Fragile, Threatened, and in Great Need: Family Planning Programs in Sub-Saharan Africa

by Roy Jacobstein, Isaiah Ndong, Wuleta Betamariam and John Pile

This paper addresses three aspects of the situation family planning programs in sub-Saharan Africa face today: 1) the current and future need for family planning; 2) the fragility of family planning programs and services, as reflected in recent trends in representative countries; and, 3) the challenges and opportunities these programs face as they try to address the needs of the people they serve.

1. Current and future need for family planning in sub-Saharan Africa

Use of family planning is very low in sub-Saharan Africa. Of sub-Saharan Africa's 101 million women of reproductive age (MWRA), only 13.5%, or 13.6 million women, currently use a modern method of contraception. By contrast, 53% of MWRA in less developed regions overall and 54% in the world use modern contraception, as do over 70% of women in Northern and Western Europe. [1] At the same time, awareness of family planning is lower in sub-Saharan Africa than in other regions.

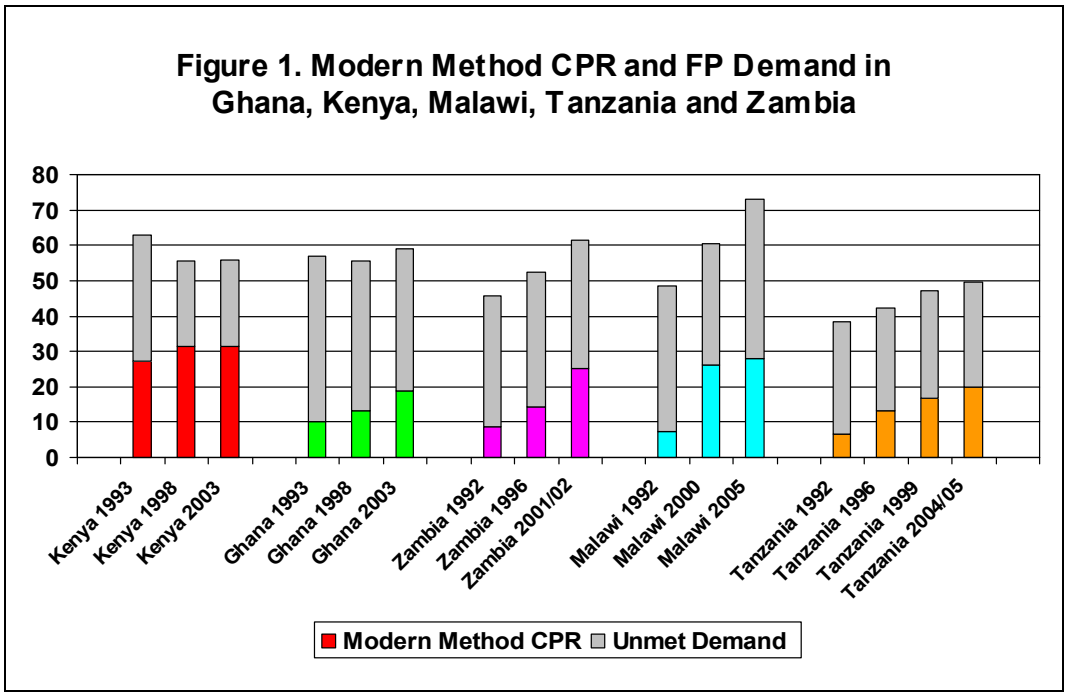
Unmet need in sub-Saharan Africa is high, with nearly three of every 10 sub-Saharan women—over 30 million women in total—having unmet need for modern contraception. In West Africa, average unmet need for modern contraception is 34%, and in East and Southern Africa it is 31%. Nineteen of the 31 sub-Saharan African countries, including Senegal, Ethiopia, Malawi, Uganda and Zambia, have levels of unmet need for modern contraception between 30% and 40%, and six countries—Congo, Gabon, Ghana, Comoros, Togo and Rwanda—have levels that exceed 40%. In contrast to other regions, which have seen levels of unmet need for modern contraception fall, there has been little or no reduction in this unmet need the past decade in sub-Saharan Africa.[2]

