Using Microcredit and Family Planning Services to Increase Contraceptive Use in Ethiopia

Researchers:

Jaikishan Desai

Alessandro Tarozzi

Sector(s): Finance, Gender, Health

Location: Amhara and Oromia regions of Ethiopia

Sample: 6,440 households in 356 villages

Target group: Rural population Women and girls

Outcome of interest: Earnings and income Sexual and reproductive health Women's/girls' decision-making

Intervention type: Credit Training

AEA RCT registration number: AEARCTR-0001056

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Partner organization(s): Amhara Credit and Savings Institute (ACSI), Amhara Development Association (ADA), David and Lucile Packard Foundation, Family Health International (FHI 360), Oromiya Credit and Savings Share Company (OCSSCO), Oromiya Development Organization (ODA)

The ability to control fertility can have broad social and economic consequences, as families experiencing unwanted pregnancies may find it harder to pay for their children's education, healthcare, and general wellbeing. In Ethiopia, researchers tested whether linking microcredit and family planning services could increase contraceptive use more than either program in isolation. Neither the linked program nor the isolated programs had any detectable impact on contraceptive awareness, use, or intention to use.

Policy issue

As much as 50 percent of all pregnancies worldwide are unplanned or unwanted, accounting for nearly 300,000 new pregnancies every day. The ability to control fertility can have broad social and economic consequences, as families experiencing unwanted pregnancies may find it harder to pay for their children' s education, healthcare, and general wellbeing. Recent evidence suggests that access to contraceptives may improve economic outcomes and reduce poverty by allowing women to optimally time births, increasing investment in education and participation in the labor market at childbearing ages. Knowledge and availability of contraceptive methods are both important factors influencing contraceptive adoption decisions, but equally important are socioeconomic factors, such as a woman' s ability to earn money, which can influence the financial tradeoff between contraceptive use and childbearing. Some have argued that credit programs that encourage borrowing by women can increase the opportunity cost of women' s time, potentially increasing their control over household resources, and empowering them to express their fertility preferences. However, more research is needed to establish this link.

Context of the evaluation

The study took place in the rural regions of Amhara and Oromia in Ethiopia, where households are largely subsistence-oriented and agriculture and livestock are the main sources of income. While 18 percent of households reported taking or repaying a loan in the prior 12 months, borrowing by women was infrequent. Prior to the study in 2003, there were clear demographic and socioeconomic differences between the two regions. Fertility was high in both regions but distinctly higher in Amhara, where women married earlier, began childbearing sooner, had more births, and desired more children than their counterparts in Oromia. Contraceptive use was minimal in both regions, with the contraceptive prevalence rate at 7.4 percent in Oromia and 3.5 percent in Amhara. Intentions to use contraceptives were also higher in Oromia, where 71 percent of nonusers said they intended to use contraceptives in the future, while the corresponding figure for Amhara was 46 percent.

Women sit in a row outside, talking to each other.

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Details of the intervention

The evaluation was conducted in Amhara and Oromia by Family Health International to evaluate the impact of community-driven family programs, and to determine whether linking microcredit and family planning programs could increase contraceptive use more than what could be accomplished by each program on its own. Program activities in each region were provided by different organizations in different areas: Credit activities were provided by the Amhara Credit and Savings Institute (ACSI) and the Oromia Credit and Savings Share Company (OCSSCO). Family planning programs were provided by the Amhara Development Association (ADA) and the Oromia Development Association (ODA). In the experiment, 55 administrative areas in Amhara and 78 in Oromia were randomly allocated to one of four groups receiving different combinations of credit and family planning services:

1. Both credit and family planning services were provided
2. Credit only provided
3. Family planning services provided only
4. Comparison group, no new service provided

The credit programs provided by ACSI and OCSSCO targeted poor households and emphasized women borrowers, though no specific activities or criteria were used to seek out this target group. Each organization had a specific set of criteria that it used to select borrowers, of which creditworthiness, a viable business plan, and poverty were the most salient. Borrowers formed small groups and took on collective responsibility for repayment of year-long loans at prevailing market interest rates. Credit officers helped fill out loan applications and monitored the groups through monthly and biweekly meetings.

The family planning programs provided by ADA and ODA was community-based, where selected community residents received training, a uniform, and a fee for their services. They made house-to-house visits to provide information about birth control pills and condoms. They also provided referrals for clinic-based services like injectibles–the main method in use in these regions–but they did not actually provide this contraceptive. The organizations also coordinated other events to provide information on family planning, reproductive health, and sexually transmitted diseases, including HIV/AIDS.

A baseline survey in January to April of 2003 collected demographic information for 6,440 households spread over 356 villages in the 133 administrative areas where the family planning and credit organizations intended to expand in the following years. A follow-up survey was completed between April and July 2006.

Results and policy lessons

Between the two surveys in 2003 and 2006, the study areas witnessed substantial changes in fertility behavior and socioeconomic status, but these changes appear largely unrelated to the programs in question.

Contraceptive use increased by nearly 9 percentage points in Amhara and 14 percentage points in Oromia. Awareness of contraceptives also increased to 97 percent in both regions, as did the share of non-users who said they intend to use contraception in the future. Over this time period, economic indicators also changed: the percentage of households that took a loan in the prior 12 months more than doubled in both regions. While much of the borrowing in 2006 was still undertaken by males, the proportion of households in which a woman borrowed increased substantially, from 3 percent to 10 percent in Amhara and from 2 percent to 14 percent in Oromia.

While the changes are remarkable, particularly given the relatively short period of time between the two surveys, the evidence suggests that they were not associated with the interventions. Neither type of program significantly increased contraceptive use beyond that observed in the comparison group. Linking credit and family planning services also did not increase contraceptive use any more than what was achieved by either program on its own. In addition, the programs appear to have been ineffective at changing reproductive behavior and preferences. This is true for women in all age groups.

Hypotheses for the lack of program impact: Researchers hypothesize that linking has such a limited impact because the credit programs reach only one-quarter of all adults, and only provide information, which is important, but probably not the main constraint to contraceptive use. If linking were to take a form that altered the incentive structure for contraceptive use, say by offering credit on better terms to women or to contraceptive users, it might have a greater impact, although this study offers no evidence for this possibility.

The second finding, that the family planning programs of ADA and ODA had no measurable impact on contraceptive use, is perhaps more surprising. Researchers hypothesize that the most likely cause for the lack of impact is the fact that community health agents only supplied condoms and pills, but not injectibles, the most commonly used contraceptive method in the area,

which most women preferred.

Desai, Jaikishan, and Alessandro Tarozzi. 2011. "Microcredit, Family Planning Programs, and Contraceptive Behavior: Evidence From a Field Experiment in Ethiopia." Demography 48(2011): 749-782.