Moving Family Planning Programs Forward: Learning from Success in Zambia, Malawi, and Ghana

The Repositioning Family Planning Case Study Synthesis Report

September 2005

USAID
FROM THE AMERICAN PEOPLE

the ACQUIRE project

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Executive Summary

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well-documented, the attention and resources directed toward improving family planning programs in developing countries has been decreasing, even though need remains high. This is particularly true for Sub-Saharan Africa; for the region as a whole, only 14% of women are using modern methods of contraception (PRB, 2004). To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. Case studies were undertaken in three countries that have been successful in increasing contraceptive use and lowering fertility—Ghana, Malawi, and Zambia—so that lessons learned from these case studies can be used to guide strategy development and identify key investments.

The table below shows the declines in total fertility fate (TFR) and increases in contraceptive prevalence rate (CPR) seen in Ghana, Malawi, and Zambia. It is important to note that behind these national averages, there is a great deal of regional variation. For example, in provinces in Zambia, the CPR ranges from 7% in Luapula to 40% in Lusaka. Contraceptive use is higher in urban areas than in rural areas in all three countries. Malawi has seen the most dramatic increase in CPR in rural areas, from 6% to 24% between 1992 and 2000. While CPR has improved among all wealth quintiles in each of the three countries, only in Malawi did the CPR increase significantly among the poorest women. Although prevalence increased more in Malawi and Zambia than in Ghana, Ghana has seen the most significant decline in fertility. This highlights the importance of looking at multiple measures of success to truly understand a country's situation.

Table 1. Total fertility rate (TFR) and contraceptive prevalence rate (CPR) in Ghana, Malawi, and Zambia

Country	Time 1		Time 2
Ghana	(1993)		(2003)
TFR	5.2	⇒	4.4
CPR	10.1%		18.7%
Malawi	(1992)		(2000)
TFR	6.7	⇒	6.3
CPR	7.4%		26.1%
Zambia	(1992)		(2001–2002)
TFR	6.5	⇒	5.9
CPR	8.9%		22.6%

Sources: Ghana—GHS, Noguchi Memorial Institute for Medical Research, and ORC Macro, 2004; Malawi—NSO and ORC Macro. 2001; Zambia—CSO, CBOH, and ORC Macro, 2003.

Experiences in these three countries point to the importance of several programmatic factors. Respondents emphasized the central importance of *accessibility* and getting the systems in place and functioning so that family planning services are available

consistently and reliably. Important system changes included strengthening the contraceptive logistics system to function more efficiently and effectively; training providers, with a focus on training trainers to enhance sustainability; developing and disseminating policies to remove unnecessary barriers; having services available five days a week; and ensuring that services are affordable. *Broadening method choice* has helped to address women's needs: "The range of methods encouraged women to come forward because now they had a wide range to choose from," a respondent in Zambia explained. Efforts in this area highlight the importance of introducing (or reintroducing) methods in a holistic manner, including training providers and addressing their biases, providing equipment and supplies, and incorporating community outreach and education. Programs in Ghana and Zambia were successfully scaled up through an emphasis on local ownership, a phased and evidence-based approach, and use of the original project site to share lessons.

Family planning programs in these three countries were successful not just through supply-side interventions, but also through effective and innovative efforts on the demand side, including both working with the community and bringing services closer to rural populations. The messages that were effective in *creating demand and changing behavior* were developed in consultation with the community to ensure that they were appropriate and meaningful. A respondent in Malawi explained that "initially the approach we had was wrong. We said you should have four children. That is wrong. You can't dictate to people. We should be saying there should be spacing, there should be a period of resting." These family planning programs incorporated efforts at *going beyond the clinic walls* through community-based distribution (CBD), which included not only provision of methods but also motivation and referral. The CBD programs in Malawi were more extensive than in those in Zambia, which most likely accounts for the greater success in increasing contraceptive use in rural areas.

Public-private partnerships, either with social marketing programs or with a strong nongovernmental organization, enabled these family planning programs to achieve greater coverage. The public sector is essential for ensuring national coverage and for providing a legitimizing role, while the private sector can address more controversial issues, can be more aggressive, and often has closer links to the community.

The priority areas for investment in family planning will depend on the specifics of each country, but experience from Ghana, Malawi, and Zambia points to the following as the four areas for focus, *the ABCDs of family planning:*

A) Available supplies

B) Basic systems for service delivery

C) Community involvement and outreach

D) Demand creation

It is recommended that any country begin with some form of participatory strategic assessment to identify the specifics within this general framework.

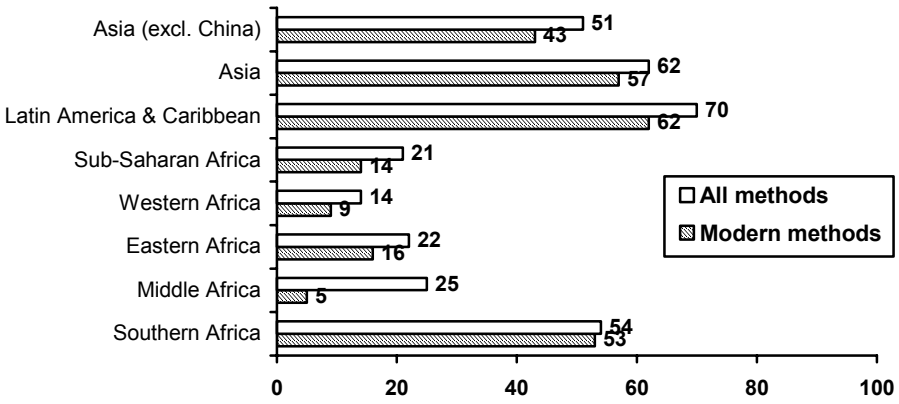
For all of these interventions, it is not just what is done but how you do it that makes the difference. The following principles should guide these efforts:

- Instill ownership
- Address equity
- Ensure no missed opportunities, in particular looking for ways to more effectively integrate family planning with HIV/AIDS programs
- Use evidence to plan, advocate, and scale up success
- Stay the course, recognizing that change takes time and requires continuity in support

Introduction

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well-documented, in recent years the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though need remains high. This is particularly true for Sub-Saharan Africa; for the region as a whole, only 14% of women are using modern methods of contraception (Figure 1) (PRB, 2004). By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Singh et al., 2003).

