AFIDEP African Institute for Development Policy

Bridging Development Research, Policy & Practice

Drivers of Progress Towards Universal Access to Family Planning in Eastern and Southern Africa

27 September, 2011

Regional meeting of SEAPACOH, Kampala, Uganda

Repositioning Family Planning and Reproductive Health in Africa: Lessons Learnt, Challenges, and Opportunities

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Broader Study

Enhancing Progress Towards Universal Access to Safe Motherhood and Reproductive Health in Eastern, Southern, and Western Africa

In partnership with IPPF – Africa Regional Office

SRH and Maternal Health Issues Examined

- Maternal Health and Safe Motherhood
- Family Planning and Fertility
- SRH Needs of Adolescents and Youth
- Integration of SRH and HIV
- Health Financing

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Key Messages from the Study

- There is reasonable progress in improving use of Family Planning, but it is slow and varied
- The slump experienced in the 1990s is being reversed, indicating that the RH shackles are being overcome
- There are huge service gaps and worrying reversals in progress even in countries that have made good progress

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Key Messages from the Study

- Investments in RH are quite limited, and the heavy dependence on donor support in many countries raises concerns about sustainability of RH programs

- Key factors driving progress include:
  - Political will and commitment
  - Sustained funding and commodity security
  - Equity-focused facility and community-based programming

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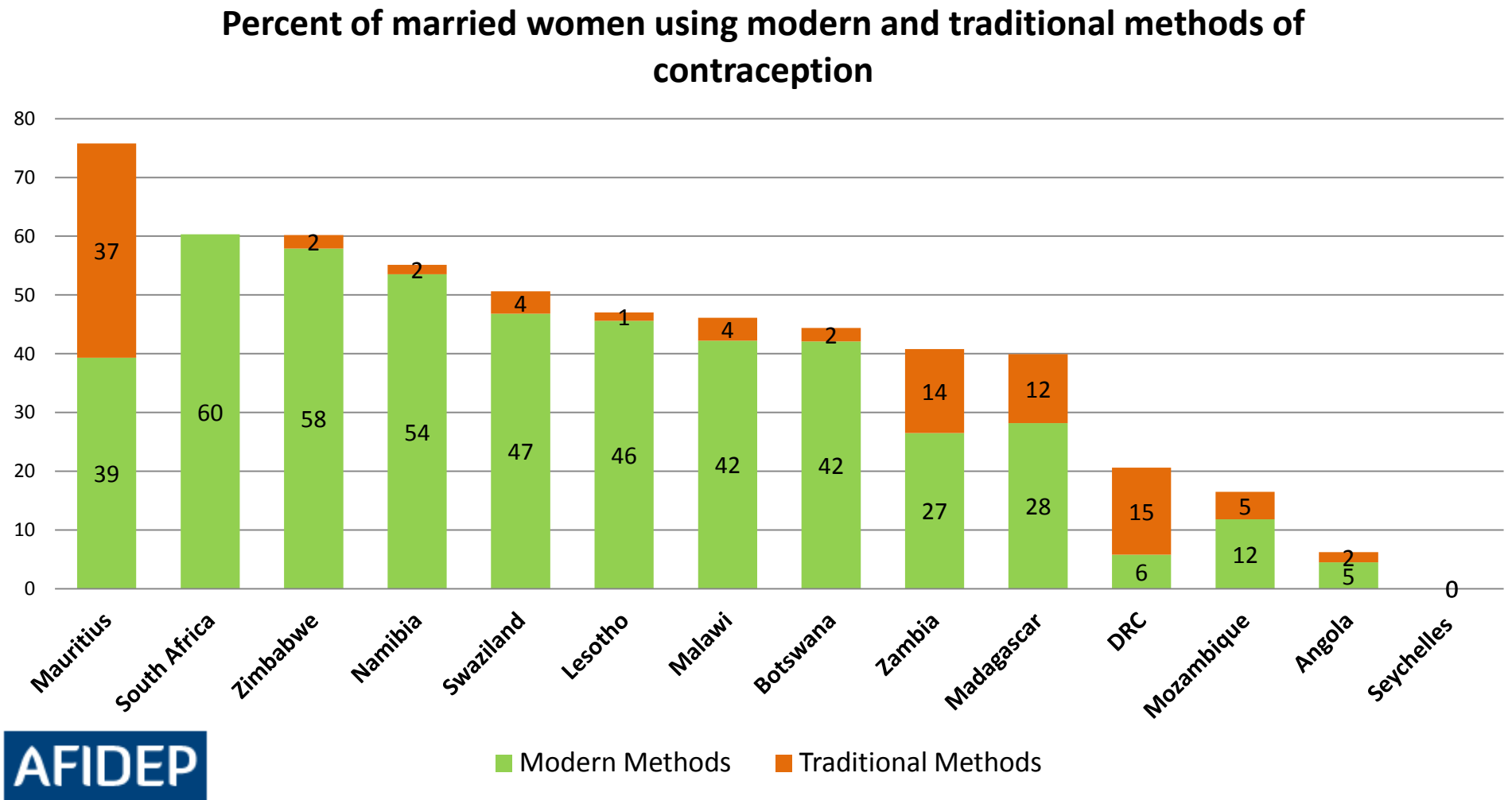
Use of family planning varies considerably in SADC region



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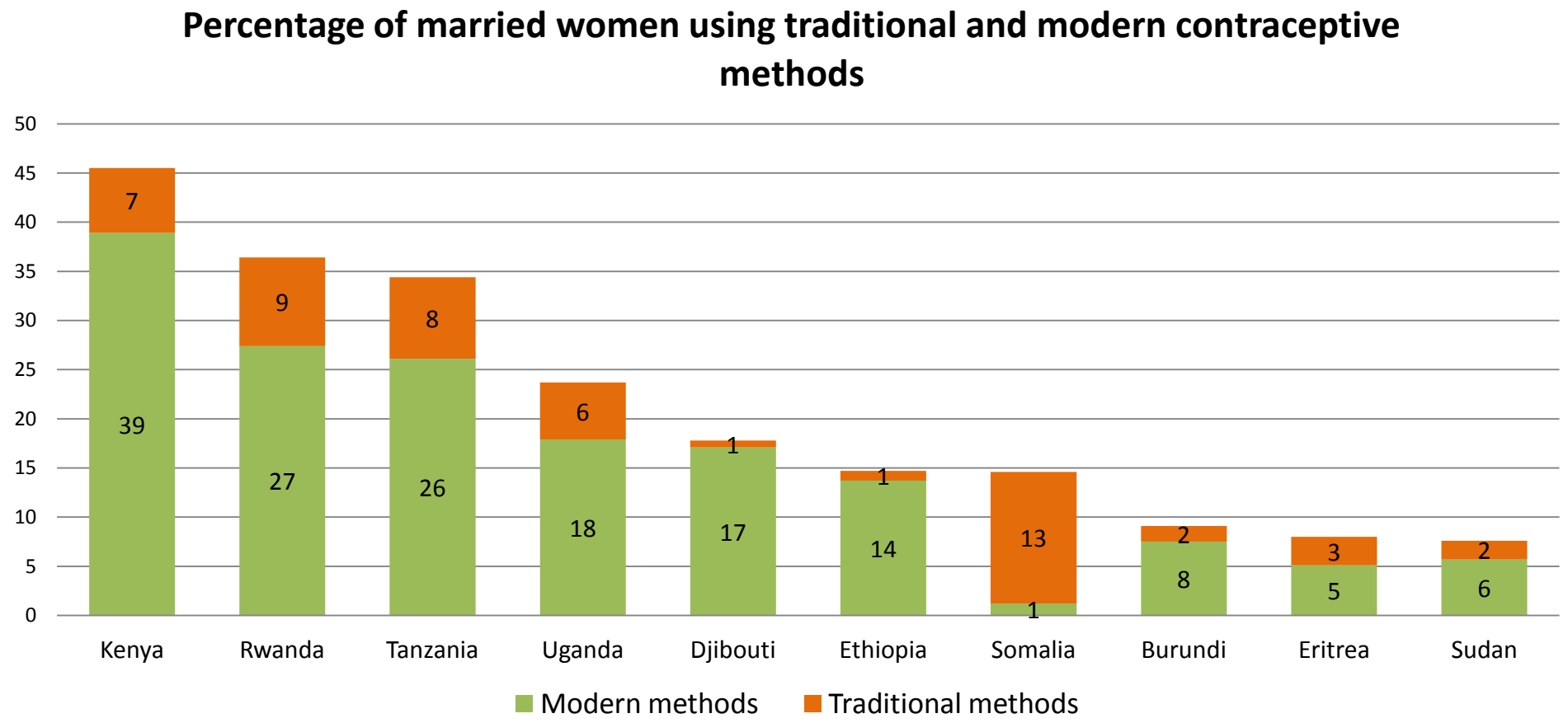
Use of family planning varies considerably in Eastern Africa



