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Population and Reproductive Health Challenges in Eastern and Southern Africa: Policy and Program Implications

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REGIONAL MEETING OF SOUTHERN AN D EASTERN AFRICA PARLIAMENTARY ALLIANCE OF COMMITTEES ON HEALTH (SEAPACOH)

27-30 September, 2010,
Munyonyo Commonwealth Resort, Kampala, Uganda.

Key Population Issues in the Region

- Rapidly growing population and urbanization
- Young age structure and high dependency ratios
- Poor child and maternal health outcomes
- High unmet need for family planning and sexual and reproductive health services
- High prevalence of HIV/AIDS
- High vulnerability to effects of climatic change and environmental degradation

Population Indicators – Africa's Regions

	Pop 2010 (Millions)	Pop 2050 (Milions)	Growth Factor	% of Global Pop 2010	% of Global Pop 2050
Africa	1,412	2,084	2.0	17%	22%
Africa - Eastern	465	709	2.2	6%	7%
Africa - Southern	63	68	1.2	1%	1%
Africa - Middle	188	296	2.3	2%	3%
Africa - Northern	262	329	1.6	3%	3%
Africa - Sub-Saharan	1,207	1,831	2.1	15%	19%
Africa - Western	435	682	2.2	5%	7%
World	8,108	9,485	1.4	100%	100%

Regional Population Indicators

	Average Number of Children Born	% Using Contraception	% Below $2 a Day	Life Expectancy at Birth
Africa	4.7	23	65	55
Africa - Eastern	5.3	23	78	53
Africa - Southern	2.5	58	74	48
Africa - Middle	5.9	7	18	69
Africa - Northern	3.0	44	45	55
Africa - Sub-Saharan	5.2	17	74	52
Africa - Western	5.5	10	76	51
World	2.5	55	48	69

Population Indicators in E&S Africa

	Pop 2010	Pop 2050	Growth Factor	Average # of Births
Burundi	8.5	16.8	2.0	5.4
Ethiopia	85	173.8	2.0	5.4
Kenya	40.1	65.2	1.6	4.6
Malawi	15.5	37.4	2.4	6.0
Mozambique	23.4	44.2	1.9	5.1
Namibia	2.2	3.6	1.6	3.4
Rwanda	10.4	28.3	2.7	5.4
Seychelles	0.09	0.1	1.4	2.3
Swaziland	1.2	1.8	1.5	3.7
Tanzania	45	109.5	2.4	5.6
Uganda	33.8	91.3	2.7	6.5
Zambia	13.3	37.6	2.8	6.2
Zimbabwe	12.6	22.2	1.8	3.7
Total	291.1	631.8	2.2	

Reproductive Health Indicators

	Deliveries by Skilled Personnel	Child Mortality Rates	% HIV + (Male)	% HIV + (Female)
Burundi	34	188	1.6	2.5
Ethiopia	6	173	1.6	2.4
Kenya	42	118	3.2	6.7
Malawi	54	186	10.2	13.5
Mozambique	48	215	10	14.9
Namibia	81	107	12.2	18.6
Rwanda	52	179	2.3	3.2
Seychelles	-		-	-
Swaziland	69	147	20.2	32.1
Tanzania	43	162	5	7.6
Uganda	42	147	4.3	6.6
Zambia	47	185	12.4	18
Zimbabwe	69	114	12.2	18.7

