

# Fragile, Threatened, and Still Greatly Needed— Family Planning Programs in Sub-Saharan Africa



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## Introduction

This Advocacy Brief is intended to help inform efforts to secure greater programmatic attention to family planning (FP) in Sub-Saharan Africa. In it, we present evidence that many FP programs in Sub-Saharan Africa are fragile (performance has fallen off), threatened (future program performance is challenged), and still greatly needed to meet health, equity, poverty alleviation, and economic development goals. We draw here upon findings of case studies of the FP programs of Ghana, Malawi, Senegal, Tanzania, and Zambia (see text box, page 8). We also present data from Nigeria, the most populous Sub-Saharan African country; Kenya, long a leader in FP in Sub-Saharan Africa; and Uganda, whose fertility is among the highest in Africa and whose population is projected to more than triple in the next 40 years, to become the fourth most populous Sub-Saharan African country. Together, these eight countries comprise 40% of Sub-Saharan Africa's population (UN Population Division, 2007). All are facing the same difficult dynamics in terms of threat and need.

## Status and Trends in FP Parameters in Sub-Saharan Africa Overall

*Use of modern FP is very low* in Sub-Saharan Africa: Only 18% of married women use a modern method of contraception, compared with 63% in Latin America and 61% in Asia (48% excluding China). This level of contraceptive use represents only a small rise in the contraceptive prevalence rate (CPR) from the level of 13% seen in the late 1990s–2001 (PRB, 2002; and PRB, 2008a). At the same time, *unmet need is high*: Twenty-nine of the 31 Sub-Saharan African countries that have had a recent Demographic and Health Survey (DHS) have levels of unmet need for modern FP exceeding 20%, with 19 of them having levels of unmet need between 30% and 49%. In contrast to other regions, *little or no reduction in unmet need* has occurred the past decade in Sub-Saharan Africa. *Unmet need for modern methods is higher than current use* (i.e., met need) in many Sub-Saharan African countries, in some cases substantially so. Whereas 18 million married women in Sub-Saharan Africa use modern FP, 25 million have an unmet need (Westoff, 2006; and PRB, 2008a). A concomitant to this low FP use and high unmet need is *very high fertility and rapid population growth*: Sub-Saharan Africa's total fertility rate (TFR) is 5.5 lifetime births per woman, substantially higher than the TFR of Latin America (2.5) and Asia (2.4; 2.8 excluding China). Fifteen of the 31 Sub-Saharan African countries with a recent DHS have TFRs that exceed 6.0 (PRB, 2007). This level is essentially unchanged from the late 1990s, when the region's overall TFR was 5.6 lifetime births per woman (PRB, 2002). Sub-Saharan Africa's 2008 population will more than double by 2050, an increase of nearly a billion people (UN Population Division, 2007) (see Table 1, page 2).

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## Fragility of Sub-Saharan African FP Programs

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Many of Sub-Saharan Africa's most successful FP programs have experienced *a marked reduction in progress, if not a complete halt*, as is reflected in their CPRs, TFRs, and levels of unmet need for modern contraception. Low use of modern FP in tandem with high unmet need and high unwanted fertility implies that Sub-Saharan African FP programs are not currently able to meet their citizens'

**Table 1. Population Trends (to the Nearest Million)**

Country	1990	2000	2008	2050
Sub-Saharan Africa	519	680	828	1,761
Ghana	16	20	24	42
Kenya	23	31	39	85
Malawi	9	12	14	32
Nigeria	95	125	152	289
Senegal	8	10	13	25
Tanzania	26	34	42	85
Uganda	18	25	32	93
Zambia	8	11	12	23

**Source:** UN Population Division. 2007. *World population prospects: The 2006 revision population database* (medium variant projections). New York. Accessed at: <http://esa.un.org/unpp/>.

