INFORMED CHOICE FOR MODERN CONTRACEPTIVE USE: Evidence from 24 countries served by the UNFPA Supplies Programme

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I. Background

The 1994 International Conference on Population and Development (ICPD) was a landmark that put people's rights at the heart of development, and affirmed sexual and reproductive health as a human right. Family planning is included in the broader context of reproductive, sexual health, and reproductive rights by Chapter VII of the ICPD Programme of Action (POA), and one of the POA key action points on family planning is that "all countries should assess the extent of national unmet need for good-quality family-planning services…seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law.[1]" In 2000, leaders from 189 nations agreed on eight Millennium Development Goals, including the contraceptive prevalence rate (CPR) as one of the MDG indicators; in 2005 a further indicator, on unmet need for contraception, was included within MDG Target 5b (i.e. to achieve, by 2015, universal access to reproductive health).

Over the course of the past two decades since ICPD, the emerging global indicators have mainly focused on unmet need or use prevalence – both valuable indicators of whether or not women have the opportunity to access and use family planning, yet the ICPD emphasis on family planning quality has lagged behind.

The recently adopted Sustainable Development Goals (SDG) include access to sexual and reproductive health services, as well as the fulfillment of reproductive rights, among their Targets. Under Goal 3 (Ensure healthy lives and promote well-being for all at all ages), Target 3.7 states that by 2030, countries should "ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes". The emphasis of the precise target is again focused on ensuring that people have access to services, and opportunity to use them. At the same time, Transforming our World, the 2030 Agenda for Sustainable Development[2] that was approved this past September in New York, places the goals in a broader commitment to human rights principles, gender empowerment, and a transformation of infrastructure and public services that will empower people, enhance their opportunities and choices, and protect them from undue harm. In this light, the SDGs offer an opportunity to re-visit aspirations within the ICPD Programme of Action in 1994, for *quality* reproductive health services, which the POA defined as including provider counseling, and a choice of contraceptive methods.

Among the indicators currently proposed for the measurement of Target 3.7 is a robust indicator on the extent to which demand for family planning is fulfilled by access to modern methods. Defined as "the

[1] UNFPA. 2014. Programme of Action of the International Conference on Population Development, 20th Anniversary Edition.

[2] Available from https://sustainabledevelopment.un.org/post2015/transformingourworld. Accessed on September 24, 2015.

proportion of family planning demand satisfied by use of modern methods (mPDS)[3]", this offers to governments important insights into the reach of modern family planning, and where public demand can be addressed through better programming or supply chains. However, valuable as this indicator can be for programming, the indicator offers no insight into dimensions of quality care, such as the extent of counseling, or the choice of methods offered to clients, each previously identified as important to the quality of family planning (Bruce, 1990).[4]

This paper addresses that gap, by decomposing the modern contraceptive prevalence rate (mCPR) to identify users of modern contraception who received counseling on potential side effects of the method they are using, and counseling on alternate methods available. This analysis allows a further qualification of the mCPR indicators, by adding a quality of care component to the analysis of contraceptive use dynamics. The analysis included below provides a description of the quality of care variables (counseling on side effects and counseling on other methods available); its correlations with current contraceptive dynamics (mCPR); its differentials according to key family planning variables (method used and source of method) as well as social, demographic and economic characteristics (age, education, place of residence and household wealth); and the observed trends in progress towards a higher quality of family planning services, especially during the past 10 years.

The addition of this qualification and analysis will allow governments to review their performance not only in delivering modern methods of family planning, but in doing so in a manner consistent with the principles and values of the ICPD POA, and with the stated goals of the SDGs to "achieve universal health coverage and access to quality health care" in order to promote physical and mental health and well-being, and extend life expectancy for all. The last section of the paper identifies entry points on the way forward to maximize the effect of good quality family planning services when responding to the evolving needs of women and couples.

Studies examining the influence of quality in family planning services on the uptake and continuation of contraceptive use have found that overall satisfaction with the quality of services is a critical determinant of continued use of contraception and utilization of family planning services can be increased by emphasizing both structural and process quality of care (Williams et al. 2000; Mariko et al. 2003).[5][6] Women's informed contraceptive decisions can be enhanced if family planning providers play a

[3] mPDS represents the percentage that the modern contraceptive prevalence rate (mCPR) represents on the total demand for contraception (TD). TD is the sum of contraceptive prevalence rate (CPR) and the unmet need for contraception rate (UNR).

[4] Bruce J: Fundamental elements of the quality of care: a simple framework. Stud Fam Plann 1990, 21(2):61-91.

[5] Williams T, Schutt-Aine J, Cuca Y: Measuring Family Planning Service Quality through Client Exit Interviews. International Family Planning Perspectives 2000, 26(2):9.

[6] Mariko M: Quality of care and the demand for health services in Bamako, Mali: the specific roles of structural, process, and outcome components. Soc Sci Med 2003, 56(6):1183-1196.

more active role in contraceptive counselling (Kim et al. 1998).[7] A recent study on early discontinuation of Norplant indicated that family planning providers should properly counsel the couple before providing any contraceptive method, including informing about the method-related side effects and explore women's expectations of the method (Huda et al. 2014).[8]

UNFPA has been supporting voluntary family planning in 46 priority developing countries through UNFPA Supplies (formerly known as Global Programme to Enhance Reproductive Health Commodity Security)[9]. The UNFPA Supplies programme countries have high maternal death rates, low rates of contraceptive use, and a high unmet need for family planning. The fund is one of the largest providers of contraceptives, and is committed to ensuring a choice of methods and accurate information for all women and adolescent girls. For 24 of the priority countries with available data, this paper provides a review of whether women who accepted contraception were provided information on the potential side effects of the methods they were using, and whether women were informed about available methods. A trend analysis is provided for 12 countries with two data points available during the past 10 years.

