

National Study in Rwanda Family planning barriers

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INTRODUCTION

Over the last two decades, Rwanda has registered tremendous improvement in family planning (FP). The contraceptive prevalence rate (CPR) in the country has tripled from 17% in 2005 to 53% in 2014-15. However, the 2014-15 Rwanda demographic and health survey (RDHS) showed a slow increase in the use of modern FP methods compared to the previous five years (only around a 3% increase), and the unmet need for contraception remains unchanged at 19% compared to the previous five years. The drop-out rate of FP users is high for unknown reasons, and yet, over the years, many strategies have been put in place to speed up FP uptake in order to reap the “demographic dividend.”

Therefore, there is a need to generate evidence to inform new strategies to address the challenges affecting the FP program, including the identification of the barriers to FP uptake and exploration of the factors associated with the low increase in the modern CPR.

METHODS

A cross-sectional analytical design was used to identify the barriers to FP uptake among women aged 15–49 years in Rwanda. A sample size of 3,365 women was estimated, and a two-stage clustersampling technique was used, with 128 randomly selected clusters from six randomly selected districts (three with high CPRs and three with low CPRs).

At the household level, married or cohabiting women were interviewed using a structured questionnaire with questions about possible barriers to FP uptake. Focus group discussions were used to obtain insights from these women, their husbands/partners, community health workers (CHWs), and young adolescents about the FP barriers in those districts. Key informant interviews were conducted with other FP stakeholders such as health-service providers, district officials, development partners, and central-level officials, so as to have a global picture of the FP barriers in Rwanda.

Data were collected at the household level by trained staff from the School of Public Health, College of Medicine and Health Sciences, University of Rwanda, who used electronic tablets and field notetaking with voice recorders for qualitative data analysis. Quantitative data were cleaned and analyzed using Stata v13, whereas qualitative data were manually analyzed through the thematic analysis of content.

The frequencies of all variables were plotted, and bivariate analyses of key variables were performed across two categories of outcomes (FP discontinuation and FP uptake); finally, multivariate logistic regression was performed to identify the factors associated with FP discontinuation and uptake. Qualitative data were triangulated with the quantitative findings to capture a comprehensive snapshot of the FP situation in Rwanda and strengthen the evidence required for key actions to increase the CPR. The study was ethically approved by the institutional review board of the College of Medicine and Health Sciences, the Ministry of Health, the National Institute of Statistics, and the Ministry of Local Governance.

RESULTS

This study reached 3,459 married or cohabiting women against the estimated sample size of 3,365, yielding a response rate of 102.8%. The majority of these women were between 30 and 34 years of age, and 74.6% of them were living in rural areas. More than half (61.1%) had received at least primary-level education, more than three-fourths were covered by health insurance (78%), and almost half belonged to Ubudehe category 3 (49.7%).

The study found that 74.6% of the 2,889 women who had ever used FP methods had stopped using them at some point in their lives. Injectables were the most prevalent method that was last stopped (62.1%), followed by oral contraceptive pills

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(22.7%, n = 489); the distribution of the last-stopped method did not vary across different categories of sociodemographic characteristics.

Compared with Nyarugenge District, Rusizi (adjusted odds ratio [aOR] = 2.20, $p < 0.001$) and Bugesera Districts (aOR = 1.82, $p = 0.003$) were statistically associated with FP discontinuation. As the number of pregnancies increased, the likelihood of FP discontinuation also increased (women with 2 or 3 pregnancies: aOR = 4.91, $p < 0.001$ and women with 4 or 5 pregnancies: aOR = 5.67, $p < 0.001$, compared to women with 0 or 1 pregnancy: aOR = 5.98, $p < 0.001$).

Women who wanted more children in less than two years had an 88% increased chance of stopping FP when compared with women who did not want any more children.

Through focus group discussions and key informant interviews, other barriers to FP uptake were reported in addition to those identified through the multivariate analysis: side effects/health concerns related to FP methods (also descriptively stated by 45.2% of women who had ever stopped using FP), the need to have another child (also descriptively stated by 35.9% of women who had ever stopped using FP), FP method failure, geographical inaccessibility (i.e., a long distance between the user's residence and the nearest FP service-delivery point), the need to change the FP method used, rumors in the community about contraceptives, cultural beliefs such as considering many children a sign of wealth, religious beliefs, lack of communication among couples, lack of trained staff to offer long-acting reversible contraceptives (LARCs) and permanent methods of contraception, poor FP counselling, and the inability of CHWs to provide counselling and adequately manage of the side effects of FP methods.

The CPR for any FP method was 58%; this rate was low in Rusizi, Nyaruguru, and Bugesera Districts, and among women aged less than 25 years, those without health insurance, illiterate women, and Methodists, Baptists, and Pentecostals.

The most prevalent FP methods were injectables, implants, and oral contraceptive pills. Descriptive barriers to FP uptake were the same as those identified for FP discontinuation, and additionally included being pregnant at the time of the survey and a distance of more than 1.5 hours between the women's residence and the FP service-delivery point.

Focus group discussions and key informants also highlighted the lack of information on FP, lack of CHWs who can provide LARCs, and lack of confidentiality when consulting CHWs as factors impeding FP uptake.

Among the youth (15–24 years), FP uptake was more likely among women in Musanze District, those who wanted children in more than two years, and those who had more than one child. Refusal by service providers to offer the preferred method of contraception, lack of information about FP, and lack of parental support were reported by the youth as key barriers to the utilization of FP services.

An insufficient number of functional youthfriendly services and youth centers throughout the country, lack of parental support, and the cost of FP services were also reported as big hindrances towards the effective utilization of FP services by the youth.

In conclusion, the current speed of increase in the CPR is not promising if Rwanda is to achieve its FP-related targets and sustainable development goals. Efforts to increase the awareness of the population with regard to FP and to address the rumors regarding its side effects and complications as well as cultural beliefs are required to increase FP uptake and reduce FP discontinuation. Key strategies for increasing FP uptake are the community-based provision of FP services, approaching the leaders of the Methodist, Baptist, and Pentecostal churches to discuss their role in the utilization of FP services, using all opportunities for integrating other health services with messaging on FP, and increasing FP resources in Adolescent Sexual and Reproduction Health and Rights facilities.