Figure 1. Regional contraceptive prevalence rates



To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. In the face of scarce resources, weak infrastructure, and a growing focus on HIV/AIDS, it is extremely difficult for African country programs to make significant gains in strengthening their family planning programs and thereby raising contraceptive prevalence. USAID has committed itself to providing incremental assistance to a selected number of focus countries at the very early stages of program development.

Therefore, USAID has undertaken a project to document the success of the family planning programs in three countries in Sub-Saharan Africa over the past 10–20 years and to identify which program interventions led to that success. The three countries selected for analysis are Ghana, Malawi, and Zambia, all of which have shown considerable growth in contraceptive prevalence and significant fertility decline despite a challenging environment and limited resources. Their success can provide guidance for other Sub-Saharan African countries. The case studies will be used by USAID to guide strategy development for Repositioning Family Planning and to inform efforts to identify key investments for the region.

Methodology

This report synthesizes the lessons learned from three case studies conducted in Ghana, Malawi, and Zambia. The sources of data for these case studies included in-depth interviews with 118 key informants and document reviews. Field work in Ghana took place from October 20–29, 2004, with 44 interviews. Forty-two individuals were interviewed for the Malawi case study, with field work from January 31 to February 10, 2005. The Zambia case study was conducted from February 14 to 25, 2005, and 32 people were interviewed. In addition, the teams visited several health centers and met with groups of community volunteers and family planning clients. Quotations from interviews with key informants appear throughout the report. The following were the main questions addressed in these interviews:

1. What do you feel have been the main achievements and successes of the family planning program in [country] in the past 10 years?
2. What were the main reasons for these achievements and successes (including program factors, policies, and societal/cultural factors)?
3. What were the main challenges or constraints encountered in implementing the family planning program?
4. How were these challenges addressed?
5. Are there any regions of the country or segments of the population that have been more challenging to effectively provide services to? If so, what has been done to meet their needs?
6. What are the current priorities for the family planning program in [country]?
7. What do you see as the main lessons learned from the work on family planning in [country]?

The information presented in this report gives a picture of the family planning programs in Ghana, Malawi, and Zambia; based on the data and opinions of key informants, general lessons learned are identified. However, these findings have some limitations. First, we are considering the programs over the past 20 years, and sometimes getting accurate information about past conditions and actions can be difficult. This is due both to turnover of staff and to the fact that people are generally more conversant about their current programs. Often, projects have been inadequately documented and evaluated, making it difficult to determine exactly what was achieved. In addition, directly attributing particular outcomes—e.g., increases in contraceptive prevalence—to specific interventions is difficult. However, based on the wide range of information gathered, it is possible to make general conclusions about effective aspects of the programs that contributed to each country's success.

Experiences in Ghana, Malawi, and Zambia

Table 2 provides information on several key indicators for the three case study countries.

Table 2. Key indicators for Ghana, Malawi, and Zambia

Indicator	Ghana	Malawi	Zambia
Population (in millions)	21.4	11.9	10.9
Total fertility rate (TFR)	4.4	6.3	5.9
% using modern contraceptive method	18.7	26.1	22.6
Infant mortality rate (IMR) (deaths per 1,000 births)	64	121	95
% urban population	44	14	35
HIV prevalence (%)	2.2	14.2	16.5
Life expectancy (male/female) (in years)	58 (57/59)	44 (42/45)	35 (35/35)
% of adults literate	74	62	80
% of population below poverty line (urban/rural)	39.5 (18.6/49.9)	65.3 (54.9/66.5)	72.9 (56.0/83.1)

(Sources: PRB, 2004; World Bank, 2004)

What Was Achieved?

Ghana, Malawi, and Zambia have all achieved success in their family planning programs, as evident in the increases in contraceptive use and the decreases in the total fertility rate (TFR).[1] However, there have been notable differences in the speed of these changes, in the equity of improvements, and in rural-urban or regional disparities.

Increases in contraceptive use

Table 3 shows the increases in the prevalence of modern contraceptive use among currently married women in Ghana, Malawi, and Zambia.

Table 3. Prevalence of modern contraceptive use, Ghana, Malawi, and Zambia

Country	1988	1992–1993	1996–1998	2000–2003
Ghana	5.2	10.1 (1993)	13.3 (1998)	18.7 (2003)
Malawi	N/A	7.4 (1992)	14 (1996)	26.1 (2000)
Zambia	3.4	8.9 (1992)	14.4 (1996)	22.6 (2001–2002)

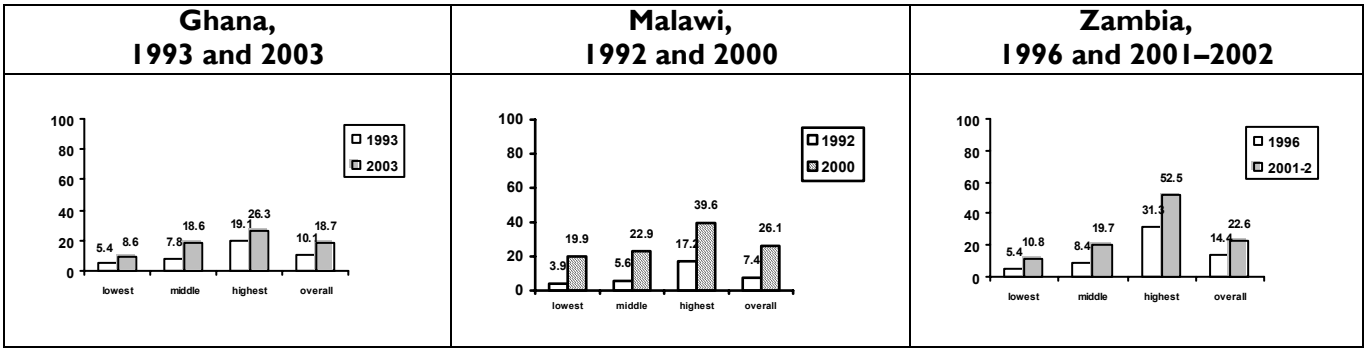
Sources: Ghana—GHS, Noguchi Memorial Institute for Medical Research, and ORC Macro, 2004; Malawi—NSO and ORC Macro. 2001; Zambia—CSO, CBOH, and ORC Macro, 2003.