II. Data and Methods

The analysis uses data from 24 countries participating in the global programme to enhance reproductive health commodity security (GPRHCS-UNFPA) with a recent Demographic and Health Survey (DHS)[10] (i.e. Benin, Bolivia, Burkina Faso, Burundi, Ethiopia, Gambia, Ghana, Honduras, Kenya, Liberia, Malawi, Mali, Mozambique, Nepal, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Uganda, United Republic of Tanzania, Yemen, Zambia, and Zimbabwe). Trend analysis of informed choice is also included for 12 countries with two DHS studies completed since 2007. The bulk of the analysis presents the evidence across these countries regarding the quality of family planning services[11]. The main indicators used are the percent of women currently using modern methods (mCPR), and two indicators for informed choice: the percentage of women who were informed about possible side effects when adopting the currently used method (female sterilization, implants, injections, IUD or pill), and the percentage of women who were informed about other methods available when adopting the current method. The analysis is descriptive and results are presented via tables and graphs. Estimates are generated using SPSS 16.0.

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[7] Kim, Y. M., Kols, A., & Mucheke, S. (1998). Informed choice and decision-making in family planning counseling in kenya. International Family Planning Perspectives,24(1), 4.

[8] Huda, F. A., Chowdhuri, S., & Sirajuddin, M. F. R. (2014). Importance of appropriate counselling in reducing early discontinuation of norplant in a northern district of bangladesh. Journal of Health, Population and Nutrition, 32(1), 142-8.

[9] UNFPA 2012. The Global Programme to Enhance Reproductive health Commodity Security. Annual Report. New York.

[10] For more information about the Demographic and Health Survey Program (DHS) use http://www.dhsprogram.com/

[11] Bruce, Judith. 1990. "Fundamental elements of the quality of care: A simple framework," Studies in Family Planning 21(2): 61–91. Six main areas identified: choice of methods, information given to clients, technical competence, interpersonal relations, mechanism to encourage continuity of care, and appropriate constellation of services

A. Measures of Contraceptive Use

Contraceptive use is defined in this study as the percentage of currently married or in union women (15-49) using contraception at the time of the survey (DHS or MICS)[12]. Modern methods include female sterilization (tubal ligation, laparectomy, voluntary surgical contraception for women), male sterilization (vasectomy, voluntary surgical contraception for men), contraceptive pill (oral contraceptives), intrauterine contraceptive device (IUD), injectables (Depo-Provera), implants (Norplant), female condom, male condom (prophylactic, rubber), diaphragm, contraceptive foam or jelly, lactational amenorrhea method (LAM) and other modern methods including the cervical cap or contraceptive sponge. Abortions and menstrual regulation are not considered modern contraceptive methods.

B. Informed Choice

The two indicators of informed choice and counseling have each been previously identified within the "Framework for Quality of Family Planning Services" (Bruce, 1990): 1) information about whether or not clients were counseled regarding potential side effects of the chosen method; and 2) whether or not clients were informed about other available methods of family planning.

Definitions of informed choice indicators in this study are consistent with the recently revised DHS definitions. The question on side effects took the general form: "When you first started using the current method, were you told about side effects or problems you might have with the method?" If the respondent indicated "No" to this question, a follow-up question on side effects is asked "Were you ever told by a health or family planning worker about side effects or problems you might have with the method". If women said "Yes" to either of these two questions, they were considered informed about side effects. Similarly, there are two questions on other methods in the DHS questionnaire: "When you first started using the current method, were you told about other methods of family planning that you could use", and "Were you ever told by a health or family planning worker about other methods of family planning that you could use". If women said "Yes" to either of these two questions, they were considered informed about other methods.

The analysis is confined to women currently using one of five modern methods (female sterilization, implants, injections, IUD, and pill); and who initiated use within the preceding five years of the survey. Analysis is confined to these five methods due to informed choices data are only collected among women who are using these five methods. Analysis is conducted for all women of reproductive age, as well as women who are currently married or in union. Data is presented for four main indicators referring to the percentage of women who were informed about: a) side effects; b) other available methods; c) both side effects and other available methods; and d) neither side effects nor other methods. The interpretation of these variables as indicators of "quality of care" in family planning, is

[12] For a more detailed information, please check www.dhsprogram.com and http://mics.unicef.org/

admittedly partial, as these offer only a limited snapshot of the seven elements of quality identified by Bruce (1990).

C. Analytic Approach

For each of the 24 UNFPA supplies countries, we present the proportion of women who were provided with information on the potential side effects of methods they were using, the proportion of women who were informed about other available methods, the proportion of women who were informed about both side effects and other methods, and the proportion of women who were informed about neither side effects nor other methods, regardless of marital status.

In addition to national estimates, weighted average levels of informed choice are also computed for UNFPA Supplies countries, and for two developing regions for which the available surveys represent at least 60 percent of all women of reproductive age. As indicated in Table 1, 24 surveys that were conducted between 2008 and 2014 cover 61 percent and 75 percent of the populations of women aged 15-49 in East and Southern Africa, and in West and Central Africa. We use the 2015 population size of women age 15-49 years in each country as the weights for calculating the regional average, and the weighted average for UNFPA Supplies countries. Population estimates are obtained from the World Population Prospects 2015 revision (UN 2015)[13].

Countries are classified according to their level of modern contraceptive use among currently married and in union women. We examine whether the level of women who were informed about the side effects is correlated with the overall national level of contraceptive use.

Levels of informed choice are also disaggregated by background characteristics of the respondents, including current contraceptive method, first source for the current method, age group, place of residence, highest education level of the women, and wealth index. Disparities across different characteristics are examined.

Table 1. Number of countries and percentage of women aged 15-49 sampled in selected surveys that include data regarding informed choices and contraceptive use, by region and for the 24 UNFPA Supplies countries, 2008-2014

Regions[a]	Number of countries represented by surveys	Percentage of women aged 15-49 represented by surveys
East and Southern Africa	10	61.4
West and Central Africa	10	75.0
Latin American and the Caribbean	2	2.9
Asia and Pacific (excluding China)	1	1.2
Arab States	1	7.7
UNFPA Supplies Countries	24	67.3

[a] Using UNFPA regional classifications.

[13] United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision. New York: United Nations.