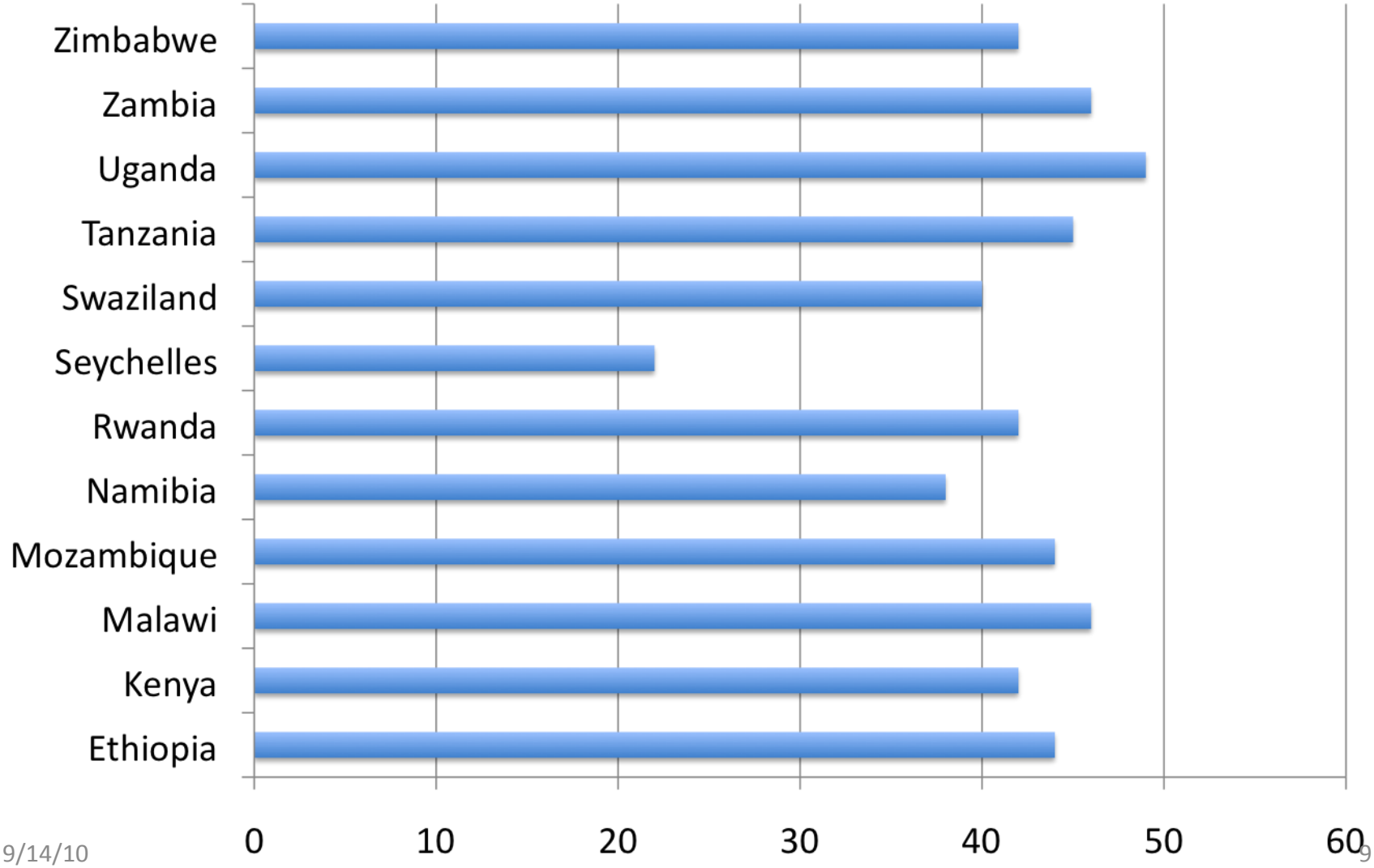
Broad Wellbeing Indicators

	% of Pop < $2 Per Day	Life Expectancy at Birth
Burundi	93	50
Ethiopia	78	55
Kenya	40	57
Malawi	90	49
Mozambique	90	48
Namibia	62	61
Rwanda	90	51
Seychelles	-	73
Swaziland	81	46
Tanzania	97	55
Uganda	76	52
Zambia	82	42
Zimbabwe	-	43

Options for Addressing Rapid Population Growth

- Increase Mortality?
- Migration?
- Reduce Fertility by providing contraceptive methods to whose who want to limit number of children
  - Its about stabilizing growth
  - To what level? (replacement level fertility)
  - It takes long to stabilize population growth

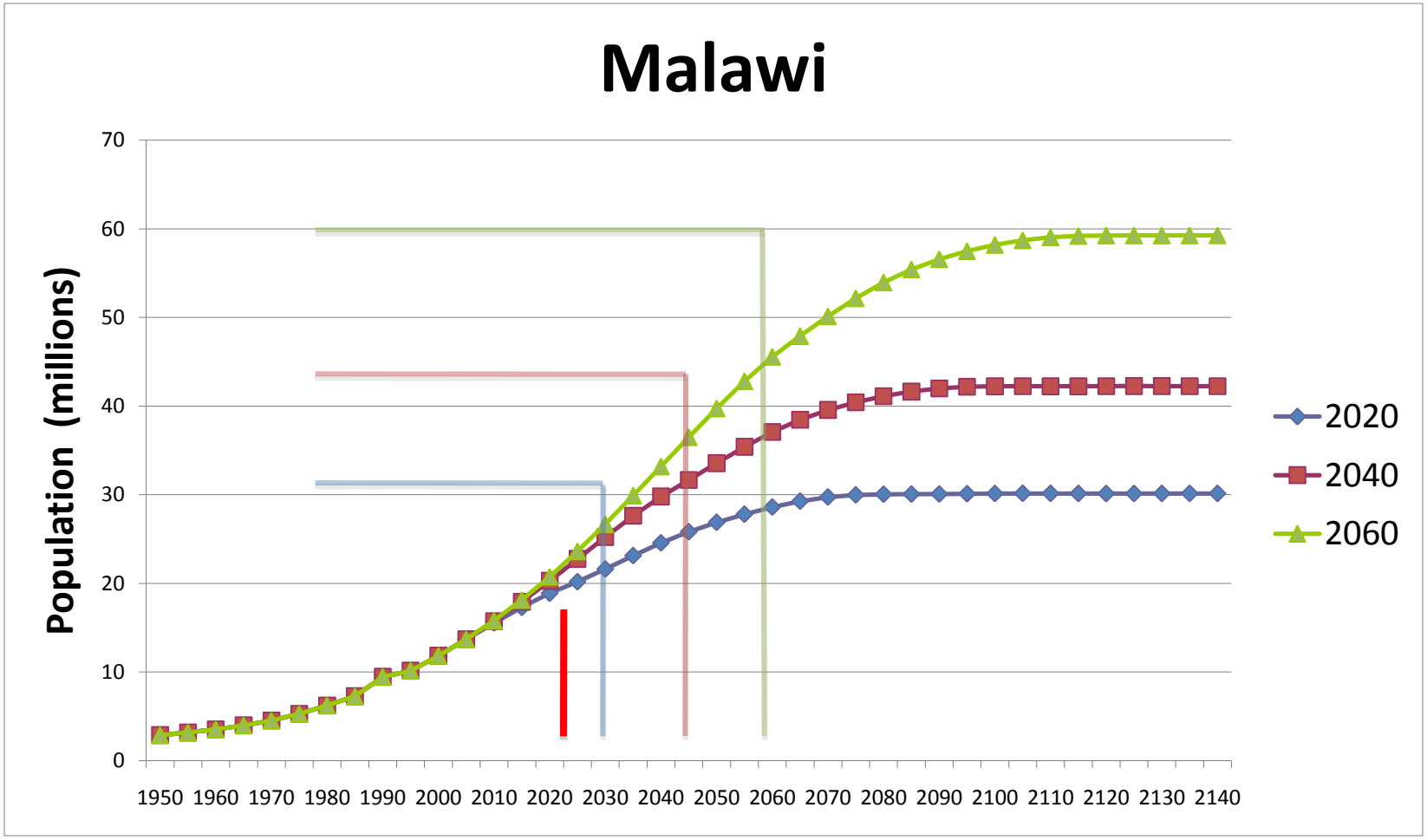
% of Population Under 15 Years



The future of countries' population size, depending on three scenarios of fertility decline to replacement level

May 2010

The year in which a country reaches replacement level fertility has a major impact on its ultimate population size.