[1] Total fertility rates are calculated for women aged 15–49 and are based on births in the three-year period preceding the survey. Rates may differ slightly from those published in 1988, 1993, and 1998, as these were based on births in the five years preceding the survey.

Behind these national numbers, however, there is a great deal of regional variation. For example, while the contraceptive prevalence rate (CPR) increased in Zambia to about 23% nationally, it varied greatly by province, from a low of 7% in Luapula Province to highs of 37% and 40% in Copperbelt and Lusaka Provinces. This can be explained in part by the fact that programs have primarily focused on these more densely populated urban areas because they can show the greatest impact of their programs. In Ghana, CPR ranges from lows of 8% and 10% in Northern and Upper East to highs of 25% and 26% in Brong-Ahafo and Greater Accra. For Malawi, there is minimal regional variation, although at the district level the CPR varies from about 16% in Salima to 38% in Blantyre.

In all three countries, the CPR is higher in urban areas than in with rural areas. For example, in Ghana, the CPR in urban areas is 24%, compared with 15% in rural areas; in Zambia, the urban rate is almost three times as high as the rural rate (39% vs. 14%). It is notable that Malawi has seen the most significant increase in rural areas, with the CPR having increased from 6% to 24% between 1992 and 2000; in comparison, the CPR rose from 17% to 38% in urban areas.

Figure 2. Prevalence of modern contraceptive use, by wealth quintile, Ghana, Malawi, and Zambia



Sources: Ghana—GHS, Noguchi Memorial Institute for Medical Research, and ORC Macro, 2004; Malawi—NSO and ORC Macro. 2001; Zambia—CSO, CBOH, and ORC Macro, 2003.

It is also striking to compare the changes in contraceptive use by wealth quintile in the three countries. While the CPR has improved among women in all wealth quintiles in each of the three countries, only in Malawi has the CPR increased significantly among the poorest women. In Zambia, the CPR ranges from a low of 11% for the lowest wealth quintile to 53% for the highest; the range in Ghana is from 9% to 26%, while in Malawi, women in the lowest wealth quintile have a modern method CPR of 20%, compared with one of 40% among the wealthiest women (Figure 2).

Declining Fertility Rates

Although contraceptive use has increased more in Malawi and Zambia than in Ghana, it is in Ghana where the most significant decline in fertility has occurred (Table 4). Most of the fertility decline in Malawi and Zambia has been in urban areas, with little change for rural women. In Ghana, however, fertility declined in both urban and rural populations, although the TFR is significantly lower among urban than among rural residents (3.1 vs.

5.6 lifetime births per woman in 2003). It should be noted that the TFR has been lower in Ghana than in Malawi and Zambia for many years. This is at least in part attributable to the dramatically different levels of urbanization in the three countries; while only 16% of Malawi's people live in urban areas, almost half (44%) of Ghanaians are urban residents.

Table 4. TFR, by urban/rural residence, Ghana, Malawi, and Zambia

Country	Time 1		Time 2
Ghana	(1993)		(2003)
Urban	4.0		3.1
Rural	6.4	⇒	5.6
Total	**5.2**		**4.4**
Malawi	(1992)		(2000)
Urban	5.5		4.5
Rural	6.9	⇒	6.7
Total	**6.7**		**6.3**
Zambia	(1992)		(2001–2002)
Urban	5.8		4.3
Rural	7.1	⇒	6.9
Total	**6.5**		**5.9**

Sources: Ghana—GHS, Noguchi Memorial Institute for Medical Research, and ORC Macro, 2004; Malawi—NSO and ORC Macro. 2001; Zambia—CSO, CBOH, and ORC Macro, 2003.

The experience of Ghana is considered something of a mystery, since contraceptive use has increased slowly and not to a very high level, yet fertility has dropped significantly. Although there is no clear explanation, several factors may have contributed to this discrepancy, including:

- A shift from traditional to modern methods of contraception
- Underreporting of contraceptive use
- Induced abortion
- Changes in behavior other than contraceptive use (e.g., changes in coital frequency) as the desired number of children decreases (Blanc & Gray, 2000).

The situation in Ghana highlights the importance of looking at multiple measures of success to truly understand a situation. This is particularly true in Sub-Saharan Africa, where the correlation between contraception and fertility remains weak. In a review of this situation, one study concluded that the weakness of this correlation in many countries in Sub-Saharan Africa has to do with these countries' being at an early stage of the fertility transition and that most likely this link will become stronger with time (Westoff & Bankole, 2001). It is the CPR that we can more closely and clearly link to program interventions, since fertility is affected by so many factors; in the end, though, the reason to increase contraceptive use is to help women and couples achieve their reproductive intentions and to improve reproductive health. In the box on the next page, community volunteers in Zambia described what they saw as the benefits of family planning.

Defining Success:

Community volunteers in Zambia speak about the benefits of family planning

- Spacing children improves the health of women and children: *"Now we don't have children dying of malnutrition."*
- *"Most people have realized that family planning is important for their families."*
- Previously, *"children were being laid like eggs, with no planning for them. When family planning came to us, we found it very helpful. Now we can manage to take our kids to school."*
- Women have time to do other things.
- Family planning has improved relationships between husbands and wives: *"Marriages are more stable because couples have time for each other."*
- *"Family planning is bringing development not only with the family but at the national level. If they have three or four children rather than 10 then they can educate them and bring development to the family and the nation."*

Three Stories of Success

Zambia: Ready for change

Initially, family planning programs received minimal support in Zambia: "Politicians didn't see family planning as part of development but as part of the white man's efforts to control the growth of the black population." In addition, a number of factors contributed to high fertility in Zambia, such as low educational levels, desires for large families, high levels of infant and child mortality, and low levels of family planning knowledge and use. A shift occurred in Zambia in the early 1990s, however, as the reintroduction of multiparty democracy brought about a number of changes, including health-sector reform. The Population Policy of 1989 also signaled changing attitudes toward family planning, highlighting that overall economic development depended on lowering fertility, that family planning was good for the welfare of the mother and the child, and that information and access to family planning services was a fundamental human right. There was a strong focus on family planning during the 1990s, with a number of champions ensuring that it received necessary emphasis. Now, with the prevalence of HIV/AIDS among adults at 16%, it is not surprising that many of these champions have moved away from family planning to focus on addressing HIV/AIDS.

