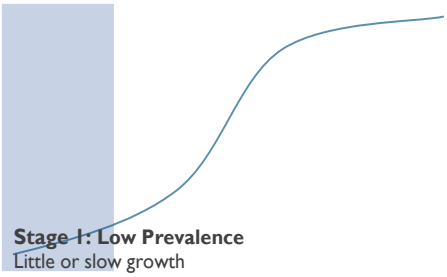
Exploring Opportunities for mCPR Growth in Eritrea

When assessing potential opportunities for family planning, it is important to consider a wide range of areas related to demand for contraception, availability and access to services, quality and equity, and the enabling environment. This opportunity brief brings together a range of data sources to allow for exploration of these key areas. This brief is meant to provide an overview of key data and population segmentations to spark conversations about prioritization and potential impact. Further analysis, including additional segmentation by residence or region may reveal additional nuances.

Putting Growth in Context: the S-Curve

Historical data shows us that contraceptive use grows in an S-shaped pattern. This is characterized by slow growth and little annual change when mCPR is low (Stage 1), an opportunity for rapid growth in the middle during the transition from low to high mCPR (Stage 2), and slowing growth as mCPR reaches its maximum (Stage 3). While all countries will go through this general pattern, the duration and speed of growth seen in each stage will vary. Understanding this concept provides countries with a template that can assist in:

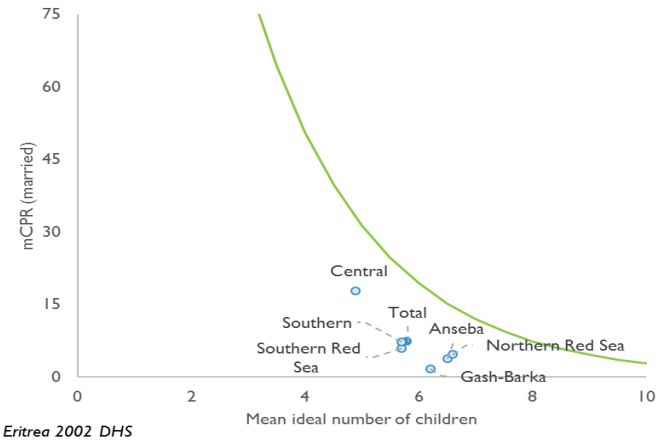
- Identifying program priorities
- Setting realistic targets for growth and contraceptive prevalence goals
- Maximizing the potential of obtaining the demographic dividend



Nationally, Eritrea has an mCPR (MW) of 14% in 2022, placing them in Stage 1. During this stage efforts are needed to change social norms around family planning, stimulate demand, and establish the infrastructure and providers to deliver quality family planning services. Since large annual growth in mCPR is unlikely, the focus should be on precursor indicators that look at changes in demand for FP and increased access through system expansion.

Stages may vary sub-nationally, this should be examined when thinking about sub-national goal setting and planning.

Assessing Demand



Eritrea 2002 DHS

The 'demand curve' (green line) represents the likely maximum mCPR that could be reached given the mean ideal number of children, which represents a wider set of social constructs that may be influencing the motivation to use, or not use, contraception. The gap between where a country or region sits and the curve is the 'potential use gap'- an estimate of the maximum mCPR growth that could be expected within current levels of demand.

At the time of the 2010 EPHS the mean ideal number of children in Eritrea was 5.8. Based on this, at the national level, there was a modest potential use gap, meaning there was some room for additional growth in mCPR without changes in demand.

Countries should consider sub-national variation; geographic variation is shown on the graph. Other segmentation could also be considered (e.g. wealth, education).

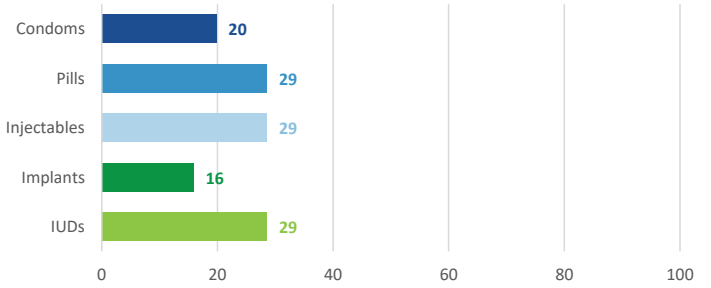
Each blue dot in the graph represents a data point from the DHS; the solid dot shows the National value. The green 'demand curve' is based on global data. Within any country, there is some range on the true maximum based on contextual factors, and therefore, some areas may sit above the curve. In these areas additional mCPR growth may be limited without further changes in demand.