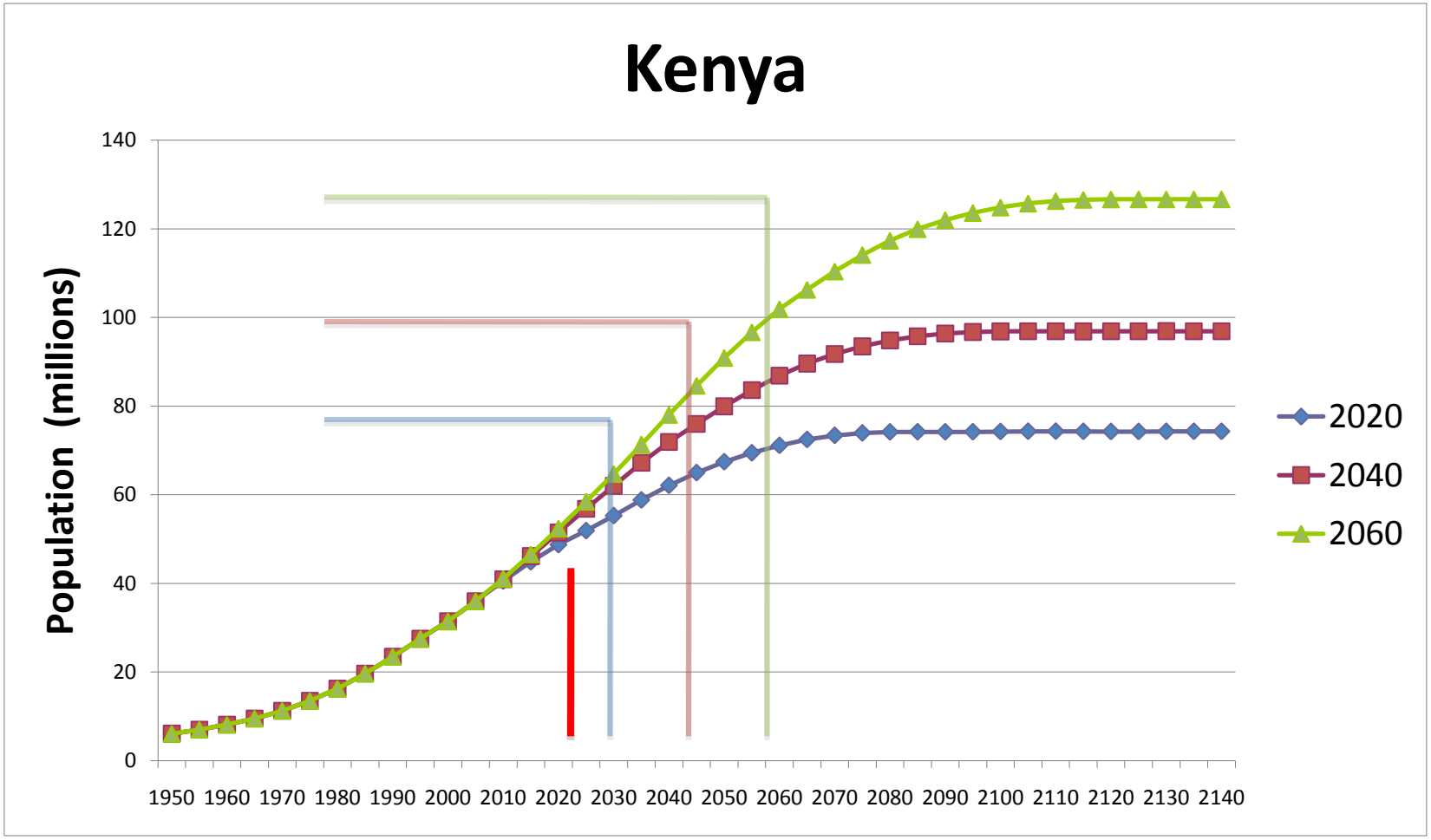


Total fertility rate: 5.21 (2010)

Unmet need for family planning: 10.4% (2004)