Very high fertility and rapid population growth are a concomitant to this low contraceptive use and high unmet need. Fertility reduction has stalled in most countries in sub-Saharan Africa. Sub-Saharan Africa's total fertility is 5.6, with TFR even higher in Western Africa (5.9), Middle Africa (6.3) and Eastern Africa (5.7). Fourteen countries have TFRs higher than 6, with Niger's TFR of 8.0 being the highest in the world. The three most populous sub-Saharan African countries, Nigeria, Ethiopia and Congo, have TFRs of 5.9, 5.9 and 6.7 respectively. These levels are unsustainably high, significantly hampering individual health and welfare, and national development. Congo, whose GDP is less than US$2 per capita, will see its population triple in 45 years, from 61 million to 183 million. Ninety-one percent of Nigeria's 131 million people live below US$2 per day, and its population is projected to double to 258 million by 2050. Similarly, Ethiopia, with 77 million people, of whom 78% live on less than US$2 per day, will have 170 million people by 2050.[3]

In sum, by any measure—contraceptive prevalence, demand for modern contraception, unmet need, total fertility, or unwanted fertility—*there is great need today in sub-Saharan Africa for quality FP services* that are well aligned with people's fertility intentions. Furthermore, these needs will grow considerably in the next decade, as the largest cohorts of people in

history continue to enter and move through their reproductive years, and as Africa continues to modernize and urbanize (both of which increase demand for family planning services). Just to maintain current levels of CPR will require expansion of these services by at least 40%.

2. **The fragility of family planning programs in Africa: DHS evidence from five sub-Saharan African countries** (See Figure 1)



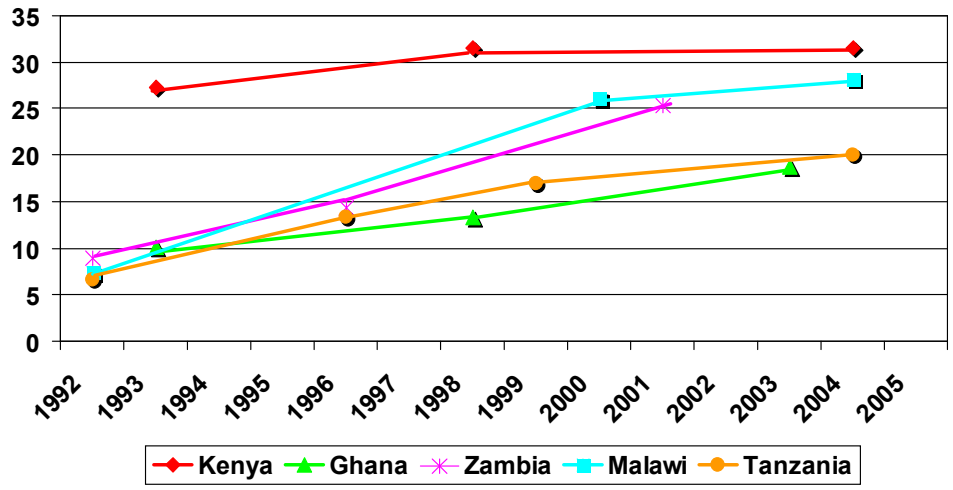
Family planning service programs in sub-Saharan Africa today are very fragile. Reflecting this fragility, even the most successful programs, such as those of Ghana, Kenya, Malawi, Tanzania and Zambia, have recently experienced a sharp reduction in their rate of progress, as measured by rises in CPR and reductions in TFR. Furthermore, family planning program efforts in the most populous countries have yet to translate into even double digits in modern contraceptive use, e.g. Ethiopia has a modern method CPR of 6% and Nigeria has an 8% modern method CPR.