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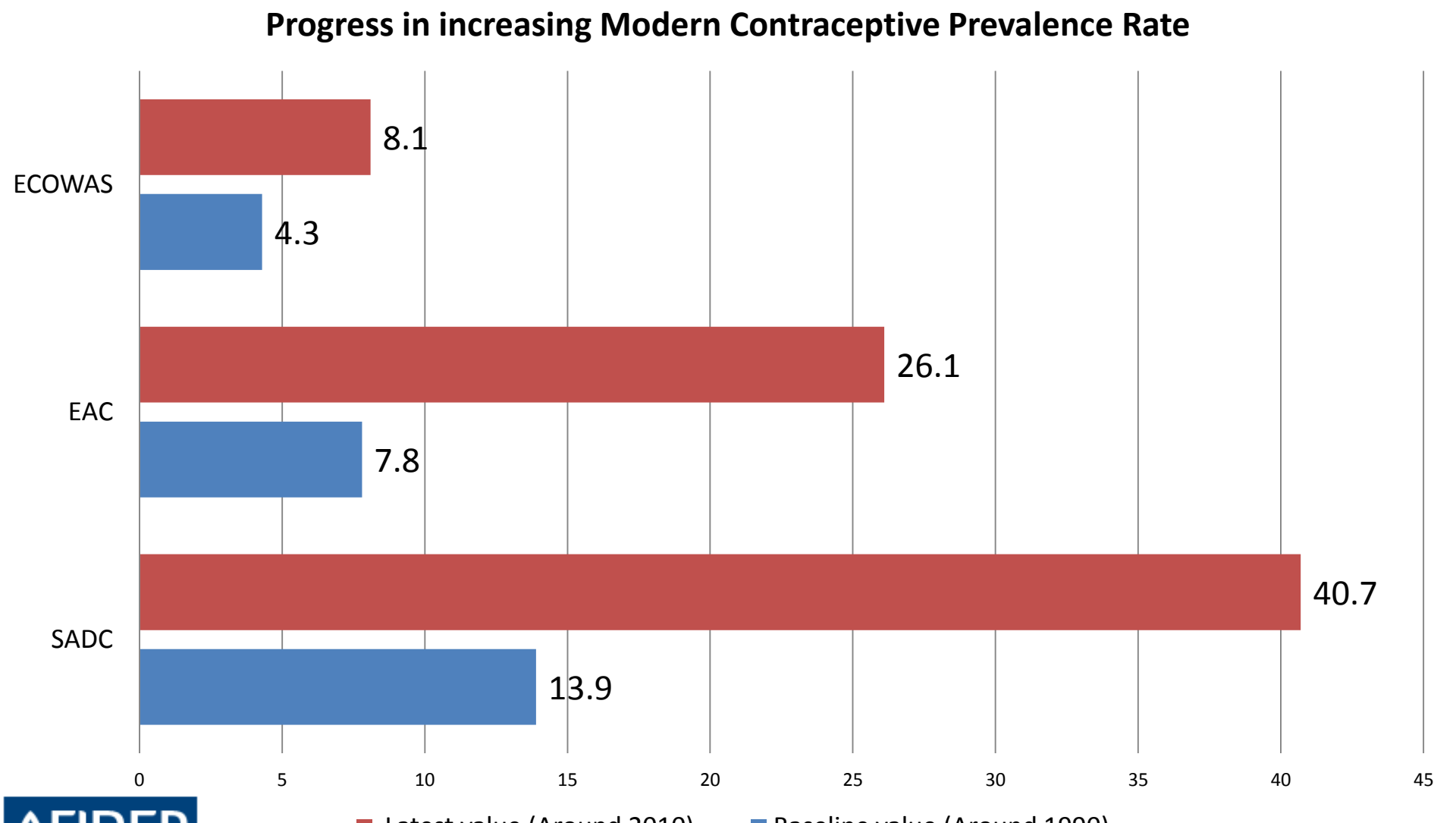
SADC has made the most progress in increasing use of modern contraception, followed by EAC



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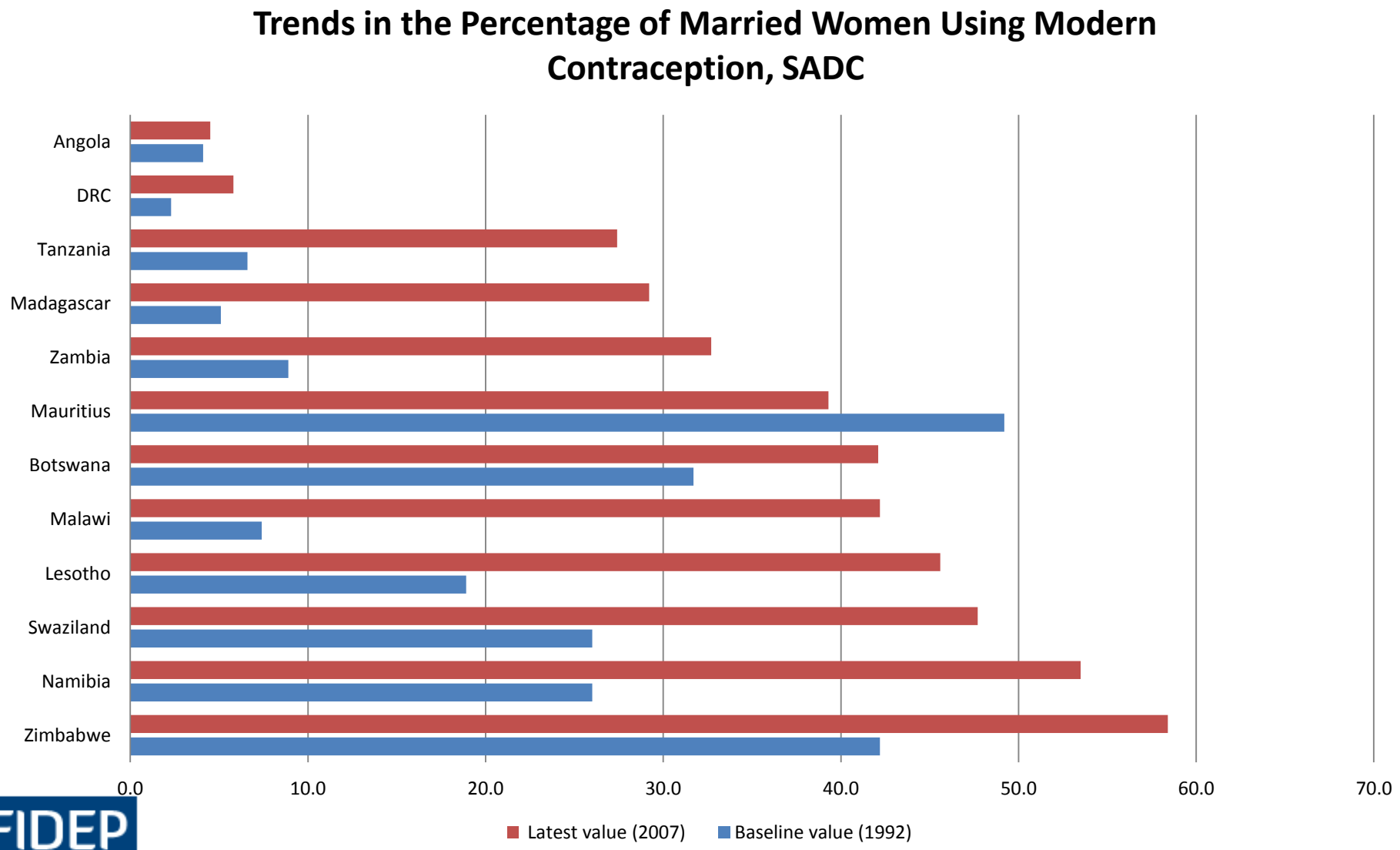
Contraceptive use increased in almost all countries in SADC, albeit at varying rates



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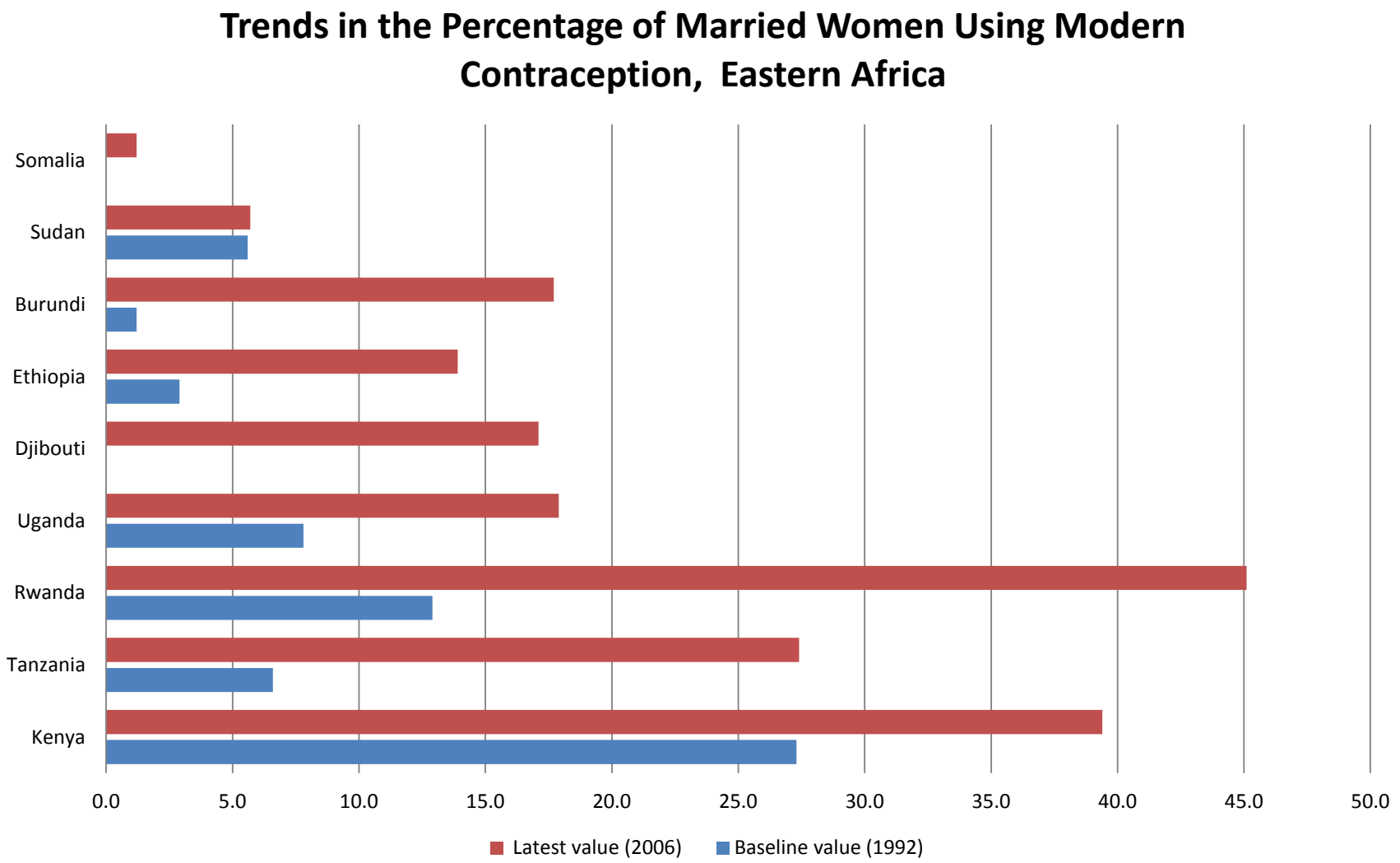
Contraceptive use increased in all countries in EAC, albeit at varying rates