Population Referene Bureau

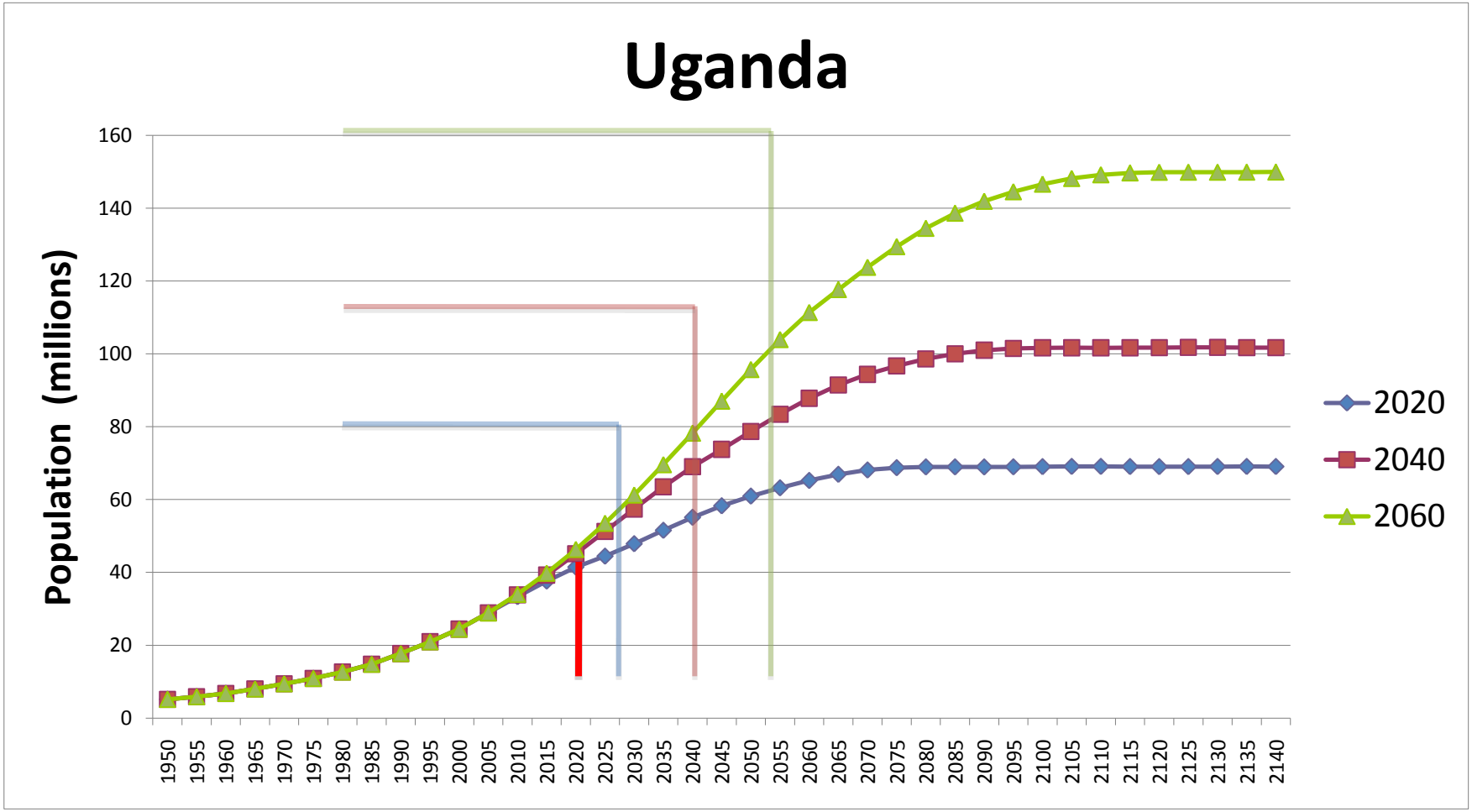
The year in which a country reaches replacement level fertility has a major impact on its ultimate population size.



Total fertility rate: 4.54 (2010)

Unmet need for family planning: 10.1% (2003)

The year in which a country reaches replacement level fertility has a major impact on its ultimate population size.



Total fertility rate: 5.30 (2010)

Unmet need for family planning: 16.1% (2006)

Family Planning Indicators

	% Using Modern FP	Unmet Need for FP - Spacing	Unmet Need for FP- Limiting	% of Unwanted Pregnancies	% of Mistimed Pregnancies
Ethiopia	14	20	14	16	19
Kenya	39	14	10	20	25
Malawi	38	17	10	20	21
Mozambique	12	11	8	4	16
Namibia	53	11	15	27	27
Rwanda	27	25	13	15	24
Swaziland	48	-	-	37	27
Tanzania	20	15	7	5	18
Uganda	18	25	16	13	33
Zambia	33	17	11	16	26
Zimbabwe	58	8	5	13	20

Given that contraceptive technologies are available, how do we address the barriers that couples face to use family planning??

Commitment on Barriers

- The 1994 International Conference on Population and Development (ICPD)
  - Called on “all countries . . . to identify and remove all the major remaining barriers to the utilization of family-planning services.”
  - Set the goal of “public, private and non-governmental family-planning organizations to remove all program-related barriers to family-planning use by the year 2005 . . .” (United Nations 1994).

