

POPULATION ACTION  
INTERNATIONAL

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**AFRICA'S  
POPULATION  
CHALLENGE:  
ACCELERATING  
PROGRESS IN  
REPRODUCTIVE  
HEALTH**

**COUNTRY STUDY SERIES #4**

**JAMES E. ROSEN  
SHANTI R. CONLY**

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WASHINGTON DC



## **About Population Action International**

Population Action International (PAI) is dedicated to advancing policies and programs that slow population growth in order to enhance the quality of life for all people.

PAI advocates the expansion of voluntary family planning, other reproductive health services, and educational and economic opportunities for girls and women. These strategies promise to improve the lives of individual women and their families while slowing the world's population growth.

To these ends, PAI seeks to increase global political and financial support for effective population policies and programs grounded in individual rights.

PAI fosters the development of U.S. and international policy on urgent population issues through an integrated program of policy research, public education and political advocacy. PAI reaches out to government leaders and opinion makers through the dissemination of strategic, action-oriented publications, broader efforts to inform public opinion, and coalitions with other development, reproductive health and environmental organizations.

## **About This Report**

This report is the fourth in a series, including studies on China, India and Pakistan, which examines family planning and other reproductive health services in the developing world. The report highlights the progress countries in sub-Saharan Africa have made towards expanding access to these services and the key challenges they face, drawing on research by and interviews with experts on Africa, and information the authors gathered during visits to African countries.

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Cover: Traditional West African textile

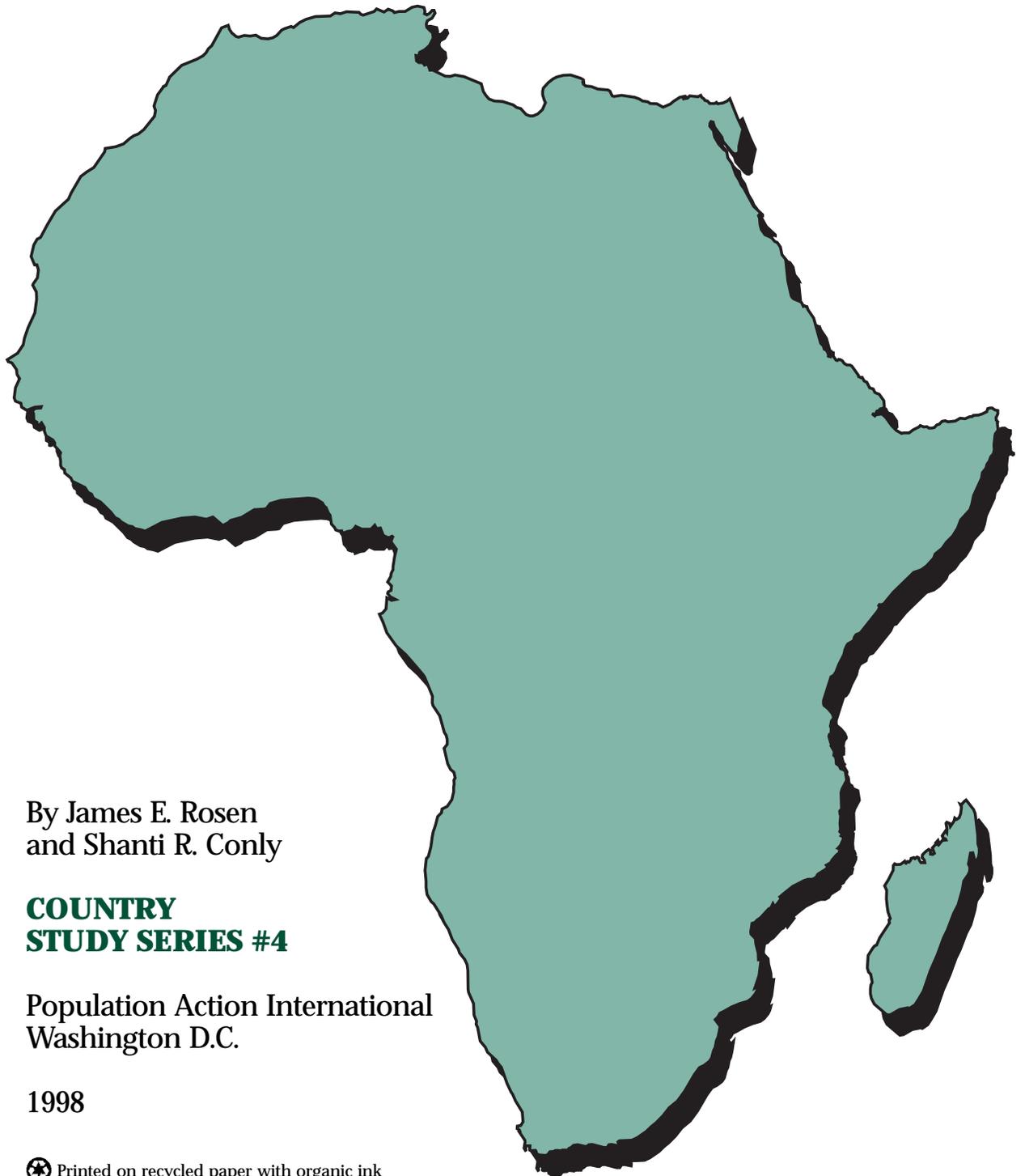
ISSN: 1085-3636

Library of Congress Number: 98-065400

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# AFRICA'S POPULATION CHALLENGE: ACCELERATING PROGRESS IN REPRODUCTIVE HEALTH



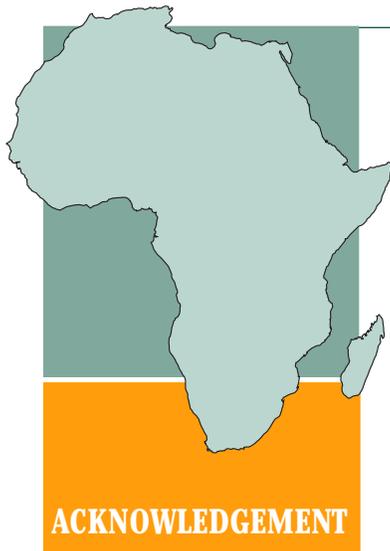
By James E. Rosen  
and Shanti R. Conly

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STUDY SERIES #4**

Population Action International  
Washington D.C.

1998

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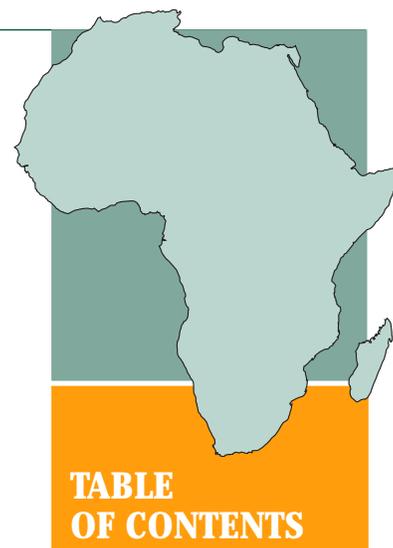


**M**any colleagues contributed to this report – unfortunately, too many for us to acknowledge them all individually. The authors especially benefited from discussions and field visits in Ghana, Kenya and Senegal. Deryck Omuodo of Winam Associates in Kenya and Alle Diop of the Futures Group in Senegal, as consultants to PAI, did an outstanding job of organizing programs for us in those countries. Alex Banful and Kojo Lokko of the Ghana Social Marketing Foundation graciously volunteered to set up meetings and site visits in Ghana, which again were extremely productive.

We are grateful to the dozens of officials from donor, government and private agencies in these countries and in the United States who so generously gave of their time to meet with us and share their knowledge and expertise. In addition, we are deeply indebted to the program managers and clinic and outreach staff who showed us their achievements and problems on the ground, helped us make contact with clients and gave us invaluable insight into the delivery of reproductive health services.

Many thanks, too, to those colleagues on both sides of the Atlantic who enriched the report through their comments on an earlier draft. They include: Ian Askew, Barney Cohen, Joseph Dwyer, Marguerite Farrell, Nancy Harris, Joan Healy, Ray Kirkland, John Kekovole, Virginia Ofosu-Amaah, Fred Sai, Placide Tapsoba, Richard Turkson and Susi Wyss. Naturally, the report's flaws are the responsibility of the authors.

Finally, thanks to the many PAI staff who helped to shape and edit the report. In particular, we thank Karen Helsing and Beverly Johnston, who provided excellent research support and prepared the charts, tables and boxes for the report. Anne Marie Amantia and Jennifer Wisnewski also did an outstanding job of helping us gather the background literature for this project.



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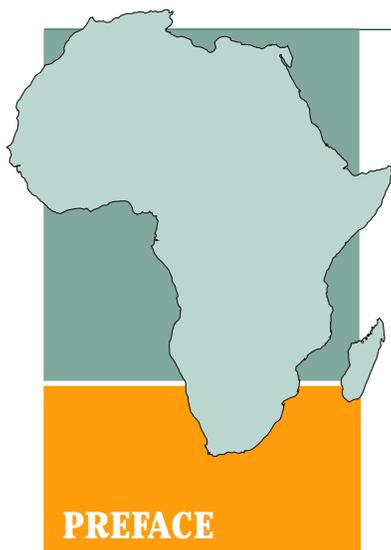
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# SUB-SAHARAN AFRICA



Population Size (1997):	622 million
Births Per 1,000 Population:	43.8
Annual Population Growth Rate:	2.8%
Births Per Woman (Total Fertility Rate):	6.1
Population Doubling Time:	25 years
Percentage of Couples Using Contraception:	18%
Infant Deaths Per 1,000 Births:	105
Maternal Deaths Per 100,000 Births:	980
Literacy Rate Male/Female:	67%/47%
GNP Per Capita:	\$490



*Dr. Fred T. Sai has had a long and distinguished career dedicated to addressing the health risks women and children face as a result of frequent childbearing. The highlights of his career include co-founding the Planned Parenthood Association of Ghana and the Africa region of the International Planned Parenthood Federation (IPPF) and serving as senior population adviser to the World Bank, chair of the 1994 International Conference on Population and Development and President of IPPF. He received the 1993 UN Population Award for his involvement and global leadership in this field.*

**H**aving devoted much of my life to improving the health of women and children in sub-Saharan Africa, I am happy to see African governments enthusiastically embrace the agenda adopted by the 1994 International Conference on Population and Development (ICPD). The concept of total reproductive health speaks to Africans. We see not only a need through family planning to prevent the health risks of frequent childbearing, but also to reduce the high toll of illness and deaths associated with pregnancy and childbirth and to prevent the spread of sexually transmitted diseases (STDs), including HIV/AIDS. Yet despite a sea change from their earlier passivity, most governments in the region could do much more to improve reproductive health.

Although we Africans face enormous challenges in the area of reproductive and child health, I am optimistic that we are making headway. Infant and child death rates had been declining steadily across the continent until economic problems and the AIDS epidemic recently slowed progress. Contraceptive use is increasing and birthrates are falling in several countries, although it is too early to see an impact yet on population growth. Botswana, Kenya, South Africa and Zimbabwe are leading the way, and I expect my own country, Ghana, to join their ranks soon.

Nevertheless, there are several areas where major changes are still needed.

As a physician, it is my view that reproductive health generally and family planning in particular have received too low a priority in Africa. Family planning remains overly medicalized, especially in light of the huge unmet need for services and the scarcity of doctors in rural areas. African governments need to relax restrictions on contraceptives that have a safe record of use elsewhere – the pill over the counter is better than a risky abortion. Health care workers need to listen to people to learn the best ways to reach them with services.

Governments also cannot do it alone. Private groups were in the vanguard of reproductive health and early family planning efforts in Africa. Even

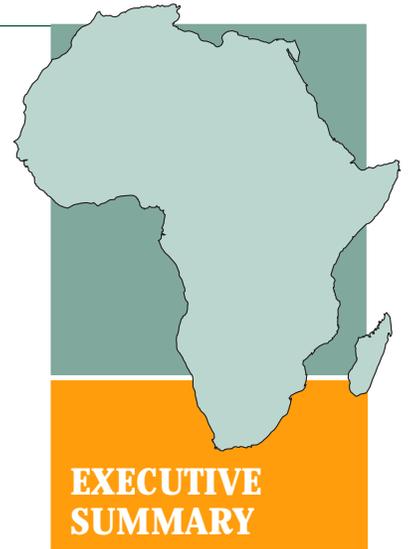
though governments are now strengthening services at public sector health facilities, private groups still have a pioneering role to play in identifying creative new approaches. The challenge now is to mobilize different groups and harmonize their contributions.

The ICPD has made it possible for Africans to talk about previously taboo topics such as female genital mutilation and unsafe abortion. But our deep ambivalence about adolescent sexuality is causing us to fail our rapidly growing population of young people. These young people *are* Africa's future, and we need to make sure they get the information and services they need to protect themselves from AIDS and other STDs and early pregnancy. Over the long-term, efforts to help young people postpone pregnancy will also benefit society by increasing the span between generations and slowing population growth. The clock is ticking and time is of the essence if we are to avoid losing a generation.

I am struck that all these problems – unwanted pregnancy, risky sexual behavior contributing to AIDS and other STDs, infant and child deaths, poor access to education – are interrelated, as are their solutions. There is mutual synergy, for example, between educating girls and expanding reproductive health services. When mothers use family planning, their daughters are less likely to stay home from school to help care for younger siblings and help with housework. If teenage girls have access to good family life education and reproductive health services, they are less likely to get pregnant or get AIDS and drop out of school. When women are educated, they can more easily insist that their partners use condoms.

Finally, solutions to these problems require the sharing of experiences – both within Africa and with other regions. I am delighted to see the increase in South-to-South exchanges and partnerships, including within Africa. As a member of Population Action International's Board of Directors, I hope this report in its own small way can contribute to the sharing of African experiences.

Dr. Fred T. Sai



Sub-Saharan Africa\* is experiencing a period of extraordinary change. Across the continent, policy reforms are contributing to dynamic economic growth. Greater political openness has strengthened the commitment of African governments to meeting the basic needs of their people.

Despite these positive trends, sub-Saharan Africa faces a development challenge greater than any other region. Much of the continent's population remains desperately poor. With record numbers of adolescents entering their childbearing years, in less than three decades Africa's population is projected to double again from the current level of 620 million. Meanwhile, many African nations are struggling to provide health and education services to populations expanding at about three percent a year. In many countries, rapid population growth is contributing to degradation of the environment and undermining prospects for prosperity.

Africa's hopes for a better future depend in large part on improving the health of its people. Better access to good quality reproductive health services, particularly family planning, is key to improving health status – especially for women. The reality of reproductive health in Africa, however, is far from ideal. Women begin childbearing in their teens and have an average of six children. Just 18 percent use contraception, and the level of unmet need for family planning – over one-quarter of married women or more than 22 million women – is higher than in any other region. Early and frequent childbearing means that 1 in 15 women in Africa dies in pregnancy or childbirth. Meanwhile, AIDS has struck hard in eastern, central, and southern Africa, where roughly 1 in 10 adults – both men and women – are infected with HIV.

Yet traditional attitudes favoring large families are changing rapidly,

owing to the growth of cities, the rising cost of living and lower child death rates, among other factors. Demand for family planning has increased dramatically in some countries, and the decline in birthrates – limited as recently as a decade ago to only a few countries in the region – appears to be spreading steadily across the continent.

In much of Africa, however, large families are still the norm. This situation is reinforced by low levels of education, particularly among women, and social barriers to the full economic participation of women. Yet, school enrollment rates declined or came to a standstill during the economic crisis many African countries experienced in the 1980s.

Compared to countries in other developing regions, African countries have only recently begun to adopt population policies and initiate family planning and related reproductive health programs. Since the 1980s, however, African governments increasingly recognize the individual and societal benefits of smaller families. In the last decade there has been steady growth in the number of countries establishing national family planning programs and in the scope of these efforts. In Botswana, Kenya and Zimbabwe, which established family planning programs early on, family planning use now approaches or exceeds 40 percent of married women of childbearing age.

Still, Africa has a long way to go. In addition to meeting the growing need for family planning and reproductive health services, African countries must expand access to education for girls and economic opportunities for women. This will require significantly increased financial contributions from African governments and households, as well as international donors. In sum, addressing poor reproductive health and rapid population growth is a daunting task requiring comprehensive action on many different fronts. Priority areas for action by governments and international donors are summarized below.

\*The terms "sub-Saharan Africa" and "Africa" are used interchangeably.

*Africa's hopes for a better future depend in large part on improving the health of its people.*

*Government health services, despite their weaknesses, are the primary source of contraceptive services.*

## **Expanding and Improving Family Planning and Related Reproductive Health Services**

With only half the population having easy access to health care, most countries face an enormous challenge increasing the coverage and quality of family planning and reproductive health services.

### **Expanding Access**

***Governments must increase overall coverage of basic health care to expand access to family planning and reproductive health services.***

Over the long-term, governments need to aggressively expand primary health facilities and staff – especially in rural and urban areas lacking adequate services – and raise the quality of basic health services. Health sector reform efforts must include family planning and other reproductive health services within the package of basic health services they support.

***Governments need to complete the process of building capacity within existing public sector health services to provide quality family planning care.***

Government health services, despite their weaknesses, are the primary source of contraceptive services and often the only source of modern health care for the poor. Governments must ensure that all public sector health facilities have the trained staff and supplies they require to consistently offer an appropriate range of contraceptive services.

***Governments need to expand and strengthen outreach efforts at the community level.***

Community outreach programs can extend family planning education and services beyond the clinic and help bridge the cultural divide between the client and the clinic setting. To strengthen these programs, governments should allow community workers to distribute oral contraceptives,

while providing training and adequate medical back-up to address concerns over nonprescription distribution of this method. Outreach programs need to build stronger referral networks to clinical services, intensify the coverage and frequency of home visits, and increase involvement of the community in all stages of program design and implementation.

***Governments must remove legal and regulatory barriers that limit access to family planning and reproductive health services.***

Governments should move quickly to repeal the outdated laws prohibiting the sale and promotion of contraceptives still in effect in some French-speaking countries, and ensure that the legal system supports efforts to implement reproductive health programs. They also need to remove import duties and taxes that contribute to higher commercial prices for contraceptives. With doctors in short supply, governments should modify regulations preventing trained nurses and nurse-midwives from performing procedures such as Norplant and IUD insertions.

***With the support of donors, governments need to strengthen the basic management systems that support these services, especially contraceptive supply.***

Public sector health and family planning services are expanding across Africa; at the same time, countries are decentralizing the management of these services. To meet these challenges, countries need to expand and improve training of managers and technical personnel at all levels. In particular, if services are to satisfy the rising demand for contraception, governments and donors must improve contraceptive supply systems by training staff and upgrading management information systems.

***Governments and donors must intensify efforts to tap the full potential of the private nonprofit and commercial sectors.***

Nongovernmental organizations (NGOs) in Africa continue to pioneer new approaches to family planning service delivery and to play an important advocacy role. Governments should draw on NGO expertise in areas such as training, and strengthen links between NGO outreach programs and public sector clinics. Meanwhile, international donors should expand funding for NGO services while helping NGOs move towards greater self-sufficiency.

Although many Africans cannot afford even low-cost health services, the private, commercial sector has some potential to expand its provision of family planning and related reproductive health services. To encourage greater participation of the private sector, governments must create a more positive legal and regulatory climate for private activities.

Social marketing programs, which promote and sell subsidized contraceptives through commercial networks, have expanded rapidly in sub-Saharan Africa. With AIDS prevention as their primary goal, most programs have focused on condom distribution. Social marketing efforts need to broaden the range of contraceptive methods provided, including highly popular oral and injectable contraceptives. Governments should also work to eliminate barriers to the effectiveness of these programs such as advertising bans and restrictions on sales outside of pharmacies.

### **Improving Quality**

***Both government and NGO programs must shift towards a more client-oriented approach to reproductive health services.***

Both the choice of contraceptive methods available to African couples and public knowledge of these methods have steadily increased. Still, health staff in many countries place unwarranted obstacles to family planning use and clients do not always receive accurate and complete information. Improved support to front-line health staff is crucial to address these problems and improve counseling and

service quality. Programs should use supervisors more in training of field staff and raise the frequency of supervisory visits. To correct misperceptions on the part of health workers about contraceptive methods, governments need to give field staff clear guidelines for provision of contraceptives based on medically sound criteria. To complement these efforts, public education must build a better base of knowledge about reproduction and contraception at the community level, including information on sources of services.

***To promote availability of a broader choice of contraceptive methods, family planning services must also include access to long-acting clinical methods.***

Interest in clinical methods such as voluntary sterilization has been steadily growing in Africa, but access to such services and levels of use remain very low. As a practical approach to meeting the demand for clinical methods, governments should establish services selectively in sites where quality – especially with respect to counseling and infection prevention – can be maintained. Programs also need to work to dispel rumors and misinformation through better counseling and information about clinical methods. With the increasing popularity of injectable contraceptives, programs should test safe and effective ways for health auxiliaries and community agents to administer injections.

### **Reaching Adolescents and Men**

***Governments must ensure that young people have the information, skills and means to protect themselves from unwanted pregnancy, AIDS and other STDs.***

Despite growing awareness of the risks associated with unprotected sexual activity among adolescents, access to reproductive health services and information for young people remains severely constrained by laws, policies and the biases of health work-

***To encourage private sector family planning services, governments must create a more positive legal and regulatory climate.***

*Although African men play an important role in childbearing decisions, family planning programs have for the most part ignored their needs.*

ers. Governments need to expand and improve school-based sexuality education, and make information and services more easily accessible to out-of-school youth, for example through community-based peer education programs. Public sector clinics need to make adolescents feel more welcome; where feasible, governments and NGOs should also establish special youth-friendly clinics or centers which provide both reproductive health and other services.

***Family planning and reproductive health programs need to encourage men to take more responsibility for contraception and be more supportive of their partners.***

Although African men play an important role in childbearing decisions and are crucial to efforts to prevent sexually transmitted diseases (STDs), family planning and reproductive health programs in the region have for the most part ignored their needs. To address this gap, clinics providing contraceptive services must be made more comfortable and welcoming to men. Countries must also expand the pool of physicians able to perform vasectomy and improve training to counteract the negative attitudes many health workers have towards the procedure. Public education efforts – especially those emphasizing AIDS and STD prevention – should strongly encourage men to use condoms consistently with casual partners and to improve communications with their partners on reproductive health issues.

### **Improving Population Policy**

***Governments must strengthen formulation and coordination of population policy.***

Agreement at the 1994 International Conference on Population and Development (ICPD) on a comprehensive approach to slowing population growth raised awareness of a whole host of needs relating to improving reproductive health and women's status. To meet this new set of chal-

lenges, governments must strengthen existing national institutions charged with development and coordination of population policy. With support from the international community, they should build the capacity of these institutions to analyze the potential impact of demographic trends on various aspects of development.

Population policy institutions also need to address concerns about the impact of AIDS on population growth. These institutions need to stress the health benefits of family planning and reinforce the synergies between family planning and AIDS/STD prevention. Such institutions should provide policymakers with current and accurate information on important trends relating to AIDS – for example projections that population will likely continue to grow even in the hardest hit countries.

### **Strengthening Links Between Family Planning and Other Reproductive Health Services**

***Programs should improve links between family planning and other reproductive health services.***

Despite growing evidence of the advantages of a comprehensive approach linking related reproductive health services, existing family planning programs have had difficulty effectively incorporating such services, especially in the area of STD prevention. To successfully integrate services, programs must train workers in new skills, make equipment, drugs and other medical supplies required for diagnosis and treatment available, adapt client counseling and information, and broaden public education campaigns. To achieve effective links, programs must carry out thoughtful testing and introduction of new strategies. While broadening the scope of population programs, governments must take care not to undermine family planning services, which are still new, weak and badly needed.

***A top priority is for health and family planning services to do more to prevent the spread of HIV/AIDS and other sexually transmitted diseases.***

The seriousness of the AIDS epidemic requires urgent government action. Family planning programs represent an important but underused vehicle to reach those at risk of HIV infection – especially women. In the absence of a low-cost treatment for AIDS, programs should emphasize preventive efforts through education, promotion of condom use and infection control in clinical procedures. At the same time, health services should seek to improve STD screening and treatment – especially since treatment of common sexually transmitted diseases appears to significantly lower chances of HIV transmission.

***To lower risk of maternal death, governments must improve access to emergency obstetric care, with special emphasis on expansion of postabortion services.***

Despite heightened awareness, maternal death rates in Africa show no sign of decreasing. To prevent maternal death, countries must make long-term investments in upgrading facilities, equipment and staff skills to make emergency obstetric care broadly available. In the short-term, efforts to prevent maternal death should emphasize community-wide education to help identify potentially dangerous situations in pregnancy and childbirth, and when and how to take action. The establishment of emergency transportation networks at the community level should also be a priority.

To complement these efforts, health ministries and NGOs should continue to educate policymakers and the general public about the prevalence and health impact of unsafe abortion. Meanwhile, governments should redouble efforts to train health workers in emergency postabortion care, including easier access to family planning information and services for women treated for abortion complications.

## **Improving the Status of Women**

The lack of gender equality in Africa affects the ability of women to use contraception and other reproductive health services and increases their risk of unwanted pregnancy and AIDS and other STDs. The most effective long-term strategy to empower women is to encourage parents to send their daughters to school – and keep them enrolled – while simultaneously expanding economic opportunities for women.

***Governments need to strengthen efforts to raise school enrollment for girls.***

Governments must apply a broad range of interventions to address the complex reasons that prevent girls from entering and completing school. Governments need to find ways to use existing facilities more efficiently and shift spending from higher education to primary and secondary education. Priorities include lowering the direct and indirect costs of attending school for girls and their families, and recruiting more women teachers. Increasing enrollments will also support the desire of many young women to delay marriage and childbearing, with important consequences for future population size in the region.

***Countries must eliminate institutional and legal barriers that prevent women from becoming equal partners in development.***

Governments can help empower women by ensuring that women – who do the bulk of farming – obtain better access to farm technology and credit. Through efforts to reduce employment discrimination, governments can also improve the chances of formal sector employment for women and give parents further motivation to keep their daughters in school. Governments should also ensure that legal systems promote equal rights for men and women, especially in matters such as

***Despite heightened awareness, maternal death rates in Africa show no sign of decreasing.***

*Given the poverty of the region, donors must continue to bear a large share of the costs of providing reproductive health services.*

inheritance and property rights within marriage.

***Efforts to halt the practice of female genital mutilation must focus on community education and involve health professionals.***

Female genital mutilation (FGM) affects half of all women in sub-Saharan Africa and contributes to women's reproductive health problems. African societies must bear the primary responsibility for efforts to end FGM, although the support of the international community remains important. Health professionals should expand their involvement in efforts to educate men and women about health problems associated with the practice and recognizing and treating complications of FGM. Ultimately, both formal and informal education is likely to be key to ending this deep-rooted cultural tradition.

## **Assuring Adequate Funding**

Some wealthier countries in Africa can bear a greater proportion of the costs of family planning and other reproductive health programs. But most countries are extremely poor, and both governments and individuals are limited in their ability to pay for services. Current funding falls far short of the estimated \$2 billion in the year 2000 and \$3.5 billion by 2015 required to meet projected family planning and reproductive health needs in the region. Mobilizing the resources to bridge this gap is thus an enormous challenge.

***Governments, private households and international donors must all increase their financial contributions if countries are to reach the goal of universal access to the basic package of reproductive health services by the year 2015.***

African governments spent only about \$200 million in 1990 for all preventive health services, including family planning and reproductive health services. Many African govern-

ments could increase spending on basic health care by shifting priorities from military to social spending, reallocating resources from curative to preventive services, continuing to decentralize health services and gradually introducing appropriate user fees.

Given the poverty of the region and the magnitude of resources required to implement ICPD objectives, donors must continue to bear a large share of the costs of providing reproductive health services in the region. To meet the commitments made by the international community at the ICPD, donors must at least double their collective contribution for family planning and reproductive health in the region by the year 2000 from the current level of roughly \$500 million annually.

***Donors and governments must work together to make better use of limited population assistance.***

Donors need to overcome differences in style and purpose to work together more effectively for the benefit of national programs. To help build sustainable programs, donors should maximize use of local family planning and reproductive health experts, and support increased collaboration and sharing of experience among African countries.

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The comprehensive agenda described above will require enormous effort by donors and African governments. The task is large, yet attainable if governments increase their commitment to reproductive health and family planning programs. Africa's relatively recent adoption of population policies and programs has given its policymakers the chance to learn from both the mistakes and achievements of other regions which have grappled with the problems of poor reproductive health and rapid population growth. African countries – with help from the world community – can build on these experiences and achieve their own full potential for development.

**T**he potential for economic development in sub-Saharan Africa is greater now than at any time in the past quarter century. With the spread of democracy to more countries, a new generation of leaders appears more responsive to the needs of their people. Although civil strife still plagues parts of the continent, many long-running conflicts have ended, sparking hope for greater political and economic stability. A recent upturn in economic growth has generated optimism about the long-term prospects for improving incomes.