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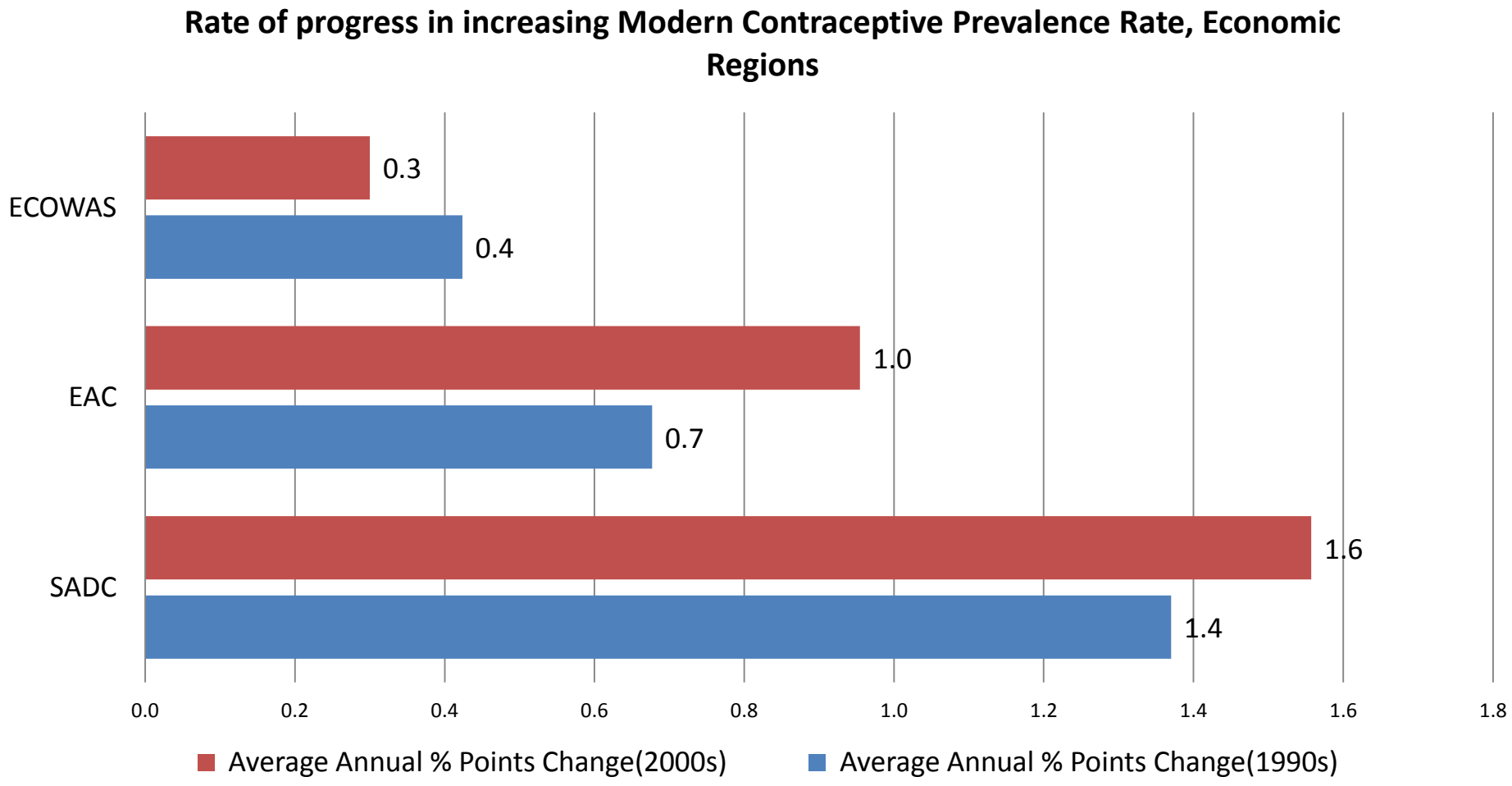
Progress in increasing FP use accelerated in EAC and SADC in the 2000s, but stalled in ECOWAS



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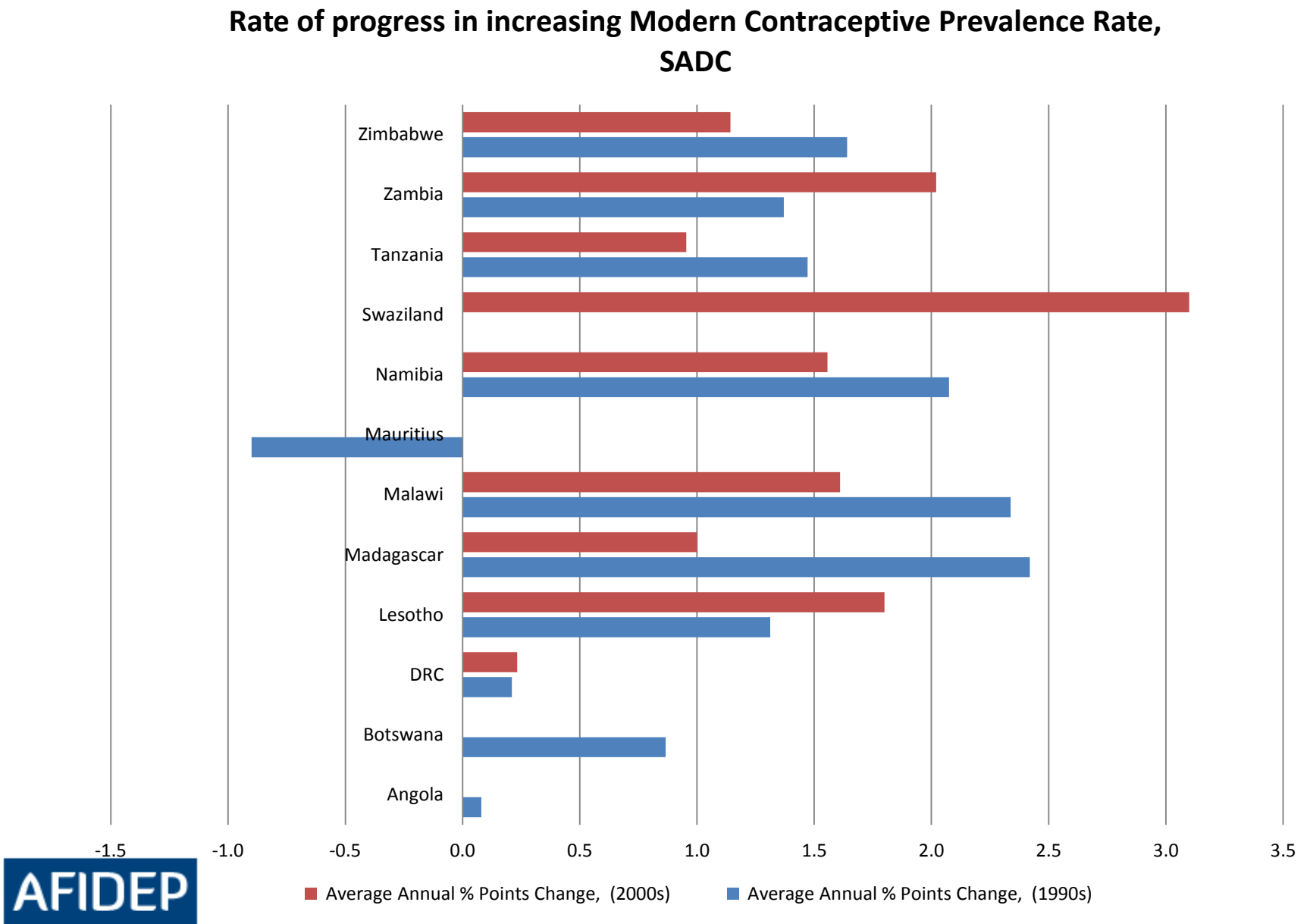
Increase in contraceptive use slowed down during the 2000s except in Zambia and Lesotho



