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UNMET NEED AND DEMAND FOR SMALLER FAMILIES IN RWANDA

Unmet need is the percentage of women who do not want to become pregnant but are not using contraception.

45%

The percentage of married women in Rwanda using a modern method of contraception.

Couples who discuss family planning together are more likely to desire smaller families.

Rwanda faces development challenges that stem from several factors: low per capita income, the legacy of the social and political upheaval experienced in the 1990s, and high population density. Low contraceptive use and high rates of fertility among Rwandan women contribute to the country's population growth and high population density. These factors strain economic and natural resources and potentially contribute to ethnic tensions, such as those that fueled the country's 1994 genocide, during which up to 1 million Rwandans were murdered.¹ As recently as 2005, only one in 10 married women were using a modern method of contraception; and, at the country's highest fertility levels in 1983, Rwandan women could expect to have, on average, 8.5 children over a lifetime.²

Family planning programs have the potential to slow fertility and population growth. In Rwanda, contraceptive use has been on the rise in recent years, while fertility rates have been rapidly declining. Between 2005 and 2010, Rwanda experienced one of the fastest declines observed in the history of the Demographic and Health Surveys (DHS), at a rate of 25 percent.³ These changes may be attributed to the Rwandan government's leadership, renewed commitment to family planning, and its ambitious goals for fertility decline and contraceptive use, as outlined in the 2008 Economic Development Poverty Reduction Strategy (see table, page 2).

Rwanda's national population policies of the 2000s also promoted employment and education, especially for girls. Among young women, increases in education, along with improved living standards within households, contributed to the fertility decline during the late 2000s.⁴

Decentralizing the health care system and increasing the number of private health centers and hospitals, shifting service delivery closer to

the clients, and integrating family planning into all health services have helped support increases in contraceptive use.⁵ Government-implemented programs, such as performance-based financing, also motivate clinics to serve more clients, because additional funding is based on the number of clients. Despite this progress in 2010, only 45 percent of Rwandan married women were using modern methods of contraception, while nearly 20 percent of those who wanted to limit or space their births were not using contraception. These numbers suggest that more can be done to reach the family planning targets outlined in recent government policies.⁶

A paper published in 2009 by Dieudonné Muhoza Ndaruhuye and colleagues provides insight into factors associated with Rwandans' use of family planning and the country's population dynamics.⁷ Using data from the 2005 Rwanda DHS, the authors looked at four possible explanations for unmet need for contraception and demand for family planning services among reproductive-age women living with a partner: women's characteristics, their partner's characteristics, women's exposure to family planning information, and women's attitudes and their partner's perceived attitudes toward contraception.⁸ The following discussion summarizes the paper's findings.

Stimulating Demand for Limiting Family Size

Demand for limiting family size is driven by a number of economic, social, and cultural characteristics. On the individual level, these characteristics include ideal family size, current number of children, socioeconomic status, religion, and health of the woman. In the early 2000s, many health facilities in Rwanda had a religious affiliation, and 60 percent of them did not offer contraceptives. Half of the Rwandan

population was Catholic. Also shaping Rwanda's low demand for family planning in the 1990s was the country's extensive political, social, and economic upheaval. After losing so many family members in the genocide, many couples wanted to expand their families, desiring to "bring new life" both to their own homes and to the country.⁹

More recently, factors shaping the desire to limit family size include exposure to and attitudes toward family planning, as well as region of residence and partner's occupation. In 2005, women living in the country's North, West, and South provinces were significantly less likely to desire limiting their family size than women in Kigali and the East, likely reflecting the large population of displaced persons in these two regions of the country.¹⁰ Moreover, Rwandan women married to craftsmen or to men

with mid-level salaries desired smaller families than those married to men engaged in traditional agricultural activities.

Women who were not informed about family planning at a health facility were less likely to want a smaller family, and the odds of wanting a smaller family increased when women knew about a greater variety of family planning methods. When women reported that they had discussed family planning with their partner at least three times over a year, they were also more likely to report a desire for smaller family size. In Rwanda, many men continue to see a large family as a status symbol and to have misconceptions about the side effects of some contraceptives.¹¹ These male attitudes may influence women's attitudes or create barriers to women accessing modern contraceptives.