Last, we select 12 UNFPA Supplies countries with two consecutive surveys including one DHS conducted during or after year 2006, and another DHS conducted during or after year 2011. Since UNFPA Supplies started in 2007, trend analysis in modern contraceptive use, informed choices, and modern contraceptive use with information on counseling for side effects and other available methods provided between the two surveys offers a measure of one of the five strategic priorities of the UNFPA Supplies thematic trust fund – i.e. Improved access to quality reproductive health and family planning services. The 2015 population size of women 15-49 year old who are married or in union in each country are used as the weights for calculating the weighted average for the 12 countries with trend data. Population estimates are obtained from the Estimates and Projections of the Number of Women Aged 15-49 Who Are Married or in a Union 2015 revision (UN 2015)[14].

III. Results

A. Estimates of Informed Choices for Countries, Regions, and UNFPA Supplies Countries

The informed choice that women experience at the time of initiating contraceptive methods presents substantial variation across countries. Fifty-two percent of women (15-49) in the 24 countries declared being informed about possible side effects from the method and the availability of other methods at the initiation of their current method. Informed choice appears to be higher in countries of West and Central Africa (57 percent) compared to those of the East and South of Africa (48 percent).

At the national level this average shows high variance, ranging from just 25% for Ethiopia in 2011 to a high value of almost 80% in Zambia in 2013-24 and Senegal in 2014 (Figure 1). Altogether, 8 of the 24 countries scored 60% or higher while another 7 scored below 50%. At the intersection of these values we find higher values for each informed choice when observed separately, meaning that a significant group of women benefit from one type of informed choice, but not both. This pattern is observed across all countries regardless of the level of informed choice. Overall, across the 24 countries 70% of women reported receiving information regarding other methods, compared to just 59 percent who reported receiving information about side effects on the method proposed.

These findings suggest that notable proportion of women in these countries are initiating use of modern contraception without counseling about potential side effects or other methods. Similarly, the level of informed choice in these countries is not associated with the level of modern contraceptive use (see Figure 2), and the absence of proper informed choice is high in countries with both relatively low and high percentages of modern contraception use; (notable also in Kenya, Honduras, Senegal and Ethiopia included in Table 2 below).

[14] United Nations, Department of Economic and Social Affairs, Population Division (2015). Estimates and Projections of the Number of Women Aged 15-49 Who Are Married or in a Union: 2015 Revision. New York: United Nations.

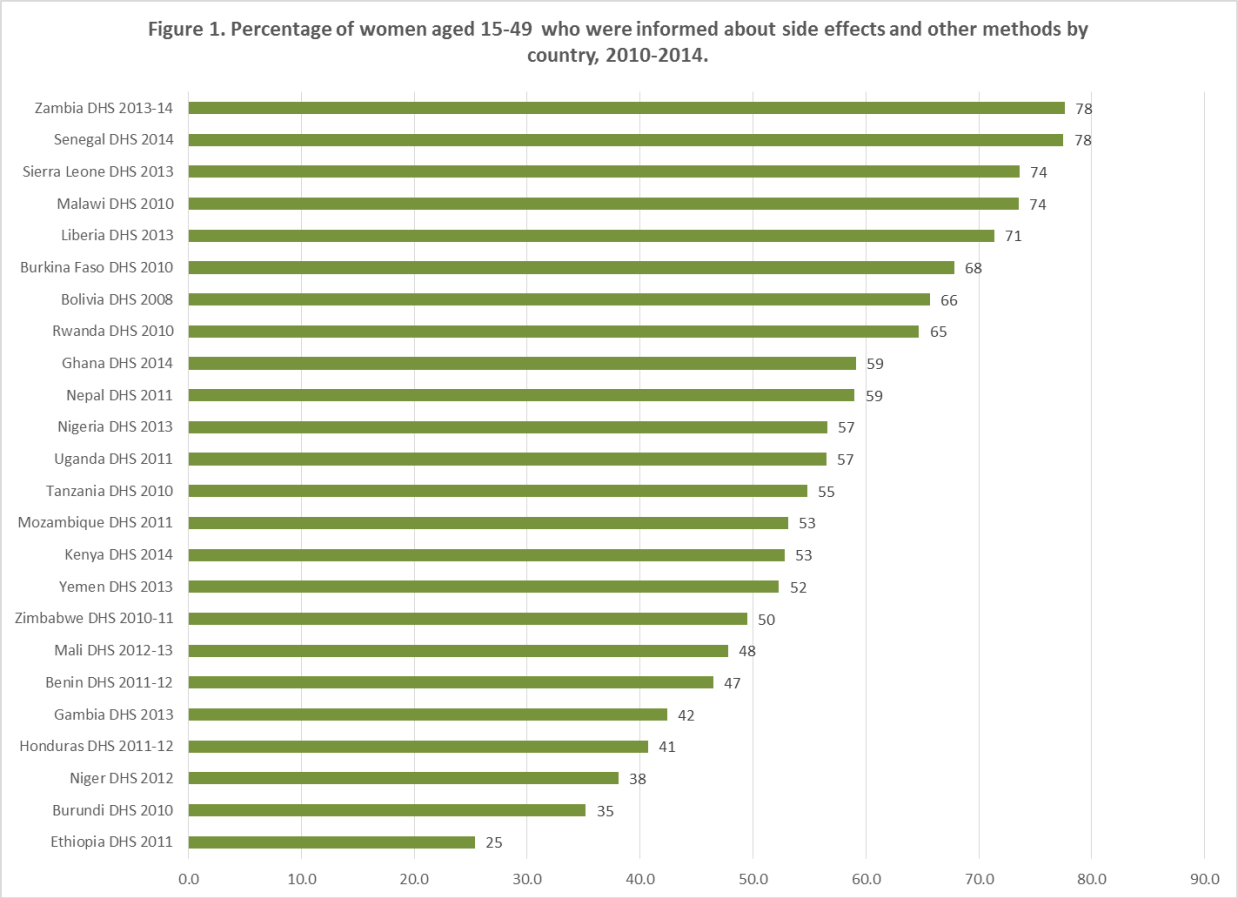
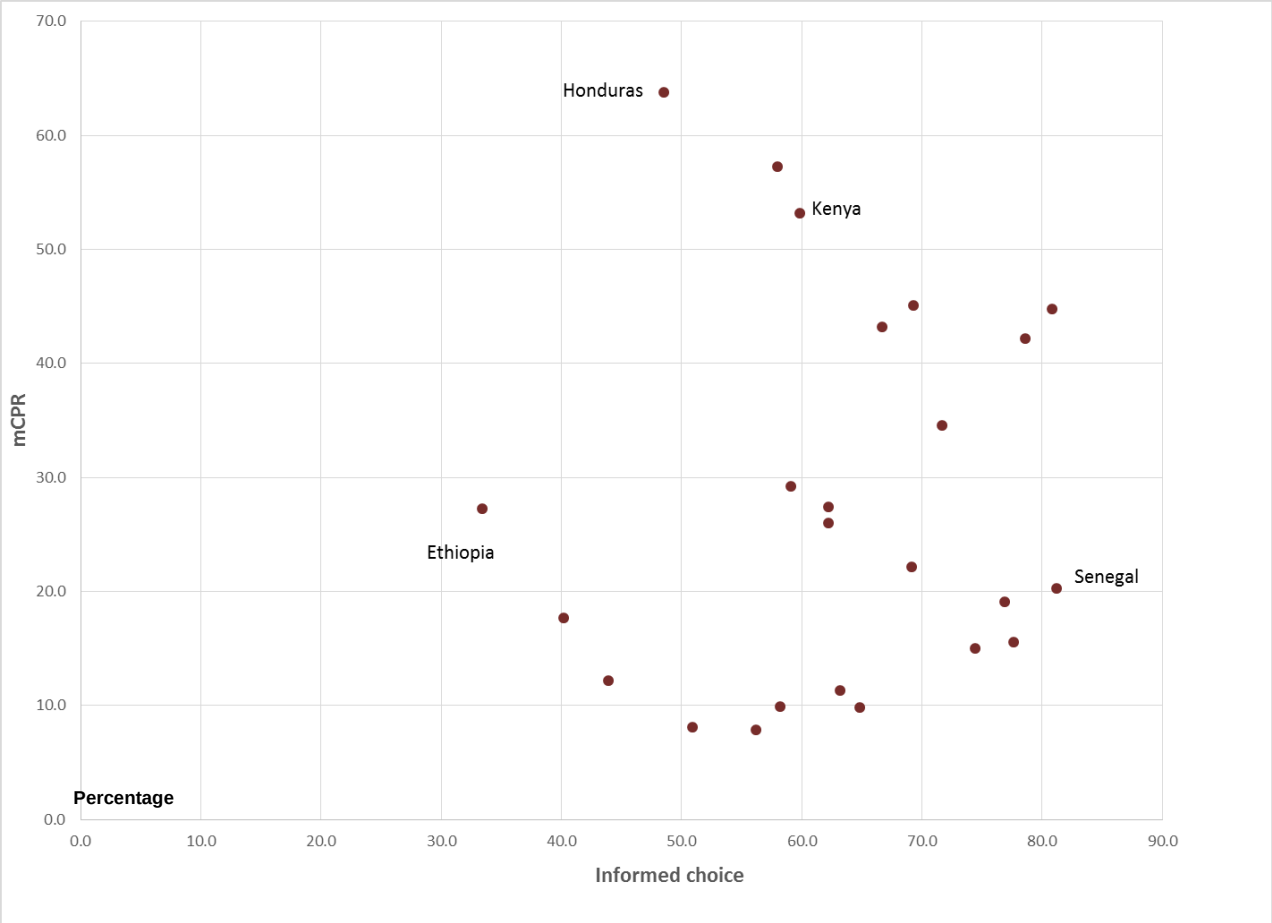