contraceptive needs. The eight countries in this analysis illustrate these trends and dynamics. All experienced an increase in CPR in the 1980s and 1990s, yet six saw these improvements diminish or cease in the 2000s (and this disquieting trend may not yet have been detected in Ghana and Zambia).<sup>1</sup> Whereas in the 1990s, modern method use almost quadrupled in Malawi and more than doubled in Tanzania and Uganda, subsequent increases were more modest in Malawi, Senegal, and Tanzania, and ceased in Kenya, Nigeria (which has yet to achieve double-digit levels of modern contraceptive use) and Uganda (see Table 2 and Figure 1, page 4).<sup>2</sup> From the standpoint of fertility, the solid declines in TFR of 0.6 births or more (from DHS to DHS) that accompanied increased FP use in the 1980s and 1990s have diminished in Ghana, Malawi, Uganda, and Zambia (declines of 0.2–0.3 births) and ceased in Kenya, Nigeria, and Tanzania, with TFRs remaining at high levels (see Table 2). Yet *all eight countries have higher total fertility than wanted fertility* (see Figure 1), which, along with the high unmet need, suggests programmatic opportunity as well as programmatic challenge.

## The Threat to FP Programs in Sub-Saharan Africa

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The Africa region suffers more than 24% of the global burden of disease, yet it has only 3% of the world's health workers and less than 1% of the world's financial resources, even with loans and grants from abroad (WHO, 2006). At the same time, FP programs in Sub-Saharan Africa are threatened by an unprecedented array of daunting challenges, as the larger health programs of which they are a part must allocate their scarce financial and human resources to other pressing priority

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<sup>1</sup> Ghana last had a DHS in 2003. Zambia's last DHS for which findings are available was conducted in 2001–2002. Zambia's 2007 DHS findings were not available at the time of the writing of this Working Paper.

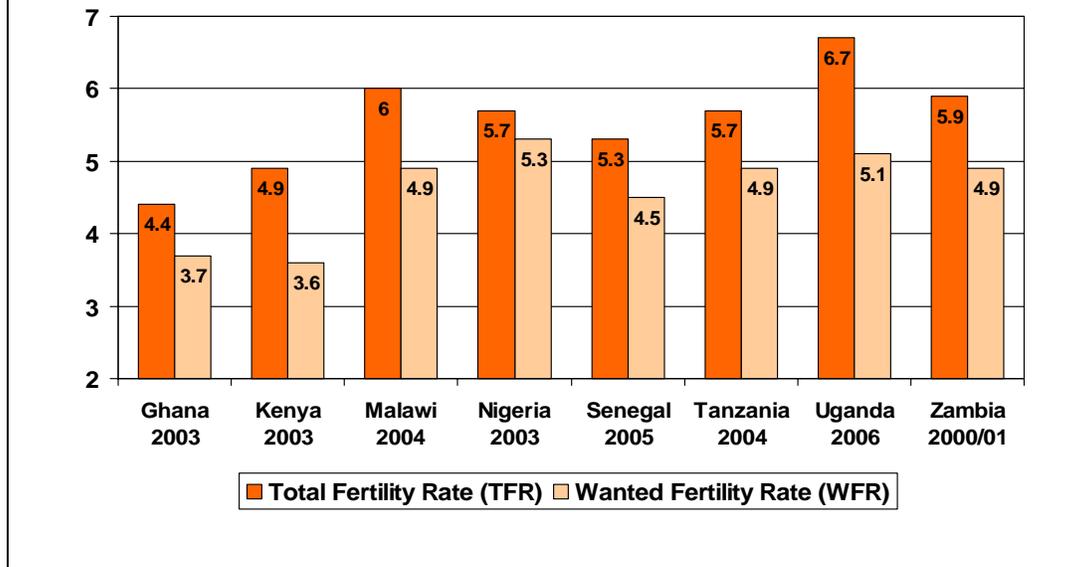
<sup>2</sup> CPR data are from respective national DHS surveys and refer to women aged 15–49 who are currently married or in union and are currently using a modern contraceptive method.