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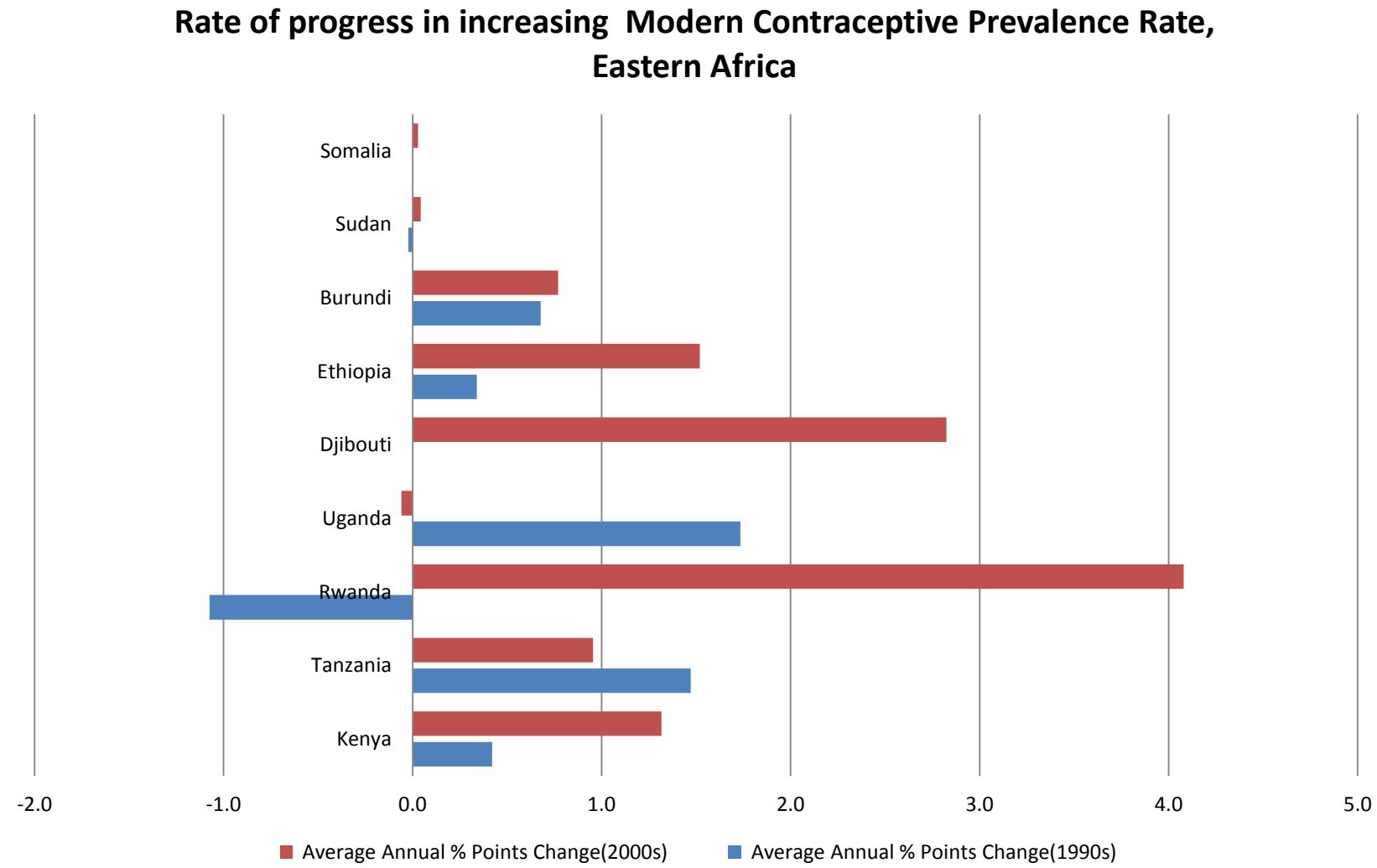
Increase in contraceptive use slowed down in the 2000s in Tanzania and Uganda



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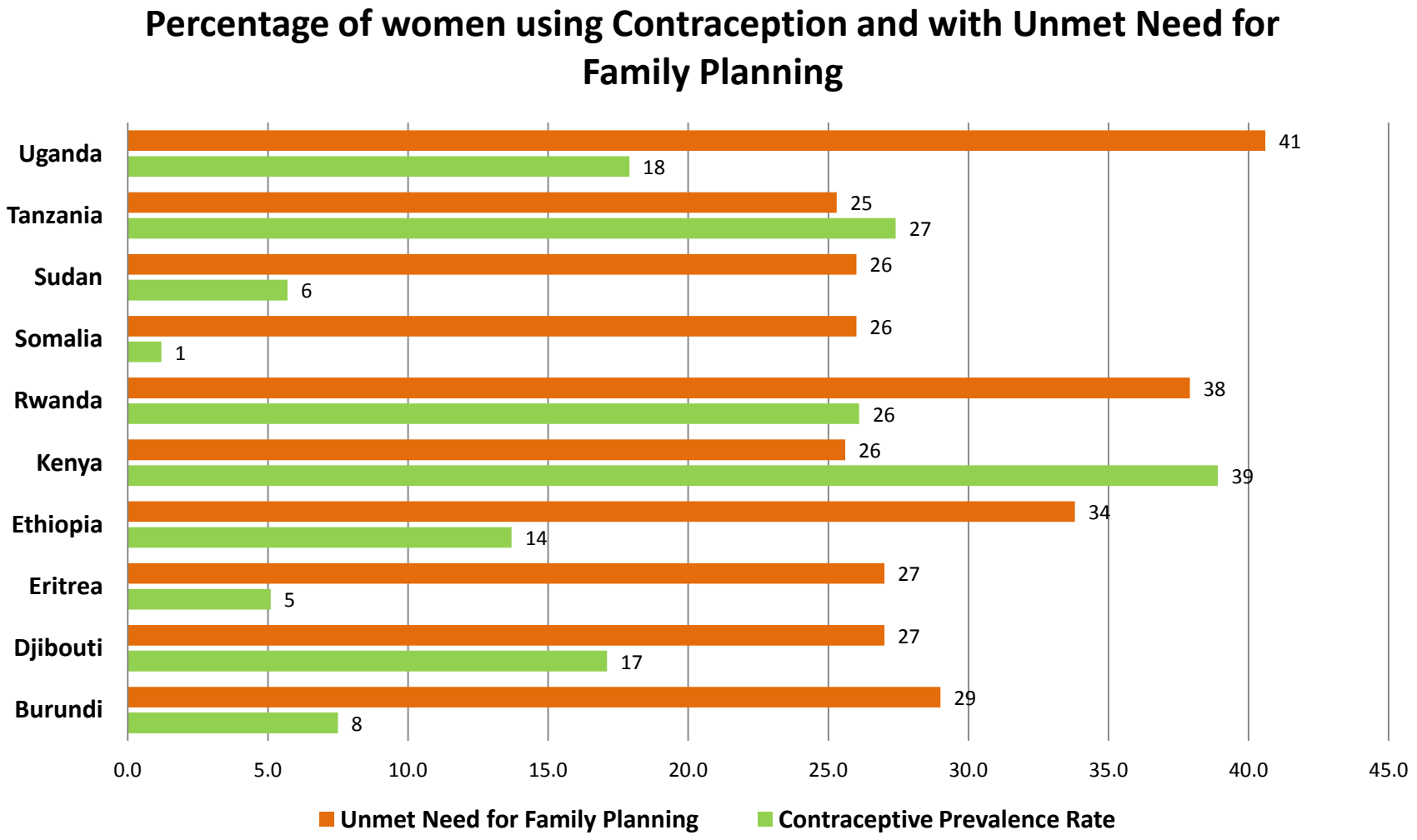
More women have unmet need for FP than those using FP in most Eastern Africa countries



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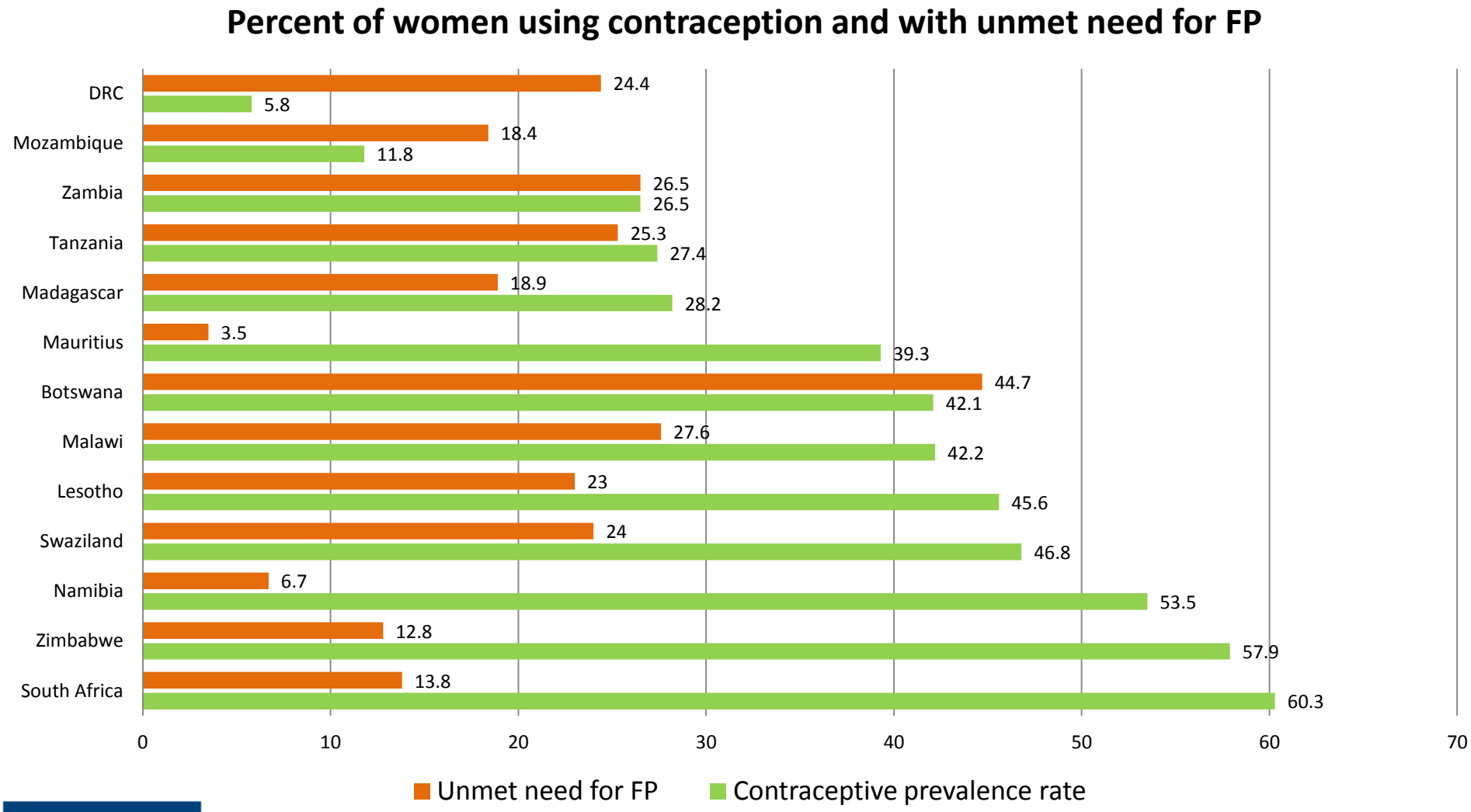
Unmet need for FP is higher than CPR in countries with low contraceptive use in SADC