Table 2. The modern contraceptive prevalence rate (mCPR) and the percentage of women informed about side effects, in four countries with extreme distributions.

Country	mCPR	Informed choice (side effects)
Kenya	53	60
Honduras	64	49
Senegal	22	81
Ethiopia	27	33

Figure 2. The percentage of currently married or in union women (15-49) informed about potential side effects, corresponding to the percentage of currently married or in union women using modern contraception



B. Disparities in Quality Family Planning Services

Informed choice differentials are variable by method used, source of method, and age of the client, and to a lesser extent by place of residence, with no clear patterns observed by wealth or education (see Figures 3a-f). In 16 of the 24 countries, informed choice is lowest among users of female sterilization. Pill users reported lowest informed choice in 6 countries, compared to just 1 country among IUD and injection users respectively (data not shown). On the other hand, highest percentages of informed choices are observed among users of implants and IUD (11 and 8 of the 24 countries respectively).

Disparities by contraceptive method are more apparent than by other characteristics. In Figure 3a, we present for each country the methods with the highest and lowest percentage of informed choice, highlighting differences in counseling for different methods, and in the level of informed choice within and across countries. In Ghana and Mali for example, the method with the highest level informed choice (IUD) is above 80% compared to slightly over 30% for the method with the lowest level of

informed choice (pill). At the other end of the spectrum, Burundi, Honduras and Yemen, with lower levels of informed choice, present smaller differences of informed choice between methods. In 8 of the 24 countries, we found a ratio of highest/lowest method of more than 2 times, in other words, the chance that women using one method were informed about side effects and other available methods in those countries is more than twice as those of women using another method.

In 19 of 24 countries, women are more likely to be informed if they first obtained contraceptives from a public sector institution[15] (Figure 3.b). In Ghana for example, the public sector is more than twice as likely to provide information on side effects and available methods compared to the private medical sector (informed choices rates 69 percent and 31 percent, respectively). Disparities are also high in Nigeria, Uganda and Mali, where women obtaining contraceptive from public sector are about 1.5 times more likely to be informed compared to their counterparts who visit private medical sector.

Variance across sources of modern contraception in the public and private medical sectors is also examined. Levels of informed choices across the public sector sources are similar, while the levels of informed choice across the private medical sources tend to be dissimilar. Women who visit private pharmacies are less likely to be informed compared to women who visit other private medical sources. For example, in Kenya, only 36 percent women who visited a private pharmacy were informed, while 50 percent of those attending the private medical sector were informed.