**Table 2. TFR, Wanted Fertility Rate, and Met and Unmet Need for FP: Trends in Ghana, Kenya, Malawi, Nigeria, Senegal, Tanzania, Uganda, and Zambia**

Country	TFR	Wanted Fertility Rate	Met Need for FP (Modern Method CPR)	Unmet Need for FP
<b>Ghana</b>				
2003	4.4	3.7	18.7	34.0
1998	4.6	3.7	13.3	24.3
1993	5.5	4.2	10.1	38.6
1988	6.4	5.3	5.2	
<b>Kenya</b>				
2003	4.9	3.6	31.5	24.5
1998	4.7	3.5	31.5	23.9
1993	5.4	3.4	27.3	36.4
1989	6.7	4.4	17.9	
<b>Malawi</b>				
2004	6.0	4.9	28.1	27.6
2000	6.3	5.2	26.1	29.7
1992	6.7	5.7	7.4	36.3
<b>Nigeria</b>				
2003	5.7	5.3	8.2	16.9
1999	5.2	4.8	8.6	17.5
1990	6.0	5.8	3.5	20.8
<b>Senegal</b>				
2005	5.3	4.5	10.3	31.6
1997	5.7	4.6	8.1	32.6
1992–1993	6.0	5.1	4.8	27.9
<b>Tanzania</b>				
2004	5.7	4.9	20.0	21.8
1999	5.6	4.8	16.9	21.8
1996	5.8	5.1	13.3	23.9
1992	6.2	5.6	6.6	30.1
<b>Uganda</b>				
2006	6.7	5.1	17.9	40.6
2000–2001	6.9	5.3	18.2	34.6
1995	6.9	5.6	7.8	29.0
1988	7.5	6.4	2.5	53.7
<b>Zambia</b>				
2001–2002	5.9	4.9	22.6	27.4
1996	6.1	5.2	14.4	26.5
1992	6.5	5.4	8.9	33.4

Source: Respective national DHS final reports.

**Figure I. Total and Wanted Fertility Rates in Ghana, Kenya, Nigeria, Malawi, Senegal, Tanzania, Uganda, and Zambia**



health needs such as combating malaria, tuberculosis, and HIV/AIDS. Thus, although international population assistance more than doubled worldwide from 2001 to 2004, increasing from \$2.5 billion to \$5.6 billion, the share devoted to FP declined from 30% of total international population assistance in 2001 to less than 10% in 2004 (Leahy, 2007; and Ethelston et al., 2004).

The devastating AIDS pandemic in Sub-Saharan Africa is not only diverting programmatic attention and resources, and thus the complements of skilled health personnel available to provide FP; it is also exacting a toll of disability and death upon the health workforce itself. Reductions in the skilled workforce available to provide FP are further occurring because of: out-migration to more developed countries; low pay; uneven distribution, deployment, and use of existing staff; retirement; and diminished programmatic investment in preservice education (WHO, 2006). These challenges have been compounded at the macro level by the unintended consequences of health sector reform and decentralization, which have devolved programmatic authority to lower levels, where the feasibility and benefits of FP are often less well known. That people want effective FP, and will use it when it is made available, is not as widely appreciated as it needs to be; nor are the health, social, and economic benefits of FP to individuals, communities, and nations. Donors have also shifted their priorities and resources to other health problems and other development sectors, in pursuit of the UN Millennium Development Goals (MDGs)—yet “the MDGs are difficult or impossible to achieve with current levels of population growth in the least developed countries and regions ... unless family planning is made easily available” (All Party Parliamentary Group, 2007).

## Still Greatly Needed: FP Services in Sub-Saharan Africa

The FP “job” is not yet completed in Sub-Saharan Africa, nor has it been realistic to hope or expect that it would be by now, given Sub-Saharan Africa’s low current use of and high unmet need for modern contraception, as well as its unfavorable population dynamics and socioeconomic conditions.

Indeed, given the high population growth rates in Sub-Saharan Africa, *FP services will need to expand by almost 30% by 2015, by nearly 50% by 2020, and by 87% by 2030 simply to maintain the current low rates of contraceptive prevalence.*<sup>3</sup> In effect, programs will have to run much faster just to remain in the same place of low use and high unmet need.