Availability of Contraceptive Methods

Is there a need for expanded access?

The graph below shows data from the Family Planning Effort Index/National Composite Index on Family Planning from a set of questions about the extent to which the entire population has ready access to each contraceptive method. For methods that score low, efforts may be needed to expand access in order to ensure women have access to a full range of methods. This could be achieved through policy changes such as task-sharing, investing in additional training of health care workers, enaging the private sector, or other interventions.

Extent to which the entire population has access to each method

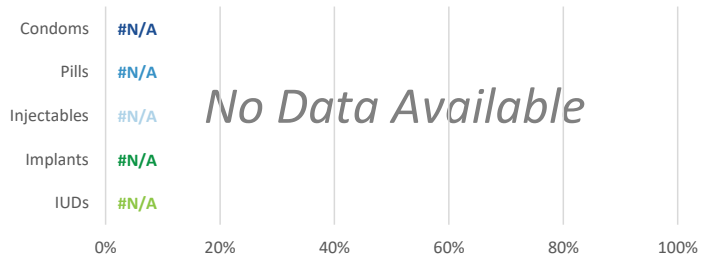


Source: FPE/NCIFP 2017

Are stock-outs a barrier?

The graph below shows data on stock-outs by method. Stock-outs can have an impact on contraceptive prevalence and method choice, by limiting avalibility of FP. Countries with high levels of stock-outs should prioritize strengthening the supply chain to ensure women have access to a range of methods. In countries where stock-out levels are low, systems must be maintained to ensure adequate stock continues to reach facilities.

Percentage of facilities stocked out, by method offered

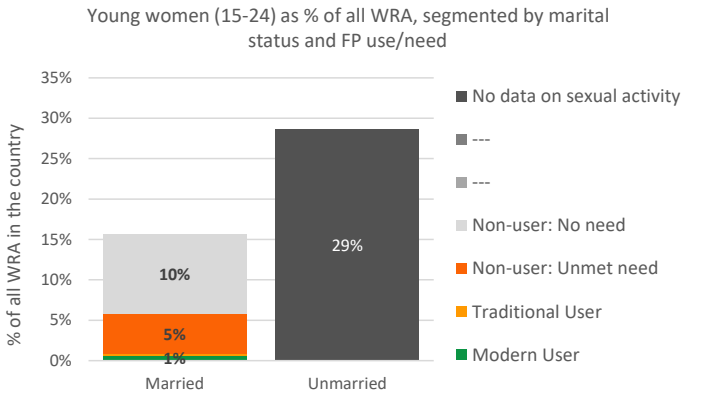


No Data

Expanding Access to Key Populations

Reaching Adolescents and Youth

The graph below shows the proportion of all women of reproductive age (WRA) who are adolescents and youth (15-24) segmented by marital status and FP use/need. These segments are important to take into consideration when thinking about adolescent and youth interventions. When a large proportion of women of reproductive age are young women with an unmet need for modern contraception (orange segments in graph), there is the largest opportunities for investments in adolescent and youth programming to lead to growth in mCPR. Attention should be paid if this unmet need is largely among married or unmarried women, as programming approaches should differ.

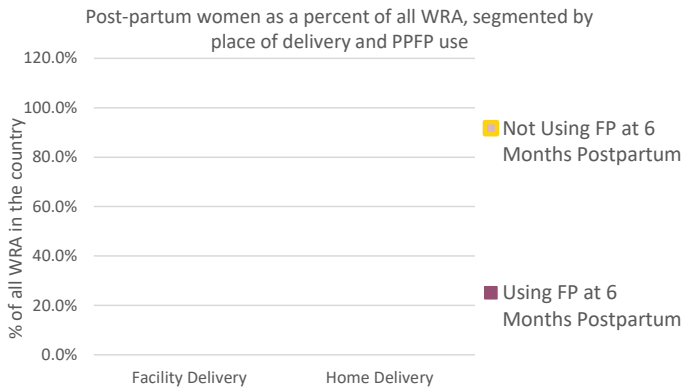


In Eritrea around 5% of all women are youth with an unmet need for modern methods (sum of orange segments). Of these young women with an unmet need for modern contraception, 100% are married, and 72% are aged 20-24.
No data was available on unmarried youth.