The marked uptake of modern contraception that occurred in the 1990s in the family planning programs of Ghana, Kenya, Malawi, Tanzania and Zambia has diminished considerably during the 2000s (See Figure 2). Whereas in the 1990s modern method use almost quadrupled in Malawi, more than doubled in Zambia and Tanzania, and almost doubled in Ghana, subsequent increases in CPR have been much more modest.

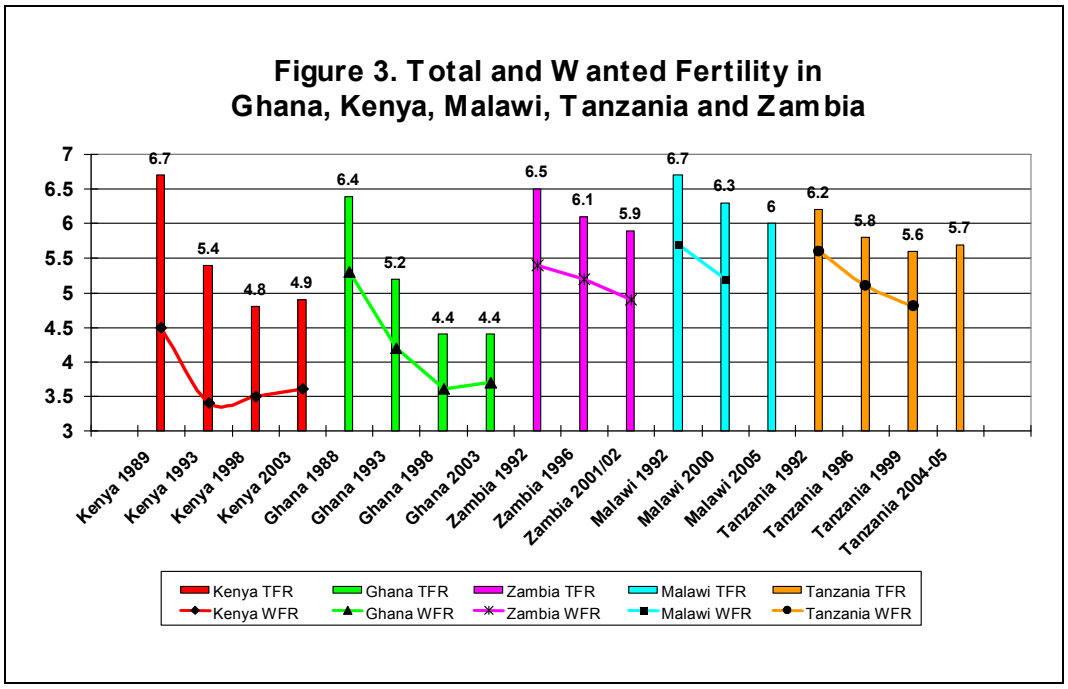
The most striking example of this "plateauing" or "stalling" has been in Malawi. While modern method CPR rose in Malawi from 7.4% to 26.1% from 1992 to 2000—a remarkable increase of 2.3% annually—it only increased 0.5% annually from 2000 to 2004, to 28.1%. The same pattern has been seen in Tanzania. There, modern method CPR rose from 6.6% in 1991 to 16.6% in 1999, an annual increase of 1.25%, but subsequent annual

increases in modern method use have been less than half that (~0.6%). And the annual rate of increase in overall CPR in Tanzania was even less, only 0.2%, from 25.4% in 1999 to 26.4% in 2004/05. Kenya, which had higher levels of CPR than these other four countries, plateaued even sooner in its modern method (and total method) CPR. Kenya's 21% modern method CPR in 1993 placed it near the top of modern contraceptive use in sub-Saharan Africa. However,- modern method use in Kenya only rose 0.6% per year the next five years, to 24% in 1998, and from 1998-2003, Kenya's modern method CPR did not rise at all.[4]

Figure 2. Trends in Modern Contraceptive Use in Ghana, Kenya, Malawi, Tanzania and Zambia