The success of the family planning program in Zambia—increasing the CPR for modern methods from 9% to 23% between 1992 and 2001–2002—shows the potential impact of research that is well-designed and implemented (MOH, 1992). The 1995 Contraceptive Needs Assessment (WHO, 1995) and the 1996 Demographic and Health Survey (CSO, MOH, and Macro International, Inc., 1997) both emphasized similar needs:

- To enhance contraceptive choice
- To improve the clinical and counseling skills of providers
- To strengthen the contraceptive logistics system
- To address misperceptions and biases in the community and among providers.

These studies then led to appropriate interventions to address the identified needs. Key stakeholders were involved in the research process, and funding was immediately made available to implement the recommendations.

Until the mid-1990s, most women who used modern family planning methods used either oral contraceptives or the condom. Interventions sought to expand contraceptive choice, in particular working to overcome long-standing biases against Depo Provera, which had essentially been banned in the country since 1982. Projects in Lusaka and Copperbelt Provinces trained providers, supplied equipment, and incorporated community involvement and outreach. This led to increased uptake of all methods and scaling up of pilot projects: "The range of methods encouraged women to come forward because now they had a wide range to choose from." Depo Provera was found to be particularly popular, and was finally registered in the country in 2004.

Another key step in enhancing choice and improving services was the launching in 1997 of *Family Planning in Reproductive Health: Policy Framework, Strategies, and Guidelines*. The new policy was published in the newspaper for public input, and it was disseminated at a meeting that included representatives from all districts in the country. An important aspect of the policy was that it addressed unnecessary barriers to services, such as spousal consent, age, and parity restrictions. The need for this was shown, for example, in the 1997 Situation Analysis Study, which found that 42% of providers felt that a client must have a child or children before the injectable could be prescribed (CSO, 1998). Therefore, training not only gave providers skills so that they would feel more confident and comfortable in providing services, but it also addressed the biases that create such barriers. Strengthening the logistics system was achieved through provision of commodities by donors and with a dedicated staff member at the Central Board of Health, and this was a fundamental factor in improving family planning services.

In addition to improving the supply-side of services, there was also a strong emphasis on demand creation through a wide range of communication activities, such as creation of a family planning logo and radio and television programs. The number of women hearing a radio message about family planning or viewing a message on television increased, and this exposure was associated with increased contraceptive use. For example, 24.4% of listeners of any radio program were currently using family planning compared with only 11.9% of nonlisteners, according to the 2001–2002 DHS.

Social marketing through the Society for Family Health (SFH) has also made a significant contribution to family planning in Zambia, through Maximum condoms (which contribute roughly one-third of the market share of condoms) and an oral contraceptive called SafePlan, which is now used by almost one in five pill users. SFH has also played an important role in raising awareness about family planning.

Projects in Zambia have incorporated a number of innovative strategies for involving the community, including male motivators, peer counselors, and women's support groups (called "circles of friends"). This work always started with meetings with community leaders—for example, going to villages during the traditional chief's tours. There have

also been efforts to move services beyond the clinic walls through community-based distribution (CBD) agents, commercial sales agents, and employer-based agents. These activities have had some success, but have tended to be on a fairly small scale, and there is still a need to improve access to family planning in rural areas, both through CBD and through strengthened clinic services.

Malawi: Choice not chance

Family planning has been remarkably successful in Malawi, particularly considering the constraints faced in the country. Malawi's CPR increased from 7% to 26% between 1992 and 2000, despite high rates of poverty, low rates of literacy, a predominantly rural population (86%), and a 14% prevalence of HIV/AIDS in the adult population. As noted earlier, it is particularly impressive that gains in CPR cut across the economic spectrum.

Although family planning had essentially been banned under President Hastings Kamuzu Banda (1964–1994), "child spacing" had been adopted as an integral part of the maternal and child health (MCH) program in the 1980s, emphasizing the health problems that women faced when pregnancies were too early, too many, too late, or too frequent. The change in the political system from an essentially totalitarian government to multiparty democracy meant that the words "family planning" could be used and that more intensive policy and programmatic activities could be undertaken.

As a result, the number of facilities providing family planning increased from two clinics in 1983 to 210 out of 742 sites in 1995; now, in 2005, family planning is almost universally available. A 1994 study had identified a number of factors that limited access, including the fact that only 28% of facilities offered family planning services on a daily basis (Tavrow et al., 1995). After this, access was improved by ensuring that services were offered five days a week and for free. Malawi has had a good mix of both public and private services and both clinic-based and community-based services. In particular, the NGO Banja la Mtsogolo (BLM), with its network of 29 clinics and extensive outreach efforts, has played a significant role in expanding access to reproductive health services. BLM's subsidy fund allows it to keep services affordable for poorer clients. When this support was removed in 2000, utilization of family planning services dropped dramatically, but when the subsidy fund was restored in 2002, the number of family planning clients again increased significantly.

Supply-side interventions focused on improving the contraceptive logistics and supplies, through the 1997 introduction of the Contraceptive Distribution Logistics Management Information System (CDLMIS), through the training of providers, and through the development and dissemination of service-delivery policies and guidelines. These 1992 guidelines removed barriers of spousal consent, age, and parity and allowed a wider range of cadres to offer various services (Ministry of Health and Population and National Family Welfare Council of Malawi, 1996).

On the demand side, multiple channels of communication in multiple languages were effectively used, including radio jingles, posters, dramas, health talks, and CBD activities, so that Malawi was "flooded with information, education, and communication (IEC) messages." One reason for the effectiveness of these messages is that they were

developed through consultation with communities—"asking them to analyze the situation. They talked about all these problems they had because of too many children," problems that included land disputes and disputes between husbands and wives.

Community-based distribution agents (CBDAs) began in Malawi in the late 1980s and have been a key contributor to the success of family planning in the country: "If we didn't have CBDAs, we wouldn't have made the headway that we managed." In a country where the majority of the people live in rural areas, often far from health facilities, CBD has been essential to make services more convenient: "We need the CBDAs—people would rather have a child than queue for hours." In addition to directly providing pills and condoms, CBDAs also help to raise awareness and normalize the idea of family planning, as well as serving as referral agents—in many cases even escorting women to clinics for services. Focus-group discussions in 2002 found that CBDAs were highly praised for giving clear explanations and for helping to overcome difficulties with hospital providers (Opportunities and Choices Programme, no date).