Source: WPP 2019 and secondary analysis from 2002 DHS

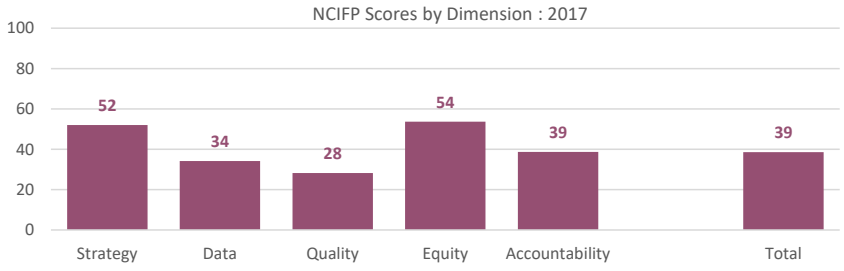
Reaching Postpartum Women

The graph below shows the proportion of all women of reproductive age (WRA) who are postpartum, segmented by postpartum FP use (PPFP). Places where a large proportion of women of reproductive age are postpartum and not using modern contraception present the largest opportunities for investments in PPFP to lead to growth in mCPR. Attention should be paid to what types of PPFP interventions might be most impactful, considering differential levels of postpartum use by place of delivery and levels of facility vs home delivery. Note: we never expect PPFP uptake to reach 100%, countries with very successful programs show uptake levels around 60-70% nationally.



No Data Available

Enabling Environment

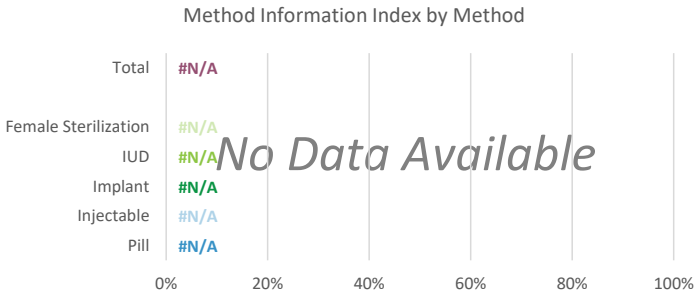


The strength of the enabling environment can impact the potential for growth in mCPR. The National Composite Index on Family Planning (NCIFP) is a new tool developed to support FP2020's efforts to better understand the enabling and policy environment for family planning. The NCIFP measures both the existence of policies and program implementation, using 35 individual scores organized under five dimensions: strategy, data, quality, equity, and accountability. Summary results are shown in the graph to the left; dimensions with low scores may signal the need for efforts to improve elements of the policy environment.

Beyond mCPR Growth: Addressing Quality and Equity

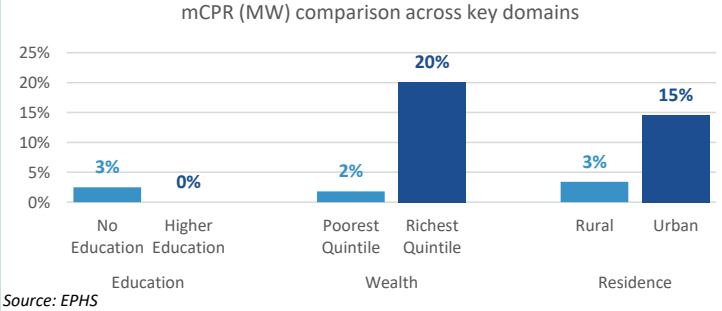
Quality

The graph below shows the Method Information Index (MII), an FP2020 Core Indicator. The MII shows the % of current modern method users who said yes to all three questions: told about other methods, told about side effects, told what to do if experience side effects. Low MII scores could indicate a need for improved quality of counseling.



Equity

The graph below compares mCPR (MW) across several domains. Inequalities in mCPR may be seen during all stages of the S-Curve, but how they should be addressed varies by stage. Stage 1: focus should be on generally expanding demand and access to facilitate shift to Stage 2. Stage 2: efforts should be made to ensure programs are increasing access to all populations, addressing disparities when possible. Stage 3: efforts should focus on eliminating these disparities.



Source: EPHS

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Analysis developed by Track20, learn more at Track20.org