When total fertility is considered, the trends in these five countries are even more worrisome, for despite ongoing if slowed increases in CPR, TFR has remained steadily high (See Figure 1). Ghana's total fertility rate, which had dropped notably from 6.4 in 1988 to 4.4 in 1998, remained at the same level in 2003. Kenya, which in 1975-78 had one of the highest fertility levels in the world (TFR 8.1), and had registered steady and significant drops in fertility through the mid-1990s (TFR of 6.7 in 1989, 5.4 in 1993, 4.7 in 1998), has now seen a stall in fertility decline, with a TFR of 4.8 recorded in 2003.[5] Similarly, TFR in Tanzania has plateaued, at higher levels and for a longer time period, with relatively little fall seen in the past 12-13 years. Malawi and Zambia also have very high and minimally falling levels of fertility, despite the increased contraceptive use there. Yet, as seen in Figure 3, demand for family planning is substantially higher than current use in all five countries, and all have higher total fertility than wanted fertility, suggesting both programmatic challenge and programmatic opportunity.



3. Family planning programs in sub-Saharan Africa: challenges and opportunities

Family planning programs in sub-Saharan Africa are fragile because they are being confronted by an unprecedented array of daunting challenges. Health programs not only must address the widespread need for family planning, they must also allocate their scarce and often declining (per capita and/or overall) financial and human resources to other pressing priority health needs such as combating malaria, tuberculosis, and HIV-AIDS. And the devastating AIDS pandemic is not only diverting program and donor attention and resources—and thus the complement of skilled health personnel available to provide family planning services—but those complements are also being reduced by the toll of death and disability that HIV/AIDS and other infectious diseases exact.

These challenges have been compounded at the macro level by the unintended consequences of health sector reform and decentralization, which has devolved budgetary and programmatic authority to lower levels where the feasibility and benefits of family planning are often less well known. That people want effective family planning and will use it when it is made available is not as widely appreciated as it needs to be; nor are the health, social and economic benefits of family planning to individuals, communities and nations. Another factor in the declining resources being made available for FP programs is "donor fatigue" with FP, which results in donor priorities and resources going to other health problems and to other development sectors, in pursuit of the Millennium Development Goals (MDGs) set by the United Nations. Yet "the MDGs are difficult or impossible to achieve with current levels of population growth in the least developed countries and regions ... unless family planning is made easily available."[6]

The overall service challenge to family planning programs in sub-Saharan Africa is to meet the growing needs of a growing population, i.e., to increase access to family planning

services. Access—the degree to which methods and services can be obtained at a level of effort and cost that is both acceptable to and within the means of a majority of the population—is the final common pathway by which various programmatic inputs and activities operate to result in use of modern contraceptive methods appropriate to clients' fertility intentions.

Barriers to access fall into a number of categories: cognitive, socio-cultural, geographic, financial, and health system-related. Among the most significant barriers to access in sub-Saharan Africa include:

- lack of availability of a range of modern contraceptives suitable for women at different stages of reproductive intent;
- lack of skilled providers able to provide these methods;
- lack of regularly available services, lack of integration of needed services (MCH or immunization or HIV), and/or sub-optimal structure and flow of services;
- medical barriers, e.g., unjustified contraindications, process hurdles, provider biases, restrictions on which cadre can provide which methods, or which category of client can receive them, and poor side effects management[7];
- lack of accurate understanding of FP methods' means of action, proper use and common side effects (by clients and/or providers); and,
- restrictive gender norms.

Each of these access barriers represents a significant and costly challenge to sub-Saharan African family planning programs. Failure to address these barriers, however, is even more costly, as it will result in inefficient and ineffective family planning programs that will fail to meet the current and future needs of sub-Saharan African women and men discussed above. The consequences of limited or poor access to family planning services are clear: the truth of the adage, "no product, no program," can be fairly expanded to "no access, no program."

Fortunately these challenges also represent an opportunity, for many lessons have been learned about how to provide effective family planning services and how to increase access to them. Furthermore, the "product" that family planning programs are offering is beneficial to individuals, communities and countries, and is increasingly perceived by them as such.