Rwanda's Population Policies

Year	Program/Policy	Description
1990	Formulation and adoption of National Population Policy	Family planning becomes a part of a broader national development policy; modern contraceptives provided throughout the country; integrates sectoral policies. Goal to halve the average number of births per woman from 8.6 to 4.0 and to reach 48% contraceptive use by 2000.
2000	Vision 2020	Poverty reduction and growth vision and strategy formulated by the Ministry of Finance and Economic Planning. Projections include lowering the population growth rate from 2.6% to 2.2% and reducing average number of births per woman from 6.5 to 4.5.
2002	Creation of Rwandan Parliamentarians' Network for Population and Development	To promote national policy on population and sustainable development.
2003	New National Population Policy for Sustainable Development of Rwanda	Integrated approach to addressing population growth by improving health and survival of children and women as incentives for smaller families; providing education and employment; and building an institutional structure that integrates gender, governance, health care, environment, and nutrition.
2005	Maternal Child Health Unit created by Ministry of Health	To respond to higher infant and maternal mortality rates and to low levels of contraceptive use.
2007	2008-2012 Economic Development Poverty Reduction Strategy (EDPRS)	Highlights the role of family planning in national development, making it a priority; sets targets for total fertility rate of 4.5 and contraceptive prevalence of 70% by 2012/13. Budget for family planning activities increases six-fold between 2004 and 2007, from US\$91,231 to US\$5,742,112.
2009	New National Population Policy	To reduce the levels of infant, child, and maternal mortality; to promote education, especially for girls; to promote long-term family planning methods and make access universal; and to focus on the needs of youth.

Sources: Dieudonné Ndaruhuye Muhoza, Pierre Claver Rutayisire, and Aline Umubyeyi, "Measuring the Success of Family Planning Initiatives in Rwanda: A Multivariate Decomposition Analysis," *DHS Working Papers* (Calverton, MD: ICF International, 2013); Ministry of Finance and Economic Planning, Government of Rwanda, *Rwanda Vision 2020*, accessed at www.gesci.org/assets/files/Rwanda_Vision_2020.pdf, on May 21, 2013; USAID Africa Bureau, *Three Successful Sub-Saharan Africa Family Planning Programs: Lessons for Meeting the MDGs* (Washington, DC: USAID, 2012); Liberata Kayitesi, "The Role of Communication in the Success of Family Planning in Rwanda," presented at the Practicum on Family Planning Communication and Advocacy Responses in Africa, Kampala, Uganda, 2009; and John F. May and Alex Kamurase, *Demographic Growth and Development Prospects in Rwanda: Implications for the World Bank* (Kigali, Rwanda: The World Bank, 2009).

Meeting the Need for Family Planning

In 2005, the vast majority of Rwandan women living with their partners approved of using family planning methods, and about one in four women wanted to stop having more children. But less than one-half of these women were using a modern contraceptive method, indicating a very high level of unmet need; in 2005, Rwanda had one of the world's highest levels of unmet need.¹²

Unmet need is a function of factors limiting access to a range of contraceptives (supply side issues such as price or availability), and factors that inhibit a desire to limit family size (demand issues such as lack of knowledge about family planning options and misperceptions about side effects).¹³ In Rwanda, women who have not been to a health facility or who were not informed about contraceptive methods during their visit to a health facility have a higher unmet need for family planning. This finding underscores the need to ensure access to health facilities and to information about family planning and the range of methods available.

In Rwanda, unmet need is highest among women with fewer than three years of education (69 percent) and lowest among women with 10 years or more of education (27 percent). This finding is consistent with other studies suggesting that development efforts aimed at increasing education might lead to greater access to or more effective use of contraceptives.¹⁴ Ndaruhuye and colleagues' findings suggest, however, that the relationship between unmet need and education may be driven by attitudes toward family planning and spousal communication. More years of schooling could mean fewer misconceptions about the side effects of contraceptives and could increase the frequency or quality of a couple's communication.

Women who believed their partner desired more children than they did, or who did not know their partner's preferences, were also significantly more likely to have an unmet need for contraception than women who believed their partner's desire was equivalent to their own. Further, women who had discussed family planning with their partner fewer than three times over the previous year had a higher unmet need for family planning than those women who had more discussions with their partners.

Policy Implications

Low demand for limiting family size and high unmet need for family planning persist in Rwanda. Factors such as attitudes toward and perceptions of family planning

significantly affect both demand for limiting family size and unmet need for family planning. Increasing access to and availability of contraception—a supply-side intervention—would only address part of the unmet need. Dispelling myths about side effects of contraceptives, assuaging concerns about men's status, and enhancing a couple's communication could also increase women's desire to limit family size and reduce unmet need.

High levels of unmet need among the least educated women in Rwanda suggest that family planning initiatives should include a focus on the least educated. The Rwandan government is committed to increasing women's education and empowerment, although increased use of family planning methods as a result of such investments are more likely to occur over the long term.

In addition to focusing investments on the least educated women in Rwanda, the government can also expand family planning services by making these services standard in all health centers and increasing community-based family planning services. The government has the opportunity to promote policies that provide full access to a range of services and methods, and ensure that all Rwandan men and women are fully informed about contraceptive availability and benefits. By providing a range of family planning methods to all women with unmet need, the government can increase contraceptive use in the immediate term, leading to better birth spacing and reduced fertility.

Interventions can also address negative attitudes toward family planning. Civil society, religious officials, public health workers, and advocates can set examples in how they speak about family planning and can encourage Rwandan couples to communicate more freely about their desired family size. These actions can also help dispel myths and reduce negative attitudes toward family planning.

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