To examine whether disparities in informed choices exist for adolescent girls, we compared the informed choices rate between those age 15-19 years and those age 25-29. In 22 of the 24 countries, higher informed choices rates are found among women aged 25-29 compared to adolescent girls aged 15-19 (Figure 3.c). The widest disparity is found in Gambia, where informed choice among women aged 25-29 is almost double that among women aged 15-19, followed by Niger (1.8 times), Nigeria (1.7 times), Uganda (1.6 times), and Burkina Faso (1.6 times).

The level of informed choices does not vary consistently with places of residence (Figure 3.d). Ethiopia and Niger have the widest disparities, where women living in urban areas are (1.7 and 1.4 times) more likely to be informed compared to those living in rural areas, while in Mozambique and Sierra Leone, the inverse was true, with higher informed choice among women residing in rural areas than those in the urban area.

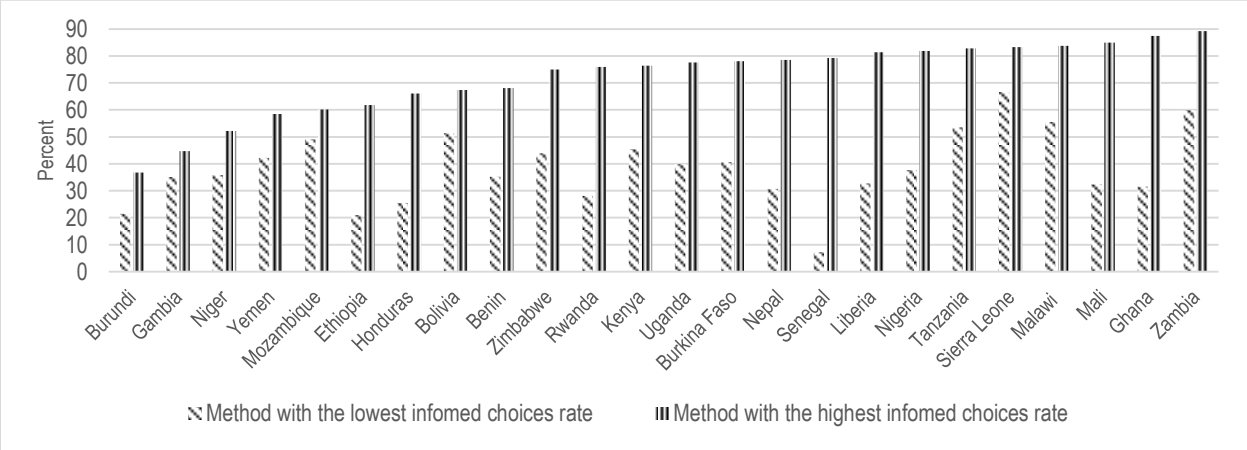
Informed choice rates among women with secondary education or higher appear slightly higher than among women with no education or primary education only, but differences were marginal in nearly half of the countries, and there were exceptions (Figure 4.e). The widest disparity is observed in

[15] The public sector offering of modern contraception typically includes government hospital, government health centre, and family planning clinic. The private medical sector typically includes private hospital or clinic, private doctor, etc. Depending on the nature of the institution, sources such as pharmacy, mobile clinic, fieldworker can be classified under public sector, private medical sector, or other private.

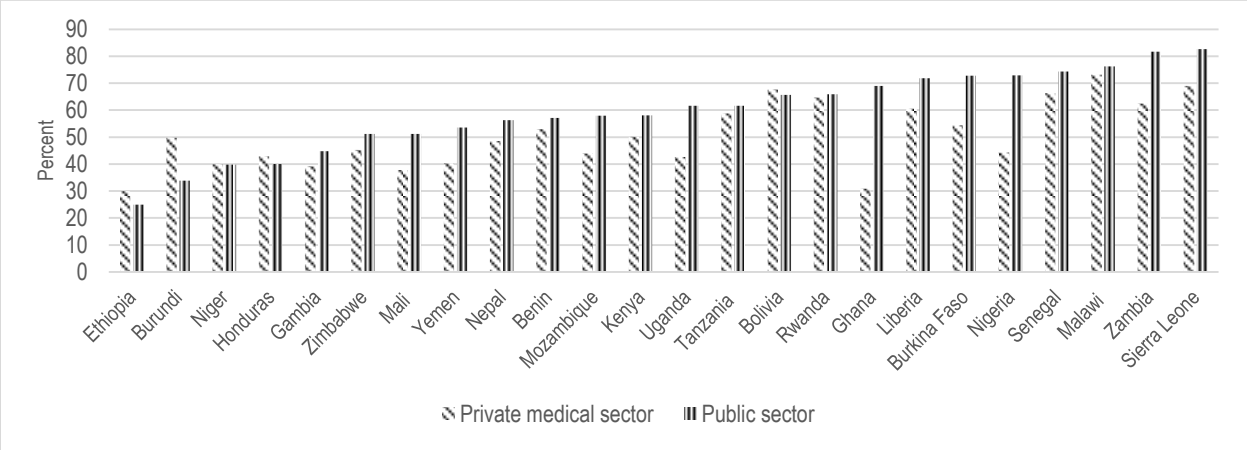
Ethiopia, where women with secondary education or higher are more than twice as likely to be informed compared to women with no education or primary education only. Finally, there was no consistent pattern between informed choice and household wealth across countries (Figure 4.f).