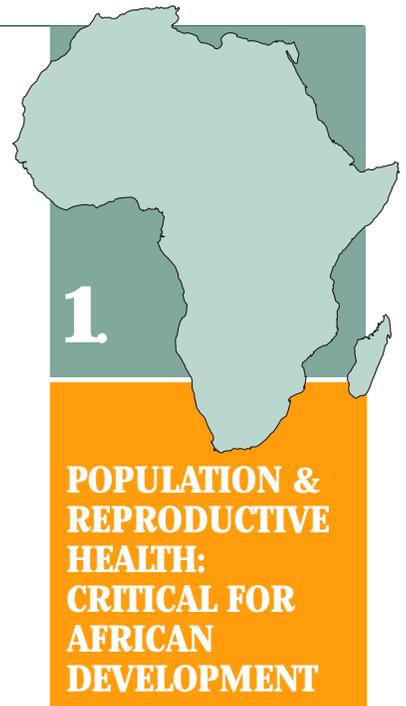
However, continued rapid increases in population could derail these fragile political and economic gains. Never has a region faced such sustained, high population growth on its path to development. Increasing at almost three percent yearly since the mid-1970s, the population of sub-Saharan Africa has doubled in just 25 years. Since large families are still the norm and a huge group of young people is about to enter their repro-

ductive years, in less than three decades Africa's population is projected to double again from the current level of 620 million – even after taking into account declining birthrates and rising deaths from AIDS.

Solid improvements in health over the last half-century are part of the story behind Africa's unprecedented population growth. Successful public health measures to control infectious diseases – especially among children – have helped cut death rates in half. In contrast, use of contraception has increased more slowly and, largely as a result, family size has only recently begun to fall.

### Family Planning and Reproductive Health: Key to Individual Well-Being

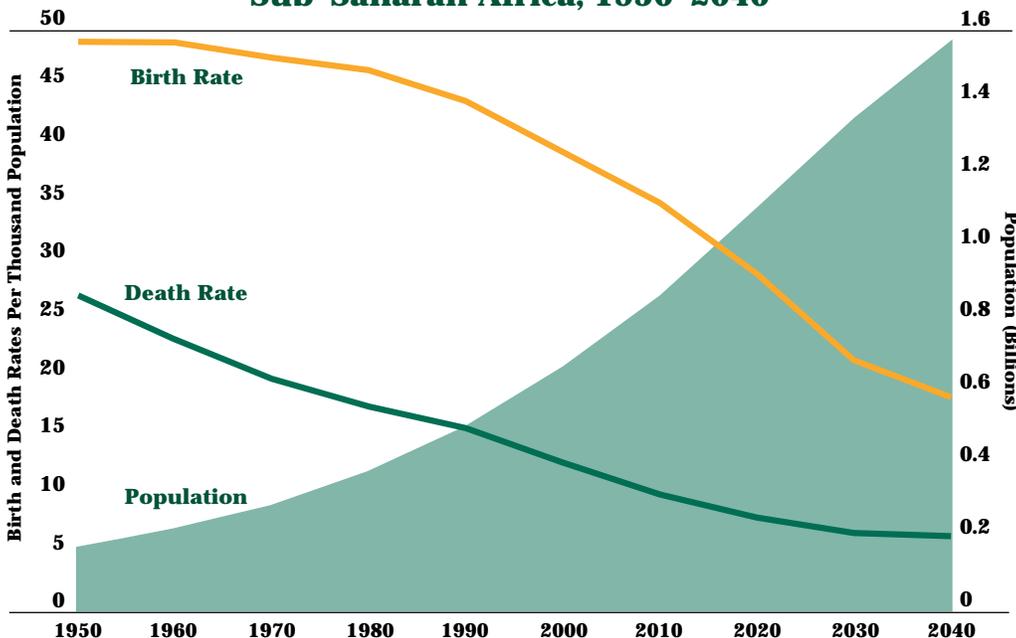
To a large extent, Africa's hopes for achieving economic prosperity and improving the health of its people hinge on better access for all African couples to quality family planning and



*Increasing at almost three percent yearly since the mid-1970s, the population of sub-Saharan Africa has doubled in just 25 years.*

FIGURE 1

### Population Size and Birth and Death Rates Sub-Saharan Africa, 1950-2040



Numbers for 1995-2040 based on United Nations medium projections.

SOURCE: United Nations. *World Population Prospects: The 1996 Revision*. New York: United Nations, 1996.

*Just 1 in 10 of the world's women live in sub-Saharan Africa, but the region accounts for 40 percent of all pregnancy-related deaths worldwide.*

related reproductive health services. Improved access to these services will have enormous benefits for individual Africans and, at the same time, contribute to slower population growth, which in the long run will benefit African society as a whole.

Nowhere, however, is the reality of reproductive health farther from the ideal than in Africa. Women bear the burden of frequent high-risk pregnancies; of raising large families; and, increasingly, of the AIDS epidemic. They also must perform household chores and most agricultural work. Together, these conditions have devastating consequences for the health and well-being not only of African women, but also of their families.

■ Just 1 in 10 of the world's women live in sub-Saharan Africa, but the region accounts for 40 percent of all pregnancy-related deaths worldwide – 215,000 deaths every year, or one every two and a half minutes. Childbearing is riskier in Africa than anywhere else – one woman dies for every one hundred births – and most women have numerous pregnancies. Less than half of women receive any kind of skilled maternity care and half are anemic. During her lifetime, an African woman has a 1 in 15 chance of dying from reasons related to pregnancy, odds over 200 times greater than those faced by women in the United States. The risks are somewhat lower in southern Africa, where incomes are higher than elsewhere in the region, access to health care is better, and women bear fewer children.

■ Young women face heavy social pressure to marry and bear children early; more than half of women give birth by age 20, a proportion that has remained substantially unchanged over the years. Early childbearing increases the risks of complications during pregnancy and reduces the chances of survival for children. It also shortens the span

between generations, contributing to greater population momentum and higher rates of population growth.

■ Although the chances of survival for African children have improved markedly over the past four decades, one in six children still does not live to see his or her fifth birthday. Moreover, the region-wide economic slump has slowed progress in battling child deaths in Africa since 1980. Child immunization rates of 50 percent – already the lowest in the developing world – are only slowly rising. Fewer than half of pregnant women are adequately immunized against tetanus, resulting in the deaths of thousands of newborn infants annually.

Meanwhile, there is strong evidence of a trend towards smaller families as African couples increase their use of family planning. The potential beneficial impact of this trend on the health of women and children is enormous. As women bear fewer children, their exposure to the risks of pregnancy decreases; the children they have are more likely to survive and live a better life.

■ A fundamental shift in attitudes towards childbearing has taken place in Africa. Over the past two decades, ideal family size has decreased considerably across the region. The decline has been particularly steep in Kenya, where desired family size has dropped from seven to four, and in Nigeria and Senegal, from eight to six. Roughly a quarter of married women surveyed – triple the proportion in the 1970s – want no more children. In Kenya, the percent is over half and in Madagascar and Uganda, over a third want to limit family size.

■ Demand for family planning has increased dramatically in some African countries, although contraceptive use is still quite low for the

region as a whole. Use of family planning in countries such as Botswana, Kenya and Zimbabwe grew rapidly in the 1980s and 1990s, and now approaches or exceeds 40 percent – levels similar to those observed in Bangladesh and India. As a result, overall contraceptive use for the region has grown at about 1 percent per year – a modest increment compared to other regions, but nevertheless a notable

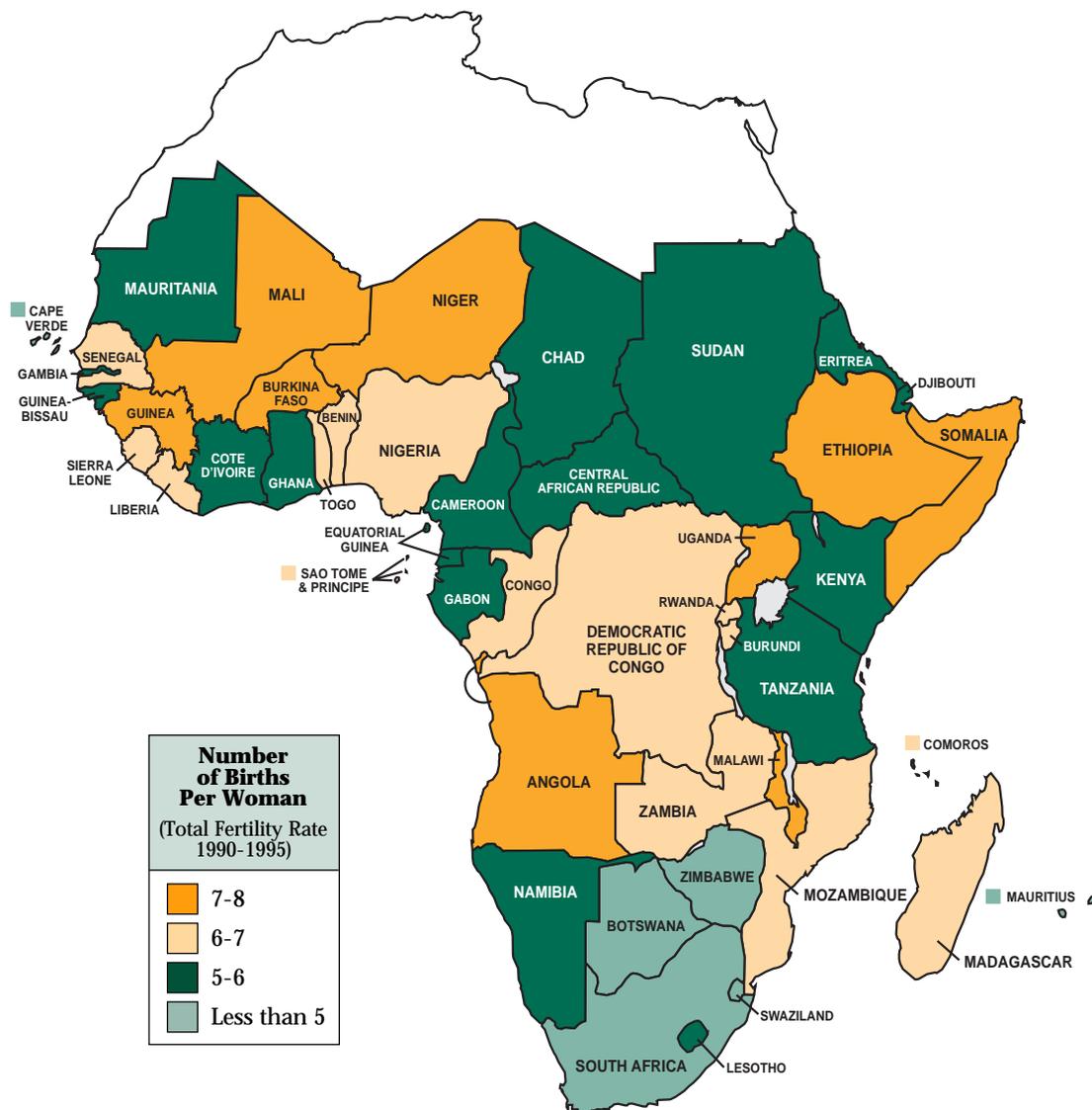
improvement after decades of little or no progress. Still, just 18 percent of married women of childbearing age use family planning – one-third the average for other developing regions; use of modern methods, at 12 percent, is even lower.

- Changes in desired family size and increased contraceptive use have stimulated a substantial fall in birthrates in a number of African

*Young women face heavy social pressure to marry and bear children early; more than half of women give birth by age 20.*

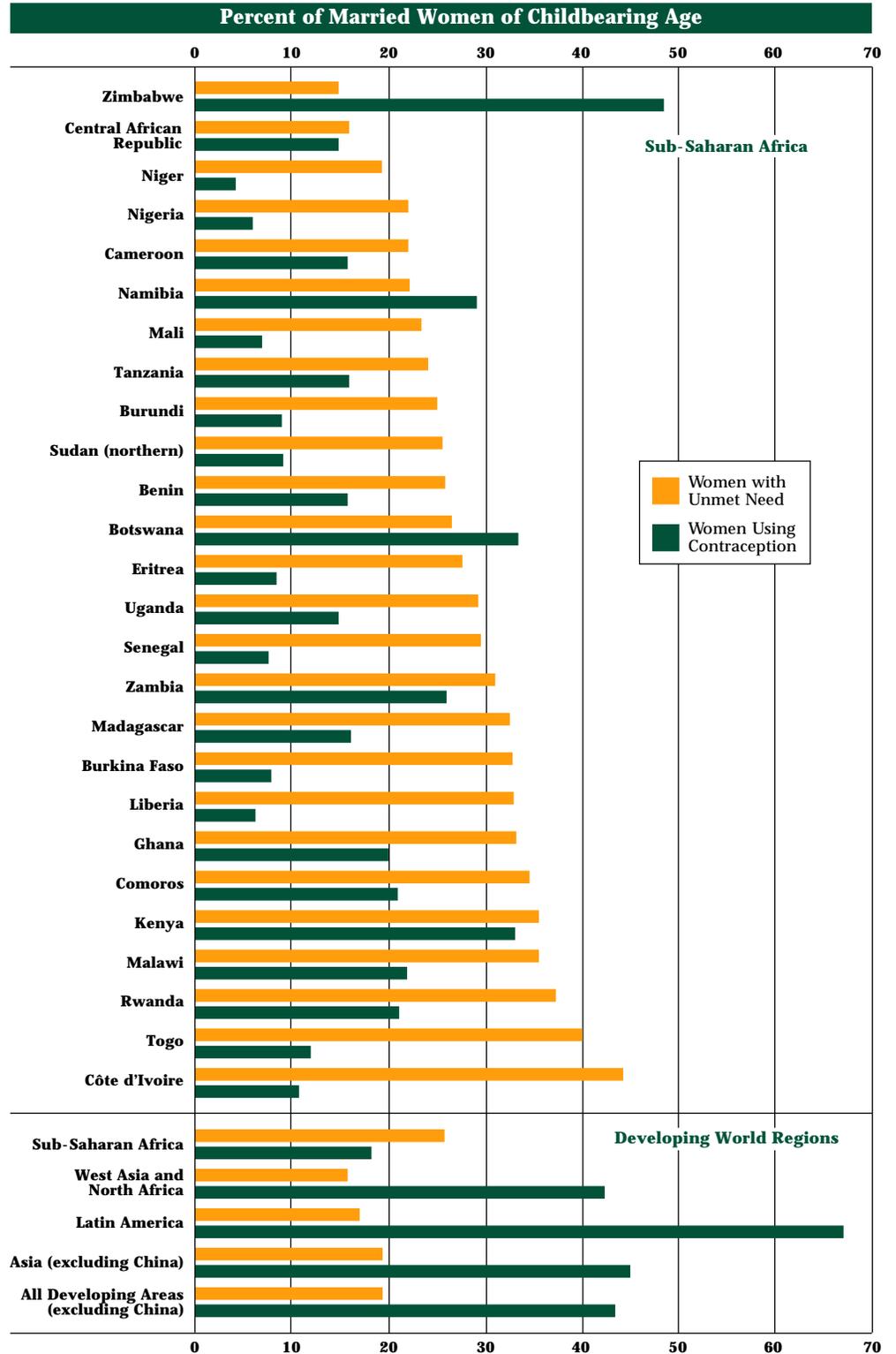
FIGURE 2

### Average Number of Births Per Woman in Sub-Saharan Africa



SOURCE: United Nations. *World Population Prospects: The 1996 Revision*. New York: United Nations, 1996.

**FIGURE 3**  
**Unmet Need for Contraception**  
**Sub-Saharan African Countries and Selected Regions**



**SOURCES:** Data from Demographic and Health Surveys, supplemented by data from UN Population Division and Population Reference Bureau.

countries, a trend that is spreading rapidly. For the region, average family size is about 6, down half a child from historical rates. A few countries, however, have experienced substantially larger declines. In Kenya, family size has fallen from 8 in the 1970s to 5.4; Zimbabwe has seen fertility decrease by a third since the 1980s to 4.3 children; between the 1980s and 1990s, smaller, but still important declines on the order of 10 to 30 percent have taken place in Côte d'Ivoire, Senegal, Zambia and at least six other countries. Both the size and speed of these declines are strikingly similar to those in other developing countries early in their transition to low fertility. Furthermore, in Africa as elsewhere, couples in cities are leading the downward trend in childbearing; family size is one to two children lower in urban than in rural areas.

Although the gap between the number of children women say they want and the number they have is small, it is widening – a strong indication that many women who wish to limit their family size face difficulty in doing so. In fact, many women in Africa want to delay or avoid another pregnancy, but are not using contraception; 26 percent of married women of childbearing age (22 million women) fit this definition of having an unmet need for family planning – a proportion higher than any other region of the world. Strikingly, in only 12 countries does unmet need exceed 30 percent of married women; 11 of them are in Africa. The rates are exceptionally high in Côte d'Ivoire (43 percent) and Malawi (36 percent).

High levels of unmet need for family planning result in numerous unwanted pregnancies and abortions. Given the severe legal restrictions on abortion in most countries, the vast majority of abortions – an estimated 3.2 million yearly – occur under unsafe conditions. Because most women lack access to good medical care, death rates

from complications of unsafe abortion are extremely high; about 22,000 African women die each year from unsafe abortion – roughly a third of all such deaths worldwide. For each woman who dies, many more suffer permanent injury or infections which can lead to infertility. Unsafe abortion also places a strain on scarce health resources; large hospitals in Kenya and Nigeria report that 60 percent of women admitted for gynecological problems suffer from abortion-related complications.

The worldwide HIV/AIDS epidemic has hit Africa especially hard. Currently, nearly 21 million adults and children are living with HIV/AIDS in sub-Saharan Africa. The virus has already killed over four million Africans – 90 percent of all AIDS deaths in the developing world. Unlike some other regions, HIV in Africa is transmitted mainly through heterosexual contact, and rates of infection in men and women are roughly equal.

The HIV/AIDS epidemic is most severe in eastern, central and southern Africa, where infection rates among adults – especially in urban areas – are staggering. More than 1 in 10 adults in Botswana, Malawi, Uganda, Zambia and Zimbabwe are infected with HIV; 10 other countries have infection rates of between 5 and 10 percent. In several large cities, more than 1 in 5 men and women carry the HIV virus; at an antenatal clinic in Harare, the capital of Zimbabwe, 32 percent of women tested positive for HIV in 1995.

Other sexually transmitted diseases (STDs), such as syphilis and gonorrhea, are also more common in Africa than in other regions. Worldwide, one out of five new cases of sexually transmitted diseases occurs in Africa. The health consequences of these diseases disproportionately affect women. In addition to the discomfort and shame women experience, sexually transmitted diseases contribute to stillbirths and infant deaths; chronic pelvic pain and infertility; life-threatening tubal pregnancies; and cervical

*High levels of unmet need for family planning result in numerous unwanted pregnancies and abortions.*

*Rapid increases in population continue to frustrate efforts to boost African living standards.*

cancer – thought to be the most common cancer in Africa. Moreover, the inflammation often associated with untreated sexually transmitted diseases increases the odds of HIV transmission.

STDs are closely linked to the problem of infertility, which is especially acute in central and south-central Africa. In countries such as the Central African Republic, Congo and Mozambique, roughly 10 to 20 percent of women are infertile – the highest infertility rates observed in the world. But in other countries, studies show high rates of STD infection even among groups previously perceived to be at low risk – for example, adolescent girls in rural Nigeria. In a culture that puts a high premium on childbearing, many infertile women are stigmatized by their communities and even abandoned by their husbands.

Africa also faces the challenge of record numbers of adolescents entering their childbearing years. The number of women in the region aged 15 to 19 is projected to almost double to 62 million by the year 2020. Although pregnancy rates in this age group have fallen, they remain extremely high and the declines have been less steep than in other developing regions. Roughly 15 percent of African adolescents give birth each year, two and a half times the rate in the United States and more than twice the average rate for other developing countries. The number of births to adolescents in Africa – about 4.5 million yearly – is on the rise because of the rapid increase in size of the adolescent age group.

Despite the risks of early pregnancy, married adolescents are only half as likely as older women to use contraception and have considerable unmet need for family planning. Many unmarried adolescents are also sexually active and are at high risk of contracting AIDS or other STDs. While they are more likely to use contraceptives than married teens, they too have a substantial unmet need for contraceptive services. As a result, many

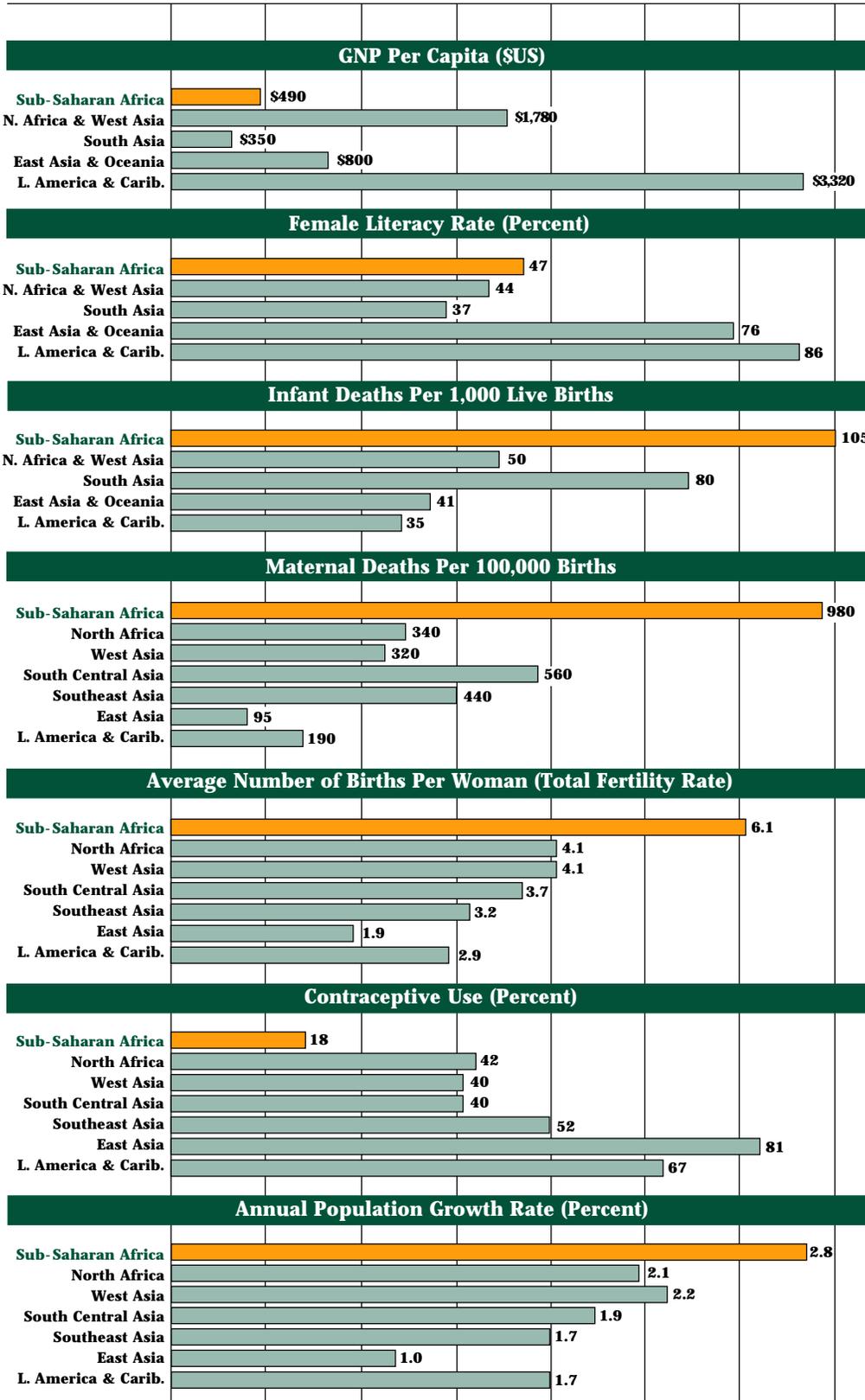
adolescents with unwanted pregnancies resort to unsafe abortion.

## **The Impact of Rapid Population Growth on African Society**

The trend towards smaller families is an encouraging sign that, in the distant future, population growth in sub-Saharan Africa could achieve a balance with the resources available for sustainable economic development. In the meantime, however, rapid increases in population continue to frustrate efforts to boost African living standards, still among the lowest in the world. For more than 20 years, population increase has outpaced economic gains as well as increases in food production, leaving the average African 22 percent poorer than in 1975. With 11 percent of the world's people, Africa produces just one percent of the world's goods and services. Currently, about 40 percent of Africans – 242 million people – live on less than \$1 a day.

Poverty is most severe in rural areas, where 7 of 10 Africans still live. Africa's economic health depends largely on the efforts of its farmers, yet it is in rural areas that rapid population growth most threatens the region's overall prospects for development. Agricultural practices such as slash and burn cultivation and nomadic livestock raising originated in an era when per capita availability of land was much higher than today. Now, however, land is scarcer as a result of population growth, and opportunities to expand the productive land base are fewer. Farmers have moved into newer, less fertile areas more prone to environmental degradation. The traditional style of agriculture is now working against farmers who have not been able to adapt production techniques quickly enough to these challenges. The pressure to grow more on less productive land has strained scarce and fragile natural resources to the point where small

**FIGURE 4**  
**Key Social Indicators for**  
**Sub-Saharan Africa and Other Developing Regions**



*Almost 40 percent of Africans are chronically undernourished and nearly one in three children—some 30 million—go hungry.*

landholders can no longer easily raise crop yields.

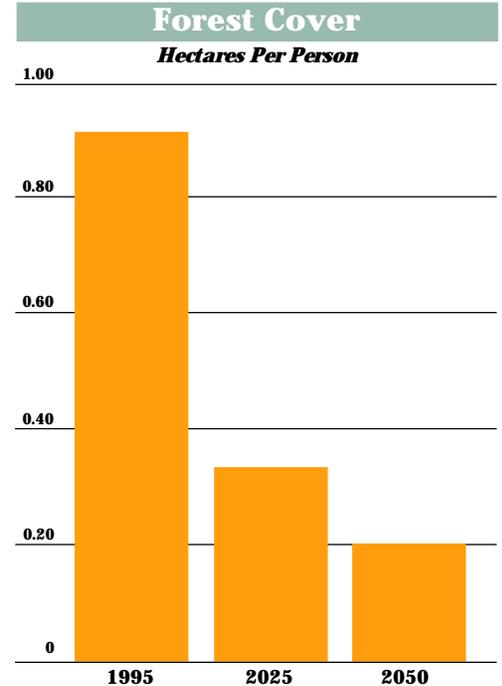
Evidence of the negative environmental effects of population growth is mounting:

- Fresh water – essential for urban and industrial growth and for increasing farm production – is becoming increasingly scarce. By 2025, a projected 6 of every 10 Africans – four times the current proportion – will live in countries that lack adequate water supplies.
- As the demand for firewood and new farmland accelerates, forests are disappearing at ever faster rates. Africa lost one-fifth of its forest cover between 1960 and 1990, and the continent now loses 38 thousand square kilometers of woodlands each year – an area roughly the size of the Netherlands.
- The loss of trees has resulted in the degradation of one-fifth of Africa’s farmland, eliminated over half of the continent’s original wildlife habitat, and contributed to adverse changes in weather and the encroachment of the desert onto previously arable land.

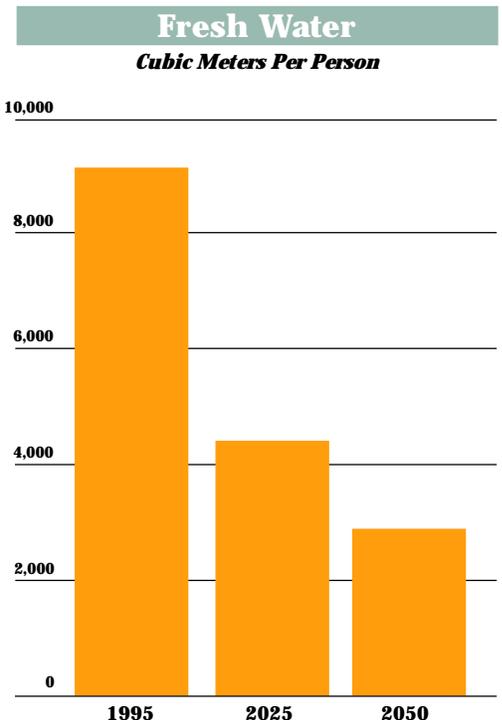
The deterioration of land quality, in combination with poor agricultural policy, has left Africa less able than ever to feed itself. Food output per person has dropped by 16 percent since the early 1960s, one of the main reasons that almost 40 percent of Africans are chronically undernourished and nearly one in three children – some 30 million in total – go hungry. This malnutrition is a major factor underlying continuing high rates of child mortality.

Future prospects for food security in Africa are sobering. Even under optimistic projections for fertility decline and increases in food production, the number of malnourished children in Africa is almost certain to

**FIGURE 5**  
**Declining Natural Resource Availability in Sub-Saharan Africa**



**SOURCES:** World Resources Institute. *World Resources 1996-97*. New York: Oxford Univ. Press, 1996; United Nations. *World Population Prospects: The 1996 Revision*. New York: United Nations, 1996.