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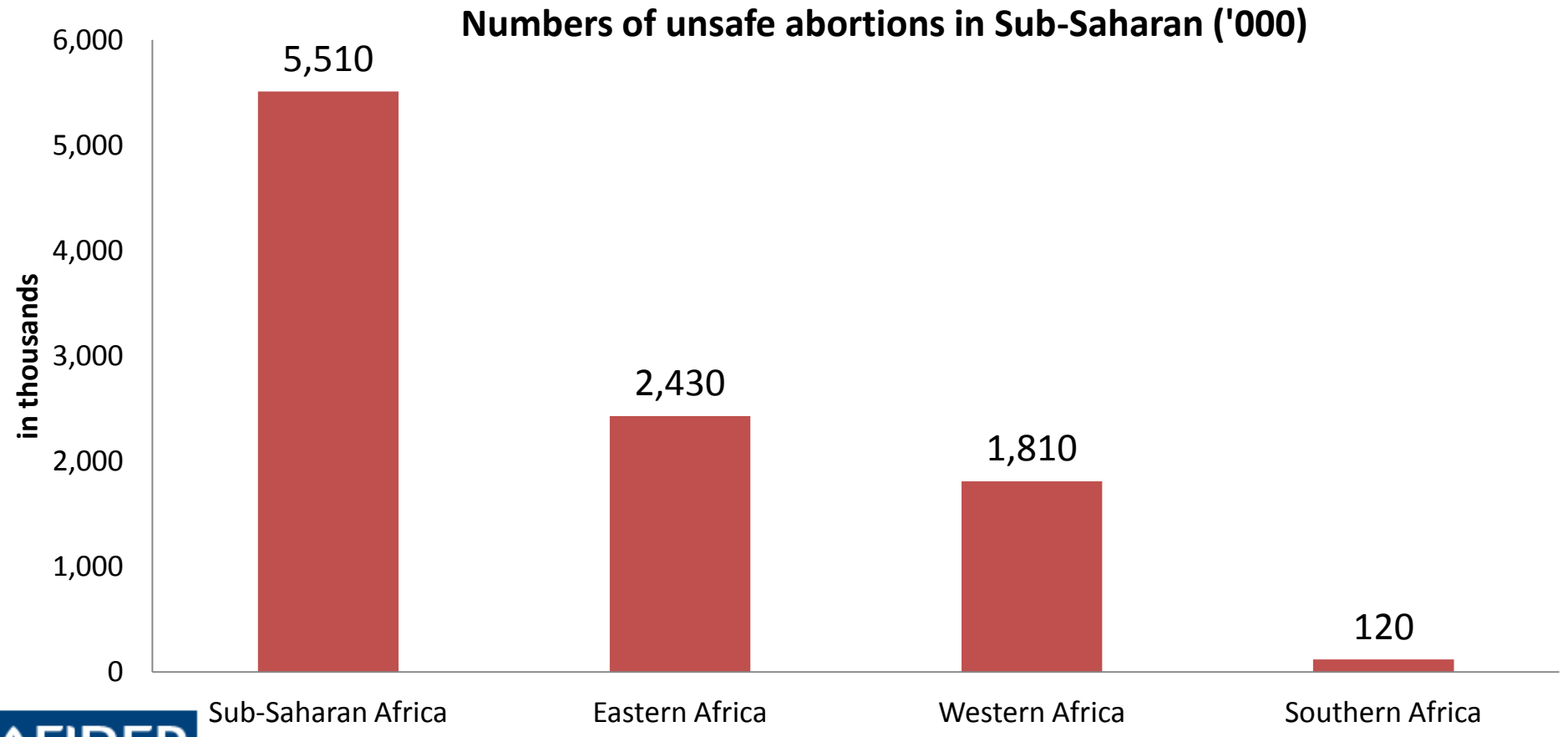
Key Barriers to Contraceptive Use

- Lack of access
- Limited method choice
- Medical and legal restrictions
- Provider bias
- Financial costs
- Opposition to FP (religious or cultural reasons)
- Psychosocial factors relating to the status of women
- Misinformation, etc.

So, what are some of the consequences of the failure to meet women and their partners' contraceptive needs?

Due to high levels of unplanned pregnancies, many women resort to induced abortion – most are unsafe abortions due to legal and service restrictions



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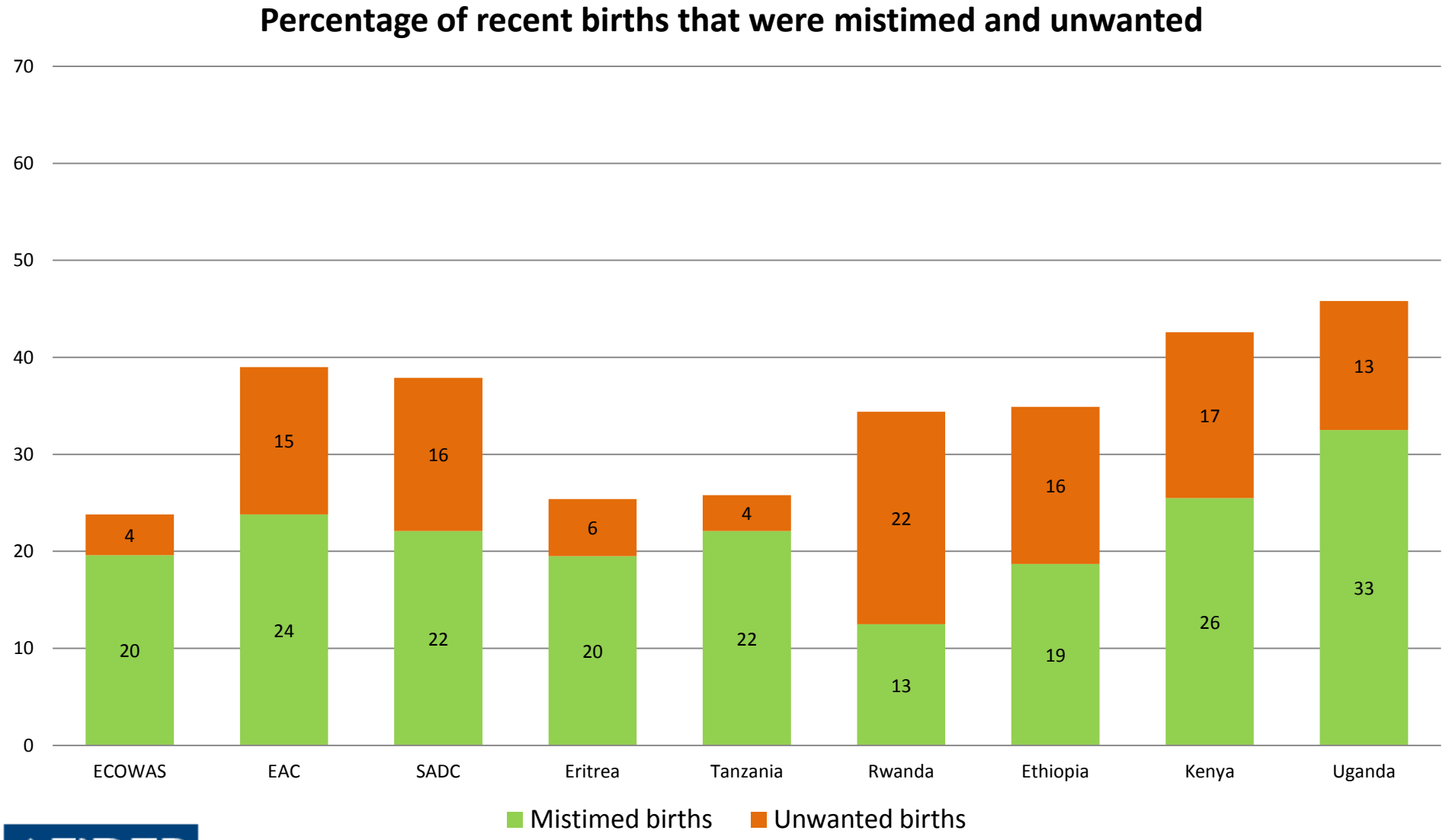
Mistimed or unwanted births in EAC and SADC are close to 2 out of 5 births (40%)