Figure 3. Disparities in the proportion of women who were informed about both side effects and other methods, by country, 2008-2014

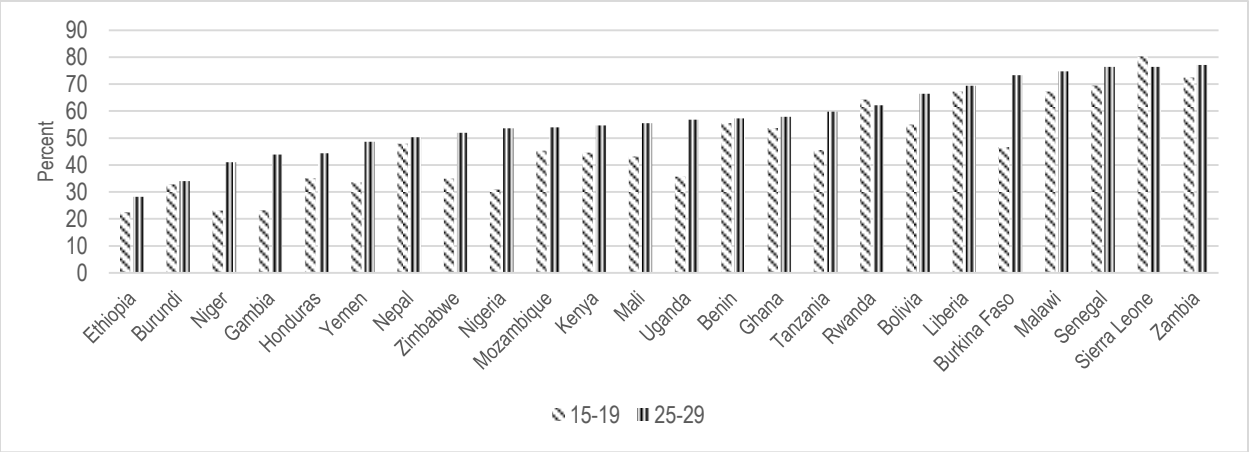
a. Between modern methods with the highest, and the lowest, levels of incomed choice



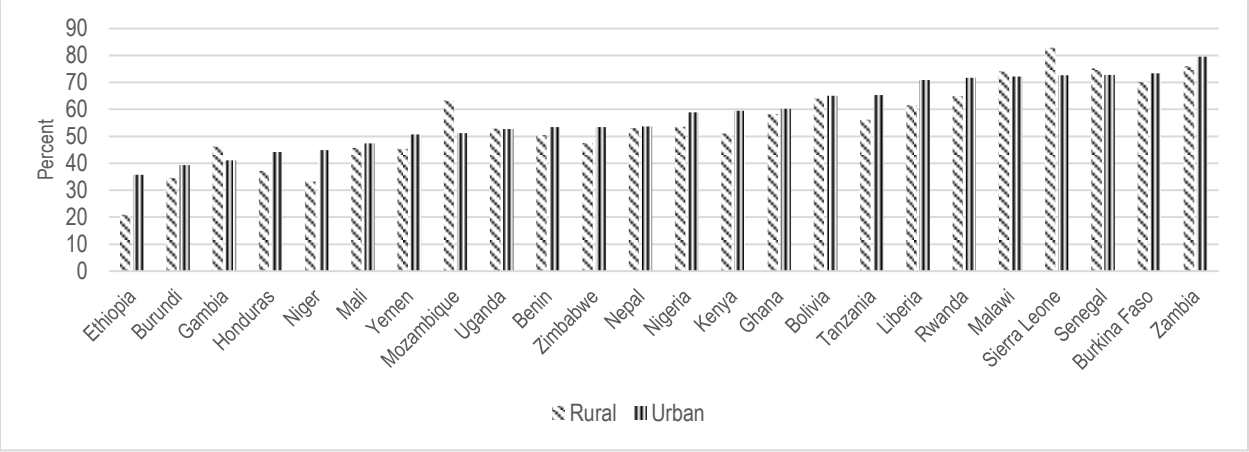
b. By first source for the current method