**SOURCE:** Tom Gardner-Outlaw and Robert Engelman. *Sustaining Water, Easing Scarcity: A Second Update*. Washington, DC: Population Action International, 1997.

continue to rise well into the next century. African farmers would have to increase production *five-fold* just to meet the region's basic food needs in the year 2050. To do so would require increasing farm yields to levels close to the maximum seen in the most successful of the Green Revolution countries in Asia. While not impossible, achieving this goal will be difficult without raising levels of education and improving road and communication networks – areas where Africa still lags far behind Asia. A rapid decline in population growth rates would make it much easier for the continent to achieve food self-sufficiency.

High rates of natural population increase, coupled with migration from rural areas to cities, have in the last half of this century spurred unparalleled growth in the size of Africa's urban population. Annual urban growth rates in excess of five percent in many African countries are putting enormous strain on the urban environment and on the capacity of local governments to provide basic services.

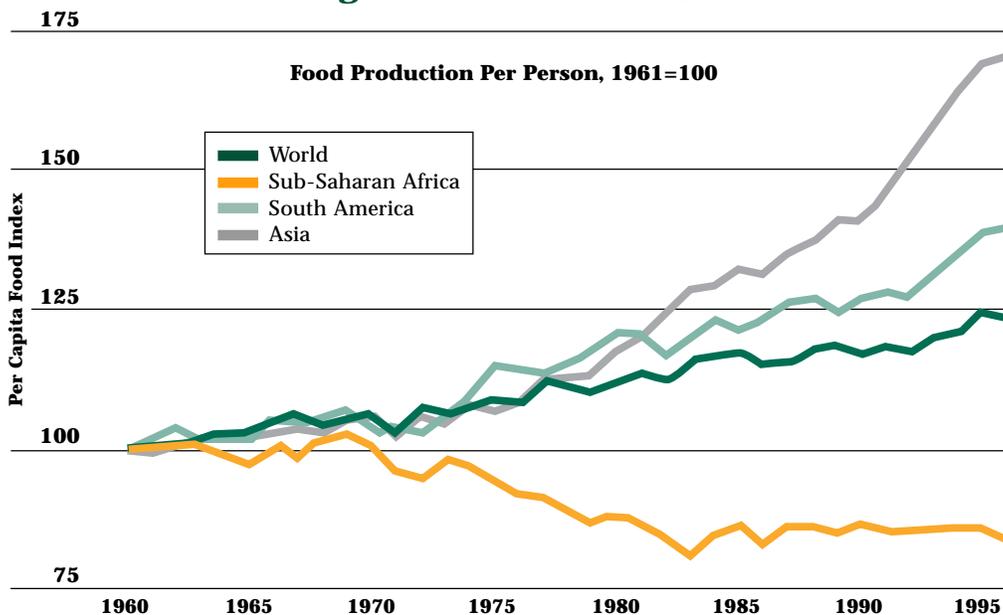
The number of people in both urban and rural areas with access to safe water doubled in the 1980s, but because of rapid growth in the urban population there were actually *more* city dwellers without safe water at the end of the decade. One result of the rapid growth of cities is that the quality of life – as measured by child survival rates – has improved only marginally in the largest cities of sub-Saharan Africa, and has actually declined in smaller cities.

As development successes elsewhere have shown, investing in people is key to economic and social progress. In Africa, however, population growth is overwhelming public services such as health and education, which are already suffering from years of economic decline and shrinking government budgets. Previous gains in school enrollment in many countries have been halted, and governments face a formidable task in simply maintaining current enrollment rates in the face of a projected doubling in the number of children of primary school age

*A rapid decline in population growth rates would make it much easier for the continent to achieve food self-sufficiency.*

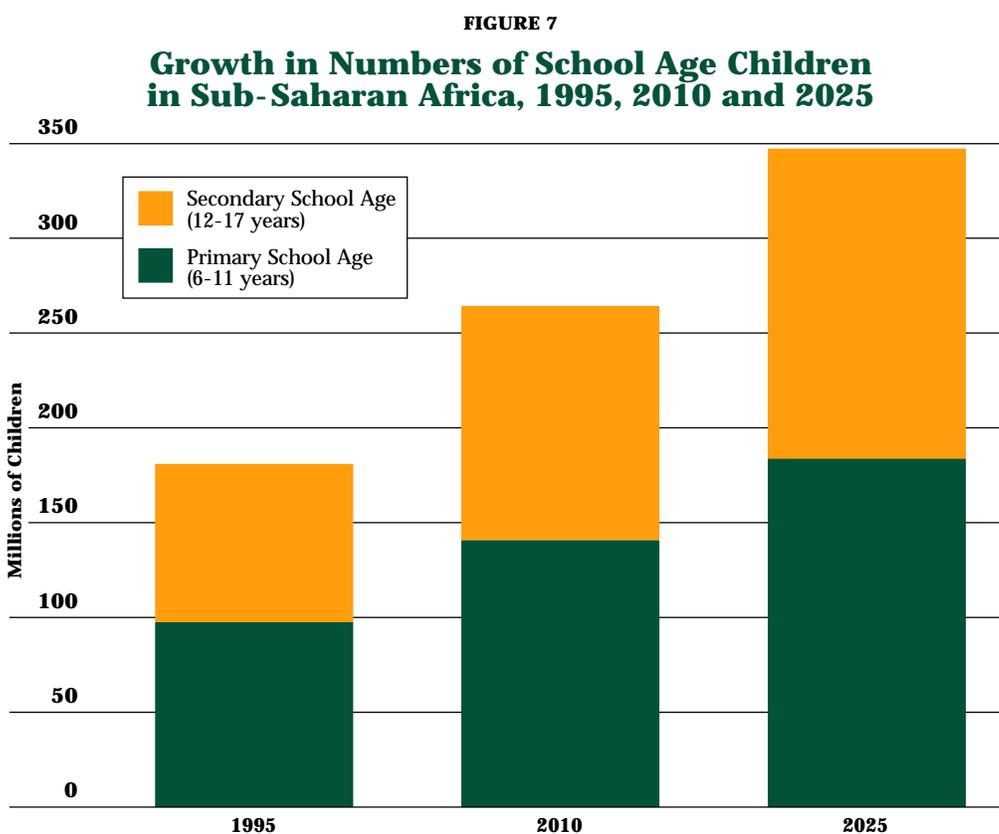
FIGURE 6

### Food Production Per Person Selected Regions and the World, 1961-1997



SOURCE: FAO.

*Investing in people is key to economic and social progress, but in Africa, population growth is overwhelming public services.*



**SOURCE:** United Nations. *World Population Prospects: The 1996 Revision*. New York: United Nations, 1996.

between 1995 and the year 2030. Faltering human investments not only endanger prospects for economic growth, but also feed the cycle of poverty, poor health and low educational attainment that contributes to pressures for large families.



**S**ub-Saharan Africa is home to thousands of ethnic groups with distinct languages and customs. The present report cannot do justice to this cultural diversity, which greatly complicates attempts to generalize about African culture or beliefs. Nevertheless, African societies share some traditional social and cultural practices affecting family structures, childbearing and rearing, and sexual behavior. Moreover, across the region – and especially in urban areas – social and economic changes have had considerable impact on Africa’s traditional culture of high fertility. In many cases these changes were first stimulated by colonial rule and have accelerated with the region’s increasing integration into the world economy. The rapid growth of cities, economic pressures and gains in child survival are also weakening the traditional preference for large families.

In many parts of Africa, however, large families are still the norm. Traditional family structures, the pronatalist views of men, and lack of educational and economic opportunities for women continue to reinforce the desire for large families. Economic pressures have heightened demands on women’s time, and their increasing reliance on children to perform housework may also be working indirectly to keep fertility high.

## **Family and Community Institutions**

Although traditional African customs and beliefs sustaining high fertility are eroding, they nonetheless remain strong, especially in rural areas. These traditions evolved when children were highly valued for their contribution to farm production and many did not survive to adulthood. Large families were considered essential to ensure that enough children survived to continue the family line and fulfill important religious, social and cultural obligations.

In many African countries, the extended family remains a strong

institution and helps to spread the responsibility of childrearing. Biological parents rarely absorb the full costs of raising their own child – thus reinforcing the tendency towards larger families. In West Africa, it is common for close relatives and friends to serve as foster parents or share child-care tasks; in Liberia, for example, children spend an average of one-third of their childhood living away from their mothers.

Relatively weak ties between African husbands and wives are also thought to contribute to high fertility. In many countries, spouses commonly live apart and keep separate incomes and budgets; mothers assume most of the costs of raising children. In countries such as Ghana, Kenya and Namibia, women head over 30 percent of households. Under these conditions, a wife may want many children as a way to maintain the bond with her husband. Moreover, the husband and other relatives – who receive much of the benefit but share little of the costs of having children – are more likely to prefer large families.

## **Marriage Patterns**

Patterns of marriage and other relationships in which sexual activity occurs are important not only for their impact on fertility but also for their effect on the spread of HIV/AIDS and other STDs. Marriage in Africa takes on different meanings depending on the society. In many African cultures, it is common for men and women to move in and out of relationships. Recent surveys show that up to a third of women in their 40s have remarried following divorce or widowhood.

Since virtually all African women marry and most marry young, they are sexually active and exposed to the risk of pregnancy for a large portion of their lives. In most African countries, half of all women marry by age 18; women in rural areas tend to marry even earlier. Although age at marriage is beginning to rise in some African

*Traditional family structures, the pronatalist views of men, and lack of educational and economic opportunities for women reinforce preferences for large families.*

*Biological parents rarely absorb the full costs of raising their own child.*

countries, for example Liberia and Senegal, there does not appear to be an appreciable decline in early child-bearing, possibly because more single women are becoming mothers.

Polygyny – the practice of a man taking more than one wife – continues as a common arrangement, with the proportion of women in polygynous relationships reaching 50 percent in some West African countries. In addition, many men who have only one wife have less formal relationships with other women, thus raising the risk of STD transmission.

The impact of polygyny on fertility, however, is unclear. Women in polygynous relationships have the same and sometimes fewer children

than do women in monogamous marriages, perhaps because polygyny facilitates the traditional practice of sexual abstinence after childbirth and may also reduce the frequency of intercourse for a woman. On the other hand, there is some evidence that polygyny may indirectly raise the fertility of women in monogamous unions; a woman in such a union may accommodate her husband's preference for more children for fear he will divorce her or take a second wife.

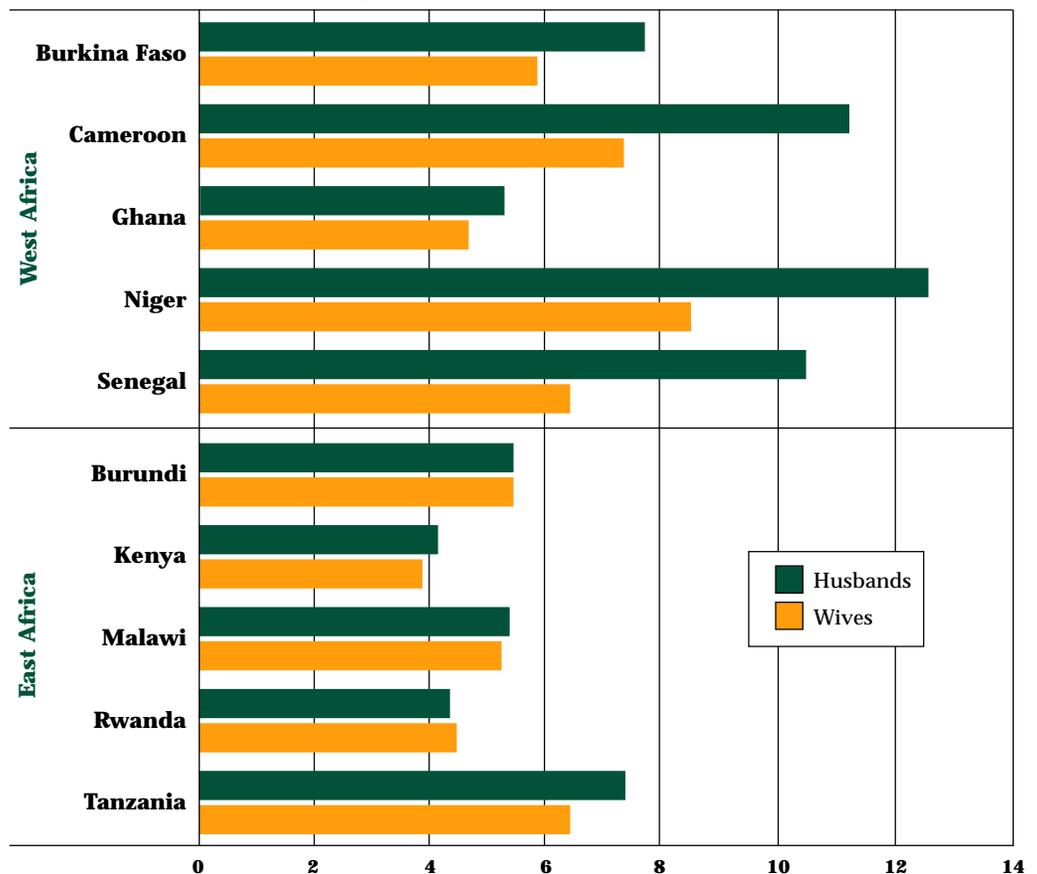
### Breastfeeding and Postpartum Abstinence

In the absence of widespread use of modern contraception, prolonged

FIGURE 8

### Desired Number of Children Selected Countries in West and East Africa

Average Desired Number of Children



SOURCE: Alex Chika Ezeh, Michka Seroussi, and Hendrik Ruggers. *Men's Fertility, Contraceptive Use, and Reproductive Preferences*. Demographic and Health Surveys Comparative Studies, no. 18. Calverton, MD: Macro International, Inc., 1996.

breastfeeding, which can provide contraceptive protection by suppressing ovulation, and sexual abstinence following childbirth have been important natural checks on fertility. These traditional customs help to delay the next pregnancy, benefiting the health of both mother and child. On average, African mothers breastfeed their babies for 21 months; however, the degree to which women breastfeed exclusively – which affects the contraceptive and health benefits of the practice – varies considerably across the region. Similarly, postpartum abstinence averages one to two years in West Africa, while in most of eastern and southern Africa three months is the norm. For the region overall, the duration of both breastfeeding and postpartum abstinence appears to have stabilized since the 1970s, after falling since the early 20th century.

## **Male Views on Reproduction**

Male attitudes towards childbearing and contraception vary significantly across Africa. In East Africa, men and women share similar family size preferences and attitudes towards family planning, a situation that is typical in most of the developing world. In West Africa, however, views of men and women are markedly different. Men in four of five West African countries want between two and four more children than their wives. In Cameroon, Mali and Senegal, fewer than half of men and fewer men than women approve of family planning. By contrast, in East Africa, with the exception of Tanzania, over 90 percent of men and women favor family planning.

Spousal communication on reproductive matters is rare. Most women have never discussed family size preferences with their husbands. Again, this problem is more acute in West than in East Africa.

Men in many African societies have a greater say than women in

childbearing decisions. Thus, large differences in family size preferences such as those seen in West Africa may help to explain low levels of contraceptive use. There is, nevertheless, encouraging evidence that these attitudes are not immutable. In Ghana, between 1988 and 1993, the expansion of family planning services and rising contraceptive use were accompanied by a large drop in the number of children men say they want and by increased male support for family planning.

## **Access to Education**

In Africa, as elsewhere, a woman's education is one of the most important determinants of family size. Countries such as Botswana, Kenya and Zimbabwe, which have invested heavily in education, have been the first to experience falling fertility. An African woman with some secondary education has more than two fewer children on average than a woman with no schooling. Girls who stay in school are more likely to marry later, have greater options in the job market and to have a greater say in household and reproductive decisions.

As more girls move through secondary school, age at marriage is likely to increase and fertility to decrease. So far, however, few African women have gone beyond primary education. Indeed, in many countries, more than half of women have never attended school. Illiteracy rates in Africa are decreasing, but remain among the highest in the world; one third of all men and half of all women cannot read or write. The male-female literacy gap is widening, and 62 percent of all illiterates are women, up from 60 percent in 1980.

Furthermore, girls have a harder time than boys gaining access to education; about 10 million more boys than girls attend school. The solid progress in girls' education since independence is at a standstill. During the

*Men in West African countries want between two and four more children than their wives.*

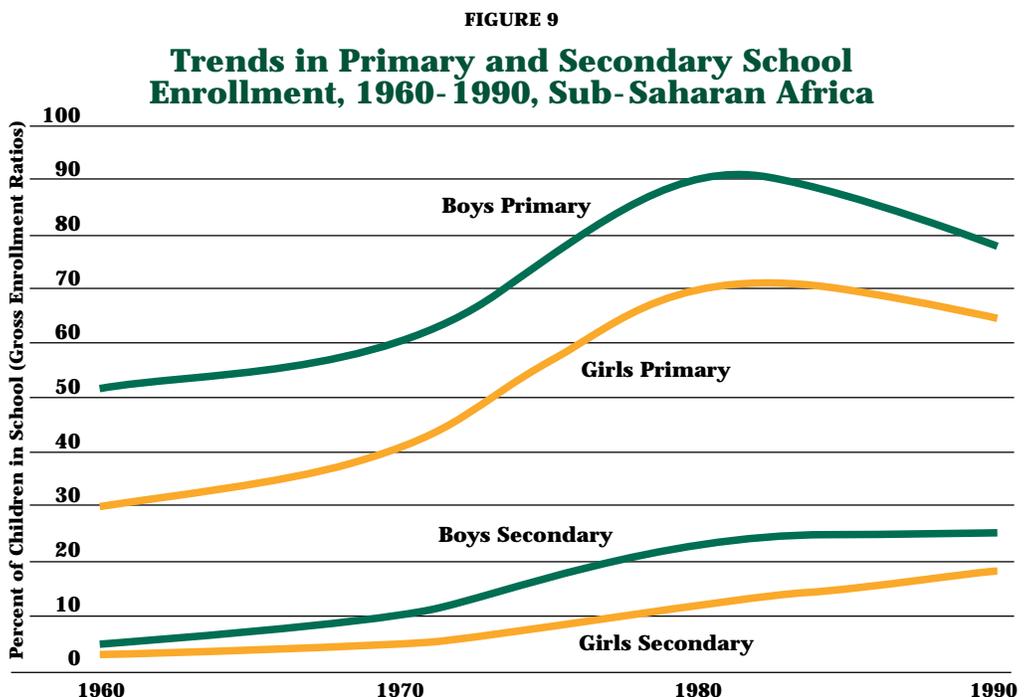
*Illiteracy rates in Africa are decreasing, but remain among the highest in the world; half of all women cannot read or write.*

1980s, school enrollment rates for girls fell in several African countries, and by more than 10 percent in Madagascar, Nigeria and Tanzania. By 1994, girls' primary school enrollment had crept back up to 67 percent – roughly the same as in 1980, but still far below the developing country average of 93 percent. Girls' secondary enrollment has risen slowly to about 20 percent, only half the average for the developing world.

Erosion in girls' education has occurred within a wider educational crisis in Africa. Government spending on education fell from \$41 per capita in 1980 to \$32 in 1994, while increasing by greater than 50 percent for the developing world as a whole. A combination of falling incomes and rising school costs has put education out of the reach of many poor families. The cost of education is also higher for girls than for boys, because of the higher cost of uniforms for girls and because concern for the physical safety and chastity of girls requires extra money for transportation.

Girls in Africa encounter many of the same barriers to education as in other developing regions.

- Parents are often more reluctant to invest in educating a daughter than a son when most women have limited income-earning opportunities, and in those cultures where a daughter's economic contribution to her family ends at marriage.
- The quality of instruction is generally poor and schools frequently teach skills irrelevant to real-world employment needs.
- Teacher attitudes, gender stereotypes in textbooks and sexual harassment contribute to a poor climate for girls' educational achievement.
- In many countries, school policy and social pressures force most pregnant schoolgirls to either drop out or resort to unsafe abortion. In Botswana, typical of many African countries, teenage pregnancy is the cause of 60 to 90 percent of schoolgirl dropouts.



SOURCE: UNESCO. *World Education Report, 1995*. Paris: UNESCO, 1995.

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## Women's Economic Opportunities

Lack of access to education, credit and formal sector job opportunities inhibit African women's chances for economic advancement. Meanwhile, formal legal systems have tended to reinforce customary discrimination against women in economic as well as family matters.

Women have a dominant role in growing food crops, yet they are disadvantaged in access to the knowledge and resources needed to improve farming techniques. Despite their importance to the rural economy, women receive just one-tenth of the credit available to small farmers. Female traders and small business owners fare no better. Furthermore, just five percent of women have jobs in the modern wage sector.

The lack of economic opportunities reduces girls' aspirations and discourages them from pursuing an education. Without education and work options, many marry young and have large families. Moreover, in the absence of national pension systems and other forms of social support, women who lack job opportunities and schooling must depend on their children for support in old age, a further incentive to have many children.

Changes in the structure of African economies are also working to keep fertility high. The shrinking of job opportunities in the modern wage economy, which has accompanied recent economic austerity programs, has disproportionately affected women, further closing off their options for employment.

Moreover, economic pressures have forced many men to migrate in search of work and to spend more time producing export crops such as cocoa or coffee – traditionally a male responsibility. As a result, customary arrangements for men to help women with food production are breaking down, increasing the time women must spend

on farming. Many women already travel long distances and spend many hours collecting fuelwood and water for cooking and cleaning; deforestation and water scarcity are adding to this burden. With demands on their time increasing, more mothers feel a necessity to keep their daughters at home to help with household tasks, and the need for extra help around the house may also serve to maintain a desire for more children.

## Violence Against Women

Violence against women in Africa is widespread as economic and social change weaken traditional protections for women and girls. Surveys in Kenya and South Africa show that between 17 and 42 percent of women are battered by a domestic partner. Partly from fear of violence, many African women exercise little control over contraception, including condom use, and thus are more vulnerable to pregnancy and HIV/AIDS and other sexually transmitted diseases. Refugee women, in particular, are exposed to violence; a recent study found that one-quarter of women in Burundian refugee camps in Tanzania were exposed to sexual violence during their stay in these camps.

## Harmful Traditional Practices

The widespread traditional practice of female genital mutilation contributes to women's health problems in Africa. The procedure, which removes the external female genitalia in varying degrees, can cause infection and bleeding – sometimes leading to shock and even death. Long-term effects include scarring, which can cause life threatening complications in childbirth, chronic infection and infertility. Women subjected to the practice often experience psychological trauma, painful intercourse and menstruation, and diminished sexual pleasure.

*Partly from fear of violence, many African women exercise little control over contraception.*

*The widespread traditional practice of female genital mutilation contributes to women's health problems in Africa.*

Female genital mutilation affects half the adult female population of sub-Saharan Africa – 110 million women. Each year roughly 2 million girls – mainly ages 4 to 12 – undergo the ritual. No religion requires the practice; it is done mainly to preserve virginity, as a rite of initiation to adulthood and to control women's sexuality. Many men will only marry women who have undergone genital mutilation.

**Social and Economic Change**

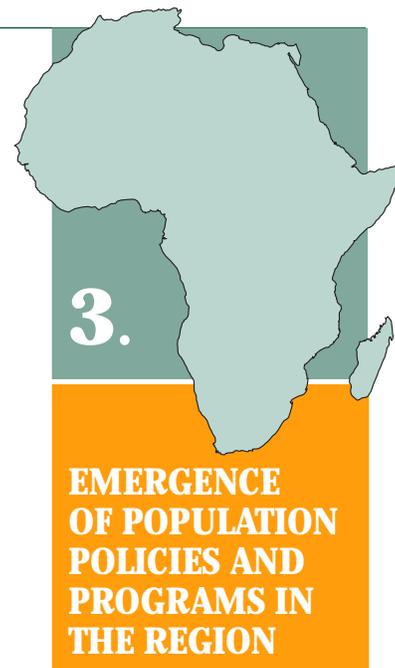
In some countries in Africa, increased use of contraception and the trend towards smaller families have gone hand in hand with improvements in child health. The three countries where fertility has fallen first – Botswana, Kenya and Zimbabwe – have also made the greatest gains in lowering child mortality. When their children are less likely to die, parents apparently feel more secure that they can achieve their ideal number of *surviving* children. Still, in many other countries, fertility has not yet begun to fall, despite a decline in child death rates. Many couples – especially in rural areas – may not yet have adapted their childbearing behavior to the lower risk of losing a child. Moreover, the impact of rising child deaths from AIDS on desired family size is still unclear.

Other forces are weakening traditional supports for high fertility. Increased seasonal migration and rapid urbanization have strengthened ties

between the city and countryside and are eroding rural customs and cultural beliefs. Although Africa still lags behind other regions, since 1970 individual ownership of radio and television has increased 4 and 20-fold respectively, exposing people to new ideas that influence their decision to have smaller families.

Moreover, many parents can no longer afford large families. Where land has become scarce, children have lost much of their economic value. Increasing numbers of parents see education as a strategy to improve the chances that their children will eventually find good jobs and contribute to the family's income. Meanwhile, the decision by a number of governments to raise school fees has further fueled demand for small families. The average family in Kenya must now pay 10 to 15 percent of annual household income just to send one child to school.

In addition, as the extended family assumes less direct responsibility for raising children, parents are shouldering a greater share of the costs of childrearing. The struggle to make ends meet also appears to be fostering closer financial partnerships between spouses, who increasingly must pool their resources to educate their sons and daughters.



Compared to countries in other developing regions, African countries have only recently begun to formulate population policies and implement family planning and related programs. Beginning in the 1980s, however, African governments have increasingly come to appreciate the individual and societal benefits of smaller families. Most governments in the region now actively seek to improve access to family planning and other reproductive health services and to lower high rates of population growth.

### **Emergence of Population Policies**

Following independence in the 1960s, African leaders showed little interest in the links between population growth and development. At the time, natural resources were more abundant than today, and economies were growing fast enough to outpace the increase in population size. Policymakers lacked basic demographic information, and a strongly pronatalist culture discouraged leaders from promoting fertility reduction. Moreover, religious and ethnic rivalries within many newly-independent states magnified the importance of population size and made any attempt to promote smaller families politically sensitive.

Africa lagged behind other regions in articulating population policies. Kenya in 1967 and Ghana in 1969 were the first countries in the region to view population growth as an obstacle to development, and remained the only countries with national policies for almost two decades.

Government attitudes towards population growth and family planning began to change in the 1980s. Leaders became increasingly aware that high rates of population growth threatened economic progress. Surveys gave policymakers a more complete picture of Africa's health problems, fertility behavior and use of family planning.

Throughout this period, international agencies played a crucial role in the development of population policies and programs through their support for data collection, training and information exchange.

The Second African Population Conference held in Arusha, Tanzania, in 1984 was an important milestone. For the first time, African leaders recognized the need for policies addressing population growth and jointly formulated a program of action.

By the early 1990s, a critical mass of African countries had acknowledged high fertility as a problem, giving the issue legitimacy as a topic of national and regional concern. At the 1992 African Population Conference held in Dakar as a prelude to the 1994 International Conference on Population and Development (ICPD), regional policymakers strongly endorsed government efforts to increase the use of family planning and slow population growth. Virtually all African countries signed onto the 1994 ICPD *Programme of Action* affirming the right to family planning and to better sexual and reproductive health.

The change in attitudes towards population issues is reflected in the upsurge in the number of countries with official population policies within the last decade. From just 2 in 1986, the number of countries with population policies had grown to 12 by 1992. Currently, some 25 countries in sub-Saharan Africa have official policies. Another measure of the important shift that has taken place is evident in the responses to periodic United Nations surveys on government attitudes towards population. In 1976, a third of countries in sub-Saharan Africa believed their fertility rates were too high and only 1 in 5 was taking action to encourage couples to have smaller families. By 1995, 37 of 47 African countries thought their fertility rates were too high, and two-thirds had programs of some sort intended to lower birthrates.

*By the early 1990s, a critical mass of African countries had acknowledged high fertility as a problem.*

*Currently, some 25 countries in sub-Saharan Africa have official population policies.*

## Development of Family Planning Services

Private groups, especially national family planning associations affiliated with the International Planned Parenthood Federation (IPPF), were the first to provide family planning services in Africa. By 1974, national associations in 18 countries offered contraceptive

services in over 500 clinics across the region. These efforts, however, served just a tiny portion of the population and were concentrated in former British colonies. In most former French colonies, the climate for family planning was hostile in part because of laws enacted during French colonial rule banning contraceptive distribution and promotion.

**FIGURE 10A**  
**Government View of Current Fertility Level, 1976**



**SOURCES:** United Nations. *World Population Monitoring* New York: United Nations, 1979.

In a few countries, governments made family planning services a priority and saw increased contraceptive use and reduced maternal risk.

■ Botswana added family planning to government health services in 1973; by the mid-1980s, 33 percent of married couples were using a contraceptive method.

■ Following independence in 1980, Zimbabwe's government strengthened family planning efforts through a national council and made contraceptive services available through community workers and all government health facilities. By 1984, 27 percent of women were using contraceptives.

*Private groups, especially national family planning associations affiliated with IPPF, were the first to provide family planning in Africa.*

FIGURE 10B

**Government View of Current Fertility Level, 1995**



Data not available for Eritrea.