One model of effective service provision, which is applicable to national- regional- and district-level FP/RH programs, is the ACQUIRE Project's "supply-demand-advocacy" Program Model for Family Planning/Reproductive Health Service Delivery (See Figure 4).[8] This model is informed by years of experience providing family planning services in many countries and settings, and reflects a holistic understanding of the components and dynamics of health systems that provide family planning and reproductive health services.

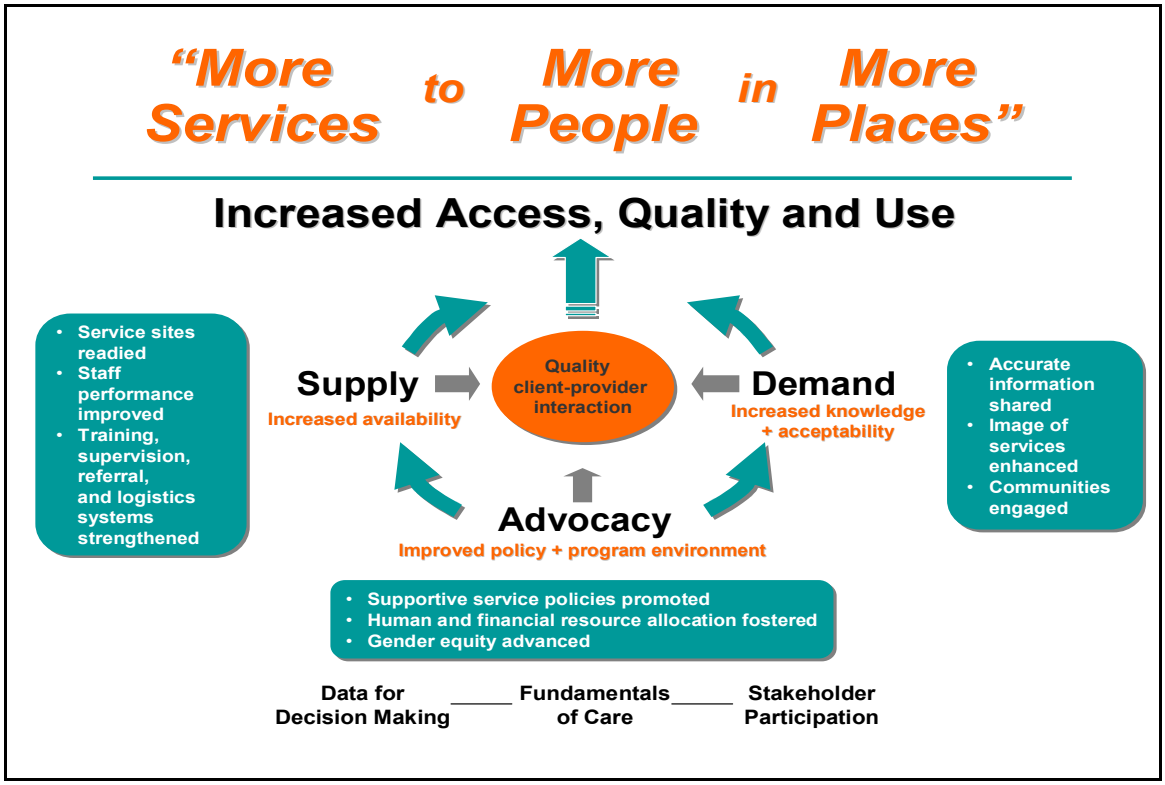
At the center of the model, because it is the key event in service delivery, is the service encounter between a knowledgeable, empowered client and a skilled, motivated service provider at an appropriately staffed and well-managed service site. This encounter is enabled by well-functioning supply-side and demand-side program elements and systems operating within a supportive policy and program environment. In the aggregate, these

interactions further the goals and mission of the health system and family planning program: increased access to and use of quality family planning services.