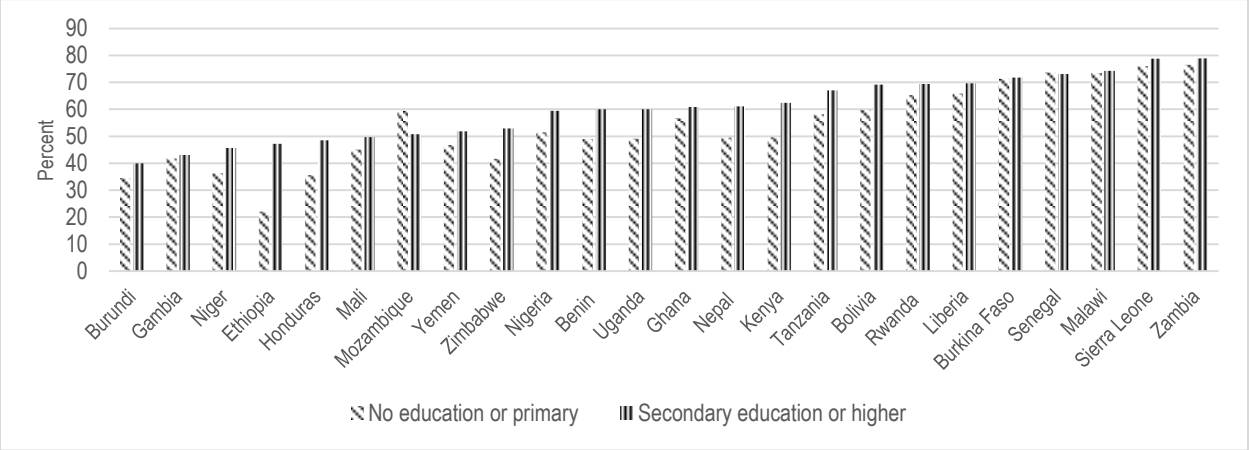
c. By age groups



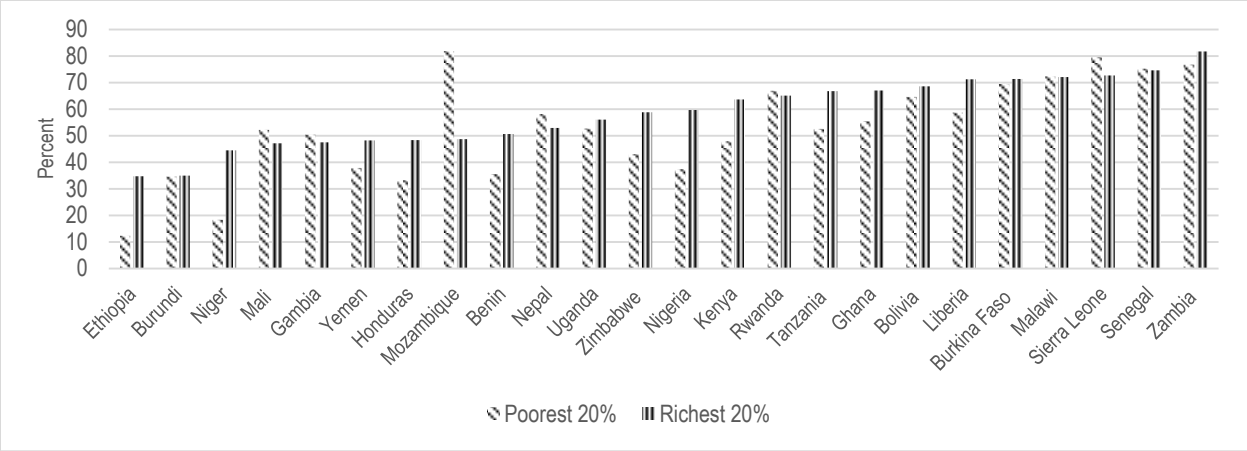
d. By places of residence



e. By highest level of education



f. By wealth index



C. Trends in Informed Choices and Contraceptive Prevalence

Twelve countries participating in the UNFPA supply programme have two recent data points, allowing a look at changes in the key indicators for informed choice (see Table 3). In 5 of the 12 countries we observed an increase of 10 percent or more in the percentage of women who were informed about side effects when adopting a modern method (e.g. Liberia, Senegal, Sierra Leone, Ghana and Nepal). Liberia in particular increased its percentage by almost 65 percent followed by Senegal with 31 percent and Sierra Leone with 20 percent. Other countries showed no significant improvements, or even declines (e.g. Benin, Uganda and Kenya). The observed changes in method choice are not correlated with either the prevalence of modern contraceptive use (mCPR), or the observed changes in mCPR, as presented in the last two columns of Table 3. The rank order of trends for counseling about side effects, other methods, and for counseling on both topics, are generally consistent across countries, suggesting internal consistency in the observed findings.

Table 3. Percentage of change in informed choice indicators and in mCPR in twelve countries with two data points during the periods 2006-2010 and 2011-2014 respectively

Countries	Change in % of informed choice for side effects or problems of method used	Change in % of informed choice about other methods	Change in % of informed choice for side effects or problems AND other methods	mCPR (%)	Change in mCPR
Liberia	65.4	42.8	91.0	19.1	85.4
Senegal	30.8	7.1	37.8	20.3	67.8
Sierra Leone	19.6	26.7	38.0	15.6	132.8
Ghana	15.0	18.8	29.1	22.2	33.7
Nepal	11.9	3.3	17.7	43.2	-2.3
Mali	9.0	16.1	10.8	9.9	43.5
Nigeria	3.5	3.6	3.3	9.8	1.0
Zambia	3.5	13.3	12.8	44.8	37.0
Niger	0.5	6.2	2.1	12.2	144.0
Kenya	-2.4	16.2	4.3	53.2	35.0
Uganda	-2.8	1.3	-0.7	26	45.3
Benin	-3.8	-7.3	-4.0	7.9	29.5

Globally, use of contraception increased substantially during the period 2000-2015 at an average annual rate of 0.2 percent. At the regional level, two regions have had a significantly higher annual rate of increase of 1 percent or more: East and Southern Africa, with an increase of 61 percent, and West and Central Africa, of 29 percent[16]. Although use of modern contraception made great progress in the last decades, progress in the quality of this reproductive health service remains in question. To answer this question, we conducted a trend analysis of informed choice for the 12 countries[17] with two consecutive DHS sources, including one conducted at or after year 2006 and another conducted at or after year 2011.

In addition to the informed choices indicators described before, we looked at trends in contraceptive use (CPR), modern contraceptive use (mCPR), use of the five modern contraceptive (pill, IUD, injections, female sterilization or implant) for which informed choices data are available (mCPR_5), and use of four modern contraceptives (pill, IUD, injections, or implant) as the UNFPA Supplies support these four commodities (mCPR_supplies). We also calculated adjusted mCPR and mCPR_5 by excluding from the respective numerators women who started the current contraceptive episode during the last five years of the survey, were using one of the five modern methods, were not informed about side effects or available methods at the time obtaining the current method, and were never informed about side effects nor available methods before.

[16] UNFPA. 2016. Universal Access to Reproductive Health: Progress and Challenges.

[17] A subset of the 46 countries involved in the UNFPA supplies programme.

The analysis of the adjusted mCPR and mCPR_5 provides insights into the dimensions of quality care by adding a quality perspective. The analysis also allows for the measurement of the UNFPA supply programme strength by looking at progress on both quantity and quality of the family planning use and services.

Informed choice about side effects, about other methods available and about both have increased by 5 to 8 percentage points among the twelve countries with two data points between 2007-2014. The percentage of women who were not informed about side effects nor other methods declined by 16 percent, from 23 percent to 19 percent. Faster increases are found in contraceptive use indicators, compared to the increases in informed choice indicators, especially for the UNFPA Supplies supported modern methods (mCPR_supplies).

Both mCPR and adjusted mCPR increase by 22 percent. Between 2006 and 2010, only 12 percent of currently married/in union women who are using modern methods and were counseled about side effects and other available methods. This number increases to 15 percent between 2011 and 2014. Similarly, the adjusted mCPR_5 increased slightly faster than mCPR_5, at 37 percent.

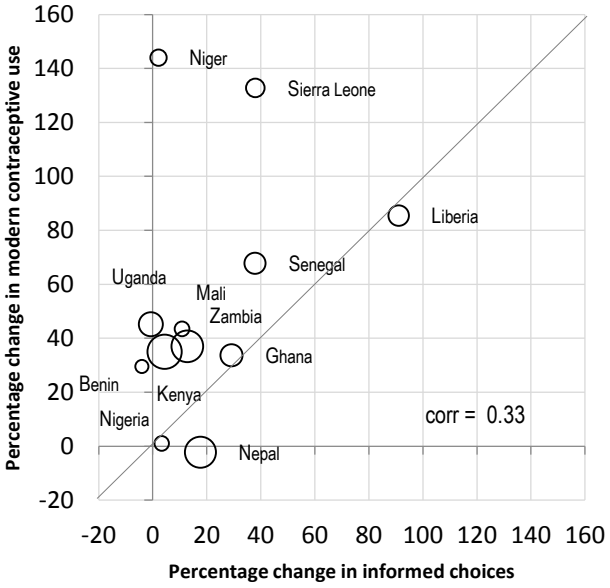
Table 4. Trends in the percentage of informed choice indicators and contraceptive use across the 12 countries with two recent data points during the periods 2006-2010 and 2011-2014 respectively.