SOURCES: UNFPA. *Inventory of Population Projects in Developing Countries around the World, 1995* New York: United Nations, 1996.

*In varying degrees, most African countries have incorporated family planning into national health services.*

The vast majority of countries, however, lacked organized national family planning programs. Even in Kenya and Ghana, which adopted strong policies early on, effective efforts to make family planning services available did not get off the ground until the early 1980s. By the mid-1980s, fewer than 5 percent of African women used contraception, while prevalence levels in developing countries outside the region had already reached 50 percent.

In the last decade, however, there has been solid growth in the number and scope of family planning programs. In varying degrees, virtually all African countries have incorporated family planning into national health services, almost always adding family planning services into existing infrastructure for maternal and child health services. This improvement is also taking place in a number of French-speaking countries.

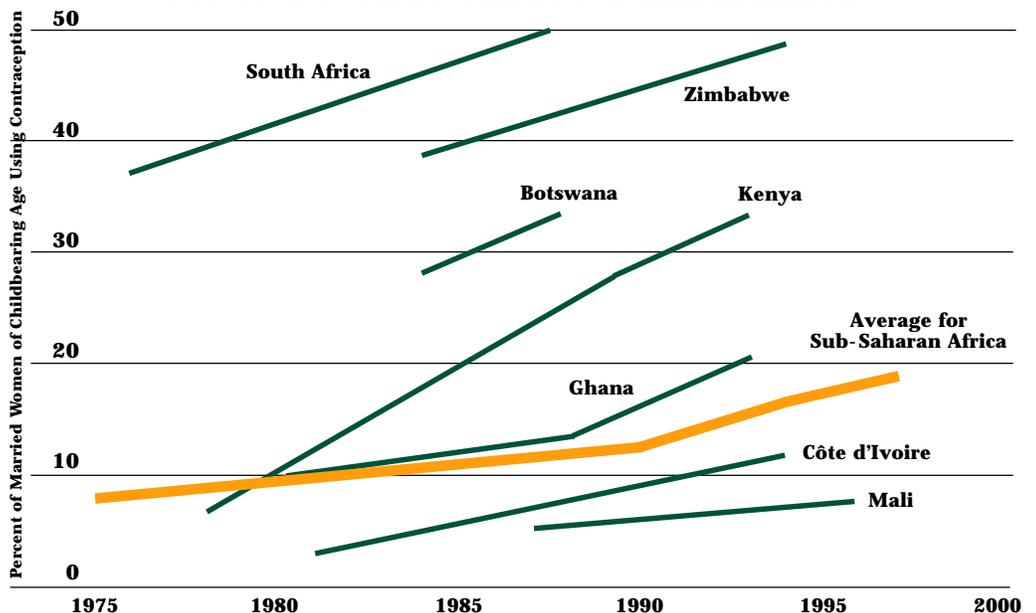
■ Senegal has invested significantly in primary health care, but until very recently family planning services were not widely available at government clinics. A national family planning program began in 1991 and is now extending its reach to smaller towns and rural areas. Use of contraception rose from 5 to 13 percent between 1986 and 1997.

■ Similarly, the government of Burkina Faso increased the number of clinics offering family planning from 90 to 750 between 1991 and 1996.

Meanwhile, efforts in the private sector have also mushroomed. National family planning associations now operate in virtually every country in the region. Social marketing programs for the subsidized commercial sale of contraceptives existed in just 4 African countries in 1985. A decade later, 22 countries had social marketing efforts, although many of these are

FIGURE 11

**Trends in Contraceptive Use Selected Countries in Sub-Saharan Africa**



SOURCES: UN Population Division. *Levels and Trends of Contraceptive Use as Assessed in 1994*. Population Studies Series, no. 146. New York: UN Department of International Economic and Social Affairs, 1996; Demographic and Health Surveys. "Selected Statistics from DHS Surveys." *Newsletter* 8, no. 2 (1997); PRB. *1997 World Population Data Sheet*. Washington, DC: PRB, 1997.

condom distribution programs focused on HIV/AIDS prevention.

As a result of the proliferation of activities, the gap in family planning program effort between sub-Saharan Africa and other regions has significantly narrowed since the early 1980s. By 1994, an index of program effort rated the region only moderately lower than North Africa and the Middle East, and Latin America. This represents an impressive improvement over the early 1980s when 31 of 35 African countries were rated as having very weak or nonexistent programs.

Still, Africa has a long way to go. Most family planning programs, especially in the former French colonies, are new and in need of strengthening. Moreover, throughout the post-colonial period, political instability, civil unrest and natural calamities have periodically halted and even reversed promising efforts to mount family planning programs in a number of countries. These include both some of the largest on the continent, such as the Democratic Republic of Congo, Nigeria and Ethiopia, and smaller countries such as Rwanda, which had one of the strongest family planning programs in French-speaking Africa before its recent troubles. Family planning, like other social programs, has also been an easy target for governments looking to slash budgets under the economic austerity packages of the 1980s and 1990s. Indeed, international donor assistance has been crucial to meeting the growing demand for services during this period.

## Current Policy Issues

Policymakers in Africa face a new set of challenges in formulating and implementing population policies. Government commitment to population and family planning programs has been crucial to their success in Africa. Yet, high levels of official commitment are still the exception rather than the rule across much of the region. There is also much room for improvement in

national and regional institutions that formulate and coordinate population programs and policy. In addition, while the ICPD's call for a broader reproductive health approach has raised awareness of a whole host of related women's health needs, African policymakers and governments are struggling with how to implement the new approach. Meanwhile, the AIDS epidemic presents population policymakers with the challenge of responding to charges that family planning programs are no longer relevant, given the potential for AIDS to lower population growth rates.

## Enhancing Government Commitment

In Africa, as elsewhere, strong national leadership has almost always been a prerequisite for successful implementation of population policy. Political support gives programs public legitimacy and the stability to withstand changes in leadership, and helps to assure adequate funding. Yet official commitment in many countries is still low. Politicians are rarely knowledgeable or serious about population issues. Most governments neither spend substantial amounts of their own resources on family planning services nor assign high quality leadership to manage population programs. Rapid turnover among top managers is common.

The high level of donor support for family planning, although key to the development of effective programs in many countries, is partly responsible for low government funding since it has also permitted governments to focus domestic resources on the many other pressing health sector priorities. As with other programs that receive a large portion of their financing from external aid, national officials often do not feel strong "ownership" of population and family planning programs.

Those African countries with successful family planning programs have enjoyed strong government

*Strong national leadership is a prerequisite for a successful population policy, but official commitment in many countries is still low.*

*Ghana's leadership, at the highest political levels, strongly and publicly supports family planning.*

support – with or without explicit population policies – over long periods of time. Kenya's government has been seriously tackling its population problem for almost two decades; long-term commitment is also a hallmark of efforts in Botswana and Zimbabwe. All three countries have enjoyed relative political stability with little turnover in population program leadership, in contrast to many other countries in the region. Still, even in Kenya, political support has flagged in recent years, raising concern that lack of visible support from national leaders will undermine progress.

Meanwhile, there are hopeful signs of increased government support in some countries. Ghana's leadership, at the highest political levels, strongly and publicly supports family planning and assigns great importance to slowing population growth. Ghanaian officials seem willing to address critical issues including the need for adolescent services. Benin, in French-speaking West Africa, also appears to be increasing its commitment to population and family planning programs. The government recently put in place a new population policy and is reported to be deeply committed to carrying out the policy. Political commitment has also increased in other French-speaking countries, for example Burkina Faso, Mali and Niger.

### **The Role of National and Regional Policy Institutions**

A number of African countries have established national population councils responsible for coordinating population activities, attracting external donor resources for population programs, providing relevant information to policymakers and integrating demographic concerns into development planning. In practice, however, other branches of government usually pay little attention to these national coordinating bodies. Most of these councils are also highly dependent

on international donor funding.

Most councils lack the resources and qualified staff to perform the in-depth policy analysis and coordination of programs needed to exert leadership on population matters. Insufficient analytical capacity hampers the ability of national councils to convey demographic and health information in ways that are understandable and useful to policymakers and program managers. Decentralization of health and family planning services is further stretching the already limited capacity of council staff as the need for coordination and advocacy at the subnational level increases. Ghana's national population council has responded to the government's decentralization efforts by establishing offices in all 10 regional capitals and forming regional population advisory committees.

A further challenge is that national councils – like the planning ministries within which they typically reside – are often without real decision-making power, and lack strong ties to the health ministries and non-governmental organizations (NGOs) that provide family planning and reproductive health services. Thus, these population councils are having difficulty defining their role in the wake of the ICPD, especially as the emphasis of population policy has broadened from family planning to reproductive health. Nevertheless, Ghana's national council has been instrumental in moving the government towards tackling the controversial issue of adolescent reproductive health, and Kenya's national council has helped to bring HIV/AIDS issues to the forefront.

At the regional level, a variety of institutions are involved in population policy development, but their record is also mixed.

- The Center for Applied Research on Population and Development (CERPOD), based in Mali, has effectively promoted development of population policies in the countries

of the Sahel (the region bordering the Sahara desert). CERPOD is also a regional leader in population policy research and analysis.

■ The African Population Advisory Committee includes prominent Africans working in population, health and education. The Committee creates a high-level forum for the kind of dialogue that normally

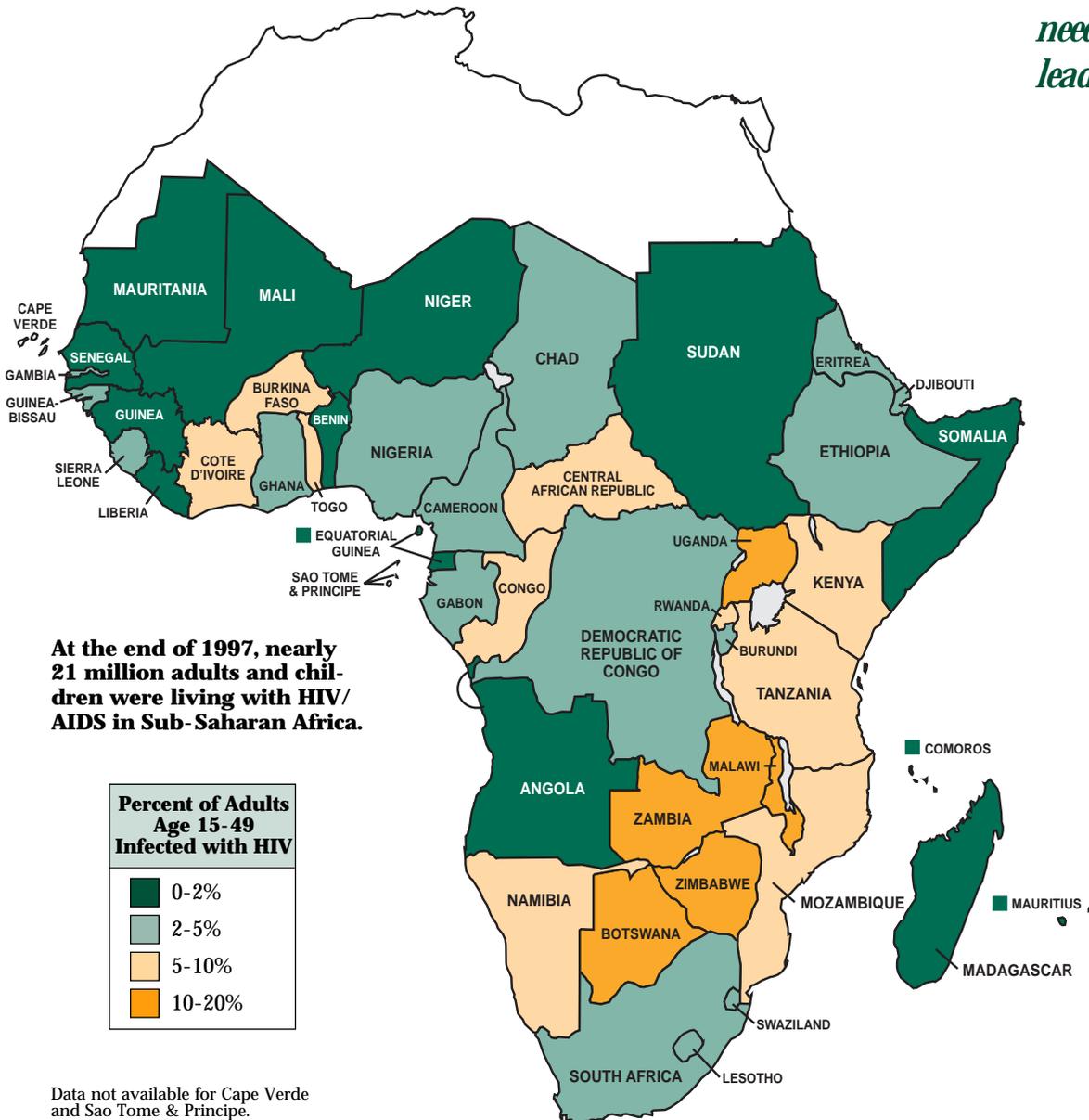
occurs only at large regional or international conferences. In addition, it has had some small-scale success in promoting greater participation of local communities in the design of population policy and programs.

■ The United Nations Economic Commission for Africa has historically played an important role in raising awareness of population issues

*A number of African countries have national population councils, but many lack the resources and staff needed to exert leadership.*

FIGURE 12

### The HIV/AIDS Epidemic in Sub-Saharan Africa



SOURCES: World Bank, *Confronting AIDS: Public Priorities in a Global Epidemic*. New York: Oxford University Press, 1997; UNAIDS, *Report on the Global HIV/AIDS Epidemic*. <http://www.unaids.org>, 1997. Data as of December 1994.

*In many African countries, the AIDS epidemic has helped speed acceptance of family planning through more open discussion of sexuality.*

and helping countries collect and analyze demographic data, but it has been less effective in working with institutions directly involved in provision of family planning services.

- The Organization of African Unity (OAU) – the most important regional political body – in recent years has consistently endorsed the view that slowing rapid population growth is key to the continent's economic and social development. The OAU established the African Population Commission in 1994 to provide leadership on population issues, but its capacity to give technical guidance has been limited.

### **Adapting Population Policies to ICPD**

The emphasis at the ICPD on meeting individual reproductive health needs and improving women's status has had special resonance with African policymakers and helped to further legitimize family planning programs. African leaders have been influenced by the evidence showing links between family planning use and lower maternal and child mortality. The Cairo conference also led a number of African countries to initiate discussions relating to unsafe abortion, adolescent reproductive health needs, and AIDS and other sexually transmitted diseases – topics which in many settings were previously considered too controversial for public debate.

Revising population policies and programs to reflect ICPD principles is a slow process, but one that countries in the region have begun. Ghana, for example, revised its population policy in 1994 to better take into account the Cairo approach. The ICPD has spurred a number of other countries to include adolescent health as an integral component of population policy. Kenya released a draft national population policy for sustainable

development in 1995; South Africa is also in the process of reformulating its population policy.

### **AIDS and Population Policy**

The growing AIDS epidemic in Africa has major implications for population policy. Lack of good information on current HIV prevalence and unpredictability about the course of the epidemic make it difficult to forecast exactly how AIDS will affect population size in a particular country. Most projections indicate that deaths from AIDS will not stop population from continuing to grow for Africa as a whole, nor cause a net loss of population in any country in the region. Some projections, however, show AIDS eventually producing negative population growth in Botswana and Zimbabwe, two of the hardest hit countries.

The uncertainty over the impact of AIDS on population growth rates has led some African policymakers to question the need for family planning programs. Still, no country has changed its population policy because of the AIDS epidemic, perhaps because health concerns, rather than concerns over rapid population growth, have been the driving force behind establishment of population policies. Indeed, in many countries, the AIDS epidemic has helped speed acceptance of family planning through more open discussion of sexuality and intensive promotion of condom use, combined with greater understanding of the health benefits of contraceptive use. Even so, the increasing burden of the epidemic on national health systems is raising difficult questions relating to the allocation of resources between HIV/AIDS prevention and other health services, including family planning.



**D**espite the positive change in official attitudes towards population issues, African governments still face enormous challenges in making high quality family planning and other reproductive health services widely available. Health systems across the region are improving, but still do not adequately cover large segments of the population. Knowledge of contraceptive methods and the range of methods available has grown considerably over the past decade, but programs often place unnecessary barriers to contraceptive use. Finally, in spite of the enthusiasm for implementing the broader reproductive health approach advocated by the ICPD, there is still a great need to improve links between family planning and other reproductive health services.

## Expanding Access to Family Planning Services

As governments increasingly provide support for family planning services in most countries in the region, African men and women are better able to obtain contraceptive services. Between 1982 and 1994 availability of contraception increased faster in sub-Saharan Africa than in other developing regions. Kenya, Zimbabwe and countries in southern Africa have made solid progress towards improving access to family planning.

Still, overall shortcomings in health systems – particularly in rural areas – are preventing more rapid increases in contraceptive use. The public sector, while an important source of contraceptive services in most countries, is struggling to make more efficient use of its limited resources. Meanwhile, private groups – both for-profit and nonprofit – have yet to reach their full potential to complement government efforts.

As a result, serious gaps in coverage remain. Demand for family planning continues to outpace services,

and millions of couples who want to delay or avoid another pregnancy are not using family planning. The average African couple still had poorer access to family planning in 1994 than couples in other developing regions had a dozen years earlier. Fewer than two of the five most common family planning methods are widely and easily available. Most rural women must travel an hour or more to obtain contraceptive services; in Zambia, half of all women must travel two hours to reach a source of family planning.

## Health Services in Africa

In general, family planning programs are stronger in countries where an increased emphasis on primary and preventive care has broadened access to health services.

Countries with relatively effective family planning programs, such as Botswana and Zimbabwe, showed a commitment early on to the expansion of public sector primary health care; both countries provide virtually universal access to health services.

However, progress on health care coverage varies considerably across the region. Despite impressive gains since independence, health services – both public and private sector – still reach only slightly more than half of Africa's population. In many countries, health care coverage is still appallingly low, especially in rural areas. In Mozambique, where the population is two-thirds rural, just 15 percent of the rural population is within an hour of a health facility; in Sierra Leone, the figure is 11 percent.

Qualified health workers are in short supply in many African countries compared to other regions. The ratio of doctors to population is lower than 1 to 10,000 in Africa; the world average is 1 to 800. Nurses are somewhat more abundant, but Africa still has only about one-third as many nurses per capita as the rest of the world.

*Demand for family planning continues to outpace services.*

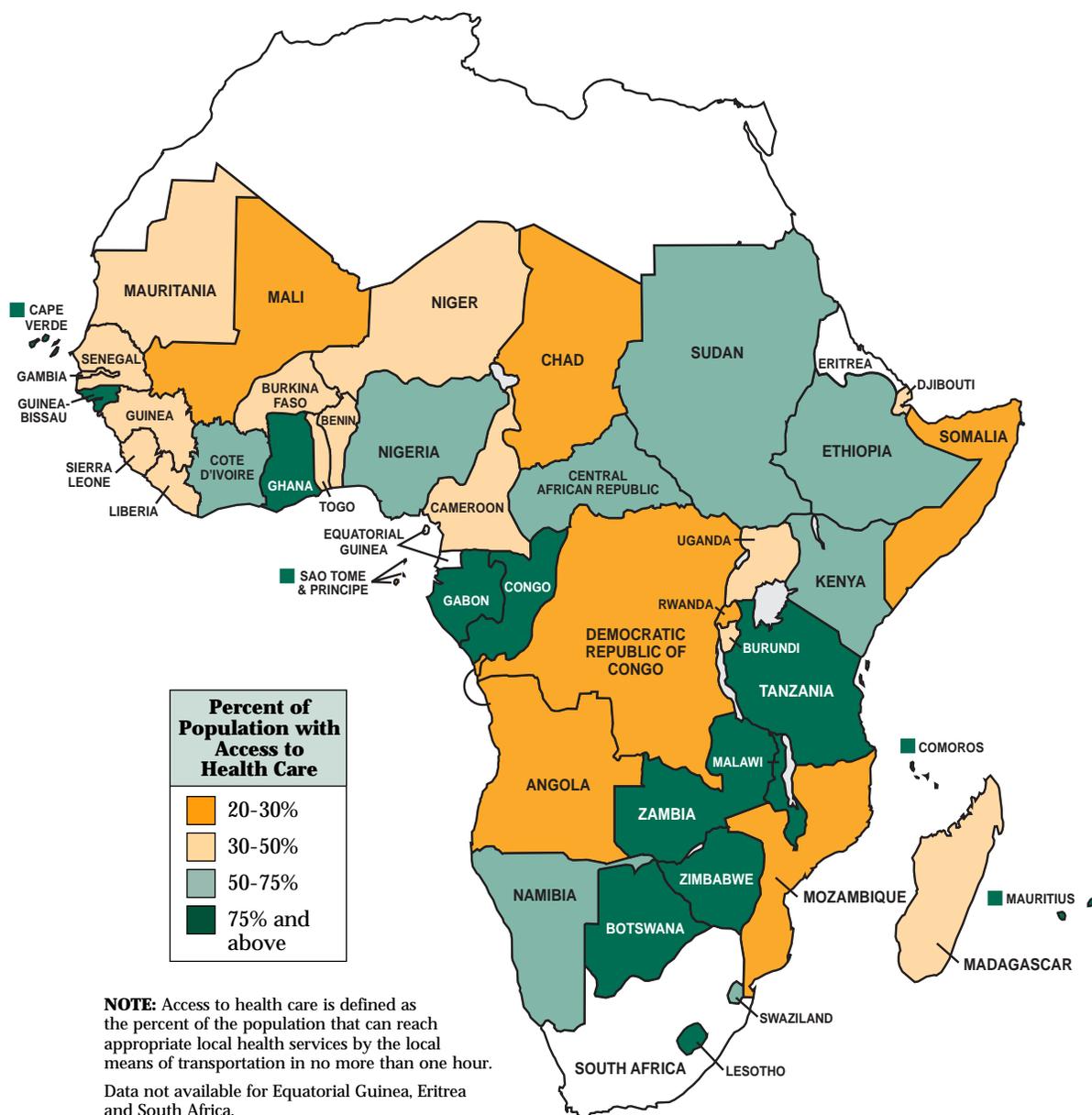
*The ratio of doctors to population is lower than 1 to 10,000 in Africa; the world average is 1 to 800.*

Moreover, many African governments inherited health systems from the colonial era oriented almost exclusively to curative care. Although efforts to redress this imbalance are underway in a number of African countries, many government health budgets remain sharply skewed in favor of large, urban hospitals providing expensive treatment.

### Access to Public Sector Family Planning Services

Despite the fact that many African governments have only recently begun to offer family planning services, the public sector is the primary source of contraceptive services in the region. On average, over 65 percent of women

**FIGURE 13**  
**Access to Health Care in Sub-Saharan Africa**



practicing modern family planning obtain services from the public sector – a proportion significantly higher than in most other areas of the world. In fact, the more successful programs in the region tend to have a very high degree of public sector involvement. In Zimbabwe, for example, the government supplies 85 percent of family planning clients.

Almost all governments in Africa provide family planning within existing maternal and child health services. A notable exception is Zimbabwe, which also provides contraceptive services through specialized family planning clinics and outreach activities. Given the severe budget constraints most African governments face, integration of family planning and health services appears to be an efficient use of scarce resources. Creating a large, parallel infrastructure to provide family planning services, as in some Asian countries such as Pakistan, is simply not an option for most African countries.

Many of the current efforts to strengthen contraceptive services are focused on rural areas, where weak health infrastructure is a major barrier to contraceptive use. For example, Ghana, like many African countries, has historically neglected investment in primary health care and rural outreach in favor of large hospitals and curative services. Family planning clinics in urban areas are relatively well-equipped and adequately staffed; in contrast, rural areas have insufficient staff and infrastructure and outreach programs are lacking. In Mankranso, a rural district of Ghana with a population of 118,000 for example, the government operates one health center and employs just one doctor and five nurse-auxiliaries to provide a full range of preventive and curative services. To improve coverage in areas such as Mankranso, the government of Ghana has set up district-level health management teams to plan and implement health services, including family planning and reproductive

health services. Compared to Ghana, in many other countries, especially in French-speaking Africa, coverage is much worse.

In African cities, where public sector health services are concentrated, access to family planning services is generally better than in rural areas. Urban government hospitals and health centers often place family planning clinics side-by-side with busy antenatal and well-baby outpatient services. Nevertheless, high rates of urbanization across Africa may be contributing to a steady deterioration in the availability and quality of family planning services in cities – especially in those peri-urban areas housing new migrants.

Because of deficiencies in coverage in rural and peri-urban areas, and the poor range and quality of services frequently offered in those facilities that do exist, many clients for both health and family planning services prefer using larger, better-equipped urban clinics, even if it means longer travel time and higher cost. Consequently, family planning services in many large urban hospitals are heavily used, resulting in long waiting times. In Kenya, where demand is growing rapidly, district hospital family planning clinics commonly serve 200 clients a day. At the same time, facilities in rural and peri-urban areas are often underused. Studies in Nigeria, Tanzania and Zimbabwe have found that a quarter of facilities serve over 80 percent of all family planning clients.

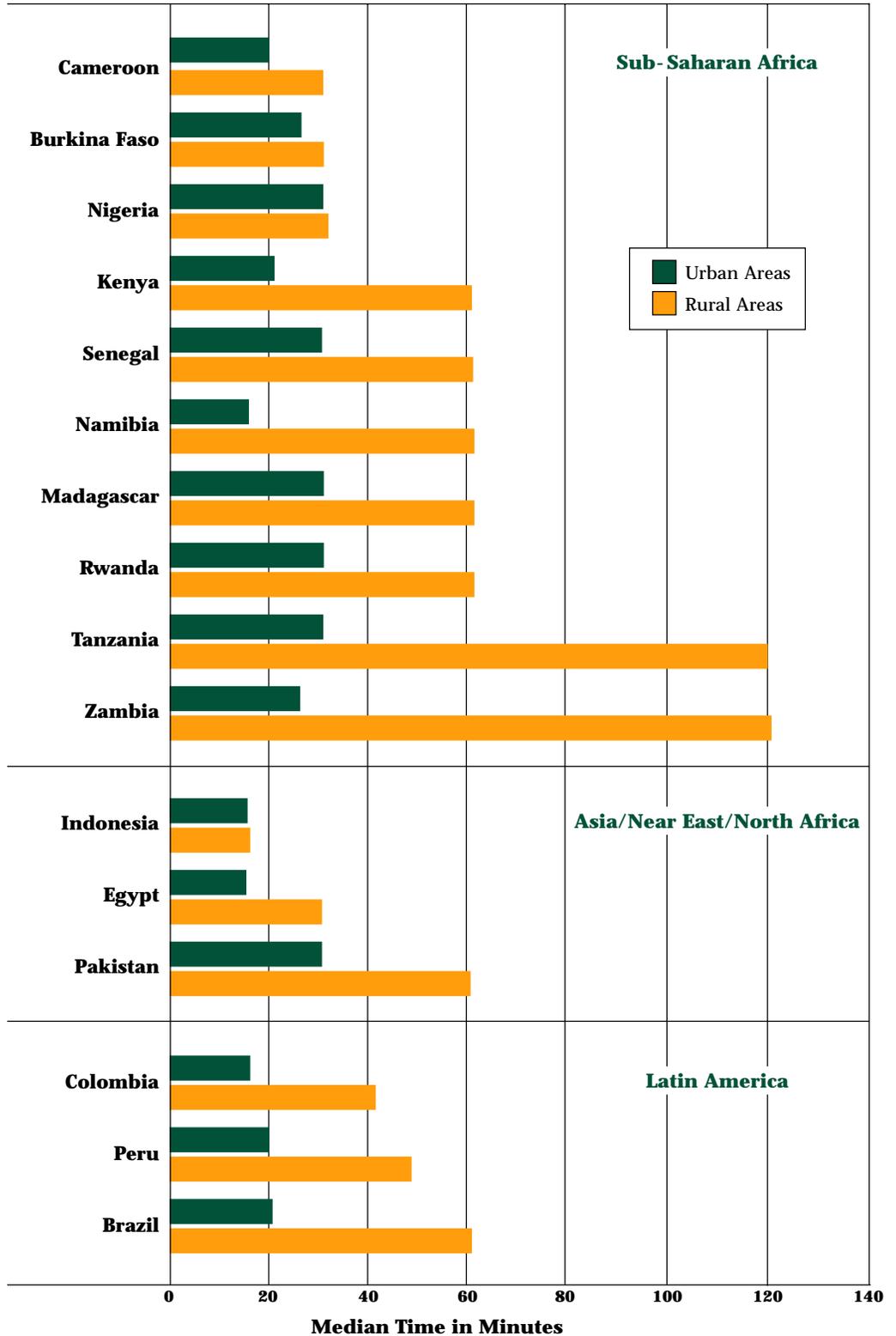
### **Support Systems for Public Sector Programs**

One of the greatest challenges governments face is improving the systems that support the delivery of family planning and reproductive health services in government health facilities. Most public sector family planning services require enhancements in management and supervision, staff training, and the supply of contraceptives, essential drugs, and medical supplies.