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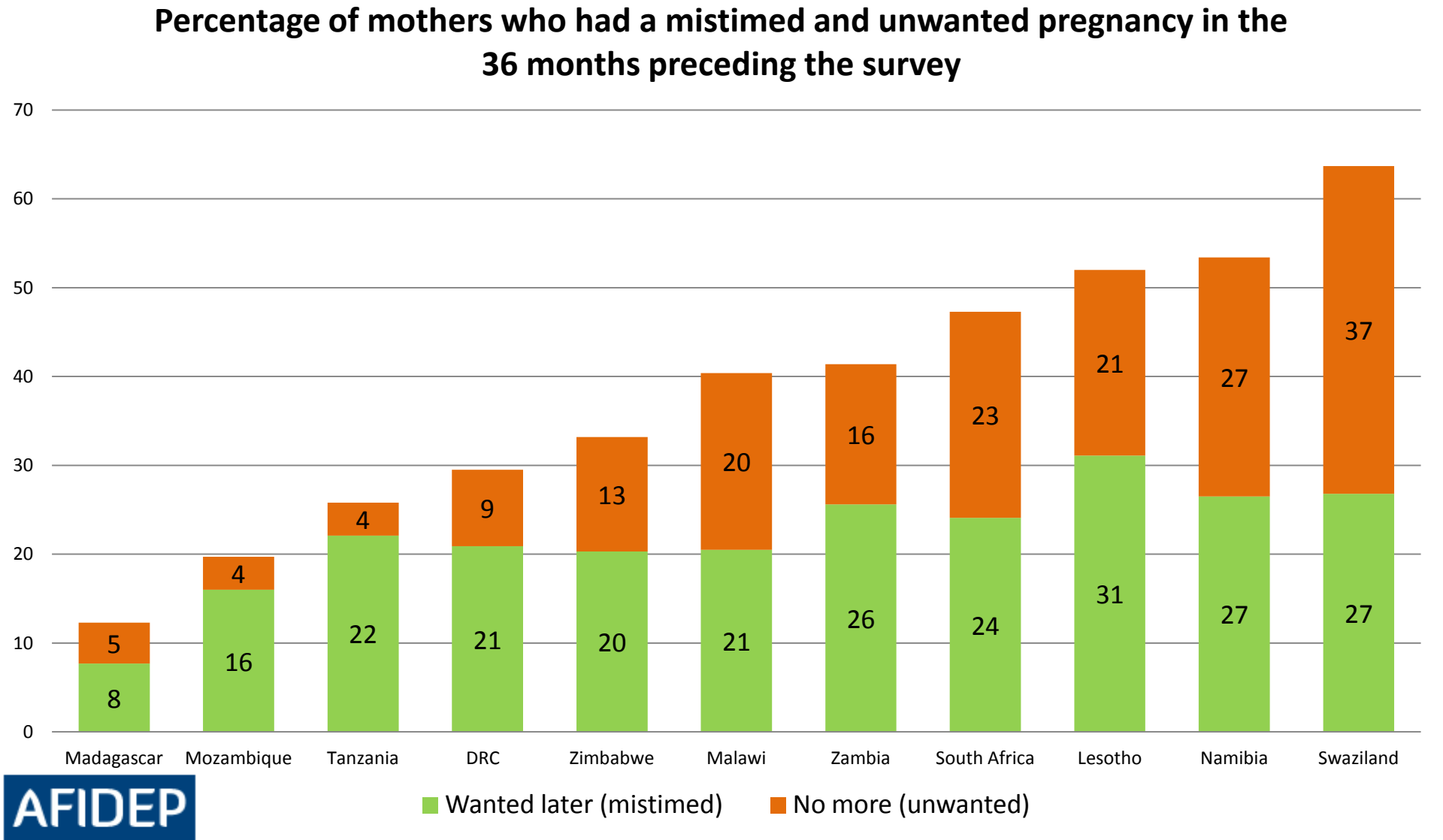
Considerable proportions of births in SADC countries are either mistimed or unwanted



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By 2050, population size will at least double in 8 out of 10 Eastern Africa countries

Country	Population Size ('000)		
	2010	2050 (projected)	Growth factor
Burundi	8,383	13,703	1.6
Djibouti	889	1,620	1.8
Eritrea	5,254	11,568	2.2
Ethiopia	82,950	145,187	1.8
Kenya	40,513	96,887	2.4
Rwanda	10,624	26,003	2.4
Somalia	9,331	28,217	3.0
Sudan	43,552	90,962	2.1
Tanzania	44,841	138,312	3.1
Uganda	33,425	94,259	2.8
Total	**25,441**	**58,801**	2.2

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By 2050, population size will at least double in 7 out of 15 SADC countries

Country	Population Size ('000)		
	2010	2050 (projected)	Growth Factor 2010 -> 2050
Angola	19,082	42,334	2.2
Botswana	2,007	2,503	1.2
DRC	65,966	148,523	2.3
Lesotho	2,171	2,788	1.3
Madagascar	20,714	53,561	2.6
Malawi	14,901	49,719	3.3
Mauritius	1,299	1,367	1.1
Mozambique	23,391	50,192	2.1
Namibia	2,283	3,599	1.6
Seychelles	87	91	1.0
South Africa	50,133	56,757	1.1
Swaziland	1,186	1,679	1.4
Tanzania	44,841	138,312	3.1
Zambia	13,089	45,037	3.4
Zimbabwe	12,571	20,614	1.6

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Only 5 countries in EA and SA had met the Abuja declaration to commit 15% of the national budget towards health in 2009

SADC Countries			Eastern Africa	
Tanzania	18.1		Tanzania	18.1
DRC	17.0		Rwanda	16.8
Botswana	16.7		Djibouti	13.9
Madagascar	15.1		Burundi	11.8
Mozambique	12.6		Uganda	11.6
Namibia	12.1		Ethiopia	11.4
Malawi	12.1		Sudan	9.8
Seychelles	11.4		Kenya	5.4
Zambia	10.8		Eritrea	3.1
Swaziland	9.3			
South Africa	9.3			
Angola	8.4			
Mauritius	8.3			
Lesotho	8.2			

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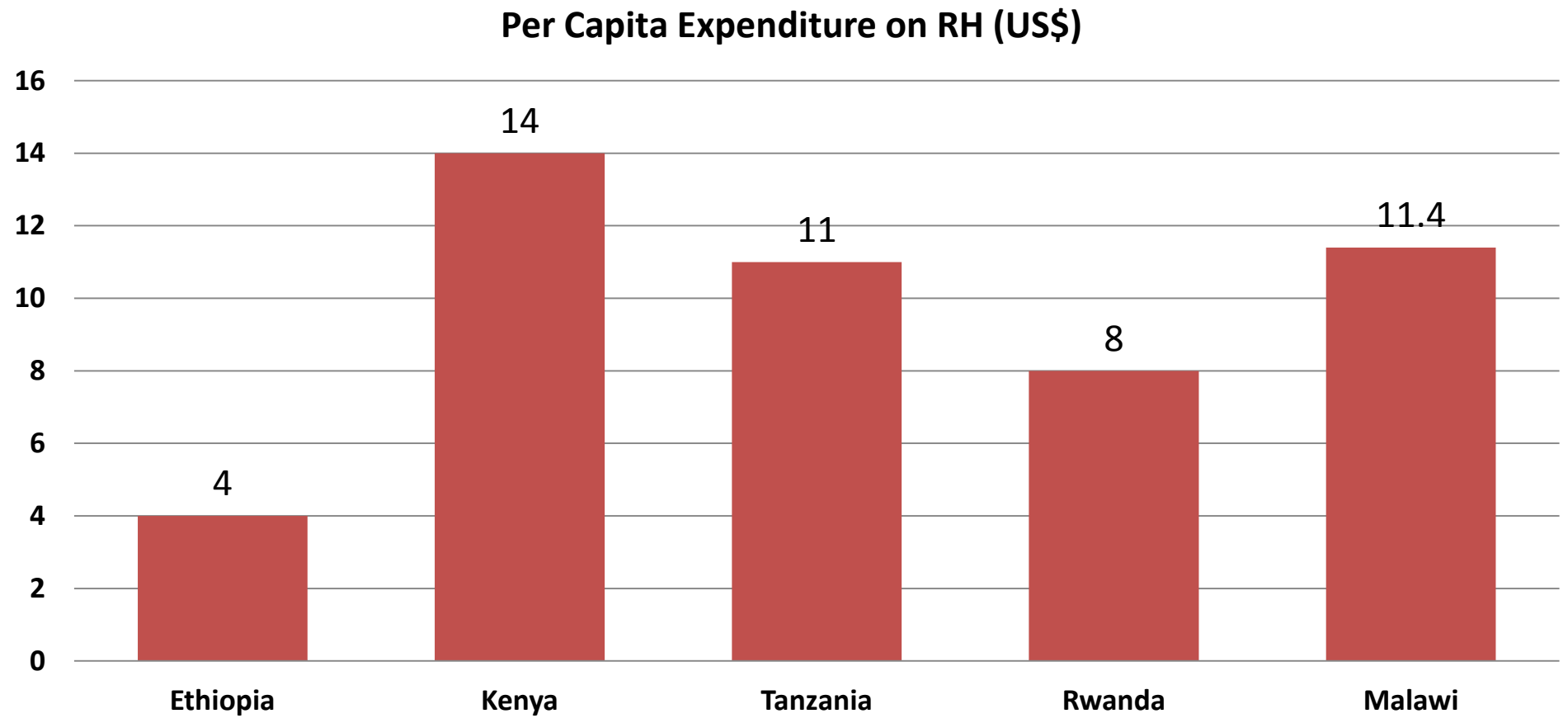
Per capita RH expenditure on women of reproductive age is quite varied