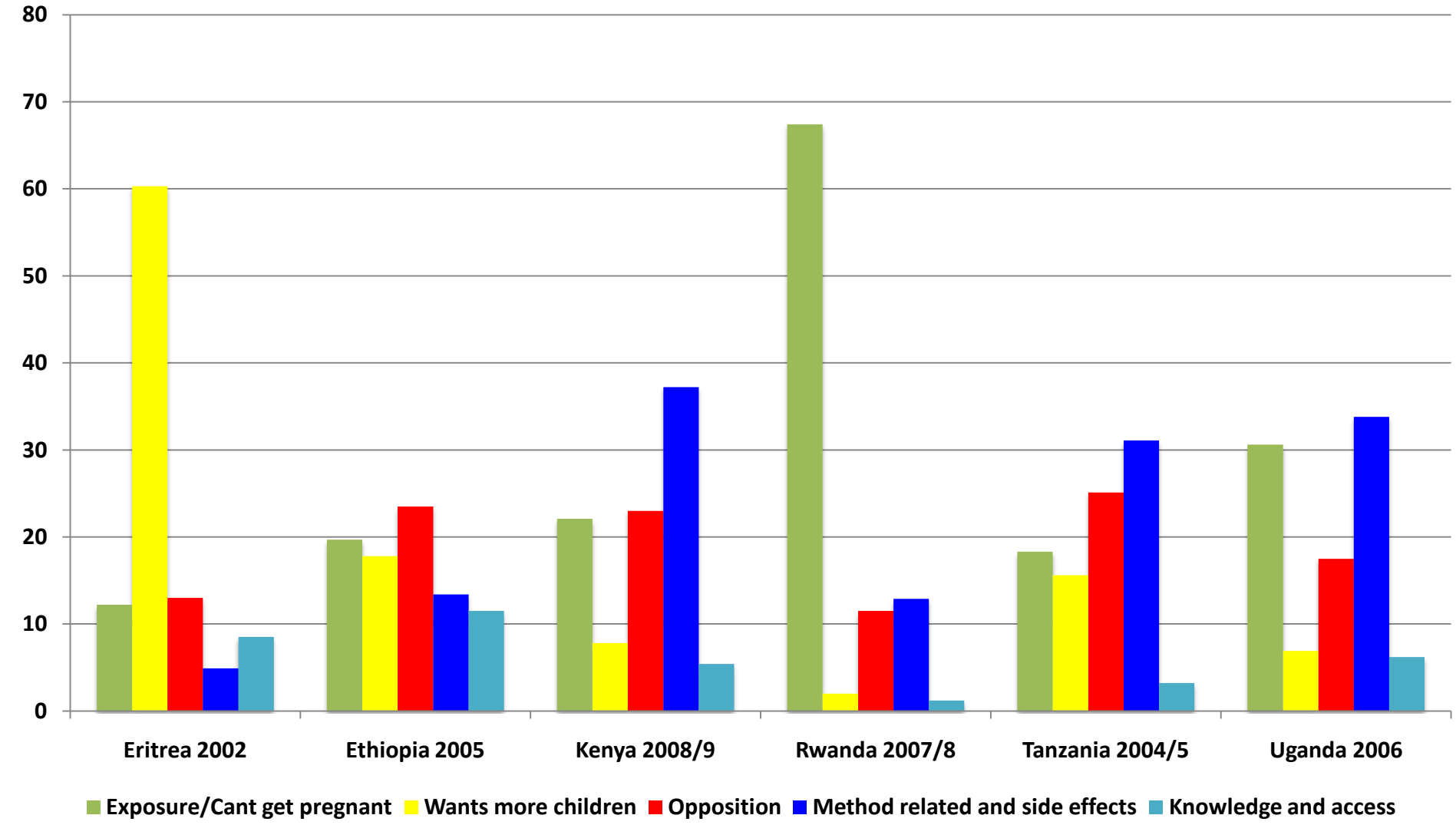
Reasons for Not Using FP among Married women

	Fertility Reasons	Opposition to Use	Lack of Knowledge	Method Related Reasons
Ethiopia	38	24	11	14
Kenya	40	31	2	24
Malawi	39	16	1	38
Mozambique	76	10	4	9
Namibia	43	14	4	21
Rwanda	44	22	2	22
Swaziland	59	12	-	23
Tanzania	34	25	3	31
Uganda	38	18	6	33
Zambia	55	11	2	26
Zimbabwe	54	16	1	24

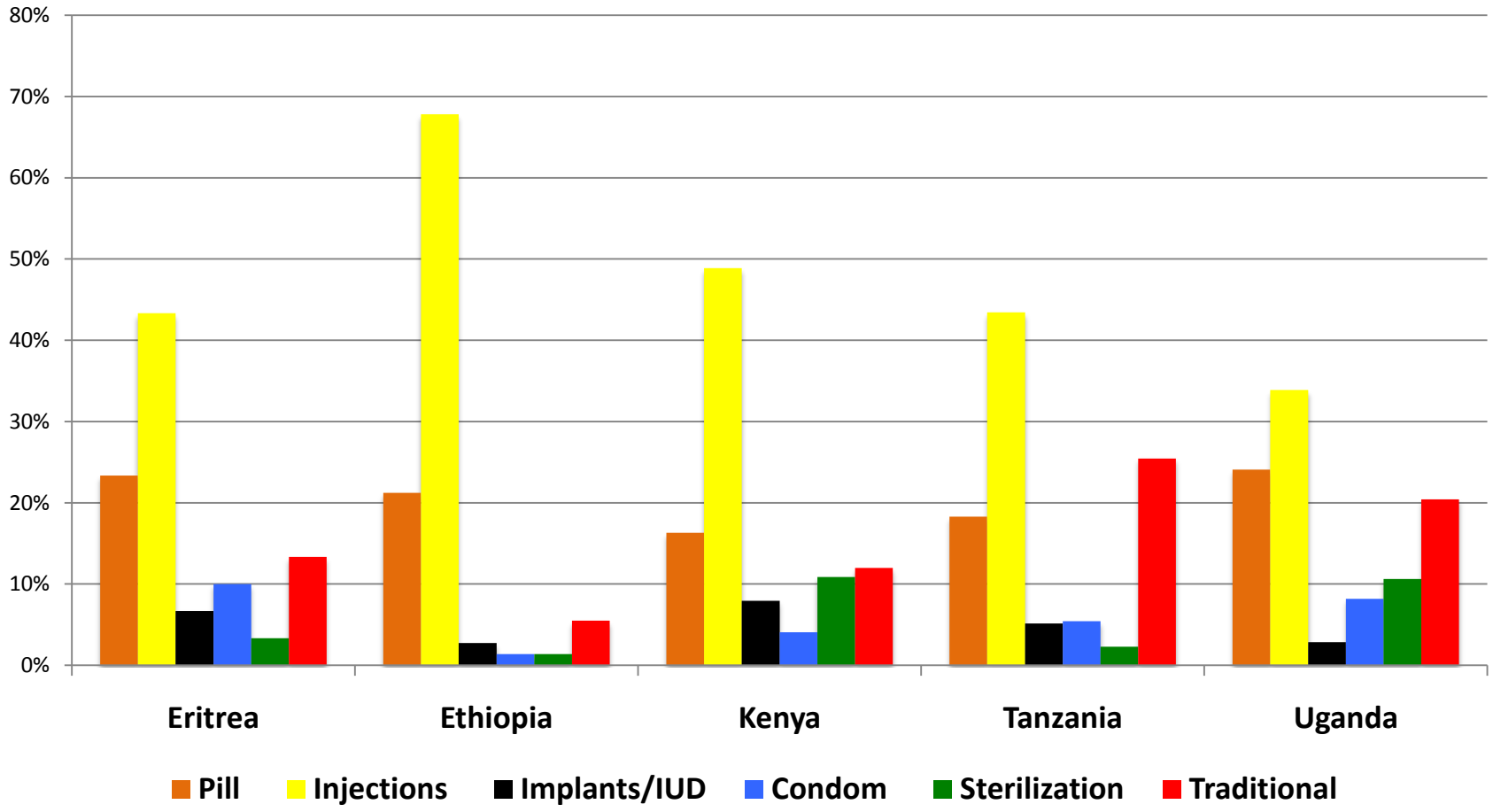
Key Barriers

- Limited method choice
- Financial costs
- Psychosocial factors relating to the status of women
- Medical and legal restrictions
- Provider bias
- Misinformation