The health rationale alone is a compelling reason for the increased provision of FP services. Sub-Saharan Africa is the one region of the world that has not experienced a significant reduction in maternal mortality (Hill et al., 2005). A Sub-Saharan African woman today has a one in 22 lifetime chance of maternal death,<sup>4</sup> and for every 109 births, one woman dies in pregnancy or childbirth (UNICEF 2007)—and for every woman who dies, approximately 30 others suffer injuries, infections, and disabilities. Ensuring access to FP services in Sub-Saharan Africa could avert more than 70,000 maternal deaths and prevent more than 250,000 children from losing their mothers, *every year*<sup>5</sup>; in addition, FP prevents more mother-to-child transmission of HIV than do antiretroviral drugs (USAID, 2006).<sup>6</sup>

Not only is unmet need for modern FP high today in almost all Sub-Saharan African countries, but *the largest cohorts of young people in Sub-Saharan Africa's history are entering their reproductive years*, a phenomenon that will continue well into the remainder of this century (PRB, 2007).<sup>7</sup> The certain large increase in future need and demand for FP services that these young and growing cohorts represent will be intensified further by Sub-Saharan Africa's very rapidly increasing urbanization, which almost invariably fuels higher demand for FP services. Sub-Saharan Africa's 5% annual urban growth rate is the highest in the world (and twice its overall annual population increase of 2.4%, also the world's highest (UNFPA, 2007). Whereas 28% of Sub-Saharan Africans lived in cities in 1990, 37% did in 2006, and this proportion will rise to 48% by 2030 and 60% by 2050 (UN Population Division, 2008) (see Table 3, page 6). The additional pressure for services that urbanization imposes on already fragile FP programs is suggested by the current urban-rural differentials in modern method CPR in the eight countries under analysis, which range from 25 percentage points in Zambia (39% vs. 14%) and 22 percentage points in Uganda (43% vs. 21%) to eight percentage points in Malawi (35% vs. 27%) and Nigeria (14% vs. 6%).<sup>8</sup>

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<sup>3</sup> These figures represent the projected rise from 2005 to 2030 in the Sub-Saharan African female population aged 15–49. This number is projected to rise from an estimate of 180.7 million in 2005 to 205.6 million by 2010 and to 301.4 million by 2030. These data are taken from the medium variant projections in: UN Population Division, 2007.

<sup>4</sup> By contrast, among the 10 top-ranked European and other industrialized countries, where women are guaranteed good quality health and FP services that minimize their lifetime risk, fewer than one in 16,400 will die from complications of pregnancy and childbirth—an almost 750-fold difference (Women Deliver, 2007).

<sup>5</sup> These figures are extrapolated from an estimate that, if contraceptive services were available and women with unmet need availed themselves of these services, 142,000 pregnancy-related deaths would be averted worldwide and 505,000 children would avoid loss of their mothers (and 1.4 million infant deaths would be avoided) (Vlassof et al., 2004) and an estimate that 50% of worldwide maternal mortality occurs in Sub-Saharan Africa (Hill et al., 2005).

<sup>6</sup> Most of the 2.25 million young children living with HIV and AIDS, who were infected by their mothers, live in Sub-Saharan Africa, where the vast majority of HIV-positive pregnant women also live. A number of models and analyses indicate that FP services prevent HIV infection in more infants than does antiretroviral therapy, and at lower cost (USAID, 2006).

<sup>7</sup> Forty-three percent of Sub-Saharan Africa's population is below the age of 15. In the eight countries in this analysis, this population cohort ranges from a low of 40% in Ghana to a high of 50% in Uganda.

<sup>8</sup> DHS surveys show that the eight countries under analysis all have urban-rural differentials in modern method. Fertility differentials are equally striking, with urban TFR much lower than rural TFR, by 2.2 to 2.9 lifetime births per woman (with the exception of Nigeria, where the difference is 1.2 births).