*Studies in Nigeria, Tanzania and Zimbabwe have found that a quarter of facilities serve over 80 percent of all family planning clients.*

**FIGURE 14**  
**Travel Time to Family Planning Services**  
**for Married Women Using Modern Contraceptives**

Median Time in Minutes



**SOURCE:** Sian L. Curtis and Katherine Neitzel. *Contraceptive Knowledge, Use, and Sources*. Demographic and Health Surveys Comparative Studies, no. 19. Calverton, MD: Macro International, Inc., 1996.

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## Management and Supervision

The quality of leadership of health and population programs in Africa has improved immensely in the past two decades. Countries have accumulated experience in designing and running programs, and African governments have made efforts to expand and professionalize the cadre of public health managers.

A critical mass of qualified family planning and reproductive health professionals is gathering strength in West Africa, although it has yet to reach levels already achieved in eastern and southern Africa. All over the continent, Africans now occupy technical assistance positions for major international agencies working in reproductive health and population – in contrast to the past, when expatriates almost exclusively held these posts.

Still, as is the case with the public sector in general, there is a shortage of professionals qualified to design, manage and evaluate health and family planning services. This shortage has been exacerbated as international donors have cut back funding for long-term training of health professionals. Furthermore, AIDS has decimated the ranks of young, educated health sector managers in several countries, including Malawi and Zimbabwe.

Management shortcomings diminish the capacity of programs to effectively absorb additional funding, a serious concern in countries where rapid expansion of services is needed. Frequent turnover in top management positions and the continuing exodus of highly-qualified staff in search of better paying work and greater opportunity for professional advancement outside the region undermine program continuity. Low salaries and lack of opportunities for advancement affect staff motivation and contribute to personnel shortages.

Program supervision is another area that needs strengthening virtually everywhere in Africa. Funds for super-

vision are often minimal, resulting in infrequent visits. For example, a 1995 study in Kenya found that, in the six months prior to the study, 43 percent of Ministry of Health clinics had received no supervisory visit; a 1994 study in Senegal found an even lower frequency of supervision. The quality of supervision is also of great concern. Lacking the resources and skills to help workers resolve service delivery problems, supervisors often focus on administrative and data collection tasks.

## Training

The quality of national training programs varies greatly. Countries such as Ghana, Mali and Zimbabwe now design and conduct training successfully without external assistance. Yet, despite significant investments, many African countries still lack sufficient, trained health workers with the skills to provide quality family planning and other reproductive health services. In particular where governments have only recently introduced family planning services, training workers has proved to be a difficult and costly task.

Moreover, most countries face a shortage of skilled trainers and a lack of appropriate materials and curricula. The rote learning tradition, particularly strong in French-speaking countries, is a formidable obstacle to introducing competency-based training approaches that emphasize practice and mastery of essential skills that trainees will use on the job. In addition, training often ignores management and supervisory skills. Finally, trainee follow-up and evaluation rarely occur according to plan because of budget and time constraints.

Governments and donors are responding to the need to lower costs and increase training efficiency through two fundamental shifts in approach. The first is a move towards on-site training of staff as a team in the clinics where they work. Training

*Despite significant investments, many African countries still lack sufficient, trained health workers.*

*Marked improvements in contraceptive supply systems over the last 10 years are part of the reason for the rapid increase in availability of family planning services.*

in regional or national training centers tends to be expensive, is rarely sustainable without significant donor financing, and disrupts services by taking clinic staff out of the field for extended periods. Moreover, it generally does not replicate the conditions in which most health personnel work on a daily basis. While training staff in the clinics where they work may be more cost-effective, it also requires better and more frequent supervision and follow-up.

The second change in approach is a greater focus on improving the family planning skills health workers learn during their initial or preservice training. This method has the advantage of training larger groups of workers at lower cost, helping to institutionalize services on a broad basis and creating a critical mass of trained personnel. After a steady growth in interest since the early 1980s, most African medical, midwifery and nursing schools now include instruction on family planning. Currently, many schools aim to develop comprehensive curricula covering both family

planning and related reproductive health skills.

### Contraceptive Supply

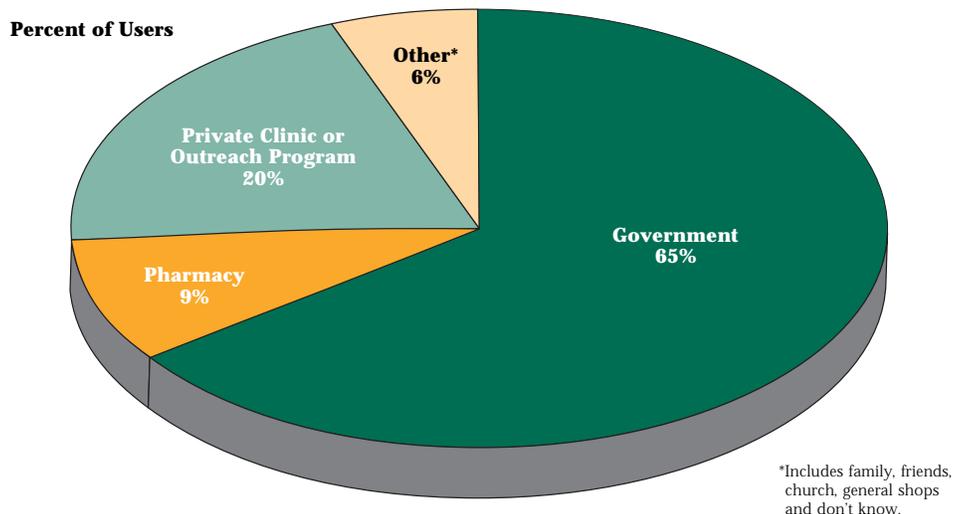
An adequate and regular supply of contraceptives for both clinics and outreach workers is a crucial but often overlooked component of program effectiveness. There are probably few problems that are more likely to discourage a new family planning user than traveling some distance to a clinic and not being able to find the contraceptive method of his or her choice.

Marked improvements in contraceptive supply systems over the last 10 years are part of the reason for the rapid increase in availability of family planning services. In Kenya, a sustained technical assistance effort supported by U.S. funds has significantly raised the consistency with which contraceptive supplies are available; similar progress has been made in Tanzania, also with U.S. support.

Still, most contraceptive supply systems continue to need upgrading

FIGURE 15

### Source of Modern Contraceptive Methods Sub-Saharan Africa



SOURCES: Sian L. Curtis and Katherine Neitzel. *Contraceptive Knowledge, Use, and Sources*. Demographic and Health Surveys Comparative Studies, no. 19. Calverton, MD: Macro International, Inc., 1996; PRB. *1997 World Population Data Sheet*; various Demographic and Health Surveys.

and are ill-equipped to meet the rising demand for contraception in many countries. In varying degrees, all contraceptive distribution systems in Africa suffer from some common problems, many related to wider inadequacies in the procurement and management of essential drugs. Reliable information on numbers and patterns of contraceptive users are often unavailable, clinic staff typically have no background in supply management, and policymakers rarely understand the importance of a well-functioning contraceptive distribution system. Lacking good information, planning is usually weak and procurement often inefficient and wasteful.

As a result, the supply problems that afflict family planning programs worldwide are particularly severe in Africa. Clinics around the region are frequently without adequate stocks of contraceptive methods. Shortages are particularly acute for IUDs, injectables and progestin-only oral contraceptives; it is not uncommon for half or more of clinics to be out of one or more methods on a given day.

### **Access to Family Planning Through the Private Sector**

There are promising opportunities for expanding the role of the private sector in provision of family planning and reproductive health services in Africa. The Cairo conference gave private efforts a boost in the region by recognizing the potential contribution of NGOs, including women's groups. Furthermore, governments increasingly recognize that, with declining resources and deteriorating health systems, private sector partners can help share the responsibility of providing health services. Finally, the rapid expansion of African social marketing programs is an encouraging sign that consumers are willing to purchase subsidized contraceptives through existing commercial networks.

Compared to some other regions, however, the private sector

in Africa currently plays a relatively small role in provision of family planning services. On average, non-governmental organizations and private for-profit clinics serve roughly 1 in 5 contraceptive users, somewhat below the developing country average of almost 30 percent. Commercial pharmacies supply about 1 in 10 contraceptive users – about the same as in other developing countries.

### **The Contribution of NGOs**

The pioneering efforts of private, nonprofit groups in Africa laid the groundwork for transforming public attitudes and government policy in favor of family planning. African NGOs, particularly national family planning associations, have also been in the forefront in testing and implementing new approaches such as community-based distribution of contraceptives, adolescent services and male involvement in family planning. Currently, many of these organizations are breaking new ground in incorporating related reproductive health services into existing family planning programs.

A second important private source of family planning services – especially in English-speaking countries such as Kenya, Nigeria and Zambia – are clinics run by Protestant churches. The Christian Health Association of Kenya, a coalition of over 200 of these clinics, provides almost 10 percent of contraceptive services in the country. (Church institutions, including the Catholic Church, provide 40 percent of all health services in Kenya).

Increased external assistance will most likely be necessary if private voluntary groups are to significantly expand their current limited role in providing family planning services. Some of the more well-established national family planning associations are poised to substantially expand their efforts. However, overall, NGOs account for only between 5 and 10 percent of all health care spending in

*The pioneering efforts of private, nonprofit groups laid the groundwork for transforming public attitudes and government policy.*

*Professional associations of doctors, nurses and midwives have been important catalysts for improving public health policy.*

most African countries. Most NGO family planning programs – especially in French-speaking West Africa – remain small and urban-based, and their management capacity is limited.

The relationship between government and family planning NGOs varies considerably from country to country. In Ghana, Kenya and Senegal there is a healthy partnership between the public and private sectors. In countries such as Ethiopia, however, governments still place important legal and administrative barriers to the work of NGOs. These barriers reflect the discomfort some governments have with the role of NGOs as advocates for the poor and, in some cases, as competitors for scarce international aid.

### **Private For-Profit Health Providers**

The private, commercial sector is smaller in Africa than in other developing regions, but has the potential to expand its role both as an advocate for family planning and related reproductive health services and as a direct provider of such services. Professional associations of doctors, nurses and midwives have in many parts of the region been important catalysts for improving public health policy. Furthermore, across Africa, private health practitioners are getting more involved in provision of contraceptive services. In Ghana, for example, many midwives maintain private practices and include family planning among their services. In 1996, 500 midwives – mostly in rural Ghana – served 20,000 new family planning clients. Similar efforts to encourage private midwives to provide family planning services are underway in Nigeria and elsewhere in Africa.

Programs to promote employer-based family planning services have had some success in Africa. With modest amounts of technical assistance, many such programs have become almost wholly sustainable with private resources. In Zimbabwe, where the employer-based approach has been

particularly intensive, roughly 70 large companies directly provide some type of family planning service through existing company health clinics. A number of large employers in Kenya provide similar services.

Efforts to include reimbursement for contraceptive services in private insurance plans have also proven successful in Zimbabwe and Madagascar. In Zimbabwe virtually all plans – covering seven percent of the population – pay for family planning; in Madagascar, 12 of 22 national employee insurance plans, covering 390 businesses and 12,000 workers, have added contraceptive services and STD prevention activities.

### **The Role of Social Marketing of Contraceptives**

The importance of social marketing programs, which promote and sell subsidized contraceptives through commercial networks, increased dramatically in Africa during the 1990s. Between 1991 and 1995, the number of countries using the social marketing approach grew from 8 to 22. Initially, the U.S. foreign aid program was the sole supporter of social marketing efforts in Africa, but by 1995 other donors were financing a third of existing African programs.

African social marketing programs differ from those in Asia and Latin America in that most began with AIDS prevention rather than family planning as their primary goal. As a result, most programs have focused on condom distribution. Condom sales quadrupled between 1991 and 1995 to 166 million annually – one-quarter of worldwide social marketing totals. Yearly sales of 55 million condoms in Nigeria and 20 million in Ethiopia place those programs among the 10 largest contraceptive social marketing programs in the world.

The emphasis on AIDS prevention has increased support for social marketing programs by African governments. For example, concern over high

AIDS prevalence in neighboring countries persuaded the government of Chad to approve a condom social marketing program in 1996, despite earlier misgivings. Resistance from religious conservatives has been less than expected, and condom sales in 1997 reached three million, in a country of just seven million people.

In some countries where social marketing programs have made good progress with AIDS prevention campaigns, efforts are now underway to expand the focus to include family planning. For example, the formerly condom-only project in Côte d'Ivoire has launched a brand of oral contraceptives and is marketing a new brand of condoms to married couples.

However, major barriers remain to broadening the scope and coverage of social marketing programs. Promoting condoms for family planning *and* prevention of sexually transmitted diseases requires distinct sales messages, packaging and distribution channels,

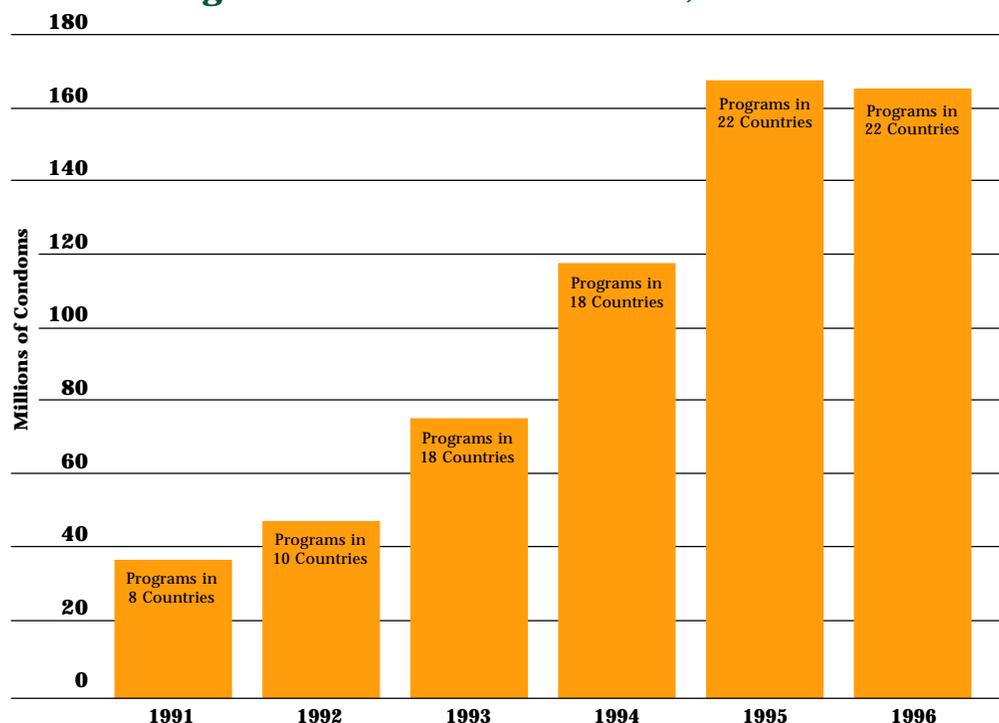
yet markets in most countries are not big enough to support separate brands cost-effectively. Donors have often earmarked funds specifically for AIDS prevention, and have lacked the flexibility to expand social marketing programs to include contraceptives other than condoms. Coordination is often difficult between separate national AIDS control and family planning programs. Except for some of the more developed countries of the region, such as South Africa, commercial networks outside cities are weak, limiting distribution efforts in rural areas.

In addition to the emphasis on STD prevention, strong legal and regulatory barriers have hampered the introduction of other contraceptives – particularly oral pills and injectables – into social marketing efforts. Conservative medical groups generally oppose over the counter sales of oral contraceptives and have prevented the launch of an oral pill in Zambia. Pharmacy owners often block sales

*Where social marketing has made good progress with AIDS prevention, efforts are underway to include family planning.*

FIGURE 16

### Sales of Condoms Through Social Marketing Programs in Sub-Saharan Africa, 1991-1996



SOURCE: DKT International. *Contraceptive Social Marketing Statistics*. Washington, DC: DKT, 1991-1996.

*The environment for community-based family planning has improved dramatically since the 1980s.*

of social marketing products outside of formal commercial channels, thus cutting off distribution channels through the far more numerous chemist shops and retail outlets. Many countries – including those with relatively strong family planning programs, such as Zambia, Kenya and Malawi – restrict television and radio advertisements for contraceptives.

### **The Importance of Outreach Programs**

Many years of experience in Africa and elsewhere show that community outreach programs can effectively

extend family planning education and services beyond the clinic while ensuring client safety. Especially in rural areas where family planning is new, trained volunteers or paid workers from the community can help bridge the cultural divide that usually exists between the client and the clinic-based health worker.

The environment for community-based family planning in Africa has improved dramatically since the 1980s; virtually all countries now have some type of outreach program. Yet, in contrast to Asia, most are small-scale, private efforts; there are still few large-scale government ventures.

### **Out of the Clinic, Into the Community Kenya's Community-Based Family Planning Programs**

Community-based family planning programs in Kenya are many and varied, and have made a significant contribution to the success of national family planning efforts. Each program focuses on bringing appropriate family planning counseling and supplies out of the clinic and into the community, although programs differ in size, field worker selection, compensation and supervision, range of methods and services, and ties to clinical services.

A recent review of selected programs shows that field workers can be extremely effective in serving their local communities. In the areas they cover, outreach workers supply 40 percent of all women who use oral contraceptives, condoms or spermicides – the principal methods that field workers distribute. Yet, national surveys have tended to understate the effectiveness of the community-based approach. For example, the 1993 Kenya Demographic and Health Survey reports that outreach workers supply just 2.5 percent of users of modern contraception. The low figure reflects in part the limited geographical range of the field workers; only between one-fifth and one-half of Kenyan women live in communities served by outreach workers. In addition, many clients have family planning needs which the field workers cannot directly meet given the limited range of methods they provide.

Field workers do, however, play a significant role in referring clients for clinical contraceptive methods. Rural outreach workers in the various programs refer on average between 3 and 35 clients annually for methods such as injectables, IUDs and female sterilization. Because of gaps in reporting, these numbers most likely substantially underestimate the true volume of referrals.

The visibility and active involvement of outreach workers have been crucial components of program success. In communities served by outreach programs, nearly 60 percent of both women and men know a field worker. Furthermore, of current contraceptive users that know a field worker, 35 percent of condom users and 57 percent of oral contraceptive users obtain their supplies from that worker.

Some of the countries in Africa where family planning programs have been most successful have invested heavily in community outreach. Kenya pioneered the community-based approach in Africa in the 1980s; it now has the most extensive outreach effort in the region, with 25 programs employing roughly 17,000 community agents, including 9,500 government workers.

Zimbabwe's 800 paid full-time community family planning workers are the cornerstone of its successful national program; community workers supply one in five users of modern contraceptive methods. Mali's government has placed male-female outreach teams in almost 600 villages, with plans to expand to an additional 1,320 villages by the end of 1998. Governments in Tanzania and Uganda are also moving rapidly ahead with community-based programs.

One obstacle to progress is the need and the time required to reaffirm in every country that nonclinical program strategies such as community-based distribution of contraceptives are viable and safe for clients. In most countries, community workers are only permitted to distribute condoms and spermicides in addition to their responsibilities for client education on family planning and referral for clinical services. Despite research showing that community workers spend more time with clients and are just as good as physicians in identifying precautions for use of oral contraceptives, African doctors and even some family planning program managers remain cautious about non-prescription distribution of hormonal contraceptives via community workers. Nevertheless, in countries such as Guinea and Mali, women who obtain a prescription and initial supplies from a clinic can obtain subsequent supplies from community workers.

Setting up and running outreach programs is also a complex undertaking. Inappropriate selection of outreach workers is a common problem and a

heavy reliance on volunteers makes it harder to motivate outreach workers. Although community workers need to be supported by trained health staff and facilities, many outreach programs lack adequate links between community workers and clinics. A lack of effective management and supervision also make it an enormous challenge to blend outreach schemes with existing government services. Moreover, programs are often designed without adequate community involvement, and do not take local cultural conditions sufficiently into account.

## **Improving the Quality of Family Planning Services**

Improvements in the quality of family planning services are an important complement to expanded access to services. Africa has made substantial progress in raising the quality of family planning services, and the choice of contraceptives has steadily expanded. Still, long-term methods such as sterilization are largely unavailable; many programs create unwarranted obstacles to family planning use; and safety measures such as infection control remain a critical concern. Knowledge of family planning methods has greatly increased in the past decade, yet programs can do more to provide accurate and complete information to clients.

## **Contraceptive Choices**

Africa's relatively recent adoption of population policies and programs gives its governments the unique chance to draw on almost 50 years of international experience in building population programs in other regions. An important difference in Africa is that health concerns, rather than concerns over rapid population growth, have been the primary force behind the expansion of family planning programs in the region. As a result, African programs have avoided the emphasis of

*Africa has made substantial progress in raising the quality of family planning services, and the choice of contraceptives has expanded.*

*Oral and injectable contraceptives account for two-thirds of all modern method use.*

some older Asian programs on meeting numerical goals for recruitment of family planning clients. This target orientation has been associated with lapses in voluntarism and an overreliance in some Asian countries on sterilization. In contrast, African programs have been generally free of abuses and have relied more heavily on contraceptive methods that are appropriate for couples who want to space births.

■ Oral and injectable contraceptives account for two-thirds of all modern method use in Africa. Several brands of oral contraceptives are available in most countries, but supplies are often uncertain and government programs often substitute brands without regard to client preferences. There is a high demand for progester-

in-only pills in many countries because breastfeeding women prefer them, but programs do not consistently stock them.

■ Use of injectable contraceptives is increasing rapidly in Africa. Almost half of the recent rise in modern method use in the region can be attributed to the growing popularity of injectables. Rural women especially prefer the convenience of only having to visit a clinic once every two or three months (depending on the brand) for injectable contraceptives and like the injection because it allows them to keep their contraceptive use confidential.

■ Imported condoms – either subsidized social marketing brands or commercial products – are

### **New Approaches to Rural Outreach in Northern Ghana**

An innovative project in Ghana is demonstrating that it is possible to increase acceptance of family planning even in conservative rural areas of Africa. The Community Health and Family Planning project was begun in 1994 and is managed by the Navrongo Health Research Center of the Ghanaian Ministry of Health. Operating in a rural district where family planning use has traditionally been extremely low, the project upgraded health clinics and trained government community health nurses (CHNs) and village volunteers to provide contraceptive services and other basic health care. Rather than waiting for clients to come to them in the clinics, CHNs now make scheduled visits on their motorcycles to every family compound in the villages they serve. Nurses persevere despite rough roads and bad weather to provide basic preventive health care, including family planning counseling and supplies of oral contraceptives, condoms, injectables and foam tablets. Each village has prepared a house for their CHN where she lives throughout the work week, and it is not unusual for a nurse to wake in the morning to find a line forming at her door for care.

Full community participation is a hallmark of the effort. Project staff have continuously involved chiefs, elders, soothsayers and others with influence over reproductive decisionmaking in developing and carrying out activities. The project also uses traditional channels of leadership, communication and participation, such as village meetings and social groups.

The investment in understanding the cultural setting and the comprehensive approach to community outreach appears to be paying off. When the project began, just 2 of 900 women in pilot villages were using modern contraceptives; after one year, 255 women became contraceptive users.

increasingly accessible in pharmacies, shops and health clinics. By international standards, availability of condoms as well as oral contraceptives is close to the developing country average. For the region as a whole, condoms still account for a relatively low share of modern method use, just 4 percent. However, condom users make up a significant proportion of family planning acceptors in Côte d'Ivoire (49%), Central African Republic (31%), Zambia (24%) and Ghana (22%).

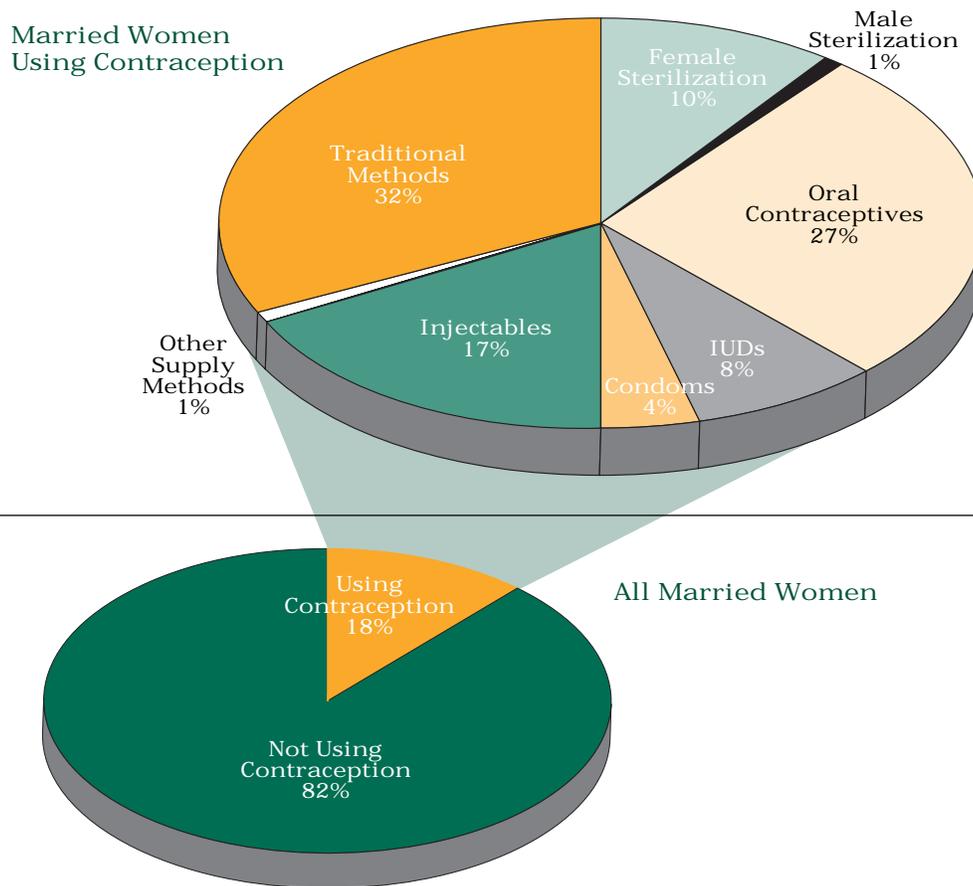
- Studies in a number of African countries have shown relatively high levels of acceptability for the

female condom, currently the only product controlled by women that protects against both STDs, including HIV/AIDS, and pregnancy. Despite the high cost of the female condom relative to the male condom, interest in the method is growing. In Zambia, for example, the government recently acquired 500,000 female condoms for distribution at government clinics and through commercial outlets as part of the contraceptive social marketing effort.

Offering a wide range of contraceptive methods is important to improving client satisfaction and is generally linked to higher family

*Limited access to long-term methods of family planning remains a major constraint to expanding contraceptive choices.*

**FIGURE 17**  
**Contraceptive Method Mix, Sub-Saharan Africa**



**NOTE:** Based on the most recent available survey data. Average date, 1990.

**SOURCE:** UN Population Division. *Levels and Trends of Contraceptive Use as Assessed in 1994*. Population Studies Series, no. 146. New York: UN Department of International Economic and Social Affairs, 1996.

*Female sterilization is the most widely used contraceptive method in the world, but levels of use in Africa remain extremely low.*

planning use. In Africa, however, the limited access to long-term methods of family planning remains a major constraint to expanding contraceptive choices.

■ IUD use is low, just 8 percent in Africa compared to 13 percent for developing countries, excluding China. A growing problem is that health workers are reluctant to perform IUD insertions owing to the lack of adequate supplies such as gloves to help protect them from exposure to HIV/AIDS. Low IUD caseloads also limit training opportunities in insertion and removal. In addition, given the high prevalence of STDs in many countries and the limited diagnostic tools available, many health workers are concerned about the increased risk of pelvic infection associated with IUD use in women who may have an STD.

■ The contraceptive implant Norplant has been introduced in a number of countries in sub-Saharan Africa, but has yet to have a major impact on contraceptive use. Studies in Ghana, Kenya and Nigeria have shown that African women like the convenience of Norplant. However, removal of the method remains a problem in countries where there are still few sites for removal, underscoring the importance of follow-up care. The higher initial cost of the device relative to other long-term methods such as the IUD has also limited the quantities that donor agencies have been willing to provide.

A further obstacle to expanding method choices is that, except in a few African countries, there is little domestic capacity for producing drugs and medical devices of any kind, including hormonal contraceptives. Most countries depend on imported contraceptives and other essential drugs, and are likely to do so for the foreseeable future.

## Access to Sterilization

Female sterilization is the most widely used contraceptive method in the world, but levels of use in Africa remain extremely low. Even though roughly one-quarter of married African women do not want more children, only about one percent currently rely on sterilization.

Nevertheless, evidence points to a growing interest in voluntary sterilization. Clinics in nine countries supported by AVSC International reported almost 25,000 procedures in 1994. In Kenya, where nearly 14,000 procedures now occur a year, the proportion of married women for whom sterilization is the method of choice more than doubled between 1984 and 1993, to 5.5 percent. Doctors in Ghana performed 2,300 sterilizations in 1996, a 50 percent increase over the previous year. Demand in Malawi, Tanzania and Zambia appears to be strong and growing.

Strong cultural factors, in part, continue to inhibit demand for sterilization. African women often refrain from choosing permanent contraception out of fear that they may want another child in the event of divorce and remarriage or the death of a child. Additionally, women considering sterilization often face strong opposition from husbands and extended family members.