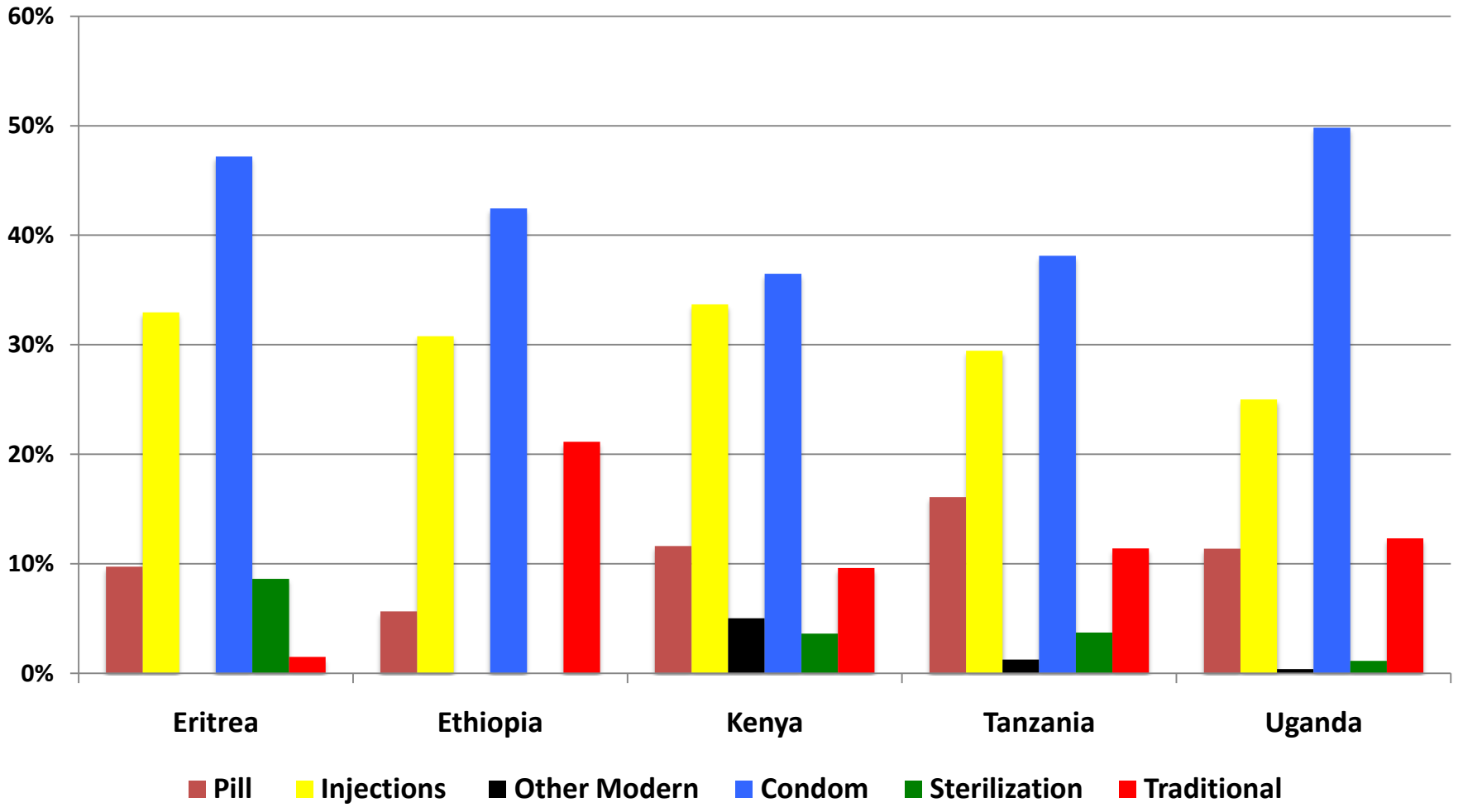
Reasons for not planning to use FP in Future



Contraceptive Method Mix – Married Women



Contraceptive Method Mix – Sexually Active Single Women



Cost

- Cost includes expenses for purchase of contraceptives and costs incurred in getting to the source.

- In Africa 97 percent of users would be unable to pay the full cost of modern methods of contraception (Green 2002).

- So, unless contraceptives are provided free of charge or at minimal cost, and as close to the communities as possible, chances are that many current users will discontinue use and potential users will not adopt family planning.

Women's Status & Psychosocial Factors

- Poor women, un-educated women, and those in strongly patriarchal societies face the biggest barriers to information about FP and psychosocial barriers to contraceptive use
  - Especially where women require approval from husbands of mothers in-law

Couple Approval of Family Planning – Woman's Response

	Eritrea 2002	Ethiopia 2000	Kenya 2003	Rwanda 2005	Tanzania 2004/5
Both Approve	35	36	61	59	59
Respondent approves, spouse disapproves	12	13	16	10	16
Respondent approves, spouse unknown	11	19	8	16	10
Respondent disapproves, spouse approves	4	1	1	1	1
Both disapprove	25	13	9	5	9
Respondent disapproves, spouse unknown	8	9	2	3	2
Respondent unsure	6	8	2	6	2

Medial Barriers

- Women are often subjected to unnecessary medical procedures that are not supported by medical evidence as a prerequisite for gaining access to contraceptive methods.