**Table 3. Urbanization Trends in Ghana, Kenya, Malawi, Nigeria, Senegal, Tanzania, Uganda, and Zambia (to the nearest million)**

Country	1990		2010		2030		2050	
	% urban	No. (in millions)						
Sub-Saharan Africa	28	147	37	324	48	630	60	1065
Ghana	38	6	52	13	65	22	76	32
Kenya	17	4	22	9	33	21	48	41
Malawi	11	1	20	3	33	8	48	15
Nigeria	35	33	50	79	63	144	75	218
Senegal	39	3	43	6	53	10	65	17
Tanzania	19	5	26	11	38	25	54	46
Uganda	11	2	14	5	21	13	33	31
Zambia	38	3	38	5	44	8	57	13

Source: UN Population Division, 2008.

The need for expanded FP services is also compelling from the standpoint of alleviating the burden of poverty, because seven of every 10 Sub-Saharan Africans currently live in poverty (less than US\$2 per day), with four of every 10 living in extreme poverty (less than US\$1 per day) (Chen & Ravallion, 2007). Six or more of every 10 people in all eight countries under analysis live in poverty, including 97% of Ugandans, 91% of Nigerians, and 87% of Zambians (World Bank, 2005).<sup>9</sup> Yet the population of almost every country in Western, Eastern, and Middle Africa, including the eight countries in this analysis, will more than double from 2000 to 2050. Uganda's population will almost quadruple, rising from 25 million (32 million in 2008) to 93 million in 2050, and Nigeria's population will grow during that time by an additional 164 million people, to 289 million (see Table 1). If poverty rates do not decline, more than 350 million people in these two countries alone will be living in poverty in 2050, over 280 million of them in extreme poverty.

The implications of such extremely high levels of population growth, coupled with the even more rapid urban growth—when already three of every four urban dwellers today live in slum conditions in Sub-Saharan Africa—are stark. Hundreds of millions more people—more than 1.25 billion people overall—will be living in poverty in 2050, and Sub-Saharan African countries will thus have even greater difficulty elevating their level of socioeconomic development and maintaining their often-tenuous political stability. FP services are the key intervention for addressing and ameliorating these difficult dynamics. The good news is that demand for FP services in Sub-Saharan Africa has never been higher, and that the requisite FP service interventions are known (see text box, page 8); what is needed is committed and sustained political and programmatic will, translated into greater financial and human resources for FP, with health systems translating this increased will and resources into the delivery of effective services.

## Conclusion

FP services are needed more than ever in Sub-Saharan Africa to help meet individual and family welfare and health goals, as well as national economic and social development goals. Without concerted attention

<sup>9</sup> Poverty levels (under U.S. \$2 per day) for the other five countries are: Ghana, 79%; Kenya, 58%; Malawi, 76%; Senegal, 63%; and Tanzania 60%; 85% of Ugandans live in extreme poverty (under U.S. \$1 per day), as do 70% of Nigerians and 64% of Zambians.

and increased priority given to FP services by policymakers and program leaders and by interested bilateral and multilateral donors, Sub-Saharan African FP programs will likely continue to be fragile, and their performance will continue to plateau or decline. Contraceptive use will remain low, unmet need for modern FP will remain high, and fertility will remain high—higher than desired and higher than can be sustained. Individual health and well-being will be jeopardized, poverty will become even more widespread (affecting more than one billion men, women, and children), national development goals will be difficult (if not impossible) to achieve, and political stability will be endangered.

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## Moving Programs Forward: The Repositioning Family Planning Case Studies

Case studies of the FP programs of Ghana, Malawi, Senegal, Tanzania, and Zambia were undertaken by the ACQUIRE Project in 2004–2006 for the Repositioning Family Planning Initiative of USAID’s Office of Population and Reproductive Health. This Initiative was launched out of concern that FP was “falling off the map,” especially in Sub-Saharan Africa, even though long-standing health, development, and equity rationales for FP remained relevant and compelling. The five retrospective, broad-brush country case studies had two purposes: 1) to inform advocacy for greater support of, and programmatic attention to, FP; and 2) to identify those program factors and interventions that accounted for the success that these programs had theretofore realized. The case studies were based on key informant interviews, review of serial DHS surveys, and review and analysis of local program data and documents, and are intended to help point program leaders and donors to priority FP program areas for sustained emphasis and sustained investment.<sup>i</sup>