Until recently, female sterilization services were virtually unavailable across much of Africa. The lack of services has contributed to low levels of public awareness; on average only half of African women know of female sterilization. Moreover, health workers typically fail to counsel clients on sterilization, and when they do, often exaggerate the side effects. Even in Kenya, one of the only countries in Africa with some access to female sterilization, as recently as 1995 only one-third of family planning clients were receiving information on the procedure during their visit to a clinic.

Contrasting experiences in Kenya

and the Democratic Republic of Congo confirm the interplay between service availability and attitudes towards sterilization. In parts of Kenya with large numbers of satisfied sterilization users, the general population has very positive attitudes towards sterilization. In the Democratic Republic of Congo, where few services are available, feelings about permanent contraception continue to be negative and rumors are widespread.

In practice, access to sterilization is difficult even at those sites where services are nominally offered. Public sector hospitals have chronic shortages of the expendable supplies required for surgery; clinics may schedule procedures only one day a week; doctors and facilities assigned to perform sterilizations are often diverted to other more urgent surgical needs.

Many of the same factors that limit access to female sterilization also severely restrict the use of vasectomy. Five percent of couples worldwide use vasectomy for family planning. In Africa, however, vasectomy is virtually unknown. Among men, fewer than 30 percent have heard of the procedure.

Where it is known in Africa, vasectomy often still carries great stigma, even where female sterilization is becoming increasingly accepted. Both men and women wrongly believe that vasectomy harms a man's health or sexual function. Family planning workers are uninformed about the procedure and biased against it. Furthermore, until recently, few doctors were trained in vasectomy. Pilot vasectomy services are now available in a few countries, including Ghana and Kenya, where knowledge has increased substantially. Still, the number of vasectomies performed yearly probably does not exceed 100 in any country in the region.

## **Safety of Clinical Procedures**

Evidence from Kenya suggests that sterilization in Africa can be as safe as

in other settings; a rate of 5.5 deaths per 100,000 procedures in Kenya is slightly below the average rate of 5.9 per 100,000 found in an analysis of sterilization experience in 35 countries. Safety in Kenya has been enhanced by attention to quality and the widespread use of simpler techniques using local rather than general anesthesia. The less complicated procedure eliminates overnight hospital stays, cutting down on costs and adding to client confidentiality.

Nevertheless, proper infection control in clinical procedures remains a crucial concern for family planning programs in the region, given the high prevalence of HIV/AIDS and other infectious diseases. Health personnel need to protect both themselves and clients from disease transmission during voluntary sterilizations, IUD and Norplant insertions, administration of injectable contraceptives and pelvic examinations.

In many African clinics, however, lack of running water and inadequate staff training result in an absence of even the most basic infection control practices. One study showed that in Senegal just 14 percent of workers wash their hands before performing a pelvic examination; the proportion in six other countries ranges from 49 to 83 percent. Many facilities are also chronically short of infection control supplies and equipment, leading health workers to reuse gloves and other materials without proper disinfection.

## **Regulatory Barriers and Staff Biases**

In many African countries, the choice and availability of contraceptives is further confined by outdated laws, regulations based on misperceptions about health risks and lacking a medical rationale, and biases among health workers. These barriers tend to be greater in French-speaking than in English-speaking Africa, partly because of the legacy of anti-family

*Proper infection control in clinical procedures is a crucial concern for family planning programs.*

*In many African countries, the choice and availability of contraceptives is confined by outdated laws.*

planning laws dating from the French colonial era.

In some former French colonies, these laws are still in effect. Although they are not strictly enforced, together with other restrictions on contraceptive availability these laws inhibit the development of family planning programs by maintaining legal ambiguities that can block access to specific contraceptive methods. In Côte d'Ivoire, for example, there is a widespread belief among family planning staff that sterilization is illegal. In fact, the lack of availability of sterilization appears to be the result of discretionary action by health authorities rather than because of a specific law.

Clinic workers across the region commonly, and unnecessarily, restrict contraceptive use based on a woman's age, number of children and marital status. Studies show that many of the health staff who create these barriers believe they are acting out of concern for the safety of their clients. However, these workers often lack adequate knowledge of the contraindications, benefits and potential side effects to the use of specific family planning methods. As a result, they often do their clients more harm than good by overemphasizing the potential dangers from contraception.

In Zimbabwe, for example, many program staff set minimum age requirements for use of contraceptives, despite guidelines dictating that family planning services be available to everyone regardless of age. Likewise, over half of health workers in Zanzibar set unwarranted age restrictions on all contraceptive methods, and many refuse to provide injectable contraceptives – the most popular method – to women with fewer than three children.

Zambia recently dropped its requirement that women obtain written permission from their husbands to receive government family planning services. Government regulations in many other African countries, however, require spousal approval for female sterilization; many field staff also apply

this restriction to other methods. For example, between 30 and 40 percent of family planning workers in Ghana require consent of the spouse before providing women with oral contraceptives, IUDs and injectables.

Contraceptive availability is further restricted by regulations that allow only physicians to provide family planning methods such as Norplant and IUDs – despite studies showing that trained nurses and midwives are just as competent in performing the procedures. Moreover, some countries impose prerequisites for contraceptive use that go far beyond internationally accepted norms for counseling and medical testing. A 1994 study in Senegal found that, to receive Norplant, most women had to wait over two months and make more than four clinic visits for various tests and counseling. Clients wanting sterilization faced similar hurdles.

As an important first step to addressing biases among health staff and unwarranted program restrictions, several African countries have developed and disseminated standardized national guidelines for providing family planning services. However, the effectiveness of these guidelines in removing unnecessary barriers thus far has been uneven. In Cameroon, the introduction of service guidelines in 1993 did not diminish biases among health workers, in part because the new rules were not specific enough in their guidance to field staff. The guidelines also failed to address the most important bias among health workers – the erroneous belief that women menstruating the day of their clinic visit are ineligible to receive oral contraceptives. In Kenya, in contrast, improved medical guidelines are thought to have played a role in large increases in referrals for female sterilization.

### **Client Counseling**

Insufficient training, poor supervision and lack of basic client education

materials leave most family planning workers in Africa with weak counseling skills. In large, busy family planning clinics, workers often lack the time to adequately counsel each patient on contraception; they have even less time available to discuss broader reproductive health topics such as prevention of HIV/AIDS and other STDs. Furthermore, as in many regions, clinic staff traditionally have not given clients enough information to make knowledgeable choices about family planning. Under these circumstances, many clients choose inappropriate contraceptive methods.

Many family planning workers in Africa do not educate clients sufficiently about correct use of their chosen contraceptive method, what side effects to expect and how to manage side effects should they occur. A study of family planning services in 10 African countries found that although two-thirds of clients on average receive information on how to use the method they chose, clinic staff consistently tell

less than half of new family planning users about potential side effects. The percentage receiving information on how to manage possible side effects is even lower – ranging between 1 percent in Côte d'Ivoire and 42 percent in Burkina Faso.

When clients do experience side effects from contraceptive use, field staff typically fail to adequately address client concerns – a shortcoming that is a major factor in the decision by many clients to discontinue family planning use. In studies in Ghana, Nigeria and Tanzania, workers discussed the possibility of switching to another method with fewer than a third of clients experiencing problems with their contraceptive method.

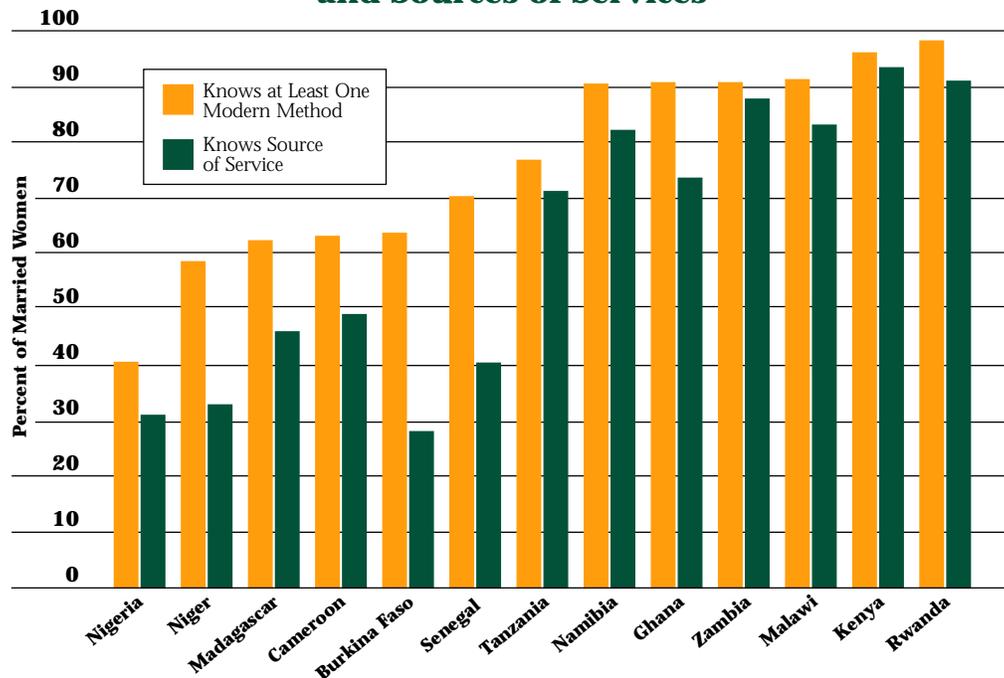
### Challenges to Effective Mass Communication

Public awareness of contraceptive methods in Africa has increased dramatically in recent years as a result of the expansion of family planning

*Public awareness of contraceptive methods in Africa has increased dramatically in recent years.*

FIGURE 18

### Knowledge of Contraceptive Methods and Sources of Services



SOURCE: Sian L. Curtis and Katherine Neitzel. *Contraceptive Knowledge, Use, and Sources*. Demographic and Health Surveys Comparative Studies, no. 19. Calverton, MD: Macro International, Inc., 1996.

*Many public information efforts fail to give potential family planning clients specific information about where to obtain contraceptive services.*

programs and public education efforts. On average, 77 percent of married women in Africa now know of at least one modern contraceptive method. Still, levels of knowledge in most African countries remain below the average for other developing country regions, and public awareness varies substantially from country to country.

In Zimbabwe and Kenya, sustained public information campaigns through mass media and community outreach have helped achieve almost universal knowledge of modern contraception. In contrast, where family planning programs are weak or nonexistent, knowledge of contraceptive methods is generally low. However, some African countries have made extraordinarily rapid advances. In Mali, the proportion of women knowing at least one modern contraceptive method rose from under 30 percent in 1987 to 65 percent by 1995.

A region-wide shortcoming is that many public information efforts fail to give potential family planning clients specific information about how contraceptive methods work, which methods are most appropriate for them and, most importantly, where to obtain contraceptive services. Indeed, almost everywhere in Africa, substantially fewer women know the source for a contraceptive method than know of the method. A good example is Burkina Faso, where 63 percent of women know of at least one modern method of family planning, yet only 28 percent know where to obtain contraceptive services. The national program in Ghana is attempting to increase knowledge of family planning sources by developing a communication strategy that will bridge the gap between knowledge and use.

To succeed, public education programs in Africa must overcome a number of difficult obstacles. Both governments and donor agencies tend to undervalue the long-term impact of health communication, relative to the pressing need for health and family

planning services. Professional opportunities for health educators in Africa are extremely limited, and Africa still lacks enough health staff who understand health education and can design and implement high quality, effective educational programs and materials. Weak communication infrastructure and lack of local technical expertise complicate program design and implementation. Moreover, lack of coordination among international donors, governments and family planning NGOs often results in fragmented and ineffective public education efforts.

Most family planning mass media campaigns use radio, the most cost-effective channel for reaching large numbers of people, especially in rural areas of Africa. Still, exposure to radio and other mass media is low in Africa compared to other developing regions. Radio costs are rising as stations increasingly charge market rates to air health education messages. Also, in many countries, the government tightly controls mass media outlets, and often restricts the broadcast of potentially controversial messages on population and family planning.

The relatively underdeveloped state of the mass media in Africa has stimulated development of other, less hi-tech approaches for disseminating health and population messages, and produced some of the world's most creative family planning communication efforts. One such program in Kenya integrates family planning and reproductive health messages into traditional forms of entertainment such as street theater, dancing, singing and puppet shows.

## **Beyond Family Planning: Broadening Population Programs**

The ICPD *Programme of Action* emphasizes the goal of universal access to basic reproductive health services. In addition to family planning, essential elements of the reproductive health

care package agreed to at the 1994 conference include pre- and postnatal care and safe delivery; prevention and management of complications of unsafe abortion; prevention of HIV/AIDS; and prevention and management of sexually transmitted diseases. The *Programme of Action* also recognizes the importance of extending family planning and reproductive health services to previously underserved groups such as men and adolescents, and of eliminating harmful practices against women, including female genital mutilation.

The intersection of all these issues makes the Cairo agenda especially relevant to Africa, where, as in other regions, governments face the challenge of implementing a significantly broader scope of health services. Important questions remain unanswered regarding which services to provide, in what combination and at what level of the health system. Financing the expanded package of reproductive health services is an important issue for Africa, where health care resources are extremely limited. Additionally, governments in many African countries have only recently incorporated family planning services into health systems. With family planning services new and government commitment to these services still fragile, there is concern that adding other reproductive health services could undermine progress to date in expanding access to family planning.

### **Linking Family Planning and Related Reproductive Health Services**

There is still only limited information on efforts to link family planning with related reproductive health services. The preliminary experience suggests that some degree of integration can enhance the effectiveness of the various components of reproductive health services. In many instances, such integration has been implemented without

undermining family planning efforts; in some cases, it has actually bolstered use of contraceptive services.

- Countries such as Uganda and Zimbabwe already have integrated family planning and reproductive health services in training curricula for health workers. Workers now learn screening and management of reproductive tract infections as part of an integrated curriculum, a skill that allows them to better meet client needs and ensure safer IUD insertion.
- Many contraceptive supply systems in Africa were initiated separately from public sector systems for the distribution of essential drugs. To some degree, the better-functioning family planning programs owe their success to a single-minded focus on the efficient supply of contraceptive methods. Now, however, governments are taking a fresh look at supply systems dedicated to contraceptive distribution alone, and are beginning to explore integrated models that may be more cost-effective in the long run. In Kenya and Eritrea, systems originally set up to manage contraceptive supply are now being used to manage supplies of essential drugs as well, to the benefit of both family planning and STD prevention efforts.
- A number of African countries, including Tanzania, Uganda and Zambia, are combining mass media messages on family planning and reproductive health and at the same time working to improve the counseling skills of health workers in both family planning and STD prevention. Moreover, there is growing interest on the part of African health education programs to incorporate messages on double protection – using condoms for disease prevention together with a more effective contraceptive method such as hormonal

*Financing the expanded package of reproductive health services is a difficult issue for Africa because health care resources are limited.*

*At existing family planning clinics, there is too little integration of family planning with other reproductive health services.*

contraception or sterilization for preventing pregnancy.

Despite these positive developments, the synergy between family planning and other reproductive health services has yet to be fully developed. At existing family planning clinics, there is often too little integration of family planning with other related reproductive health services, such as counseling for HIV/AIDS and

STD prevention. Moreover, the quality and scope of these other services are highly variable. Smaller facilities do not offer the range of reproductive health services seen at larger hospitals. However, in hospital settings, family planning is also more likely to be physically separate from other reproductive health services.

A further barrier to integration is that AIDS and STD prevention programs typically are administered

### **The Challenge of Integration: Experience from Kenya**

A recent effort in Kenya illustrates some of the challenges programs face in integrating STD prevention with maternal and child health and family planning (MCH/FP) services.

Before 1990, women in Nakuru, a city of 220,000 located 160 kilometers northwest of Nairobi, had few options when seeking diagnosis or treatment for sexually transmitted diseases. STD services were available only in the curative wings of the five clinics operated by the Nakuru city council and the health ministry hospital. Information and counseling on HIV/AIDS and other STDs were virtually nonexistent.

As a result of growing concern over the spread of HIV/AIDS, in 1990 health officials designed an approach to better identify and treat women at risk of infection. HIV/AIDS and STD services were introduced at the outpatient MCH/FP clinics which for many women serve as their only contact with the health system. At the same time, the hospital in Nakuru established a special clinic for STD treatment.

Training and adequate drug supplies have been the cornerstones of the integration effort. Staff at the outpatient clinics learn to counsel women and assess their risk of infection. They also receive training in simple techniques to screen and treat clients for common STDs and in notifying partners of clients suspected of having an STD to prevent reinfection. The project also aims to keep clinics well-stocked with drugs for treatment of common STDs.

In practice, the approach has faced some difficulties. While the city council clinics have adequate supplies of the essential drugs needed to treat common STDs, the provincial hospital and the STD clinic often have shortages. Furthermore, because of Kenyan regulations prohibiting nonphysicians from prescribing antibiotics, nurses at the city council clinics still must refer STD clients to a doctor for treatment. Most clinics also lack sufficient quantities of brochures, posters and pamphlets for client education on STDs and HIV/AIDS.

Counseling efforts also face a number of obstacles. Few women receiving MCH/FP services know that STD services are also available within the same clinic. Client knowledge of STD symptoms or modes of transmission of HIV/AIDS is often poor. Moreover, clinic staff are successful in notifying partners for just one-third of clients with syphilis and just 10 percent of women diagnosed with symptoms of other STDs.

The experience in Nakuru is typical of the challenges facing programs across Africa. The seriousness of the AIDS epidemic will require health officials to intensify efforts to seek effective models of STD prevention and treatment.

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and funded separately from other health services, often leading to disagreement among program officials over strategy and priorities. For example, in Ghana the government is attempting to introduce STD prevention and treatment at clinics providing family planning and maternal and child health services; however, poor communication between the two programs has held up these efforts.

## Key Challenges

The following are key challenges programs face in more fully capitalizing on the synergies between family planning and other reproductive health services.

## Preventing HIV/AIDS and Other Sexually Transmitted Diseases

In sub-Saharan Africa more than in any other region, sexually active men and women have closely related needs to protect themselves from unwanted pregnancy as well as from debilitating and often life-threatening disease. With HIV prevalence high in many countries and other sexually transmitted diseases common throughout Africa, there is a strong likelihood that many family planning clients already have or are at high risk of contracting a sexually transmitted disease. Despite some progress, health and family planning services have not adequately responded to this reality.

At the clinic level, there are still many missed opportunities to provide clients with information about sexually transmitted diseases. A study in 10 African countries revealed that health workers discuss sexually transmitted diseases with only 1 in 10 new family planning clients; HIV/AIDS was discussed with just 1 in 14 new family planning clients.

Lack of training in proper management of STDs and the reluctance of health workers to discuss sexually

transmitted diseases with clients are major reasons for this serious omission. Clinic staff often believe married women are at low risk of infection and are uncomfortable raising such a sensitive topic. Yet, studies show that many women perceive themselves to be at high risk and want to hear about STDs. By failing to adequately assess a client's risk of sexually transmitted disease, health workers miss an opportunity to both prevent new infections and to use simple and effective approaches to diagnose and treat common STDs.

Moreover, STD testing and referral services are weak and few family planning clients are even aware of the availability of such services. One cross-country study found that fewer than 40 of over 2,500 women seeking family planning services received an STD laboratory test or referral; less than 10 percent of clients were aware of STD or HIV/AIDS services available at the clinic they were visiting. These results are hardly surprising. Outside of large cities, few laboratory facilities exist for accurate diagnosis, and drugs for STD treatment are often in short supply, especially in public sector programs. Also, across most of sub-Saharan Africa, only physicians are allowed to prescribe the antibiotics that are used in STD treatment.

Additionally, in most African countries, STD/HIV screening and treatment services have almost always been focused on specialized urban clinics serving high risk groups such as commercial sex workers. Women from the general public shun these facilities because of the stigma attached to being identified as carrying an STD and because of the judgmental attitudes of many of the staff at these clinics. As a result, even those women who suspect they may have an STD are unlikely to seek treatment at specialized facilities; as in other developing regions, most women in Africa with an STD go undiagnosed and untreated.

To help increase the chances that women will seek and receive STD screening and treatment, African

*At the clinic level, there are still many missed opportunities to provide clients with information about sexually transmitted diseases.*

*A recent study shows that local communities want outreach workers to provide information on HIV/AIDS and other STDs.*

program managers are testing various strategies to incorporate STD services into existing family planning and maternal and child health programs.

- Training of health and family planning staff in management of STDs is moving forward in some countries. By 1995, 50 percent of family planning staff in Kenya and 66 percent in Botswana had received training in management of sexually transmitted and reproductive tract infections; less than a quarter, however, had received training in HIV/AIDS counseling.
- Mass media campaigns to inform the public about sexually transmitted diseases have been implemented in a number of African countries, often in conjunction with condom social marketing programs. These public education efforts have successfully raised awareness of AIDS; over 90 percent of adults surveyed know of the disease. Still, information campaigns have been uneven in their scope and effectiveness, and knowledge does not necessarily translate into behavior change.
- A recent study in Kenya showed that local communities want outreach workers to provide information and counseling on HIV/AIDS and other sexually transmitted diseases. Moreover, the study showed that communities also support education for young people and single men and women, a further sign of the seriousness of local concern over the impact of the AIDS epidemic. While many outreach programs in Africa – especially those run by NGOs – have already taken steps to incorporate AIDS and STD prevention activities alongside family planning information and services, they still face many challenges in effectively implementing this new approach.
- Research on the cost of adding STD services – a concern to governments everywhere in Africa – is also underway. A recent study in Kenya

found that the cost of providing integrated family planning and STD services is up to one-third lower than providing the two services separately, mainly because of savings in staff time and economies of scale from sharing space. Nevertheless, the laboratory and drug costs associated with most STD services are high. Clients will likely have to share some of the cost of these services, but setting prices too high may put services beyond the reach of many poor Africans.

### **Reducing Maternal Mortality**

It has now been 10 years since the 1987 Safe Motherhood Conference in Nairobi – a landmark event in the effort to combat high maternal mortality in Africa and other regions. Yet, despite heightened awareness among policymakers of the magnitude of the problem in Africa, maternal death rates in Africa show no sign of decreasing, and may even be on the rise in some countries.

Along with expanding coverage of family planning services, the most effective strategy to reduce maternal risk is improving essential obstetric care for pregnant women. Yet, because of limited access to overall medical care, use of maternal health services is poor; resources to handle obstetric emergencies are limited and becoming scarcer in some countries. From Nigeria, for example, there is evidence that deepening poverty and increased client fees have caused a drop in the number of women using health facilities for normal delivery services, although women with complications are still being seen with the same frequency.

Ghana, Nigeria and Uganda are attempting to address the need for emergency care through improved training of clinic and hospital staff, and improved community education. In part because of the difficulty of measuring maternal deaths within a relatively small population, these

programs have not yet demonstrated a clear impact on reducing maternal risk. In Tanzania, however, one regional hospital was able to show a substantial decrease in maternal mortality at the facility after implementing a program to improve quality of care.

In practice, African governments have done little to address the problem of maternal death; those programs that exist are small in scope. Also, experts acknowledge that initially too much effort went into approaches that proved relatively ineffective in reducing the risk of maternal death, including training of traditional birth attendants and the development of screening tools to identify pregnant women at high risk of complications.

Improved maternity care includes outreach to women who deliver at home; referral as needed for management of complications; and improved transportation for women in need of emergency care. Better treatment of complications requires improvements in facilities and staff training, especially at health centers and hospitals. By contrast, the bulk of family planning and other reproductive health services such as STD prevention can be provided at smaller health centers and posts, and through outreach workers. Therefore, at the operational level, opportunities for integrating family planning services with activities to prevent maternal death are relatively few.

## **Improving Postabortion Care**

One bright spot in the battle to reduce maternal risk is the headway being made on expanding emergency care for women suffering complications from unsafe abortion. The high number of deaths from unsafe abortion has helped spur public debate in a number of African countries, and some governments are at last taking effective action to deal with the enormous health consequences of unsafe abortion. Programs to expand access to emergency treatment of abortion

complications and postabortion family planning and reproductive health counseling and services are growing.

Manual vacuum aspiration (MVA) – a safe, simple and low-cost technique for treating incomplete abortion – has now been introduced into at least nine countries in sub-Saharan Africa, including Ethiopia, the Gambia, Ghana, Mozambique and Zambia. The new technique has lowered treatment costs and helped save the lives of many women.

The postabortion care programs in Kenya and Nigeria, both begun in 1987, are the most advanced in Africa. The Kenyatta National Hospital in Nairobi, the country's most important teaching hospital, has trained over 200 Kenyan doctors in the MVA technique, and now trains physicians from around the region. Introduction of MVA at one facility in Kenya reduced the cost of treating a woman with an incomplete abortion by 66 percent. In Nigeria, virtually all large teaching hospitals now train doctors in postabortion care; training for staff at several smaller state-run hospitals and for private practitioners is expanding.

Efforts to train nurses and other health auxiliaries in emergency postabortion care are also gaining ground. The presence of trained personnel at the nearest health facility, which often has no physician on staff, will allow women to obtain emergency services more quickly. Ghana is one of a number of countries around the region training midwives in post-abortion care; some 40 Ghanaian nurse-midwives – mostly in private practice – have received training and equipment to perform MVA. Changes in national policy support these efforts. Ghana's new national reproductive health service guidelines require that all doctors and midwives receive training in emergency postabortion care and that MVA equipment be available at all health centers and hospitals.

Family planning services are an integral part of postabortion care. Women who have undergone abortion

*Programs to expand access to emergency treatment of abortion complications and postabortion family planning are growing.*

*High rates of unintended teen pregnancy, unsafe abortion and HIV/AIDS have contributed to a public awareness of adolescent sexual health needs.*

are often in immediate need of family planning services; many are highly motivated to use contraception. However, links between family planning services and emergency postabortion care are still weak in most of Africa. Family planning services themselves are still not widely available in many countries. Even where they exist, the two services are often provided by different staff and in separate facilities. Health workers providing emergency treatment may not view contraceptive provision as their responsibility; even those clinic staff willing to provide family planning services to abortion patients often know little about which contraceptives are appropriate to provide to women who have just undergone an abortion.

A number of countries are taking steps to expand access to safe abortion. South Africa changed its abortion laws in early 1997 to allow elective abortion during the first trimester of pregnancy and for a range of reasons later in pregnancy; similar legislation is being considered in neighboring Namibia. Participants from 18 African countries at a recent symposium on removing legal barriers to sexual and reproductive health recommended that safe abortion be available in cases of rape, incest, early pregnancy and congenital malformation.

Even in countries such as Ghana and Zambia, where the law permits abortion on broad social and health grounds, access to safe abortion – especially for rural women – is still difficult. Neither the public nor health workers have a good understanding of laws regulating abortion, and the vagueness and cumbersome administrative requirements of the law leaves many doctors reluctant to provide abortion services.

### **Meeting Adolescent Sexual Health Needs**

High rates of unintended teen pregnancy and unsafe abortion, coupled

with the heavy toll that HIV/AIDS is taking in young lives, have contributed to a growing public awareness of adolescent sexual health needs in Africa. A number of innovative initiatives are underway to meet these needs.

- In Kenya, Madagascar and Nigeria, among other countries, special clinics provide STD prevention and contraceptive information and services for young people. Elsewhere, youth centers provide contraceptive and other reproductive health services as one element of more comprehensive programs including recreation, education or job skill training.
- Community-based outreach programs using youth peer counselors often have a contraceptive distribution and clinical referral component. One program in Ghana teaches young men in rural villages traditional handicraft skills while educating them about important reproductive health issues such as prevention of sexually transmitted diseases. However, most of these activities remain small-scale, private efforts, and few have been rigorously evaluated for their effectiveness.
- Contraceptive social marketing programs in African countries such as Nigeria have had success marketing condoms to young people. By making contraceptives available in commercial outlets, social marketing programs offer youth an alternative to the potential embarrassment of a clinic visit. In the Nigerian social marketing program, a youth-oriented radio series and peer education efforts complement commercial condom distribution.
- In addition, most national family planning education campaigns in Africa now have special youth components. Radio programs geared to young people in Kenya, Nigeria

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and Uganda transmit messages on sexual responsibility and information on AIDS and pregnancy prevention.

Yet, despite greater understanding of the high rates of teenage pregnancy and elevated risks of childbearing that young African mothers face, reproductive health services for adolescents remain inadequate virtually everywhere in Africa. In most countries, the provision of sexual and reproductive health information and services to unmarried young people remains highly controversial. Laws and policies severely restrict their access to reproductive health services.

The attitudes of health workers are another major obstacle to the effective provision of reproductive health services to adolescents. Field staff often refuse to provide unmarried or childless young people – especially young women – with contraceptives. As a result, many young people feel unwelcome in regular health clinics. A 1995 study in Kenya found that three-quarters of community family planning workers are unwilling to provide contraceptives to young women who have not yet given birth. By contrast, 80 percent of these workers said they would give contraceptives to young men, regardless of the number of children they have.

In varying degrees, almost every country in sub-Saharan Africa now has some sexuality education in schools, yet implementation of these programs has encountered numerous problems. Specific information on family planning methods and STD prevention is often absent from the curriculum; when it is included, it often comes in secondary school – too late for the majority of youth who have already dropped out. Moreover, teacher training and materials are generally inadequate; even when more specific information is given, it tends to be scattered throughout the curriculum, undermining the extent to which

students absorb and comprehend this information.