CBDAs talk about the satisfaction of helping their communities, but they need more of an incentive than this to continue with their work. A 1999–2003 project that implemented district-wide CBD programs in three districts led to an increase in contraceptive prevalence from 24% to 36%, and project staff believed that "the incentives are what made the project successful." The provision of bicycles was a particularly effective incentive, as were refresher courses.

Ghana: "Give them the power"

The population policy set in Ghana in 1969 was one of the first on the African continent. However, on the 20th anniversary of this policy in 1989, a blunt assessment documented the lack of progress in achieving the goals the policy had set out, in part because of the lack of grassroots involvement in its development and the lack of a strategic plan for implementation. The policy was revised in 1994 to take these factors into account, and the 1990s saw much more progress in improving family planning in Ghana. With a TFR of 4.4 lifetime births per woman and a modern method CPR of 18.7%, the country is now well on its way to meeting the goals set out in the National Population Policy of 1994: to reduce the TFR to 5.0 by 2000, 4.0 by 2010, and 3.0 by 2020; and to increase modern CPR to 15% by 2000, 28% by 2010, and 50% by 2020.

Advocacy has played a key role in raising the profile of family planning. Presentations in the early 1990s showing the impact of population growth on the education and health sector in terms of numbers of schools and hospitals that would be needed "were very revealing," and many said that prior to these presentations they had not seen family planning as an important issue. The way in which the information was presented was also important, with high-level former Ministry of Health (MOH) staff giving the information so that it was "colleagues talking with colleagues" rather than outsiders pushing an idea. Such advocacy will be important in coming years to ensure that family planning remains a priority in the various aspects of health-sector reform. Currently, the sector-wide approach (SWAp) and the Poverty Reduction Strategy tend to be strongly oriented toward the Millennium Development Goals, with limited attention to family planning,

and the sexual and reproductive health program has remained somewhat outside of the health-sector reform process (Mayhew and Adjei, 2004).

The National Reproductive Health Service Policy and Standards, developed in 1996 and revised in 2003, were an important step in removing barriers to services and, more generally, in raising the profile of reproductive health. Findings from the 1993 situation analysis study were an important impetus in bringing about the development of standardized family planning guidelines. For example, this study had found that almost 90% of service providers would not give any contraceptive method to a woman with fewer than three children, and that many would require spousal consent or that a woman be married before they would provide methods. Training in Ghana has attempted to break down these barriers; one innovative approach has been to bring in satisfied clients during provider training to address method-specific biases and misperceptions.

Having supportive policies is a key aspect of a successful family planning program, but it is only through their implementation that there is an impact on reproductive health: "A good document doesn't make a woman have good access to contraceptives." There have been a number of activities to improve family planning services in Ghana, in both the public and the private sectors and at both the clinic and community level. More than half of current users (54%) now rely on the private sector, primarily through the Ghana Social Marketing Foundation (GSMF International). A number of new methods have been made available over the past 10 years, including injectables, Norplant®, and vasectomy. Introduction of these methods has included attention to both supply and demand, has emphasized effective promotion, has been attentive to client needs, has addressed provider biases, has identified champions, and has instilled ownership. In addition, to increase access to Norplant®, nurses have been trained to provide this method, since doctors are less frequently available.

Training has focused on building the capacity of local systems to conduct training to enhance sustainability: "We give them the power… so they feel that it is their program and so they take ownership," as one technical assistance agency explained (EngenderHealth, 2004). There has also been particular attention to training providers in counseling. Over time, situation analysis studies have shown a marked increase in the proportion of providers who had received training on counseling for family planning, from 38% and 39% in 1993 and 1996, respectively, to 60% in 2002.

Under the Ghana Family Planning and Health Program (1991–1996), IEC activities addressed constraints identified by the 1993 DHS, including widespread myths, rumors, and health fears. The Health Education Unit of the MOH coordinated a campaign that involved both the private and public sectors. However, a lack of funding limited regional efforts by the public sector, and some of the advertising materials developed by GSMF created controversy, leading to the television ads being cancelled and then only allowed to air after 10:00 pm: "A negative reaction came from a vocal minority who interpreted the ads as encouraging promiscuity. Part of the problem stemmed from the lack of legitimizing mass media support from the public sector" (Adamchak, et al., 1995).

In 2001, the Ghana Health Service and private-sector partners launched the Life Choices behavior change campaign, to reposition family planning in people's mind and to dispel rumors about methods. The campaign gave people the knowledge and tools to see that family planning was directly related to their lives and their personal aspirations for a better future. Vans with information, materials, and songs moved throughout the country, enlivening community meetings and sparking debate on family planning issues. Nearly seven out of 10 men and half of the women interviewed in the 2003 GDHS survey reported that they had heard the key slogan of the campaign—"Life choices: It's your life, it's your choice."

As a member of the Ghana Health Service stated, "Even if I get educated [about family planning], if there are no commodities there, I will get pregnant." Over the years, a significant proportion of the support from USAID and the United Nations Population Fund (UNFPA) has been spent on the procurement of contraceptive methods. Along with this support, there have been important efforts to improve the logistics system. Before 1998, MOH staff's needs for additional training in logistics management had led to stockouts, so USAID provided support for training and improving the system. Since 2000, respondents stated, there have been no natural stockouts, only "artificial because of maldistribution" (meaning that it was an issue not of lack of supplies, but of whether they are moved effectively and efficiently from the central level to the regions and districts).

Ghana was the site of an innovative project in providing community-based health care. Beginning as a pilot project in Navrongo in northern Ghana, the success of the experimental phase in lowering both fertility rates and infant mortality has led the government to adopt the lessons into national policy in the Community-based Health Planning and Services (CHPS) initiative (Phillips et al., 2003.). A key to the success of the scaling up has been local ownership both at the community level and at the national level: "What is unique about CHPS is that it is the first home-grown intervention that we have developed ourselves. It is not something that was found somewhere and [that] a donor is trying to introduce in Ghana."

