Marital and Non-marital Contraception in Sub-Saharan Africa: Patterns, Trends and Determinants*

A Draft Conference Paper

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* Views and opinions expressed in this document are the author's. They do not necessarily represent the views and opinions of the US Agency for International Development.

Introduction

The conventional measure of the level of contraceptive use among women is the prevalence among women who are currently married or in union. Thus, much of what we know about patterns and trends in the use of family planning methods is tinted by contraceptive practices of married women. The choice is often because there are practical and programmatic benefits to focusing on women in union: marriage is perhaps the most important indicator of exposure to the risk of conception; the largest proportion of childbearing occurs in marital unions; in many settings, particularly in sub-Saharan Africa, marriage is almost universal; and these marriages tend to mark the beginning of childbearing. Moreover, in the early days of family planning program in Africa, some countries restricted services to only married couples, and in a few national surveys, women who have never been married were ineligible to answer survey questions on family planning and reproductive health. Under such circumstances, for comparability reasons, it was probably easier to limit the calculation of contraceptive prevalence rate to women in unions.

However, in recently years, and particularly after the 1994 Cairo Conference on Population and Development, there have been significant changes in family planning coverage and access. A significant proportion of women who are not in marital unions now have access to family planning services and only a small number of countries – mainly outside of sub-Saharan Africa – still limit population surveys to ever-married women only. Despite these changes, the most commonly used indicator of family planning adoption is still the prevalence among women in union. Thus, not many studies exist on the contraceptive behavior of women who, though single, are in stable heterosexual relationships. This paper aims to fill that gap by contributing to our understanding of the contraceptive behavior of women who are single but are sexaully active.

The main research questions that this analysis seeks to answer include the following: what is the prevalence of modern contraceptive use among single but sexually active women of reproductive age in Africa? How does this compare to the prevalence among women in unions? Is the prevalence increasing over time,

and why or why not? Is the method choice among SSAW different from that among women in union?

This paper hypothesizes that the prevalence of modern contraceptive use will be higher among single but sexually active women (SSAW) than among married women. This is because the motivation to prevent a mistimed or unwanted pregnancy may be higher among women who are not in unions: the opportunity cost of an unwanted or mistimed pregnancy may be higher for women who are single; and there could be high stigma attached to non-marital pregnancies and births. Besides, women who are highly educated and urban tend to marry at older ages and hence have longer exposure to the risk of conception, but they also tend have higher contraceptive prevalence rates. Moreover, the effort to prevent heterosexual HIV transmission has meant easier access to condoms, and condom use tends to be more common among women who are single. Hence, I expect increased trends in the use of modern contraceptives among women who are single but sexually active.

In many African countries, the age at marriage is rising, particularly among educated men and women. At the same time, there is increasing young age at widowhood in high HIV countries (Adetunji, 2001) and as many men die of HIV-related causes and in conflicts. Many women who are in stable relationships are also not able to marry and may be using contraception to avoid premarital pregnancies and births. In fact, some studies have found that the motivation to prevent an unwanted pregnancy is much stronger than the motivation to avoid STIs (Renne, 1996).

Data and Definitions

The analysis is based on data from the Demographic and Health Surveys (DHS). A total of 16 countries in sub-Saharan Africa that have participated 3 or more times in the DHS program are selected for the analysis. Six countries had only three surveys, seven had four and only three countries had five survey data points. Details about year of study and sample sizes are presented in Appendix Table A. For example, six countries had their first DHS in the 1980s (1986-89), 9

countries had their first survey in the period 1990-95. Similarly, 12 of the 16 countries had their latest survey in the past five years (2006-2010) and the remaining four had their surveys between 2003 and 2005).

The focus of the analysis is on contraceptive use among women of reproductive age (15-49) who are single but sexually active (SSA) at the time of survey. A woman is defined as single if she is not in a marital or consensual union. She is defined as sexually active if she had a sexual relationship at any time in the 30 days before the date of interview. Therefore, single but sexually active women include those who have never married, those who are divorced, and those who are widowed and separated who had sexual relations within 30 days to the day of interview. Contraceptive prevalence rates (CPR) can be calculated for all methods or for modern methods only. The CPR in this analysis refers to only modern methods, except otherwise specified.