Despite the vital importance of sexuality education programs in promoting healthy and responsible sexual behavior, conservative religious forces often strongly oppose such programs for young people. In Kenya, for example, the Catholic church has been a major obstacle to implementing large-scale adolescent reproductive health programs. Under church pressure, the Kenyan government has all but terminated sexuality education in the schools.

## **Men and Reproductive Health**

African men play an important role in decisions about the number and spacing of children. They also bear the prime responsibility for efforts to prevent the spread of HIV/AIDS and other sexually transmitted diseases.

Programs in a number of African countries are attempting to enhance the participation of men in family planning and reproductive health and increase male support for use of family planning by their partners. The prime example of this strategy is social marketing programs, which across Africa have successfully encouraged men to use condoms for both STD and pregnancy prevention. Several information campaigns in Africa have helped to improve men's knowledge of family planning and STDs, while also contributing to better communication between spouses.

Other small-scale efforts to provide services for men have had encouraging results. Community outreach efforts in Cameroon, Ghana, Kenya, Mali and Swaziland have provided men with information and contraceptives in their homes and at their places of work. A program in Cameroon enlisted male community leaders in rural areas; after one year, knowledge of condoms among men in the project communities rose from 52

*Programs in some African countries are trying to encourage the participation of men in family planning.*

*The deep cultural roots of female genital mutilation have made it difficult to mount successful efforts to diminish this practice.*

to 81 percent. In Ghana, an information campaign designed to encourage men to visit Ministry of Health facilities increased discussion of family planning between men and their partners, as well as use of contraceptive methods. Male-only clinics have also been tried in a few African countries, with mixed results.

In spite of these efforts, family planning and reproductive health programs in the region for the most part continue to ignore the needs of men. Most men lack good information on family planning and reproductive health; existing services are rarely geared towards meeting their needs. In the vast majority of clinics, men still feel neither welcome nor comfortable asking for family planning services.

### **Female Genital Mutilation**

The deep cultural roots of female genital mutilation (FGM) have made it difficult to mount successful efforts to diminish this practice. The most promising approaches thus far appear to be those that combine community education on the harmful effects of FGM with activities to persuade women who perform FGM to abandon the practice. Although in most cases it is too early to know whether these efforts are successful, one program in eastern Uganda lowered the incidence of the practice by 36 percent between 1994 and 1996. Community leaders in the program area agreed to replace the traditional ceremony with symbolic gift giving, while preserving all other aspects of the rite of passage of girls to adulthood. The project combines education on FGM with delivery of family planning and other reproductive health services.

The introduction of legal prohibitions appears to have had little impact on the practice. Anecdotal evidence suggests that enactment of anti-FGM laws simply drives the practice underground. Moreover, most African governments are reluctant to take a strong stand in opposition to FGM, in part because of continuing high levels of popular support for the procedure, including among women. In Mali, for example, where 94 percent of women have undergone FGM, fully three-quarters of women continue to support the custom. Eradication efforts are meeting vocal public resistance and are increasingly becoming a volatile political issue in countries such as Sierra Leone.

An exception to government inaction has been Burkina Faso, which in 1996 became one of the first countries in Africa to ban the practice, as part of a comprehensive national eradication program. Strategies to address the health consequences of FGM include training all staff in health ministry clinics to identify and treat complications related to FGM; establishing a referral system for women suffering complications; and employing mobile surgical teams to treat complications.

However, in Burkina Faso, as in other areas where FGM is prevalent, the role of health workers in prevention efforts is unclear. While health professionals can participate in activities to raise awareness of the harmful health effects of the procedure, their influence may be limited by strong social and cultural factors. Ultimately, reductions in the practice of FGM may depend on overall improvements in the status of women within African society. Survey evidence shows that women (and men) who are more highly educated are less likely to support the continuation of FGM.



**A**mong African countries, the ability and commitment to finance the costs of providing family planning and other reproductive health services varies widely. Some wealthier countries in the region can bear a greater proportion of the costs of national programs. But most countries are extremely poor, and both governments and individuals are limited in their ability to pay for services.

In Cairo in 1994, the international community set the goal of achieving universal access to basic reproductive health care by the year 2015. Africa, because of its poverty and current low base of services, faces perhaps the greatest challenge of any region in mobilizing the financial resources needed to reach this goal.

- With demand for family planning services increasing rapidly, the number of contraceptive users in Africa is projected to double between 1993 and 2000, to 33 million, then triple to 100 million by the year 2015. Millions of Africans also have a need for other reproductive health services, including STD prevention and treatment, and maternal and postabortion care. Countries also face the challenge of improving and expanding services for young people and men.
- Meeting these needs will require an enormous increase over current funding levels. To insure access to quality contraceptive services alone, spending on family planning will have to increase from an estimated \$300 million in 1993 to \$1.1 billion in the year 2000 and \$2.4 billion by 2015. Adequate provision of related reproductive health services will require at least an additional \$900 million annually by the year 2000, and \$1.4 billion by 2015. The resource gap for related reproductive health services is also large, since both governments and donors have thus far made relatively negligible investments in these services.

Mobilizing the resources to bridge this funding gap will be no easy task. It will require increased contributions from a variety of financing sources – national governments, international donors and private households – as well as concerted efforts to address current obstacles to increasing spending on reproductive health.

## **National Governments**

Compared to governments in other regions, African governments contribute a relatively small share of total spending on family planning – only about one-fifth on average, a reflection of the low priority most African governments have given to population and family planning. Even in Kenya, where the family planning program is among the strongest in the region, in 1993 the government share of family planning program costs was only about 10 percent.

Inadequate spending on family planning and reproductive health is also a reflection of the relatively small public sector role in health care financing; African governments on average finance only one-third of all health care costs; donors cover another 20 percent, while private households pay for the remainder.

Low spending on family planning and health in general also reflects misplaced priorities. Most African governments spend more on the military than they do for health services. Furthermore, government expenditure on health is heavily tilted towards expensive curative services that benefit a relatively small group of people. Of the roughly \$2 billion that African governments spent on health care in 1990, at most only \$200 million – 10 percent – went for preventive care, including family planning and basic reproductive health services.

Moreover, many health needs compete for available primary health funds. African governments continue

*Compared to governments in other regions, African governments contribute a small share of total spending on family planning.*

*International donors provide almost two-thirds of the financing for African family planning services.*

to battle long-standing and serious health problems such as diarrhea, malaria and acute respiratory infections, which together account for a third of the burden of disease in sub-Saharan Africa. Stronger government commitment is key to ensuring that family planning, HIV/AIDS and STD prevention, and other pressing reproductive health needs receive their fair share of limited resources. This is an emerging problem in Zambia, for example, where the government is integrating all special programs into a single package of basic health services.

### International Donors

As a source of both financial and technical support for population programs, international donors have played a more central role in Africa than in any other developing region. Bilateral donors and multilateral development banks provide almost two-thirds of financing for African family planning services; the share in other regions ranges from just 5 percent in East and Southeast Asia to 40 percent in South Asia.

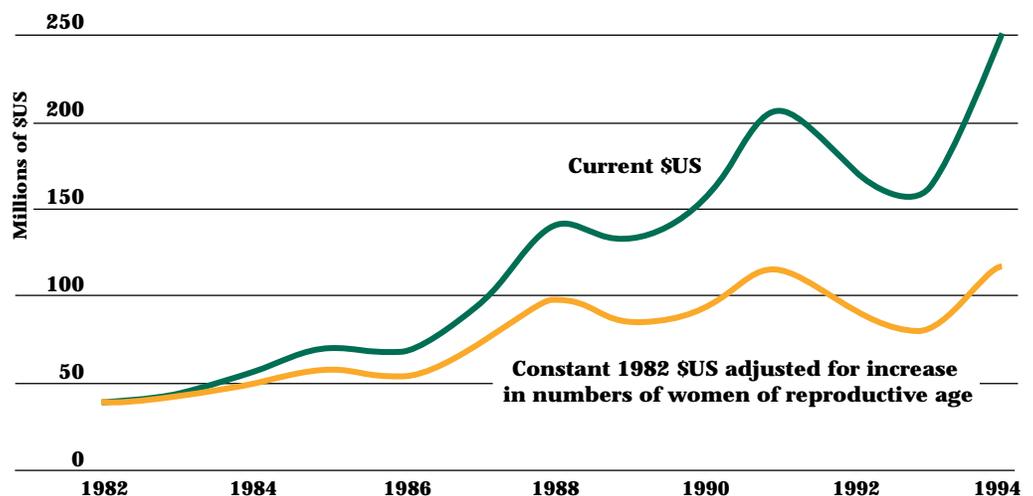
The dependence on donor population assistance is virtually uniform throughout sub-Saharan Africa. External aid represents less than half of total expenditure on contraceptive services in only 3 of 36 countries studied in 1995 – Mauritius, South Africa and Sudan.

Since the early 1980s, the volume of population assistance to Africa has increased notably. After adjusting for inflation, grant aid for population programs in Africa tripled between 1984 and 1994; meanwhile, Africa's share of global population assistance jumped from 12 to 25 percent. Population aid to Africa in 1994 totaled \$252 million, an increase of more than 50 percent over 1993. Figures for 1995 show another large increase, to \$361 million; however, part of this rise appears to reflect the use of a broader definition for population assistance.

Donor support has been concentrated in a relatively few African countries. Kenya and Nigeria have consistently been among the top three population aid recipients in Africa, each receiving on average over \$15 million per year between 1985 and

FIGURE 19

### Trends in Population Assistance to Sub-Saharan Africa



SOURCES: UNFPA. *Global Population Assistance Report, 1994*. New York: UNFPA, 1996; United Nations. *World Population Prospects: The 1996 Revision*. New York: United Nations, 1996.

1994. However, in terms of aid per woman of reproductive age, many of the smaller countries in Africa, for example, Swaziland and the Gambia, have received relatively high amounts – over \$4 per woman compared to between \$2 and \$4 in larger countries such as Kenya, Ghana and Uganda.

Using the same measure, many African countries also receive greater amounts of assistance than most other developing countries. For example, Bangladesh, the world's largest recipient of population funds, receives about \$3 per woman; other large beneficiaries such as Indonesia, India and Pakistan all receive less than \$1 per woman.

## Bilateral Donors

The **United States** has been the most important source of donor funding for population programs in Africa. U.S. bilateral population assistance, managed through the U.S. Agency for International Development (USAID) and its network of private technical assistance agencies, accounts for roughly half of all population aid to Africa; between 1989 and 1996, U.S. funding for family planning activities in the region rose from \$72 million to \$127 million.

In a number of African countries, the United States has provided consistently high levels of support. U.S. population assistance to Kenya, for example, averaged \$16 million a year between 1991 and 1996. The United States has shown significant levels of commitment in Nigeria (\$12 million a year) and Ghana (\$7 million a year). Fifteen of 20 USAID country offices fund major population and health programs; 14 support HIV/AIDS prevention activities. Beyond its financial importance, USAID – through its network of technical agencies – has been the only donor with the breadth and depth of expertise to provide hands-on assistance to all key elements of national family planning programs. It has been responsible for much of the progress in African countries to date.

Yet U.S. leadership on population issues in the region is in danger of slipping.

- Major cuts in overall U.S. population funding threaten to harm efforts in Africa, as well as elsewhere. Global U.S. family planning funding was cut by 35 percent between 1995 and 1996; 1997 budgets rose slightly, but are still 30 percent below 1995 levels.
- USAID has greatly reduced the number of countries in Africa to which it provides comprehensive assistance. Nine field missions – mostly in West Africa – were closed between 1994 and 1996. A regional effort in West Africa provides limited continued support to population programs in four countries – Burkina Faso, Cameroon, Côte d'Ivoire and Togo – where USAID has closed field missions. It is too soon to say, however, whether this arrangement will prove effective. The agency withdrew from Niger in 1997, and expects to withdraw from Zimbabwe and Guinea-Bissau within five years. Staff cuts, combined with mission closings, have reduced the number of USAID population and health experts in the field by over one-third and have left some country programs without adequate technical oversight.
- Because of disagreement over the pace of democratization, in 1997 USAID slashed its support to Kenya by half – just as demand for family planning was skyrocketing. The cuts have affected NGO programs the most; support to some NGOs has already ended, and funding for others will be phased out.

In recent years, **Germany** has emerged as an important donor to population programs in Africa, although on a smaller scale than the United States. In 1995, Germany gave roughly \$70 million to fund family planning and reproductive health

*The United States has been the most important source of donor funding for population programs in Africa.*

*UNFPA is the only population donor with a presence in virtually every African country.*

programs in 22 African countries. Substantial, further increases in German population assistance appear unlikely, however, in light of recent cutbacks in foreign aid.

Like Germany the **United Kingdom** has expanded its population assistance in Africa, and funded programs in 12 African countries in 1995. In 1996, the United Kingdom donated \$27 million for family planning and reproductive health projects in the region.

Many other bilateral donors provide support to population programs in Africa in a smaller way. Finland, the Netherlands and Sweden work in a few selected countries. Four of 12 priority countries under Japan's Global Initiative in Population and AIDS are in sub-Saharan Africa, although Japan provides very little direct support to family planning service delivery. The European Union is moving to expand its population aid to Africa, but is still very new to the sector. Despite its strong links to former French colonies, France has provided virtually no support to family planning efforts in the region; it has, however, provided limited assistance for AIDS prevention efforts.

### **Multilateral Donors**

The **United Nations Population Fund (UNFPA)** is the only population donor with a presence in virtually every African country. The Fund provides about one-quarter of total population grant assistance to sub-Saharan Africa. Roughly a third of country program allocations go to Africa; in 1995, UNFPA support for the region totaled \$73 million – double the 1993 level.

However, prospects for increased UNFPA funding remain uncertain. Although Africa is likely to receive a greater share of funds under the Fund's new system for allocating resources, UNFPA's overall income plateaued in 1996 and – due to losses from

exchange rate fluctuations – fell by about five percent in 1997.

Moreover, because its resources are spread relatively thin among many countries, the impact of UNFPA programs in any particular country has been limited. In 1996, UNFPA budgets for 30 countries in the region were under \$2 million annually. The thinness of the Fund's professional field staff has further limited the effectiveness of UNFPA programs in Africa.

Relative to the important role the **World Bank** has played in supporting population programs in other regions – especially in Asia – the Bank's efforts in Africa have been disappointing. Until the early 1980s, Kenya was the only country in Africa receiving World Bank loans for population. Since then, lending has risen substantially; between 1990 and 1996 the Bank committed about \$70 million per year for population and reproductive health programs in 28 African countries. Still, this amount represents only about one-fifth of the Bank's total lending in the sector, and lending for population in recent years is down considerably from levels achieved in 1990 and 1991.

Except in a few countries, the Bank is moving away from stand-alone family planning projects such as those previously supported in Kenya, Niger and Nigeria. Moreover, the Bank is increasingly placing higher priority on health financing and sector reform over direct support for family planning and reproductive health services. Although this shift in lending strategy may help countries improve the overall efficiency and effectiveness of health services, the change in the Bank's focus has diminished its leadership in the family planning and reproductive health field in Africa. This trend is further exacerbated by the inadequate numbers of Bank staff with expertise in reproductive health, especially at the field level.

The **International Planned Parenthood Federation (IPPF)** is an important source of funds for national

family planning associations in Africa. IPPF provided \$17 million to its African member associations and other private groups in 1995 – almost 60 percent of their total funding. As in the case of UNFPA, the share of IPPF resources going to Africa – currently about 30 percent – is expected to increase as the agency implements new funding guidelines. Still, a recent large fall in IPPF income threatens future levels of assistance to Africa

## Private Households

Consumers in Africa, as elsewhere, are willing to pay for quality curative health care services. Indeed, private African households account for almost half of all health care expenditures, including outlays of close to one billion dollars annually on drugs alone. But it is unclear how much consumers are ready to pay for family planning and other preventive reproductive health services. African households pay about 15 percent of family planning costs, a proportion higher than in most Asian countries, but only about a third of the share consumers pay in some other developing regions.

In varying degrees, almost all African countries have now instituted user fees in public sector facilities as a way of increasing revenues to help cover the cost of health care services. Yet, so far, these efforts have fallen short of expectations. On average, cost recovery programs have generated only 3 to 5 percent of recurring health costs, rather than the expected 20 percent.

The degree to which family planning services are included in cost recovery efforts in Africa varies considerably. In Ghana, the government charges for most health services, including family planning. Kenya and Senegal do not charge for contraceptives, although there is a small user fee for a clinic visit.

It is unclear how charging for contraceptives affects the use of family

planning services. Program managers often express concern that charging for contraceptives – especially in fledgling programs and in rural areas where people have little cash – can discourage family planning use. Most evidence, however, indicates that charging small amounts for contraceptives does not significantly dampen demand for services. One indication that some people are willing to pay for contraceptives is the growth of social marketing programs. However, many of these programs continue to provide contraceptives at prices far below market rates.

A further sign of the willingness of consumers to pay for health services is the success of the Bamako Initiative, a region-wide effort in part aimed at improving the availability of drugs in rural clinics. Participating local communities purchase essential drugs from governments or donors, then charge community members a modest fee and use the proceeds to support a revolving fund to ensure adequate drug supplies. However, the community drug committees which manage these revolving funds typically do not yet value contraceptives, and prefer to purchase antibiotics and other essential curative drugs.

## Issues in Program Finance

### Boosting Levels of Population Assistance

Total donor assistance to population programs in Africa appears to have risen substantially in 1994 and 1995, in part reflecting the stimulus to donor country commitments provided by the ICPD. However, the picture for 1996 and beyond suggests that the international community faces a serious challenge in maintaining this rate of increase. A number of donor countries are cutting back their population assistance because of overall

*One indication that some people are willing to pay for contraceptives is the growth of social marketing programs.*

*The ability of African governments to maintain programs after the termination of donor funding is a crucial issue.*

reductions in development assistance budgets. Income levels for UNFPA and IPPF dropped significantly in 1997. Should the stagnation in overall donor assistance continue, the donor community will be hard pressed to meet the ICPD's year 2000 goal of \$5.7 billion in population assistance in constant 1993 dollars, a large share of which is required to respond to the enormous needs in Africa.

### **Improving Effectiveness of External Assistance**

With population aid levels in danger of stagnating or even falling, improving the effectiveness of donor assistance has become even more important. Some of the major areas in need of strengthening include the following.

- **Building national capacity.** The technical assistance provided by expatriate health and family planning professionals has been of enormous importance to the development of African population programs. Yet, it has often been at the expense of building African capacity to manage programs. In their eagerness to get population programs off the ground quickly, donors have not drawn enough on African resources, nor have they done enough to create effective local policy and service delivery institutions. Especially in the public sector in Africa, institutions remain weak and human capacity limited, diminishing the long run effectiveness of population programs and hampering the capacity of the health system as a whole to function efficiently with minimal external aid.
- **Donor coordination.** Governments, lacking adequate managerial and technical capacity, often do not take enough of a leadership role in donor coordination. Greatly differing donor styles and systems are frequently counterproductive to

effective implementation of national programs. Donors have made some progress in improving collaboration and consultation in the design of projects, but the lack of in-country technical staff often leads to poor coordination during implementation and fragmented, wasteful efforts.

As population programs have come to encompass other reproductive health services in addition to family planning, coordination has become more complex. Kenya hosts 20 official donor agencies working in population and health. In the past, donors held fairly effective bimonthly population coordination meetings; now that these meetings deal with broader reproductive health programs, participants find it difficult to maintain the same depth of discussion that took place when the donor group addressed only family planning issues.

- **Promoting sustainable programs.** In the context of heavy reliance on external donor assistance, the ability of African governments to maintain programs after the termination of donor funding is a crucial issue. Donor cutbacks are occurring despite dramatic projected increases in resource needs; a 1995 study in Kenya shows yearly family planning financing requirements almost doubling from \$23 million in 1993 to \$43 million in 2000. The abrupt withdrawal of USAID assistance has posed a major setback in Kenya and several other countries.

### **Sustainability of NGO Services**

The cutbacks in USAID funding also raise the issue of the sustainability of NGO programs. In many African countries, NGOs have been heavily dependent on donor support. Meanwhile, government policies often constrain the ability of NGOs to recover costs through client fees. In Kenya, for

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example, the government has required that family planning services be free, limiting the ability of NGOs to charge for services and their sustainability.

NGO program managers also express concern that raising fees will cause their clients to shift to cheaper, public sector services or discontinue contraceptive use. Because cost-recovery is particularly difficult in the poor areas served by community-based distribution programs, these programs are especially vulnerable to the withdrawal of donor support. However, a study in Kenya found that 82 percent of clients in communities served by outreach workers were willing to pay for family planning services; a very few clients said they would stop contraceptive use altogether if asked to pay a minimal amount.

The Kenyan government is now reconsidering its policy on charging for services in light of shrinking donor support to NGOs. Meanwhile, most community-based family planning programs in Kenya are moving towards charging for services as a way of recovering some costs, including such strategies as instituting small, annual “membership” fees.

### **The Importance of Donors in Contraceptive Supply**

Donor financial support has been crucial in the purchase and management of contraceptive supplies for use in family planning and STD prevention programs in Africa. The potential for domestic production of contraceptives is extremely limited, and most African countries cannot afford to pay for imported contraceptives. External technical assistance has also played an important role in strengthening contraceptive distribution systems.

However, donors appear to be losing interest in supplying contraceptives. Sweden has sought to shift its longstanding financial support for oral contraceptives in Kenya to other reproductive health activities. USAID’s

role in contraceptive supply has been crucial – it has been the major source of technical expertise in strengthening overall supply management systems, and has a central procurement system with a strong track record of providing adequate supplies of contraceptives to countries in a timely manner. USAID’s pullback in several West African countries has reportedly left contraceptive supply systems in disarray – just when contraceptive prevalence is starting to rise in some of these countries.

### **The Potential of the Private, Commercial Sector**

Although for the foreseeable future the vast majority of Africans will remain extremely poor, with limited ability to afford even low-cost health services, there are opportunities for the private, commercial sector to serve a larger share of wealthier family planning clients. Rising incomes, the growing application of means testing at public sector facilities, and more favorable government attitudes towards commercial sector health activities are all key ingredients to making this gradual shift.

Nevertheless, important barriers continue to limit the private, commercial sector’s engagement in reproductive health and family planning. Because few Africans have formal sector jobs, most are not covered through employer health insurance schemes. Legal and regulatory barriers inhibit private, commercial health activities in many countries. In Zimbabwe, for example, qualified nurse-midwives outnumber doctors more than four to one; because of cumbersome regulations, however, few are in private practice. Moreover, most public health care systems continue to provide highly subsidized services to clients regardless of income level, thus hampering the development of private health care markets.

*Donor financial support has been essential for the purchase and management of contraceptive supplies.*





Population programs in Africa are at a crucial stage in their evolution. The intersection of increased government support for family planning and growing public demand for contraceptive services presents countries with the opportunity to accelerate their efforts to address the problems of poor reproductive health and rapid population growth. Yet, the scope of the task is daunting, especially since it will require comprehensive action on several different fronts. In addition to meeting the growing need for family planning and reproductive health services, African countries must make substantial investments in girls' education while expanding economic opportunities for women. These actions will require significantly higher amounts of funding from African governments and households and higher levels of assistance from international donors. The following recommendations identify priority areas for action by both governments and international donors.

## Expanding and Improving Family Planning and Related Reproductive Health Services

There is an urgent need in Africa to expand and strengthen family planning and related reproductive health services. By giving African men and women the opportunity to improve child spacing and end unwanted childbearing, expanded access to family planning will contribute to better health for mothers and children, while reducing reliance on abortion. Providing contraceptive services to the millions of women with an unmet need for family planning would also bring African countries one-third of the way closer to the two-child average family size consistent with population stabilization – and

advance the attainment of sustainable development.

Significant progress has been made in coverage of reproductive health care in countries such as Zimbabwe and Botswana. However, most African countries face an enormous challenge in rapidly increasing family planning and reproductive health coverage for the millions of couples – especially those living in rural areas – who currently lack access to services.

### Expanding Access

■ **Over the long run, governments must increase overall coverage of basic health care to improve access to family planning and reproductive health services.**

With only half the population in Africa having easy access to health care, it is crucial for African governments to aggressively expand primary health care facilities and staff – especially in rural and urban areas lacking adequate services – and raise the quality of basic health care. Without such improvements, efforts to expand access to family planning and reproductive health services will be extremely difficult.

At a time when African countries face so many competing health concerns, it is essential that the package of basic health services supported by health sector reform efforts include family planning and other reproductive health services. International donor agencies and family planning leaders must emphasize to governments the importance of these services to reducing infant and maternal mortality as well as to preventing the spread of HIV/AIDS and other STDs.

■ **In the short term, governments need to complete the process of incorporating quality family planning care into existing public sector health services.**

*African governments need to aggressively expand primary health care services.*

*Governments should review all laws relating to reproductive health to be sure legal systems support efforts to implement programs.*

Government health services, despite their weaknesses, are the primary source of contraceptive services in Africa, and are often the only source of modern health care for the poor. African governments must ensure that the existing network of public sector health facilities offers quality family planning services. This requires that they put in place trained staff with adequate supplies and equipment, offering the full range of contraceptive services appropriate to each level of the health system. Consistent availability of contraceptives and improved quality of services will help attract more family planning clients to the many underused public sector facilities in rural and peri-urban areas.

For the most part, countries should be able to accomplish these steps with existing staff and facilities. However, activities such as additional training and improvements in supervision, management and contraceptive distribution *will* require significant additional funding.

**■ Governments must greatly increase the scope and effectiveness of community outreach efforts to more quickly expand access to contraceptive services in rural and marginal urban areas.**

Governments can extend the reach of existing facilities by expanding community outreach programs – especially in West Africa, where the cultural barriers to family planning remain the greatest.

Governments should eliminate restrictions on distribution of oral contraceptives by community workers. A broad-based international experience has already demonstrated that community workers – with proper training in counseling and screening of clients – can safely and effectively distribute oral contraceptives. At the same time, community-based programs should build in adequate medical backup to address legitimate

concerns over nonprescription distribution of oral contraceptives.

Strategies to strengthen community outreach efforts should include building stronger referral systems between community workers and clinics, which provide methods the workers do not distribute themselves. Intensifying the coverage and frequency of home visits is another strategy which has had great success in North Africa and in Asian countries such as Bangladesh. Greater involvement of the community in all stages of program design and implementation – for example, consulting local leaders in the selection of community agents – is also important for increasing the effectiveness of outreach programs.

There is also still a need to continue testing outreach approaches to identify those best suited to a particular country or region. It is important for donors to maintain support for operations research on the design of culturally appropriate models for delivering services along the lines of ongoing efforts in the Navrongo region in Ghana. Donors and governments should also encourage greater sharing among African countries of lessons learned from such research.

**■ Governments must remove legal and regulatory barriers that limit access to family planning and other reproductive health services.**

Governments should move quickly to repeal the outdated laws prohibiting the sale and promotion of contraceptives still in effect in some French-speaking countries. Although these laws are rarely enforced, they contribute to ambivalence about family planning on the part of many medical professionals – especially in the private sector. Governments should conduct a thorough review of all laws relating to reproductive health and ensure that legal systems support efforts to implement reproductive health programs. Local NGOs, with the support

of international donors, have an important role to play in encouraging governments in these activities.

Governments must also lift regulatory barriers that prevent trained nurses and nurse-midwives from performing procedures, such as Norplant and IUD insertions; this kind of regulatory change is underway in some countries, for example in Kenya, and could significantly expand access to such methods. Governments also need to lift import duties and taxes that contribute to higher commercial prices for contraceptives.

**■ Especially as service delivery networks expand, governments need to greatly strengthen management of the basic systems that support the delivery of family planning and reproductive health services, with a special emphasis on contraceptive supply systems.**

Virtually all African countries need more and better trained managers and technical specialists to administer increasingly complex national-level reproductive health efforts. In addition, governments must develop management capability at the district and local levels as countries accelerate the decentralization of health services.

To a large extent, efforts to improve management of family planning programs will depend on broader efforts to improve public administration in Africa. Governments must redouble their efforts to professionalize the civil service, especially through better training and by improving compensation and other benefits.

Long-term commitment by both governments and donors to improve distribution and management of contraceptive supplies is needed if family planning services are to respond to the large anticipated increase in demand for contraception. Governments should concentrate on training staff and upgrading management information systems as they relate

to contraceptive supply; initial training of relevant health personnel should include instruction on supply management. Governments should implement efforts to integrate contraceptive and drug supply systems in a careful and gradual way so as to maintain the effectiveness of existing contraceptive distribution networks.

**■ The weakness of public sector health and family planning services in many countries requires an intensified effort to tap the full potential of the private nonprofit and commercial sectors.**

Governments should remove unnecessary restrictions on NGOs, and limit legal and regulatory barriers on private, commercial activities to those necessary to ensure the safety of clients. At the same time governments should encourage private practitioners – especially nurse-midwives – to provide family planning services.

Governments should draw on NGO expertise for activities such as development of national service standards and design and implementation of training. Furthermore, NGO and government family planning programs need to strengthen service links, particularly between NGO outreach workers and public sector clinics. While recognizing that governments bear the main responsibility for service provision, international donors should increase funding for NGO family planning and reproductive health services while helping NGOs improve their management and move towards greater self-sufficiency.