- The non-evidence-based requirement that women be menstruating (as a proof that they are not pregnant) at the time they start using hormonal methods or IUDs is common, even though simple history-taking provides effective ways of excluding the possibility of pregnancy

  - 67 percent of non-menstruating women in Cameroon and 78 percent in Kenya) were denied a family planning method as a result of this scheduling requirement (Stanback et al. 1997; Stanback et al. 1999).

Provider Bias

- Service providers sometimes deny access to contraception because of their own prejudices about the method or its delivery system.
  - In Ghana, during family planning consultations the health care professional did not recommend pills as the first choice of contraception and focused instead on health conditions that restrict the use of the pill.
  - Providers impose various restrictions including marriage requirements and minimum-age restrictions (Stanback and Twum)

Side Effects, Misinformation, and Fear

- Side effects, lack of accurate information, and misinformation commonly interact to create a disproportionate fear of fertility-regulation methods.

- Most contraceptives have side effects, and these can be a barrier to adoption or a reason for discontinuing a method.

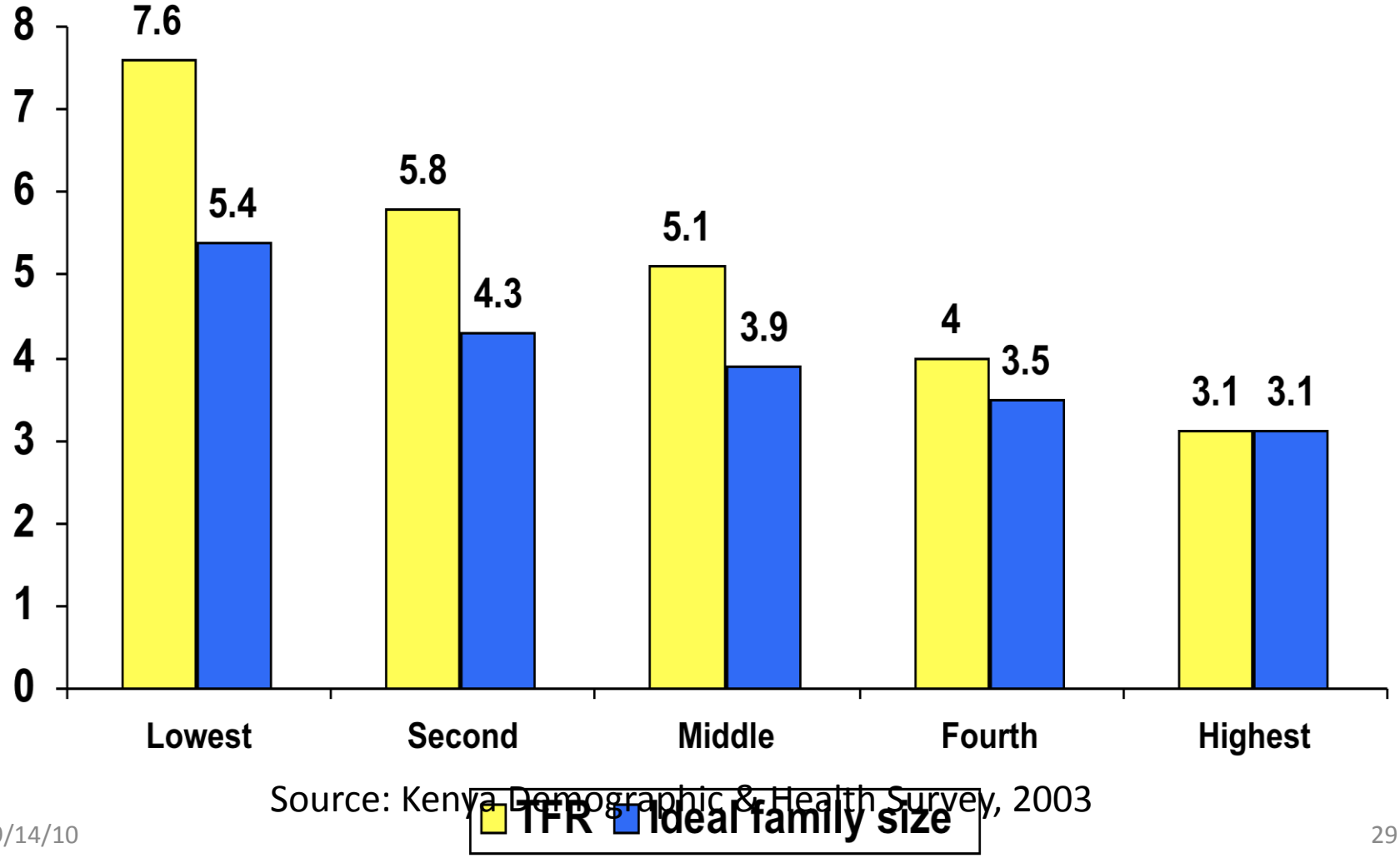
- However, perceptions of side effects are often based on misinformation and rumours,
  - the idea that the pill causes cancer;
  - the IUD will float around in the stomach;
  - injectables can cause infertility and should be used once you have several children

Abortion

- Confidential and safe abortions are highly limited to low-income women in most developing countries.
  - Poor women seeking an abortion can face exorbitant expense, sexual exploitation, pain, imprisonment, and death.
  - Poor women who need to have abortion resort to life threatening unsafe abortion
  - The rich often are able to access safe abortion even in countries where abortion is illegal