Indicators	Year 2006-2010	Year 2011-2014
% who were informed about side effects or problems of method used	61.0	64.3
% who were informed of other methods	69.5	74.2
% who were informed about side effects and other methods	53.1	57.6
% who were not informed about side effects nor other methods	22.7	19.0
CPR	22.3	25.6
mCPR	17.3	21.1
mCPR_5	13.4	17.5
mCPR_supplies (5 methods excluding female sterilization)	10.6	15.2
Adjusted mCPR	12.1	14.8
Adjusted mCPR_5	8.2	11.2

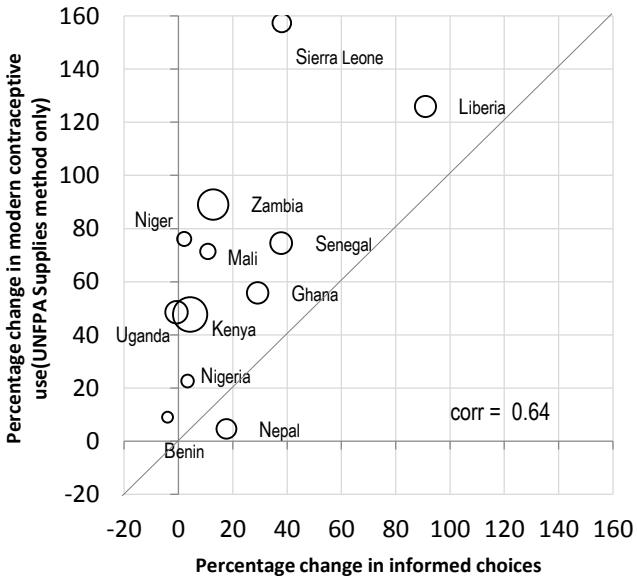
Averages for the 12 countries are informative but can also mask important cross-country variations in changes on informed choices and on contraceptive use. Figure 5 presents the changes in informed choices and modern contraceptive use by country. A relatively weak and positive correlation is found between changes in informed choices and changes in use of modern contraception (corr=0.33), while stronger positive correlation is found between change in informed choices and change in use of the 4 methods (corr=0.64). In Benin, Uganda, Niger, and Nigeria, the increase in informed choices seems to lag behind the increase in modern contraceptive use. For example, in Uganda, use of 4 modern contraceptive methods increased close to 15 percent (from 14 percent to 20 percent). During the same period, informed choices rates remained unchanged in Uganda.

Figure 5. Percentage changes in women who were informed about both side effects and other methods, and percentage changes in contraceptive use, by country, between year 2006-2010 and year 2011-2014.

a. informed choices and modern contraceptive use



b. informed choices and use of 4 contraceptive methods



[a] Bubble size the proportional to the level of modern contraceptive use in chart a) and the level of using pill, IUD, injections and implants in each country.

IV. Summary and Discussion

During the last ten years we have observed a significant increase in access to, and use of contraception, as documented in the progress achieved under MDG5b. However, this paper presents substantial evidence that recent changes in current use of contraception have not been accompanied by corresponding increases in informed choice regarding side effects and availability of other methods at the time of initiating use of modern contraception (injectables, implant, IUD, pill, female sterilization). Thus, two of five women that started using any of these methods during the five years before the study did not receive counseling about possible side effects from the selected method, and nearly one out of two did not hear about side effects or other methods.

Informed choice has improved over time in select countries, but in some countries the changes are not significant or even regressive. In 5 of the 12 countries participating in the UNFPA supply programme with comparable data, observed changes in informed choice for side effects are 10 percent or greater. We also found a weak correlation between the changes in informed choice and those observed for modern contraceptive use across most of the countries included in this analysis. The levels and trends of informed choice are similar for side effects and with regard to other methods across countries.

The differentials of informed choice examined across different characteristics are mixed. As expected, smaller disparities are observed among countries with higher levels of informed choice (70% or higher). Informed choice is different according to the method with important differences, within countries,

between methods with high and low levels of informed choice. In most of the select countries, women using implants or IUD seem to be more likely to be informed about side effects and other methods compared to women who use female sterilization or pill. The public sector appears to perform better than the private sector in the provision of informed choice for the methods they supply, and there is a particularly poor performance of informed choice provided by pharmacies. The results observed by age seem to confirm the expected trend, that is less informed choice among adolescents, but urban/rural, wealth and education trends were inconsistent.

The observation among adolescents is notable, as adolescent girls aged 15-19 often face more obstacles than adults in obtaining contraceptives. A recent study shows that the levels of contraceptive prevalence rate and proportion of demand satisfied among adolescents are markedly lower than among any other age groups. Similarly, the level of unmet need for family planning is the highest among adolescents[18]. Further analysis on adolescents' behaviour in accessing family planning services needs to be carried out in order to determine whether quality counseling is indeed less likely to be provided to adolescents, who are potentially less informed than older clients.

From a policy and programme perspective, these results provide enough evidence to warrant interventions to increase the coverage of counseling provided to family planning clients, in order to guarantee women's rights and choices around their sexual and reproductive needs. The observed variability in the provision of informed choices suggest highly unequal national norms and standards in the quality of care experienced by women intending to satisfy their need for contraception. The results also illustrate the possibilities for improving the current systems for monitoring and reporting on growing provision and accessibility of family planning, even from data currently available in routine household surveys (DHS and MICS). We place these in a context that recommends increased generation and dissemination of data on the quality of family planning services offered to clients worldwide.

[18] UNFPA. 2016. Universal Access to Reproductive Health: Progress and Challenges.