. In most countries, however, women and men younger than 30 are closer to agreement on ideal family size than in older age groups. For example, in Uganda, the lowest difference in ideal number of children between women and men occurs in the youngest (15 to 19) age group. Thus, adolescence and young adulthood may be an opportune time to emphasize couple communication when addressing fertility intentions. While in some countries, such as Bangladesh, men report a lower ideal number of children compared to women, younger age groups still have the smallest differences between women and men.

Compelling Actions Can Clarify and Support Fertility Intentions

Start with data. DHS and other surveys provide solid data to support country-level decisionmaking, but it is not sufficient for understanding ideal family size and future fertility intentions. Additional questions on reasons behind women’s and men’s

fertility intentions would provide needed insights. More qualitative research is also needed to understand the social norms that drive fertility preferences. Recognizing changing fertility preferences and women's (and men's) ambivalence toward future pregnancies may be critical to developing appropriate strategies for identifying and retaining contraceptive users with the overall goal of reducing unintended pregnancies. Such insights will support the development of more effective FP and community outreach programs.

Reach couples and men. Resources need to be invested to improve couple communications. Without addressing men's knowledge of RH, and their own health and preferences, other investments may be less effective.

Conduct more rigorous impact evaluation of programs targeting gender disparities in fertility intentions. Policymakers in FP/RH care should focus on interventions and program efforts targeting power imbalances in the household and disparities in fertility intentions between women and men.¹⁷ More research needs to assess which interventions work and why. In most cases, an impact evaluation would fill this gap. When programs are rigorously evaluated, program staff can refine their interventions to better target gender inequity and couple communications.

Support young people's changing fertility norms. In many countries, young people want smaller families than their parents. To support this trend, providers can listen to young people's concerns and provide correct information about and easy access to the full range of FP methods. RH policies may limit youth access to RH care, and social norms may affect the initiation of effective contraceptive use. Services must be accessible, and young women and men must be motivated to visit facilities. More research is needed to deepen understanding of how effective programs can help young people think about and achieve their visions for family size. Health ministries and nongovernmental organizations need to ensure that providers and clinic staff adopt gender-equitable, as well as age- and developmentally appropriate, clinic guidelines that ensure confidentiality for youth seeking services.

Acknowledgments

This brief was written by Nancy Yinger, consultant, and Charlotte Greenbaum, policy analyst, at Population Reference Bureau (PRB). At PRB, Charlotte Feldman-Jacobs, associate vice president for International Programs; Heidi Worley, editorial director; Nancy Matuszak, editor; and Barbara Seligman, vice president for International Programs, provided valuable technical and editorial guidance and support. Special thanks to Shelley Snyder and Apoorva Jadhav, of the United States Agency for International Development (USAID), for their time and comments to improve the brief. This publication is made possible by the generous support of USAID under cooperative agreement AID-AA-A-16-00002. The information provided in this document is the responsibility of PRB, is not official U.S. government information, and does not necessarily reflect the views or positions of USAID or the U.S. Government.

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