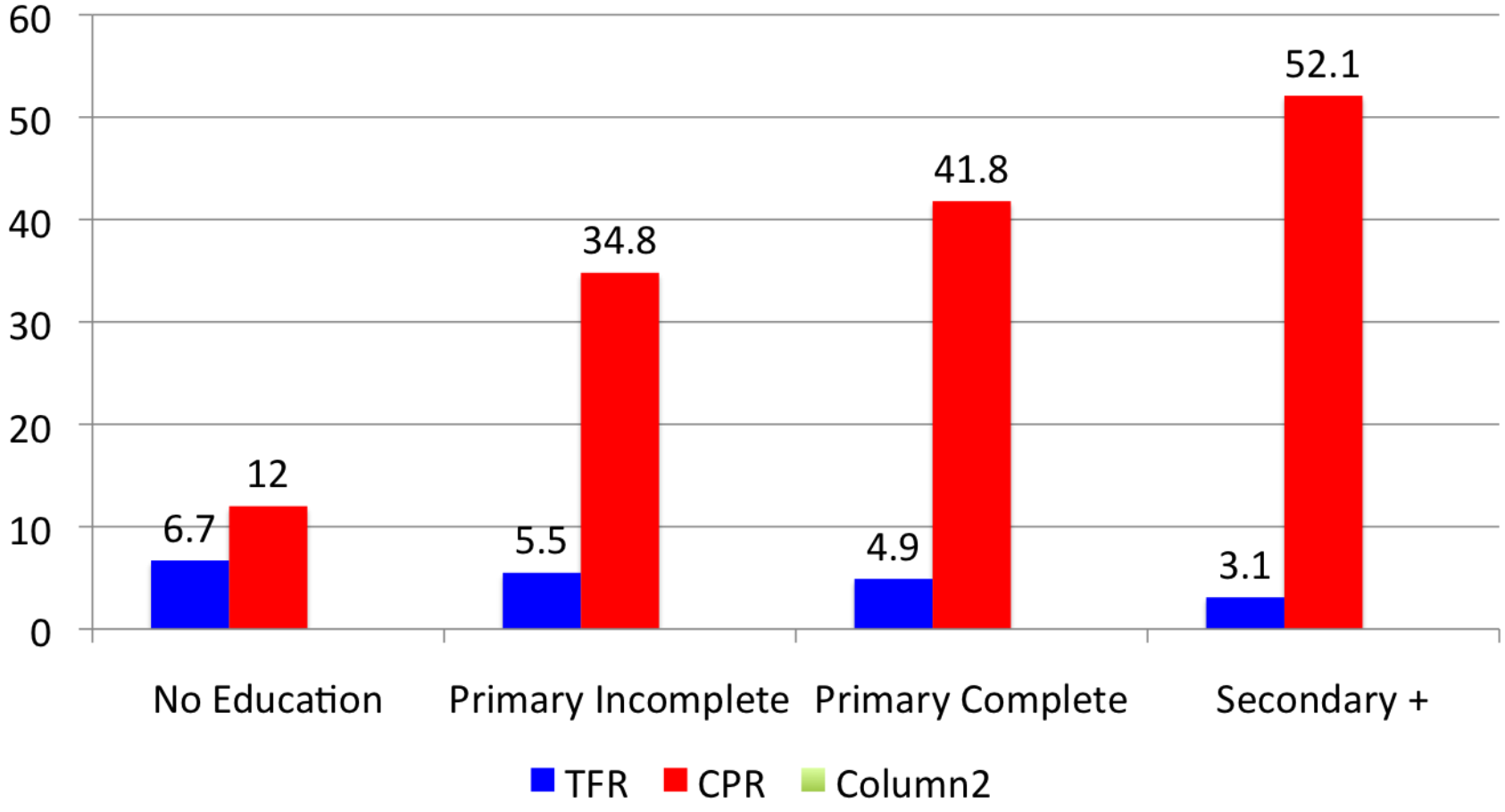
Pay Attention to Equity:

Fertility & Ideal family size by wealth status, Kenya 2003



Source: Kenya Demographic & Health Survey, 2003

Fertility and Contraceptive Use by Education, Kenya 2008



Is Female Education the Ultimate Contraceptive?

"… education reduces family size because more educated women are better able to surmount the many barriers separating them from the information and technologies they need to manage their childbearing. When these barriers are removed, then differences in fertility between illiterate and educated women largely disappear"

(Potts & Marsh, 2010)

Family Planning is a win-win Intervention

- Helps to stabilize population growth
- Improves maternal and child health
- Empowers women and families and help them address household poverty
- Enables families and governments to invest in quality of children and the future generation
  - It can not resolve all our problems, but it will help achieve a lot of he key development goals, including all MDGs

Summary

- Demand for contraception is high and there are ample health and related reasons to justify greater investment in family planning

- But we can not run away from the rapidly growing number of people and their potential impact in curtailing the region's development efforts

- Governments in countries with rapid population growth should recognize their efforts to alleviate poverty and provide educational and health services cannot keep up with the expanding needs of the people in these areas.

Way Forward

- Governments should prioritize family planning and have line items in their budgets for family planning training and services, and for commodities.

- Governments should make available the fullest possible range of contraceptive choices, including voluntary sterilization, through the widest range of distribution channels, backed up by access to safe abortion.

Way Forward

- Governments should enforce the WHO contraceptive eligibility criteria in order to minimize non-evidence-based barriers to contraception, and counter misinformation and biases among providers and clients

- Wherever possible, specialized services should be designed for youth, men and other hard-to-reach and marginalized groups.

… What can MPs Do?

- **Legislative**: Lobby governments to provide an enabling environment for FP programming and increase budgetary allocations to FP supplies

- **Programming**: Facilitate set-up of community-based Population, Family Planning and Reproductive Health initiatives in your constituency

- **Champions**: Be positive ambassadors of gender equity, empowerment of women and benefits of planning families in our constituencies (counter cultural obstacles)

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