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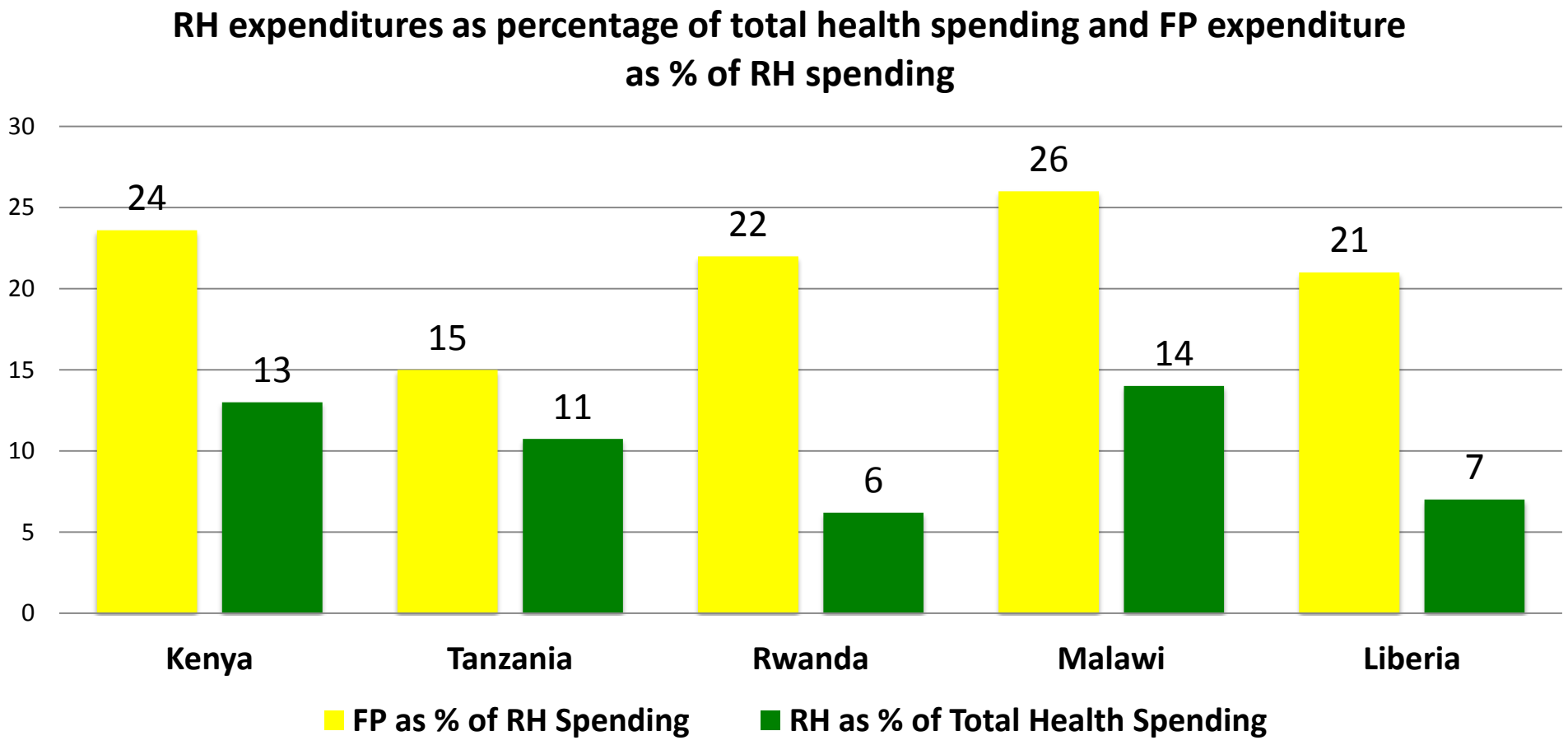
How much of the Health Budget is for RH and how much of the RH Budget is for FP?



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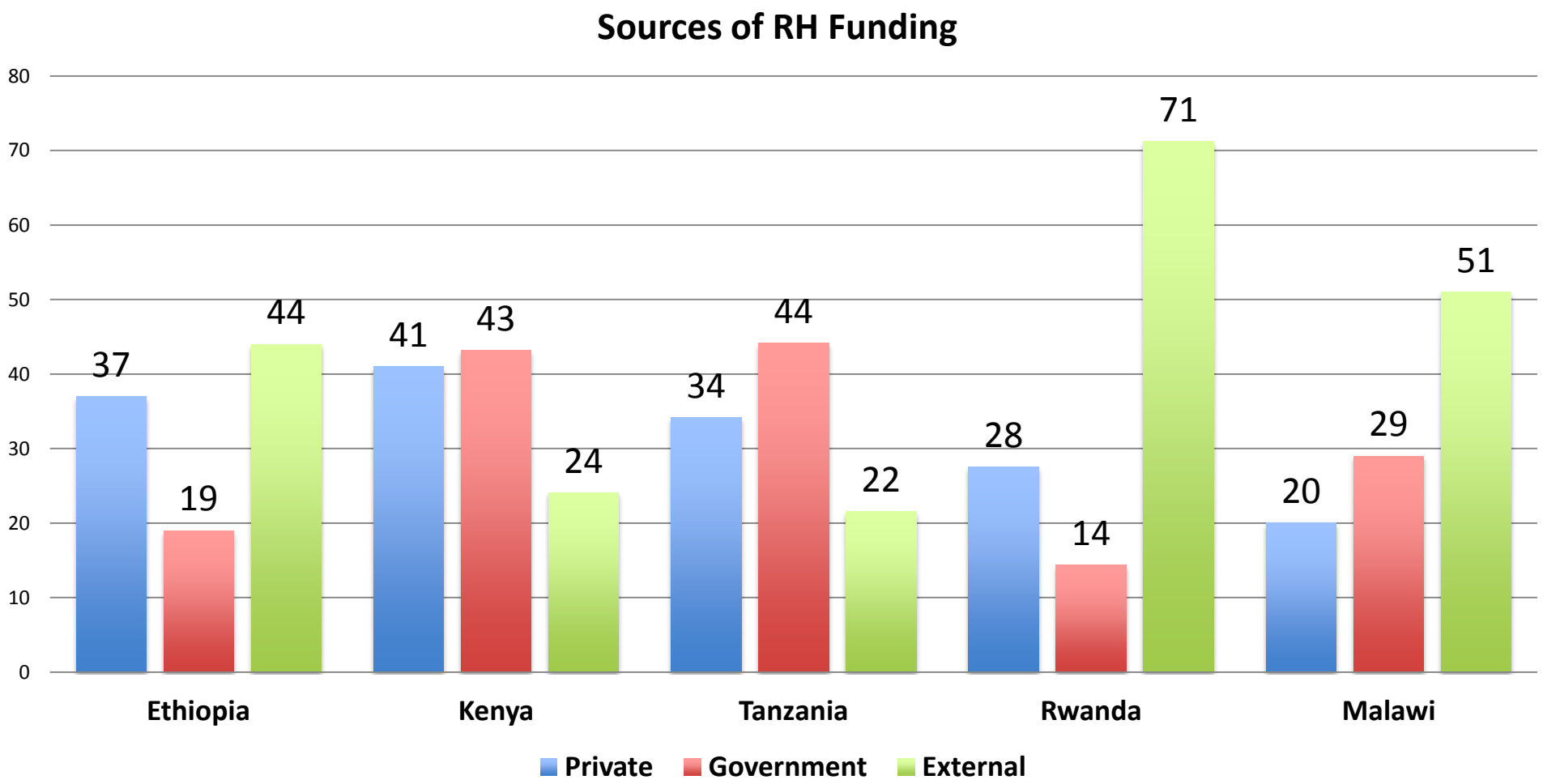
Where is the money for RH coming from?