Social marketing programs need to broaden the range of contraceptive methods they provide, with special emphasis on highly popular oral and injectable contraceptives. Governments should work with drug companies and associations of pharmacists to lift restrictions on social marketing sales outside of pharmacies and allow advertising of specific contraceptive

*Governments should encourage private doctors and nurse-midwives to provide family planning services.*

*Information campaigns must take into account that childbearing decisions often involve the extended family and community.*

methods and brands. National social marketing programs should consider collaborating to market brands on a regional basis, in order to improve the efficiency of distribution networks. This would require, however, that governments lower existing barriers to the development of regional markets.

### **Improving Quality**

■ **Quality improvements are needed to help shift health services towards a more client-oriented approach and thus ensure the future sustainability of both government and NGO programs.**

Better training, supervision and counseling, along with improvements in public education on family planning, are all important to enhance the quality of services.

Governments should accelerate the trend towards use of supervisors for on-site training of service delivery teams, both to increase the cost-effectiveness of training and to improve the relevance of training content to real world working conditions. To support this approach, governments must strengthen the ability of supervisors to provide technical support to field staff, raise the frequency of supervisory visits and budget adequately for transportation costs associated with supervision. Health ministries must also ensure more relevant instruction on family planning and related reproductive health topics in the initial training health workers receive.

To improve counseling and ensure that clients are able to make informed and appropriate contraceptive choices, governments need to give field staff clear guidelines for provision of contraceptives based on medically sound criteria. Where these guidelines do not yet exist, governments should develop national standards for family planning and reproductive health

services; good models for such guidelines now exist in a number of African countries. These guidelines should be disseminated to all health facilities through intensive on-site orientation of clinic staff. Supervision should reinforce these guidelines and ensure that clinic staff are correctly applying established standards. Governments should also incorporate these standards into both initial training for health workers and refresher training for workers already posted at health facilities.

Public education efforts can support these improvements in services by giving clients better information on how contraceptive methods work and where to obtain them. Information campaigns must take into account that childbearing decisions often involve the extended family and community, and focus on a broad audience for messages on population, family planning and reproductive health.

■ **While ensuring wide access to a broad range of contraceptive methods, family planning programs must respond better to client needs for long-term contraception by expanding the availability of clinical methods.**

Given the lead time required to develop well functioning clinical services and to change attitudes among both the public and health workers, efforts to establish high quality sterilization and other clinical contraceptive services should start early in the evolution of national family planning programs. Sterilization training should begin with initial medical education in order to increase the numbers of trained physicians, and be reinforced with refresher training for those physicians who, following their education, regularly perform the procedure.

In the short run, a practical approach to meeting the demand for clinical methods is for governments to establish clinical services in a few, selected sites where quality – especially

with respect to counseling and infection prevention – can be maintained. Programs also need to work to dispel rumors and misinformation through better counseling and information about sterilization and other clinical contraceptive methods.

To make injectable contraceptives more accessible – especially in rural areas – programs should test feasible, safe and effective ways for health auxiliaries and community agents to administer injections, an approach that has been successful in Bangladesh and some other countries. This approach will require better training of field workers to maintain injection schedules, provide good counseling and follow-up, and ensure proper infection prevention.

## Reaching Adolescents and Men

■ **Governments must ensure that young people in Africa have the information, skills and means to protect themselves from unwanted pregnancy, AIDS and other STDs.**

Governments need to expand and improve school-based sexuality education, introducing programs early enough to reach children before they become sexually active. Information campaigns are also needed to reassure parents that good sexuality education does not encourage early sexual activity or promiscuity, but rather promotes the delay of sexual initiation and more responsible sexual behavior. Schools across Africa – not only in those countries currently hard-hit by AIDS – should quickly incorporate HIV and pregnancy prevention education into their curricula, beginning at the primary level. In the African context, it is also very important to expand programs that make information and services easily accessible to the large numbers of out-of-school youth; community-based programs involving

youth who reach out to and counsel their peers is one low-cost and effective strategy.

Information aimed at youth must be accompanied by improved access to services. Making existing public sector services more attractive to adolescents is an important first step in this effort, but one that will require changes in policy and in the attitudes of the many health workers who are currently reluctant to provide contraceptive services to young people. Where feasible, and especially in urban settings, governments and NGOs should also establish special youth-friendly clinics or centers to provide health and other services.

■ **Family planning and reproductive health programs also need to encourage increased male involvement in contraceptive use and greater efforts by men to support the reproductive health needs of women.**

Family planning and reproductive health programs must shift their almost exclusive focus on women to better recognize the needs of men and the important role they play in reproductive decisions. Public information campaigns can be effective in increasing men's knowledge of family planning methods and shaping their attitudes towards family size and contraceptive use. At the same time, clinics providing contraceptive services must be made more comfortable and welcoming to men. As part of these efforts, programs should encourage greater communication between couples on reproductive matters, and public education efforts should include special campaigns aimed at men.

More training is needed to expand the pool of physicians able to perform vasectomy and to counteract the negative attitudes of many health workers towards the procedure. Increasing demand for vasectomy requires attention to many of the

*Family planning programs must shift their almost exclusive focus on women to better recognize the needs of men.*

*National population councils have important roles as advocates for population programs.*

same ingredients – such as good counseling and privacy – that are essential to improving quality of care for female sterilization clients. Recruiting satisfied vasectomy users to provide information to other men in the community who are considering the procedure has also proved to be a very effective approach in other regions.

Men are also a crucial audience for AIDS and STD prevention messages, since women are often at risk from their partners but have limited influence over male behavior. Mass media campaigns should encourage men to practice safer sexual behavior. Such campaigns must emphasize the benefits of mutual fidelity and the need for men to use condoms consistently with casual partners and sex workers to reduce the risk of infection to themselves and their wives.

### **Improving Population Policy**

#### **■ Governments must provide greater resources for formulation and coordination of population policy.**

The comprehensive approach to population policy promoted by the ICPD *Programme of Action* highlights the need for strong, national institutions that can take the initiative in planning population activities across different development sectors. With this objective, governments need to strengthen existing institutions charged with the development and coordination of population policy.

National population councils in Africa have an important role as advocates for population programs and in coordinating population policy. Where national population councils are working well, governments should link them more closely with broader national development councils and planning units; where such institutions do not yet exist or are not functioning

effectively, governments should consider integrating population policy functions into established national institutions for development policy.

Governments should expand training for staff in these policy institutions to enable them to integrate demographic analysis more effectively into national development plans. Financial and technical support from the international community can also help build the capacity of population councils and other national planning bodies to collect and use demographic information, and to present data in a way that policymakers can easily understand.

International agencies should continue to assist African countries in updating their policies and strategies to better reflect the principles of the ICPD *Programme of Action*. Especially where governments are concerned about the impact of AIDS on population growth, population policy institutions need to stress the health benefits of family planning and reinforce the synergies between family planning and AIDS/STD prevention. Such institutions should provide policymakers with up-to-date and accurate information on important trends relating to the AIDS epidemic – for example, projections that population will likely continue to grow even in those African countries hard-hit by AIDS. They also need to educate leaders about the potential for getting the epidemic under control, as appears to be happening now in Uganda where infection rates are falling.

In developing population policies, governments should also seek greater input from nonofficial players such as NGOs – including women's groups – and religious leaders. They need to disseminate these policies to a broader audience and to educate local leaders and program managers about population issues.

## **Strengthening Links Between Family Planning and Related Reproductive Health Services**

### **■ Programs need to improve linkages between family planning and other reproductive health services, without undermining the effective provision of contraceptive information and services.**

Policymakers and program managers throughout the region face a major challenge in their efforts to provide the comprehensive package of basic reproductive health services advocated by the ICPD. For this approach to succeed at the field level, programs must train workers in new skills; make equipment, drugs, and other medical supplies for diagnosis and treatment available; adapt client counseling and information; and broaden public education campaigns.

Achieving effective links among the various components of the reproductive health package will require thoughtful testing and introduction of new strategies to determine which combination of services works best to address reproductive health problems and is most cost-effective in different contexts. While broadening the scope of population programs, care must be taken not to undermine family planning services, which are still new, weak and greatly needed in many African countries.

### **■ One of the most pressing needs is for health and family planning services to do more to prevent the spread of HIV/AIDS and to screen for and treat other sexually transmitted diseases.**

The seriousness of the AIDS epidemic calls for urgent action on the part of African governments. Family planning programs are an important but underused vehicle to reach those at

risk of infection – especially married women in their childbearing years. Such programs must greatly strengthen their response to the threat posed by AIDS and other STDs.

In the absence of a low-cost treatment for AIDS, preventive efforts through education and promotion of condom use should continue to be the top priority. All women seeking family planning services should receive basic information about AIDS and STD prevention; those perceived to be at higher risk should receive more in-depth counseling. Strict adherence to infection control procedures, including handwashing, can also help prevent the transmission of infections during clinical procedures.

Community outreach programs also need to expand education on AIDS, STDs and related sexual health issues, while taking care not to overextend their field staff. These programs have a special advantage in identifying and reaching adolescents and others at high risk of infection. Governments also need to strengthen existing public education efforts that combine family planning promotion with AIDS prevention, for example, in the context of condom social marketing programs.

While the emphasis should be on prevention, health services should also seek to improve screening and treatment of STD patients – especially in light of evidence that treatment of common sexually transmitted diseases can significantly lower the chances of HIV transmission. Most health facilities in Africa lack the resources to perform sophisticated diagnostic tests, but do have the capacity to screen and treat individuals based on symptoms. Although this approach to treatment has limited effectiveness – especially in women – it is currently the best option available for African programs. Long-term improvements will require more research on cost-effective STD screening and treatment protocols. Meanwhile, high drug costs and inconsistent availability of drug

*Family planning programs are an important but underused vehicle to reach those at risk of HIV/AIDS infection.*

*Investments in girls' education and expanded economic opportunities for women are key elements of broader efforts to empower women.*

supplies further limit treatment alternatives. One simple step to expand treatment would be for governments to allow nonphysicians to prescribe drugs to treat STDs, building on precedents that permit nurses and health auxiliaries to prescribe antibiotics for management of illnesses such as acute respiratory infections.

■ **To lower the risk of maternal death, governments must improve access to emergency obstetric care, with special emphasis on expansion of postabortion services.**

Lowering maternal death rates in Africa will require long-term investments in staff training, equipment and facilities in order to improve access to emergency obstetric care. In the short-term, governments should continue to train traditional midwives in providing regular, effective prenatal care and in safe management of routine pregnancies for the majority of African women who still give birth at home. Their training, however, should stress the need to refer those women who have high-risk pregnancies or experience complications during labor and delivery.

Within communities, prevention of maternal death must start with education on the importance of early identification of potentially dangerous situations and knowledge of when and how to take action. Programs need to reach not just pregnant women, but family members and others who have influence over the decision to seek medical intervention. There is a particular need to establish mechanisms to quickly and safely transport women requiring emergency care to the nearest health facility.

At the national level, health ministries should set protocols for management of life-threatening complications and use these as the basis for training health workers at referral centers and hospitals. These efforts should be supported by the provision

of nutrition supplements to pregnant women to reduce anemia, a condition which makes women less resistant to infection and more susceptible to hemorrhage in childbirth.

As part of efforts to reduce pregnancy-related deaths, health ministries and NGOs should continue research to educate African policy-makers and the general public on the prevalence and health impact of unsafe abortion. Current efforts in a few countries to review restrictive abortion laws need to be replicated more widely in light of the important impact access to safe abortion services has on women's health.

Meanwhile, governments should redouble efforts to train health workers in emergency postabortion care, including the use of low cost, lifesaving technologies such as manual vacuum aspiration. To increase the number of sites where emergency care is available, governments should intensify efforts to expand the role of nurses and other health auxiliaries in postabortion care.

Better access to family planning services will also reduce the exposure of women to the risk of maternal death and illness, lower the number of pregnancies to high risk women and reduce the number of unwanted pregnancies that might otherwise end in unsafe abortion. Countries must pay special attention to strengthening family planning and maternity care services for adolescents, who face a greater risk of death and complications from pregnancy and unsafe abortion. In addition, women treated in health facilities for abortion complications must have easier access to family planning information and services to reduce the number of repeat abortions.

## **Improving the Status of Women**

Expanding access to family planning and related health services is central to efforts to improve reproductive health and enable couples to have smaller

families. However, investments in girls' education and expanded economic opportunities for women are also key elements of broader efforts to empower women in all aspects of their lives, including their desire and ability to use available reproductive and child health services.

**■ African governments need to strengthen current efforts to raise school enrollment for girls.**

African women must have a more equal say on decisions related to childbearing and sexual relations that affect their own health and that of their families. It is also important to support the desire of many young women to delay marriage and first birth, especially since the childbearing patterns of today's youth will have enormous impact on future population size in the region. The most effective long-term strategy to achieve these goals is to encourage parents to send their daughters to school – and keep them enrolled – while simultaneously expanding economic opportunities for women.

The full engagement of African governments and the international community is needed to expand girls' access to education. Governments must go beyond small, pilot projects and apply a broad range of interventions to address the complex reasons that prevent girls from entering and completing school, making these efforts a key element of overall strategies to improve educational investment.

Building more schools and placing them closer to rural communities are appropriate responses but may be difficult given budget constraints in many African countries. Therefore, governments need to find ways to use existing facilities more efficiently and shift spending priorities from higher education to primary and secondary education.

Governments can lower the direct and indirect costs to girls and their families by providing scholarships,

books and transportation, and adjusting the school schedule to accommodate girls' household responsibilities. Governments should also hire and promote more women teachers, both as role models and to make the classroom environment safer and more acceptable to parents uneasy about sending their daughters to schools with mostly male staff.

Through research, policy dialogue, financing of innovative programs and support for local advocacy groups the international donor community should continue efforts to encourage African governments to give greater importance to educating girls.

**■ Countries must work to eliminate institutional and legal barriers that prevent women from becoming equal partners in development.**

Improving women's economic opportunities, together with expanded access to education, will help over the long-term to redress discrimination against women and inequality. Women's unequal status – perpetuated by formal legal systems and informal traditions – currently gives them little negotiating power with respect to sexual relations and condom use, exposing them to unwanted pregnancies and AIDS and other STDs.

Governments can help to empower women by ensuring that women, who do the bulk of farming in Africa, obtain better access to farm technology and agricultural inputs and to the credit necessary to finance their farming and trading activities. Through efforts to reduce employment discrimination, governments can also improve the chances of formal sector employment for women and give parents further motivation to keep their daughters in school. Governments should also ensure that legal systems promote equal rights for men and women, especially in matters such as inheritance and rights within marriage.

*Governments can help to empower women by ensuring that women, who do the bulk of farming, obtain better access to credit.*

*Many African governments can increase spending on health by redirecting exorbitant military expenditures.*

■ **Efforts to halt the practice of female genital mutilation must focus on community education and should involve health professionals.**

African societies, with the moral and financial support of the international community, must bear the responsibility for efforts to end female genital mutilation. Legislation outlawing the practice sends an important political message; however, measures that punish practitioners are likely to be relatively ineffective in ending the traditional practice. Community education campaigns based on local customs and beliefs appear to have more potential to change attitudes towards FGM. Community health nurses, in particular, can play a greater role in educating men and women in the community about the health problems associated with the practice. Meanwhile, health professionals should expand their involvement in recognizing and treating complications from FGM. Nevertheless, appeals to stop the practice based on health concerns alone are likely to be inadequate to halt this deep-rooted cultural tradition. Again, education – of both men and women – is likely to be key.

## **Assuring Adequate Funding**

In many African countries, health needs are already great, health care systems are still weak and donor assistance for reproductive health is stagnating or falling. In this context, mobilizing the resources to fund the full range of reproductive health services advocated by the ICPD – while maintaining family planning as a central part of these efforts – remains a difficult task.

■ **Governments, private households and international donors must all increase their financial contributions if countries are**

**to reach the goal of universal access to the basic package of reproductive health services by the year 2015.**

Many African governments can increase spending on health by redirecting exorbitant military expenditures. Within the health sector, governments need to place greater priority on basic health care by reallocating resources from curative to preventive services, strengthening rural infrastructure and continuing progress towards decentralization of health services.

Even if tax revenues rise as African economies improve, many poor countries will still not be able to afford the basic package of health services. Charging clients can go part way towards making up for financing shortfalls, but introduction of user fees must be gradual and based on solid research on the willingness and ability of individuals to pay. Governments should encourage the spread of Bamako Initiative programs to improve essential drug supply and educate communities on the benefits of including contraceptives within these locally-managed efforts.

Given the magnitude of resources required to implement ICPD objectives, donors must continue to bear a large share of the costs of providing family planning and related reproductive health services. To meet the commitments made by the international community at the ICPD, donors must at least double their contributions for family planning and reproductive health programs in the region by the year 2000 from the current level of roughly \$500 million annually.

The international donor community must also search for ways to continue to support population and health programs in some of the larger “failed” states in Africa, such as Nigeria, Somalia and Sudan, whose governments for political reasons currently receive little foreign assistance. Channeling assistance through NGOs is one

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way that donors can continue to improve individual reproductive health and contribute to slower population growth without directly supporting these governments.

**■ Donors and governments must work together to make better use of limited population assistance.**

Especially as aid levels stagnate or decline, it is crucial for international donors and governments to use population assistance more effectively. Donors need to overcome differences in style and purpose to work together in a comprehensive and coordinated way that benefits national programs. Governments should strengthen their role in coordinating external assistance, as has occurred for example in Tanzania, where strong donor coordination by the Ministry of Health has been key to improving the contraceptive distribution system.

International technical assistance remains an important channel for African countries to gain access to new technologies and share “best practices” from Africa and outside the region. While outside technical assistance is often still appropriate, donors should maximize use of local family planning and reproductive health experts, thus helping to build and sustain the human resource base in both the public and NGO sectors. To further build sustainable programs, donors must increase efforts to support basic management capacity.

Donors should also encourage and provide funds for increased collaboration and sharing of experience among African countries, as USAID is doing in eastern and southern Africa. Together, donors and governments should explore and, where appropriate, foster regional partnerships. One example is the current interest of some African countries to lower program costs through joint procurement of contraceptives and other health commodities.

*Especially as aid levels stagnate, it is crucial for international donors and governments to use population assistance more effectively.*



*Sub-Saharan Africa faces a development challenge greater than any other region.*

**T**he present time is a moment of opportunity on the African continent. Africa is making new headway: democracy and economic reform are revitalizing the continent, and a number of countries are experiencing dynamic economic growth. With greater political openness, African governments are increasingly seeking to address the health and education needs of their people.

Despite these positive trends, sub-Saharan Africa faces a development challenge greater than any other region. Africa's progress has not reached enough people, and too much of the continent is still plagued by political instability. Many African nations are struggling to meet the health and education needs of populations expanding at about three percent a year. In too many countries, rapid population growth continues to threaten the natural resource base and future prospects for prosperity. The region's ability to slow current high rates of population growth is thus key to achieving its full potential for development.

The international community has good reason to care about African development. The continent is endowed with ample mineral and agricultural resources, including the greatest potential in the world for increases in farm productivity. Africa is also one of the last untapped markets for goods and services; industrialized countries thus stand to benefit by trading with a more prosperous Africa. Beyond economic self-interest, there are strong humanitarian reasons to support efforts to alleviate poverty in Africa, home to 11 percent of the world's population.

In many respects, Africa in the late 1990s resembles the East Asian economies as they began their economic take-off three decades ago. With hindsight, it is now clear that rapid declines in fertility played an important role in the "East Asian miracle." An important lesson from the success

of these Asian countries is the need to develop effective population policies and programs, while also building human capacity through investments in health and education. Currently, literacy levels in Africa are only half the levels prevailing in East Asia in the mid-1960s.

African governments need to emphasize three key strategies in their efforts to improve individual well-being and slow population growth. The first priority should be to expand reproductive health and family planning services to meet existing unmet needs. The second, to expand educational and economic opportunities, especially for women, both to improve the lives of individuals and to help encourage a desire for smaller families. The third, to slow the momentum of future population growth through education and reproductive health programs that help young people choose to delay child-bearing.

Carrying out the comprehensive agenda described above will require enormous effort by African governments. The task is large, yet attainable if these governments increase their current low levels of commitment to reproductive health and family planning programs. In Bangladesh, sustained political support has been key to the development of a strong family planning program, and has helped bring about dramatic declines in fertility even in a desperately poor country where most women are still illiterate.

The international community, meanwhile, needs to recognize the importance of investments in health and education to future stability and growth, and the continued need for donor support until countries can fully finance these services themselves. The United States, in particular, must not retreat further from the strong leadership it has provided in both funding and hands-on technical advice to reproductive health and family

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planning programs in the region. Given its unique ability to help move population programs ahead, the United States should explore ways to continue such assistance to those African countries in which it no longer maintains a bilateral assistance program or field presence. In addition, other donors need to expand their efforts.

Governments and donors should be prepared to invest years of sustained effort to build successful population programs. Over the long haul, there are bound to be setbacks and difficulties. Currently, there is no reason to expect that either the fertility or development transitions will occur more quickly and with less external aid in sub-Saharan Africa than they did in places such as South Korea and Taiwan.

Yet the needs are pressing, and Africa must accelerate the development of population programs and the current trend towards smaller families. This may be possible if African countries are willing to learn as much as possible from the experiences of other regions, while at the same time recognizing the continent's own special challenges, such as the HIV/AIDS crisis.

Africa's relatively recent establishment of population policies and programs has given it the chance to learn from both the mistakes and achievements of other regions which have grappled with the problem of rapid population growth. African countries – with help from the world community – have the potential to build on these experiences and create their own success story.

*Africa's ability to slow current high rates of population growth is key to achieving its full potential for development.*

## Statistical Annex: Demographic and Socio-economic Indicators for Sub-Saharan Africa

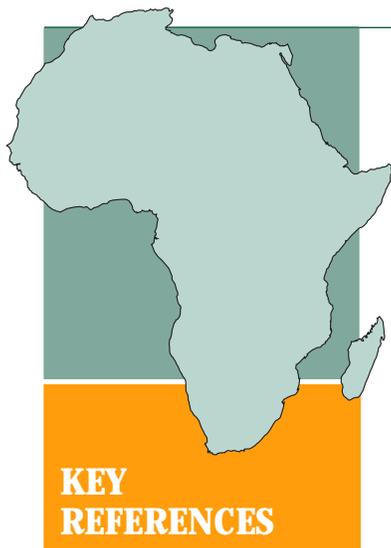
Country	1997 Population (Millions)	2025 Population UN Medium Projection (Millions)	Annual Rate of Natural Increase (Percent)	Average Births Per Woman (Total Fertility)	Women Using Contraception All/Modern Methods (Percent)
Angola	11.6	25.5	3.17	7.2	na
Benin	5.7	12.3	3.15	6.3	16 / 3
Botswana	1.5	2.6	2.62	4.9	33 / 32
Burkina Faso	11.1	23.5	2.96	7.1	8 / 4
Burundi	6.4	12.3	2.63	6.8	9 / 1
Cameroon	13.9	28.5	2.77	5.7	16 / 4
Cape Verde	0.4	0.7	2.51	3.9	na
Central African Republic	3.4	6.0	2.22	5.3	15 / 3
Chad	6.7	12.6	2.50	5.9	na
Comoros	0.7	1.3	3.15	6.0	21 / 11
Congo, Dem. Rep.	48.0	105.9	3.35	6.7	8 / 2
Congo	2.7	5.7	2.99	6.3	na
Côte d'Ivoire	14.3	24.4	2.58	5.7	11 / 4
Djibouti	0.6	1.1	2.28	5.8	na
Equatorial Guinea	0.4	0.8	2.55	5.9	na
Eritrea	3.4	6.5	2.73	5.8	8 / 4
Ethiopia	60.1	136.3	3.08	7.0	4 / 3
Gabon	1.1	2.1	2.00	5.0	na
Gambia	1.2	2.0	2.41	5.6	12 / 7
Ghana	18.3	36.3	2.87	5.7	20/10
Guinea	7.6	15.3	3.03	7.0	2 / 1
Guinea-Bissau	1.1	1.9	2.06	5.8	na
Kenya	28.4	50.2	2.59	5.4	33 / 27
Lesotho	2.1	4.0	2.56	5.2	5 / 2
Liberia	2.5	6.6	2.12	6.8	6 / 6
Madagascar	15.8	34.5	3.25	6.1	17 / 5
Malawi	10.1	20.4	2.82	7.2	22 / 14
Mali	11.5	24.6	3.17	7.1	7 / 5
Mauritania	2.4	4.4	2.54	5.4	3 / 1
Mauritius	1.1	1.5	1.42	2.4	75 / 49
Mozambique	18.3	35.4	2.65	6.5	na
Namibia	1.6	3.0	2.56	5.3	29 / 26
Niger	9.8	22.4	3.36	7.4	4 / 2
Nigeria	118.4	238.4	3.00	6.5	6 / 4
Reunion	0.7	0.9	1.61	2.4	67 / 62
Rwanda	5.9	13.0	-0.07	6.6	21 / 13
Sao Tome & Principe	0.1	0.2	na	6.4	na
Senegal	8.8	16.9	2.70	6.1	13 / 8
Seychelles	0.1	0.1	na	2.7	na
Sierra Leone	4.4	8.2	1.94	6.5	na
Somalia	10.2	23.7	3.17	7.0	na
South Africa	43.3	71.6	2.24	4.1	50 / 48
Sudan	27.9	46.9	2.09	5.0	9 / 6
Swaziland	0.9	1.7	2.81	4.9	20 / 17
Tanzania	31.5	62.4	2.88	5.9	18 / 13
Togo	4.3	8.8	2.95	6.6	12 / 3
Uganda	20.8	45.0	2.90	7.1	15 / 8
Zambia	8.5	16.2	2.63	6.0	26 / 14
Zimbabwe	11.7	19.3	2.68	4.3	48 / 42
<b>Sub-Saharan Africa</b>	<b>621.6</b>	<b>1,244.0</b>	<b>2.80</b>	<b>6.1</b>	<b>18 / 12</b>

Sources: 1997 and 2025 population size, rate of natural increase (1990-1995), and average births per woman (1990-1995): United Nations. *World Population Prospects: The 1996 Revision*. New York: United Nations, 1996; contraceptive prevalence: United Nations. *Levels and Trends of Contraceptive Use as Assessed in 1994*. New York: United Nations, 1996, and most recent Demographic and Health Surveys data; maternal mortality: WHO and UNICEF. *Revised 1990 Estimates of Maternal Mortality*.

## Statistical Annex: Demographic and Socio-economic Indicators for Sub-Saharan Africa

Maternal Deaths Per 100,000 Births	Infant Deaths Per 1,000 Live Births	Literacy Per 100 Adults 15 Years & Older Male/Female	GNP Per Capita (US\$)	Country
1,500	170	56 / 29	410	Angola
990	84	49 / 26	370	Benin
250	40	81 / 60	3,020	Botswana
930	82	30 / 9	230	Burkina Faso
1,300	106	49 / 23	160	Burundi
550	63	75 / 52	650	Cameroon
na	54	81 / 64	960	Cape Verde
700	103	69 / 52	340	Central African Republic
1,500	92	62 / 35	180	Chad
950	83	64 / 50	470	Comoros
870	128	87 / 68	120	Congo, Dem. Rep.
890	81	83 / 67	680	Congo
810	90	50 / 30	660	Côte d'Ivoire
570	112	60 / 33	na	Djibouti
820	111	90 / 68	380	Equatorial Guinea
1,400	78	na	100	Eritrea
1,400	113	46 / 25	100	Ethiopia
500	87	74 / 53	3,490	Gabon
1,100	78	53 / 25	320	Gambia
740	70	76 / 54	390	Ghana
1,600	130	50 / 22	550	Guinea
910	132	68 / 43	250	Guinea-Bissau
650	61	86 / 70	280	Kenya
610	96	82 / 62	770	Lesotho
560	157	54 / 22	450	Liberia
490	100	60 / 32	230	Madagascar
560	137	72 / 42	170	Malawi
1,200	134	39 / 23	250	Mali
930	124	50 / 26	460	Mauritania
120	120	87 / 79	3,380	Mauritius
1,500	133	58 / 23	80	Mozambique
370	60	na	2,000	Namibia
1,200	141	21 / 7	220	Niger
1,000	114	167 / 47	260	Nigeria
na	na	na	na	Reunion
1,300	105	70 / 52	180	Rwanda
na	62	na	350	Sao Tome & Principe
1,200	74	43 / 23	600	Senegal
na	15	na	6,620	Seychelles
1,800	164	45 / 18	180	Sierra Leone
1,600	125	na	120	Somalia
230	50	82 / 82	3,160	South Africa
660	73	58 / 35	480	Sudan
560	68	78 / 76	1,170	Swaziland
770	43	79 / 57	120	Tanzania
640	78	67 / 37	310	Togo
1,200	88	74 / 50	240	Uganda
940	112	86 / 71	400	Zambia
570	49	90 / 80	540	Zimbabwe
<b>980</b>	<b>105</b>	<b>67 / 47</b>	<b>490</b>	<b>Sub-Saharan Africa</b>

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