Preliminary Findings

The prevalence rates for modern contraceptive use among single sexually active women in all 16 countries are presented in Table 1 and they show steep increases in modern CPR in most of these countries over time. The absolute percentage increase between the first and most recent surveys ranged from a low of about 30% in Niger Republic to as high as 10-folds in Madagascar. Between the first and most recent surveys, the prevalence of modern contraceptive use at least quadrupled in 5 countries, at least tripled in 7 countries and at least doubled in 11 countries. The most rapid increase in absolute terms was in Madagascar (with almost 10fold increase). In the most recent survey, the country with the lowest level of modern contraceptive use among single but sexually active women was Mali (22.2%), and the prevalence was highest in Namibia – where about 78% of SSAW used a modern method.

In Table 2, modern CPR among SSA woman is compared with that among currently married women. It shows that in almost every country, the prevalence of modern contraceptive use is higher among the single but sexually active women. Sometimes, the prevalence of modern contraceptive use among the

SSAW is 9-10 times the prevalence among married women. This is especially so in some low prevalence West African countries. For example, in Burkina Faso, modern CPR among SSAW quadrupled the rate among CMW in the first survey, and by the time of the most recent DHS, that ratio had increased to about 6:1 (55% vs. 9%). Similarly in Cameroon, the ratio was 2:1 in the first survey but increased to almost 4:1. The ratio was also wide in Senegal and Mali. In East and Southern African countries, the modern CPR gap among CMW and SSAW is generally narrower. Table 2 also shows that the rate of increase in the modern CPR among SSAW tends to be faster than CPR among CMW – thus creating what looks like a widening gap between the two groups. For example, in Uganda, CPR among CMW increased from 2.5% in 1989 to 17.9% in 2006 but increased from 7.4% to 46.9% among SSAW within the same period.

Table 3 shows the gap between contraceptive prevalence rates among SSAW and married women in the first and latest DHS in each country. The results indicate that the CPR gap is generally much wider in the latest DHS than they were in the first. On average in the first surveys, CPR among SSAW was 8.2% (range from -2.1% in Madagascar to 31% in Niger), but the average gap in the latest DHS is 20.3% (range from -3.7% in Malawi to 46.6% in Burkina Faso). This shows that the CPR gap between SSAW and married women widened over time. The rate by which they widened is shown in column 4. It indicates that the fastest rate of widening was in Burkina Faso (35%) and Cameroon (29%). The gap narrowed only in Malawi and Zimbabwe. Because the interval between the first and latest DHS differs from country to country (see coulumn 5), we calculated the average yearly rate at which the CPR gaps widened (column 6) and it shows that Burkina Faso (3.5%) and Cameroon (2.2%) still had the fastest annual rate of widening. There was no change over time in Kenya and the rates narrowed the fastest in Malawi.

What contraceptive methods are used by the SSAW in these countries? To answer the question, we obtained the proportion of their CPR that is accounted for by pills, injectables and condoms. The results are presented in Table 4. It shows that the most dominant method used by SSAW is the condom. The method accounts for more than half of the CPR among SSAW in 9 countries, and

is the most prevalence method (i.e., accounts for the largest share) in 13 countries. It accounts for 92% of the modern methods used by SSAW in the Cameroons. In Niger, the preferred method by SSAW was the pill (accounting for 62% of the CPR). No SSAW in Niger was using Depo-Provera. By contrast, in Madagascar, the preferred method was Depo Provera, accounting for 61% of the CPR.

Among married women, the pattern was as expected: pills and Depo-Provera dominated the method mix. Depo was the dominant method among currently married women in 10 of the countries while the pill was the dominant method in 5. The outlier country was the Cameroon where the preferred method among married women was condoms.