What Was Done? Cross-Cutting Themes

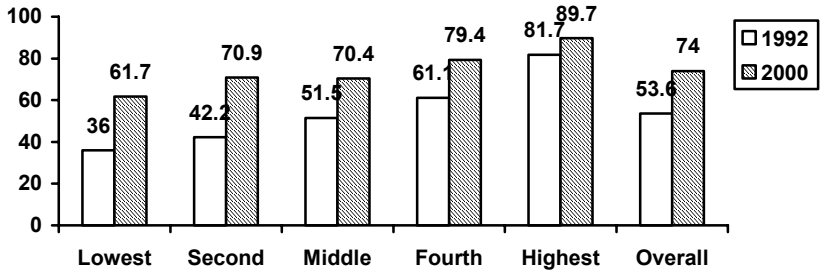
These case studies demonstrate clearly how much can be achieved even in very difficult circumstances. For example, in Malawi, roughly two-thirds of the population (65%) lives below the poverty line, the maternal mortality ratio of 1,120 is the third highest in the world, 86% of the population live in rural areas, there is frequent drought, only 62% of the population is literate, the adult HIV prevalence rate is 14%, and the health sector faces a major human resource crisis. Yet Malawi has achieved a dramatic and rapid increase in modern contraceptive use.

Key contextual factors

A number of factors beyond the family planning program influence the effectiveness of program efforts. The interviews with key informants and the document review highlighted the following six factors as being among the most important in either facilitating or hindering success of family planning programs.

- **Multiparty democracy.** In each of the three case study countries, *multiparty democracy* brought increased openness and freedom, which helped move the family planning programs forward. Respondents in Malawi highlighted that although the program started as child-spacing in the 1980s, with the change in government in 1994, there was more open discussion: "Once those obstacles were removed, you can make a lot of difference. The public was being protected by a few who said they knew what the public wanted, but the opposite was true." Likewise, in Zambia, when multiparty democracy was reintroduced in the country in 1990–1991, respondents described a change in the mentality of the country, a feeling that things had become so bad that something had to be done to improve the situation; it was "an environment that was ready for change." This was seen more broadly in the acceptance and fairly successful implementation of health-sector reform, and more specifically in the improvement of family planning services. Finally, 1992 also saw multiparty elections in Ghana, which ushered in a new era of freedom of speech and expansion of the media sector. This fostered national dialogue on many issues, including family planning.
- **Poverty.** In many cases, *poverty* has been a driving force behind fertility decline. In the past, there was a desire for large families, in part due to the economic rationality of large family size, especially in rural areas. With increasing poverty, and in some cases, decreasing availability of land and increasing desire to have children go to school, this economic rationality is lost. Poverty levels are particularly high in Malawi and Zambia. For example, in Zambia, 73% of the population lives below the poverty line (83% in rural areas and 56% in urban areas) (World Bank, 2004). While higher socioeconomic status is typically associated with lower fertility and higher contraceptive use, in these countries poverty is also leading people to want to control the size of their family.
- **Girls' education.** Increasing *girls' education* is an important support to family planning programs. Education is consistently linked with higher use of contraception and lower fertility. Many education programs explicitly include lowering fertility as one of their goals. As shown in Figure 3, it is again notable to see that Malawi has managed to bring improvements to even the poorest.

Figure 3. Percentage of girls aged 6–10 currently attending school, by wealth quintile, Malawi, 1992 and 2000



- **Health-sector reform**. In Zambia, a concerted and effective effort at capacity building at the district level helped to facilitate the implementation of

decentralization. In Ghana, there is continuing confusion about roles and responsibilities of the MOH, which is supposed to handle policy development and monitoring, and the Ghana Health Service, which was created in 1996 to take care of implementation (Mayhew, 2004).

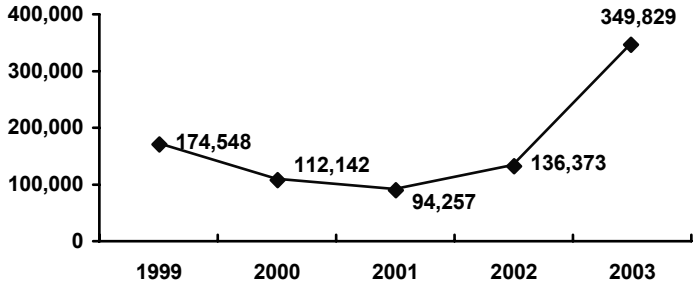
- **The International Conference on Population and Development (ICPD).** The 1994 ICPD inspired a shift from family planning to broader reproductive health. This is typically seen as a positive change, and in all three countries, significant progress has been made post-ICPD, but this shift can also contribute to a loss of focus on family planning.
- **HIV/AIDS**. The main reason for a lack of focus on family planning is the increasing focus on HIV/AIDS: "The system is overwhelmed by HIV demands, and so family planning is ignored" (Zambia respondent). This is evident in the shifts in funding: Expenditures for HIV/AIDS activities have increased almost four-fold, in real terms, over a short span of time, from $242 million in 1996 to $1,343 million in 2002. Meanwhile, spending for reproductive health and family planning increased only by 20%, from $1,058 million to $1,468 million (Ethelston et al., 2004). It is difficult to track family planning funding precisely, since many donors fund comprehensive reproductive health programs and because some funding goes through SWAps. What is clear is that at the global and national levels, HIV/AIDS is currently the primary priority, and the logical linkages and integration between HIV/AIDS and family planning are typically neglected.

Key programmatic factors

Accessibility—Get the systems in place and functioning. "Having reliable services was a key factor, because rural people don't have a lot of time to spend to wait in line" (Malawi respondent). Respondents emphasized the importance of working on systems to make services more accessible. This included getting the logistics system to function more efficiently and effectively, training providers (with a focus on training trainers to enhance sustainability), developing and disseminating policies to remove unnecessary barriers, and making services available five days a week. Utilization of services increases when they become more reliable, in part through word of mouth because women will refer their friends to reliable services.

Another key aspect of accessibility is affordability. The experience of BLM in Malawi highlights the importance of keeping services affordable. When BLM increased their fees and stopped subsidizing services in 2000, service utilization declined dramatically. When the UK's Department for International Development (DFID) provided support to restore the subsidy fund in 2002, the number of clients immediately increased to 136,373, and then practically tripled in 2003 to 349,829 (Figure 4). Based on this experience, it is clear that any cost-recovery initiatives—especially in populations with high rates of poverty—must be very cautious and designed to avoid a similar sharp falloff in service utilization.

Figure 4. Number of family planning clients at BLM facilities, Malawi, 1999–2003



Source: BLM, 2003.