Important cross-cutting programmatic imperatives identified by the model include the needs: to focus on the fundamentals of care (informed choice, medical safety and ongoing quality improvement); to use data, especially locally-generated data, for decision-making and advocacy; and to ensure widespread stakeholder participation—and thus ownership and, hopefully, sustainability. The model also emphasizes the need to heed the principles and dynamics and lessons learned about effecting behavior change, because what is involved in improving and increasing family planning services is change in the behavior of key stakeholders at multiple levels: policymakers, program managers, service providers, supervisors, community members, clients and donors.[9]

Removing access barriers and otherwise programming strategically and holistically will allow family planning programs in sub-Saharan Africa to meet a greater proportion of their citizen's unmet and future need for family planning. Without concerted attention and increased prioritization to family planning by sub-Saharan African policymakers and program leaders and interested bilateral and multilateral donors, African family planning programs will continue to plateau or decline; fertility will remain high, and higher than desired; individual health and well-being[10] will be jeopardized; and national development goals will be difficult or impossible to achieve.

Figure 4. The ACQUIRE Project's Program Model of FP/ RH Service Delivery



[1] Population Reference Bureau. 2006. *2005 World Population Data Sheet*. Washington, DC. And UNFPA, State of the World Population, 2006: http://www.unfpa.org/swp/2006/english/notes/indicators/e_indicator1.pdf

[2] *New Estimates of Unmet Need and the Demand for Family Planning*, DHS Comparative Reports # 14, Westoff, 2006.

[3] Population Reference Bureau. 2006. *2005 World Population Data Sheet*. Washington, DC. And UNFPA, State of the World Population, 2006:

[4] Detection of this loss of programmatic momentum depends to some extent upon the year of the DHS survey. For example, Zambia's rising curve from 1992-2001/02 is quite similar to Malawi's from 1992-2000; it was only with the 2004/05 DHS for Malawi that the falloff in increased uptake of modern contraception was revealed, with its CPR trajectory now more closely paralleling the dropoff seen in Tanzania. This is likely to be the pattern seen in the next DHS for Zambia.

[5] *The stall in the Fertility Transition in Kenya*, DHS Analytical Studies # 9, Westoff, C. and Cross, A. 2006.

[6] All Party Parliamentary Group on Population, Development and Reproductive Health, "Return of the Population Growth Factor: Its Impact on the Milleninum Development Goals" (HMSO, London, 2007, as cited by Campbell M, Cleland J, Ezeh A, and Prata, in "Return of the Population Growth Factor" *Science*, 315, 1501-1502, 16 March 2007.

[7] Medical barriers are "policies and practices, derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception." Shelton, J., Angle, M., & Jacobstein, R. Medical barriers to access to family planning. *Lancet* 340(8831):1334-1335.

[8] The ACQUIRE Project (Access, Quality and Use in Reproductive Health) is a USAID- funded project whose aim is to increase use of reproductive health and family planning services, with a focus on facility-based services and clinical contraception, especially long-acting and permanent contraception. ACQUIRE was competitively awarded in 2003 to a partnership headed by EngenderHealth that includes: the Adventist Development and Relief Agency, International; CARE; IntraHealth International; Meridian Group International; and the Society for Women and AIDS in Africa.

[9] Perhaps the most important lesson to heed from the study of change is that the single highest correlate with whether or not individuals (clients, providers, policymakers, and/or health units) will change their behavior is the benefit that they—not the "experts" or policymakers—perceive to any given new behavior, e.g., the adoption of family planning by a client, or its provision by a provider.

[10] The health rationale alone is compelling enough reason to work for increased family planning services in sub-Saharan Africa: a woman in sub-Saharan Africa has a 1 in 16 lifetime chance of having a maternal death, and for every 109 births a woman dies in pregnancy or childbirth. And that mortality is only the tip of the iceberg: for every woman who dies approximately 30 others suffer injuries, infection and disabilities, many of them debilitating. Ensuring access to effective family planning could reduce maternal deaths by 20–35% and child deaths by as much as 20% [source: Executive Director, UNFPA)]. Effective family planning could also save hundreds of thousands of African children every year; and effective FP prevents more mother- to-child transmission of HIV than do ARV drugs.