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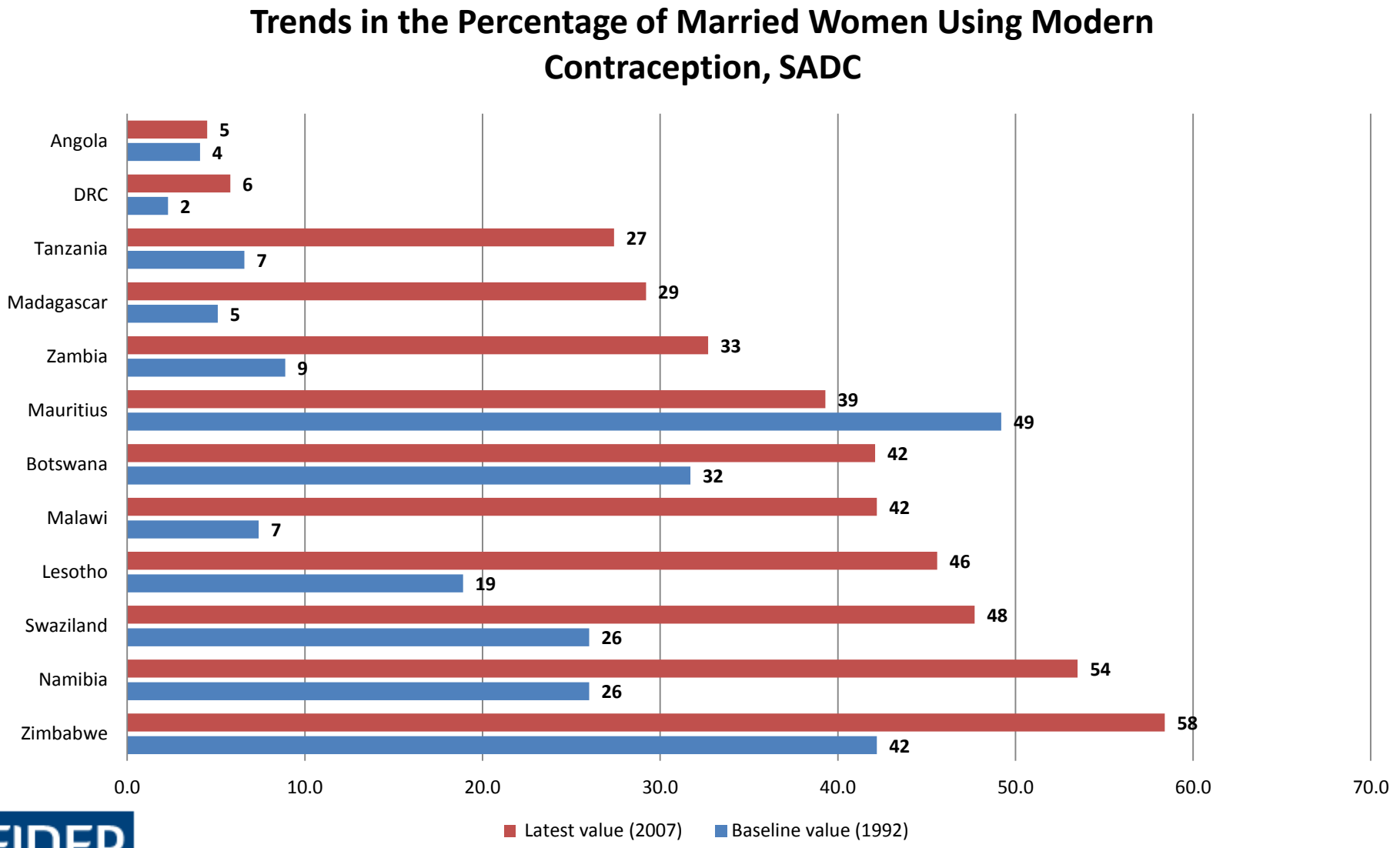
Zimbabwe, Namibia, and Swaziland have made the most progress in increasing FP use in SADC



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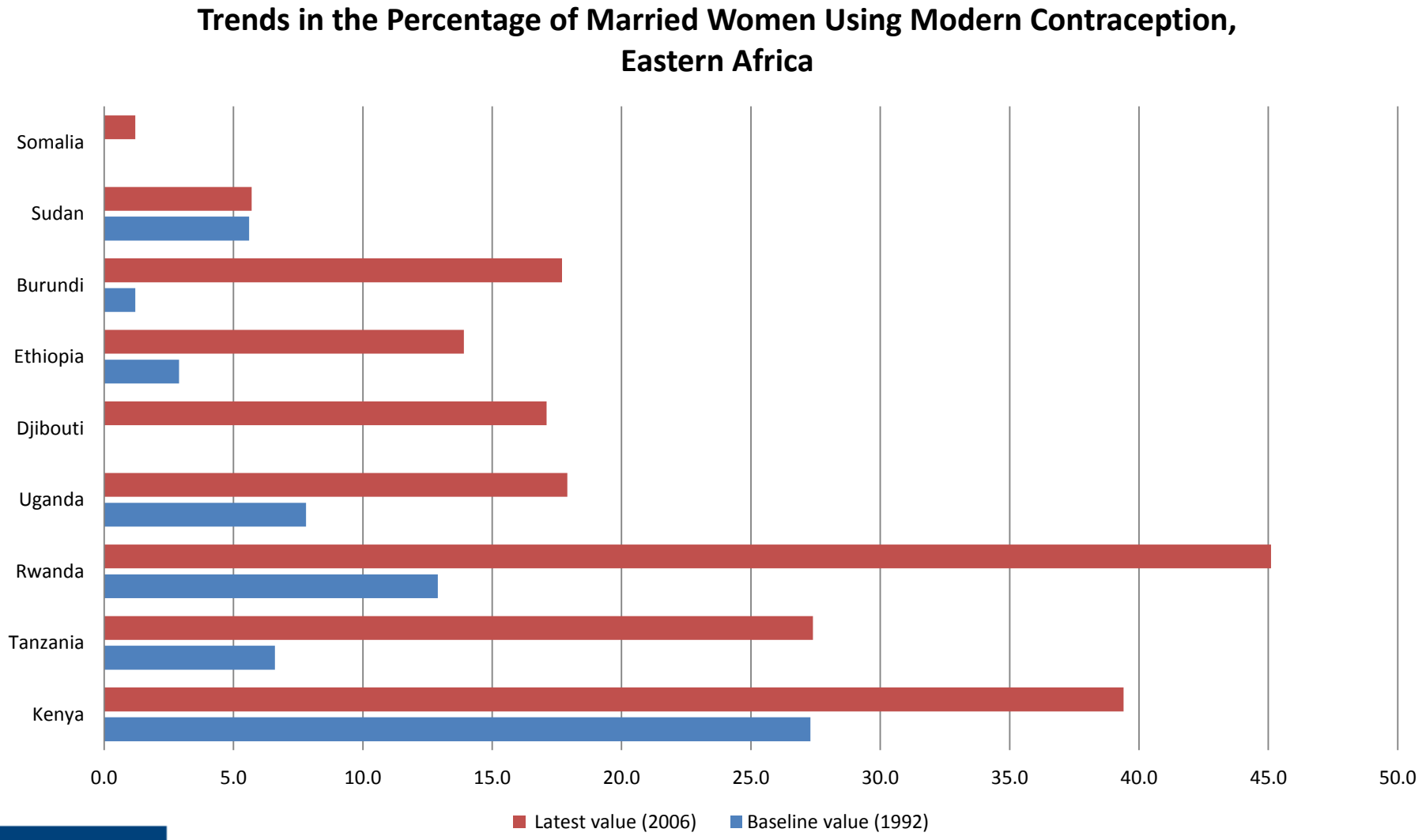
Rwanda, Kenya, & Tanzania have made the most progress in increasing FP use in EAC



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What are the drivers of progress in FP uptake in East and Southern Africa?

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1. **Political will and commitment - backed up by enabling policy and programme environment**

- Rwanda – FP championed at all political levels; people-focused development policies; investments in health infrastructure
- Kenya – First country to adopt a population policy in SS Africa; top political leadership championed FP, provided enabling environment for FP programs & external funds
- Zimbabwe – FP program on development agenda since independence in 1980

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2. **Adequate & sustained financial investments** in FP services

- Ensure commodity security through increased government and other spending on FP
- Removal of cost barriers of access to services
- Health insurance schemes

  - Rwanda, South Africa, Kenya, Namibia – removal of cost barriers in access to FP
  - Rwanda - donor funds match government agenda, where FP is among top priorities
  - Increased local and external health care spending in all countries (Rwanda, South Africa, Kenya, Namibia, Tanzania, Zimbabwe)
  - South Africa – committed government funding for FP and extensive private sector and NGO-led FP programmes

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3. **Strengthened health care system, quality of care, and** creation of an enabling program environment to **improve access** to FP

- Workforce training and performance incentives
- Wider FP method choice
  - Rwanda – Output-based culture; health worker motivation; wide FP method choice
  - Tanzania – evidence-based decision-making at district level and National FP implementation program
  - South Africa – strong public-private partnerships in provision of FP
  - Zimbabwe & Kenya – strong health care delivery system in the 1980s and 1990s

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4. **Strong community-based initiatives**, with particular focus on men, youth, and other underserved populations

- All countries making most progress have had strong community based distribution and promotion of FP
  - Rwanda – trained community health workers; community-managed health organisations to boost access
  - Kenya had strong community distribution program in the 1980s and early 1990s
  - All progressive countries – programmes focused on closing inequity gap for rural-based and uneducated women
  - Zimbabwe and Namibia – involvement of men (and youth) in FP

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5. **Sustained IEC/Promotional Campaigns**

- All countries that have made the most progress have had strong public educational campaigns about child-bearing (encouraging people to think about how many children they should have and focus on having quality children) and benefits of using family planning (particularly in Rwanda, Namibia, Kenya, and Tanzania)

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6. **Increased Socio-Economic Investments in the youth**

- All countries that have made the most progress have made sizable gains in increasing female education, reducing child mortality, and general empowerment of women
  - Female education increased substantially in Kenya and Zimbabwe
  - Reducing early marriage & childbearing, including sex education and RH services for youth
  - Community health insurance (Rwanda)
  - Micro-credit schemes for women (Kenya, Rwanda, Zimbabwe)

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Recommendations for the Governments of Eastern and Southern Africa

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Recommendations (1-3)

1. Generate and reinforce **political will and commitment** to family planning

2. Increase and sustain **financial investments** for health and more specifically for SRH programs and services

3. Intensify **outreach, quality and choice of family planning interventions** in order to reduce unmet need and unplanned pregnancies, and thereby curb deaths attributed to unsafe abortions

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Recommendations (4-6)

4. Develop specific **pro-poor policies** that address social determinants of women's health

5. Integrate population growth and related demographic dynamics in **development planning**

6. Reinforce **integration of SRH and HIV** policies, programs and services

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Recommendations (7)

7. **Health system strengthening** through impact evaluation of existing policies and programs to support evidence-based scale-up, resource allocation and capacity building of the healthcare infrastructure and workforce

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