Broadening method choice. True choice requires that methods be available, that providers have the equipment, skills, and lack of bias to provide the methods, that unnecessary barriers (e.g., age, parity, marital status, and spousal consent) are removed both in policy and in practice, and that misperceptions in the community are addressed through effective and appropriate IEC. Experience in Zambia highlights the importance of introducing methods in a holistic manner. This means looking at the health system, the users, and the context to determine which methods to introduce or reintroduce and ensuring that appropriate interventions (e.g., training, facility upgrading, and community outreach) are undertaken to make methods truly accessible.

Table 5 (opposite page) shows the trends in method use in Ghana, Malawi, and Zambia. What is most striking in Malawi is the overwhelming popularity of injectables; use of this method rose from 1.5% of women in 1992 to 16.4% by 2000. Injectables are also popular in Ghana and Zambia, though uptake of this method has been slower in Zambia due to the troubled history of Depo Provera in that country. It is interesting to note that implants are relatively well-utilized in Ghana, compared to the other countries, in part because of the concerted efforts at expanding use and the training of nurses to provide this method. Use of female sterilization is markedly higher in Malawi than in Ghana or Zambia, most likely due to focused efforts both in the public sector and by the NGO BLM to expand access. Findings from these countries, though successful, do indicate underutilization of a number of longer-term methods. For example, IUD use has become negligible in Malawi and Zambia (0.1%) and is also very low in Ghana.

Creating Demand and Changing Behavior. Experiences from Ghana, Malawi, and Zambia all point to the importance of addressing the demand side through effective IEC. Myths, rumors, and misperceptions about family planning were common in all three countries, and these continue to varying degrees. Communication activities helped to bring about a shift from seeing family planning as only for limiting the number of children (which often led people to associate family planning with not having any children at all) to seeing it as a way to space births and improve the health of women and children. The high levels of knowledge of family planning in all three countries demonstrate that IEC can be effective even in settings with low literacy. Exposure to IEC messages was associated not only with increases in knowledge but also with changes in

behavior, such as increased use of modern contraception. To develop appropriate messages, it is essential to consult with the community: "Projects fail when you dictate. It is better to ask the people" (Zambia respondent). In describing the development of IEC messages in Malawi, a respondent echoed this sentiment: "Initially the approach we had was wrong. We said you should have four children. That is wrong. You can't dictate to people. We should be saying there should be spacing, there should be a period of resting." Satisfied clients have also been effective both with clients and with providers to break down biases: "A satisfied client is the best motivator" (Zambia respondent).

Table 5. Proportion of currently married women using various methods of contraception in Ghana, Malawi, and Zambia

	Pill	Injectables	IUD	Male condom	Female sterilization	Implants	Any traditional	Any modern
Ghana								
1993	3.2	1.6	0.9	2.2	0.9	0.0	10.1	**10.1**
2003	5.5	5.4	0.9	3.1	1.9	1.0	6.5	**18.7**
Malawi								
1992	2.2	1.5	0.3	1.6	1.7	N/A	5.6	**7.4**
2000	2.7	16.4	0.1	1.6	4.7	0.1	4.5	**26.1**
Zambia								
1992	4.3	0.1	0.5	1.8	2.1	N/A	6.3	**8.9**
2001–2002	11.9	4.5	0.1	3.8	2.0	0.3	11.6	**22.6**

Sources: Ghana—GHS, Noguchi Memorial Institute for Medical Research, and ORC Macro, 2004; Malawi—NSO and ORC Macro. 2001; Zambia—CSO, CBOH, and ORC Macro, 2003.

Developing Effective Partnerships. In all three countries, there have been strong partnerships between the public and private sectors, involving either strong social marketing programs (Ghana and Zambia) or a strong NGO partner (Ghana and Malawi). In all cases, this balance has been important as each group plays slightly different roles. The public sector typically has wider, national coverage, and, as was shown in the early experience with IEC activities in Ghana, they have a strong legitimating power. The private sector is often able to address more cutting edge or controversial issues, can be more aggressive, and often has closer links to the community (e.g., NGOs). It should be noted that having a partner with strong clinic-based services (e.g., BLM in Malawi) was part of the reason for the higher utilization of female sterilization in Malawi, as this is a service that a social marketing partner cannot directly provide. Planned Parenthood associations have been significant partners in Ghana (PPAG) and Zambia (PPAZ), in particular through PPAG's CBD program in Ghana. With the Mexico City Policy reinstated, however, these organizations are experiencing financial crises that have led them to the cut a number of their programs, which will certainly have detrimental effects on reproductive health services in their countries.

Scaling Up with Evidence. The experiences of the Navrongo Community Health and Family Planning Project in northern Ghana and the Expanding Contraceptive Choice/ Pilots to Regional Programs work in Copperbelt Province in Zambia demonstrate

effective processes of using evidence to change national policy (see box below). Important aspects of these processes included local ownership (e.g., the principal investigator for the Expanding Contraceptive Choice study was the provincial health officer), a phased approach (smaller replication followed by larger scale expansion), and use of the original site for sharing lessons learned.

Ghana: Scaling-Up Process From Research Project to National Policy	**Zambia: The Steps in Scale-Up Expanding Contraceptive Choice in Copperbelt Province (and beyond…)**
1. *Preliminary*. 1994. Navrongo pilot. Determined what is appropriate. 2. *Experimental*. 1996. Navrongo Community Health and Family Planning project (CHFP). Tested what worked best and identified innovative ways of involving communities in planning, managing, and sustaining primary health care. Late childhood mortality was reduced by 38%, TFR declined by one birth per woman, and CPR increased from 3% to 20%. 3. *Replication*. 1998. Nkwanta. Looked at whether the intervention could be replicated. Began with having the DHMT from Nkwanta visit Navrongo for a six-week orientation, highlighting the importance of counterpart training. This successful replication brought credibility that scaling up could work. 4. *Scaling up*. 2000. Community-based Health and Planning Services initiative (CHPS). Adoption of Navrongo service model for all 10 regions and 110 districts of Ghana.	1. *Assessment*. 1995. Identified need to expand contraceptive choice 2. *Pilot*. 1996–2001. Introduced new methods, including Depo-Provera, provided supplies and equipment, developed new tools for training and supervision, and employed a variety of ways of communicating with and involving the community. Worked in three districts covering 240,000 people. Key findings included: • Injectable users had a clear preference for Depo Provera over Noristerat. • The number of new acceptors increased for each method. • Continuation rates were high. 3. *Pilots to Regional Programs*. 2002–2005. Expanded to eight districts with population of 1 million, with three broad sets of activities: expanding contraceptive choice, training health care workers, and bringing together communities and the health care system. Managed by Provincial Health Office. 4. *Adoption as a national best practice*. 2005. This is currently being planned by the Central Board of Health.