The main, overarching concept that emerged from the case studies is that of *fragility*—In the face of the kinds of challenges discussed in Section IV of this brief, even the most successful programs were experiencing reduced or stalled progress.<sup>ii</sup> To take the most salient example, at the time of the Malawi Case Study in 2004, Malawi was rightfully considered a “success.” However when the results of the 2005 Malawi DHS became available, it was clear that Malawi was following the same pattern of falloff in progress seen in Tanzania, whereby the strong gains of the 1990s in terms of higher modern contraceptive use, lowered fertility, and decreasing unmet need for modern FP had diminished substantially.<sup>iii</sup>

The case studies concluded that the following are the key programmatic factors and emphases that, by their presence or absence, accounted for relative success in the five countries: 1) **increasing the accessibility of FP services**; 2) **broadening method choice**; 3) **creating demand and changing behavior**; 4) **developing effective partnerships**; 5) **scaling up with evidence**; 6) **keeping focus through championship and leadership** (at the policy, advocacy, and service levels); and 7) **going beyond the clinic walls**. On the supply side, the studies underscored the importance of having FP services and a range of methods be regularly and reliably available, affordable, and free of unjustified policy and practice barriers (i.e., “No access, no program”) On the demand side, the studies pointed to the importance of information, education, and communication (IEC) activities, using multiple channels of communication, to increase individuals’ and communities’ accurate understanding of FP, as well as of healthier RH/FP practices; this was found to be feasible even in poor and low-literacy settings and to be associated not only with increased knowledge, free of rumors, myths and misconceptions, but also with more positive attitudes and increased use of FP. The importance of having respected and influential organizations and individuals act not only as full partners in the FP program, but also as effective champions and leaders, was also underscored.

For investment and programmatic attention in the future, the case studies recommended four areas of priority focus, termed the “ABCDs” of FP: **Available supplies**; **Basic systems for service delivery**; **Community involvement and outreach**; and **Demand creation**. The studies highlighted the need for political will and commitment, with concomitant supportive policies and sustained funding. The studies also concluded that as important as *what* should be done is *how* it should be done, suggesting that the following principles should guide program efforts: ensure widespread stakeholder participation and ownership; focus on the fundamentals of service delivery (safety, quality, and informed choice); ensure no missed opportunities; use data, especially locally generated data, for advocacy, program strategy, and scale-up; and address and promote gender equity. Finally, programs should “stay the course”: Continuity in support and programming is needed, and such an effort is worth making, as the payoffs to individuals, communities, and nations are large when the availability and use of quality FP services becomes more widespread and a societal norm.

<sup>i</sup> The country case studies can be found at [www.acquireproject.org/index.php?id=258/](http://www.acquireproject.org/index.php?id=258/).

<sup>ii</sup> “Everything has been sideswiped by AIDS,” said a key informant in Tanzania—and indeed, 50% of hospital beds in Tanzania were occupied by AIDS patients, with AIDS being the leading cause of death in people aged 15–49. Other factors mentioned in Section IV of this brief also contributed to diminished investment in and attention to FP. Decentralization of program responsibility (without adequate funding) led to diluted commitment to and programming for FP, as did integration of health services. For example, in Malawi and Tanzania, after FP logistics were integrated into overall logistics, the absence of a separate procurement unit dedicated to FP led to confusion and recurrent stockouts.

<sup>iii</sup> This pattern of fragility in the face of the many difficult challenges may well also be demonstrated in Ghana and Zambia. Ghana’s 2006 multiple indicator cluster survey (a different methodology from that used in the DHS, and thus not strictly comparable to it) found a modern method CPR of 14.1%, whereas the 2003 DHS had found a modern method CPR of 18.7%. Zambia’s DHS results are due later in 2008.