Keeping Focus through Champions. In Malawi, respondents talked about a highly motivated group of individuals in the early 1990s who pushed the family planning program, as well as the importance of family planning coordinators at the district level. In Zambia, having a person specifically in charge of contraceptive logistics was described as a key factor in the improved ability to have reliable supplies at health facilities. In Ghana, the expansion of CHPS has been more effective where there is a district leader who is strongly behind the program. With the shift of emphasis to HIV/AIDS and with SWAps and basket funding, there is risk of previously vertical programs, such as family planning, losing their focus and thereby losing their effectiveness. Repositioning Family Planning is a timely initiative to make sure that family planning remains a priority. Such champions are needed at all levels, from donor agencies to health facilities.

Going Beyond the Clinic Walls. All three countries have had successful community-based programs, such as in Navrongo in Ghana. It is Malawi that has made the most

impressive progress at a national level in terms of getting services to its rural population, in large part due to the CBD programs and other outreach efforts. The impact of CBDs goes beyond just provision of pills and condoms, as they also raise awareness of family planning and refer women for services. It is important that CBDs are linked with strong clinic services.

Priority Areas for Investment in Family Planning

The priority areas for investment in family planning will, of course, depend on the specifics of each country, but experience from Ghana, Malawi, and Zambia points to the following as the four areas for focus, the *ABCDs of family planning*:

A) Available supplies

B) Basic systems for service delivery

C) Community involvement and outreach

D) Demand creation

It is recommended that each country begin with some form of participatory strategic assessment to identify the specifics within this general framework.

A = Available supplies. "You have to make sure the commodities are available. That was the greatest thing we did" (Malawi respondent). It is a straightforward concept—No product, no program. This is part of element B, described below, but it is so fundamental, particularly in the short to medium term, that it deserves special attention and focus. The gap between the need for donated supplies and the funding available to purchase them is projected to reach hundreds of millions of dollars annually by the year 2015. According to UNFPA, the cost of contraceptives (not including condoms for HIV prevention) rose from $222 million in 1992 to $657 million in 2002, but donor support fell from 40% of total supply costs between 1992 and 1996 to 30% in 2002 (Ethelston et al., 2004).

B = Basic systems for service delivery. Overall, there is a need to make sure that the systems that support family planning are working, that commodities are getting to health facilities, that providers are getting regular updates, and that "those systems don't fall apart in the context of the overwhelming demands of ARVs [antiretrovirals]," as a respondent in Zambia explained. In particular, this means ensuring adequate training and infrastructure so that services are provided daily and reliably. For sustainability, it is essential to train both trainers and supervisors so they have the skills and comfort to effectively monitor the quality of services. Training must build clinical and counseling skills and also address biases. Many countries have policies to eliminate barriers such as age, parity, spousal consent, and marital status, but these policies are only meaningful if they are followed by those providing services. Policies must also allow appropriate cadres to provide services to improve access, as was done in having nurses in Ghana provide Norplant®.

C = Community involvement and outreach, such as CBD**. "**Because of social constraints, we need to get services as close to the client as possible for family planning. That is what works—decentralizing access and bringing it to the doorstep" (Ghana respondent). This is particularly important for people living in rural areas, who represent a significant proportion of the population in most Sub-Saharan African countries. For the region as a whole, almost seven out of 10 people (69%) live in rural areas. It is also

important to frame family planning in the context of people's actual and expressed needs and to use existing community structures.

D = Demand creation. In the three case-study countries, IEC activities played a critical role in the success of the family planning programs. There were many misperceptions about family planning in general and about certain methods specifically. It was particularly important that messages be developed properly and that they emphasize the health benefits of spacing.

For all of these interventions, it is not just *what* is done but *how* you do it that makes the difference. As described in the section on key programmatic factors, the following principles should guide these efforts:

- **Instill ownership**. In Malawi, in the first phase of the USAID-funded Support to AIDS and Family Health (STAFH) Project, it "looked like a stand-alone project." Then, with the amended project in 1998 (USAID/Malawi, 1998), the technical assistance agencies worked through the MOH and in many cases were based within the Reproductive Health Unit (RHU), creating "camaraderie and a team spirit. It was a very good group working together towards the same goal." In Zambia, respondents emphasized problems with parallel structures, stating that with current USAID projects, "we worked together this time, which was not the case before." There was praise in Ghana for projects that worked through subagreements directly with the country's 10 regions, so that the regions chose sites and participants for training and workplans were developed collaboratively. This also means identifying and supporting champions for family planning in donor agencies, ministries of health, technical assistance organizations, health facilities, and communities.
- **Address equity**. In implementing and evaluating projects, it will be important to continue to look beyond national averages to ensure that improvements are truly national in scope and cut across the economic spectrum. Malawi's achievements are impressive on this front and help to show what is possible when there is a strong emphasis on access, both in economic and geographic terms.
- **Ensure no missed opportunities**. In particular, there must be improved integration between HIV/AIDS programs and family planning (e.g., when training staff in the prevention of mother-to-child transmission of HIV [PMTCT], also train them in family planning, add family planning to voluntary counseling and testing for HIV, etc. As a respondent in Zambia observed, "We are now spending a lot of time and effort on PMTCT, on diagnosing, counseling and providing ARVs to infected mothers and their children. However, we shouldn't have missed all these steps before she was pregnant." Donors need to reduce barriers in their funding that hinder such integration.
- **Use evidence to advocate and to scale up success**. There are a number of examples of research findings being used to identify and develop interventions in these three countries, and there is a continuing need to improve evaluation to enhance our understanding of what works and what fails. In addition, Ghana and Zambia both show successful models for scaling up pilot programs to national policy, and these lessons should be shared widely and utilized.

- **Stay the course.** There should be a focus on programmatic sustainability while working towards greater financial sustainability. Donors and technical assistance agencies need to acknowledge that change takes time and requires continuity in support. Otherwise, there is a risk of losing the gains that have been made and needing to continually start over and rebuild rather than consistently moving forward.

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