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

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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
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
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
Use of family planning varies considerably in SADC region

Percent of married women using modern and traditional methods of contraception

<table>
<thead>
<tr>
<th>Country</th>
<th>Modern Methods</th>
<th>Traditional Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mauritius</td>
<td>60</td>
<td>37</td>
</tr>
<tr>
<td>South Africa</td>
<td>58</td>
<td>2</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>54</td>
<td>2</td>
</tr>
<tr>
<td>Namibia</td>
<td>47</td>
<td>4</td>
</tr>
<tr>
<td>Swaziland</td>
<td>46</td>
<td>1</td>
</tr>
<tr>
<td>Lesotho</td>
<td>42</td>
<td>4</td>
</tr>
<tr>
<td>Malawi</td>
<td>42</td>
<td>2</td>
</tr>
<tr>
<td>Botswana</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>Zambia</td>
<td>27</td>
<td>12</td>
</tr>
<tr>
<td>Madagascar</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>DRC</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Mozambique</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Angola</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Seychelles</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
Use of family planning varies considerably in Eastern Africa

Percentage of married women using traditional and modern contraceptive methods

- Kenya: 39% modern, 7% traditional
- Rwanda: 27% modern, 9% traditional
- Tanzania: 26% modern, 8% traditional
- Uganda: 18% modern, 6% traditional
- Djibouti: 17% modern, 1% traditional
- Ethiopia: 14% modern, 1% traditional
- Somalia: 13% modern, 2% traditional
- Burundi: 8% modern, 2% traditional
- Eritrea: 5% modern, 3% traditional
- Sudan: 6% modern, 2% traditional
SADC has made the most progress in increasing use of modern contraception, followed by EAC.
Contraceptive use increased in almost all countries in SADC, albeit at varying rates.
Contraceptive use increased in all countries in EAC, albeit at varying rates.

Trends in the Percentage of Married Women Using Modern Contraception, Eastern Africa

- Somalia: Latest value (2006) = 1.0, Baseline value (1992) = 0.5
- Sudan: Latest value (2006) = 6.0, Baseline value (1992) = 5.0
- Rwanda: Latest value (2006) = 45.0, Baseline value (1992) = 35.0

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

Rate of progress in increasing Modern Contraceptive Prevalence Rate, Economic Regions

- **ECOWAS**:
  - Average Annual % Points Change (2000s): 0.3
  - Average Annual % Points Change (1990s): 0.4

- **EAC**:
  - Average Annual % Points Change (2000s): 0.7

- **SADC**:
  - Average Annual % Points Change (2000s): 1.6
  - Average Annual % Points Change (1990s): 1.4

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

Rate of progress in increasing Modern Contraceptive Prevalence Rate, SADC

- **Zimbabwe**
- **Zambia**
- **Tanzania**
- **Swaziland**
- **Namibia**
- **Mauritius**
- **Malawi**
- **Madagascar**
- **Lesotho**
- **DRC**
- **Botswana**
- **Angola**

- Average Annual % Points Change, (2000s)
- Average Annual % Points Change, (1990s)
Increase in contraceptive use slowed down in the 2000s in Tanzania and Uganda.
More women have unmet need for FP than those using FP in most Eastern Africa countries.

Percentage of women using Contraception and with Unmet Need for Family Planning

<table>
<thead>
<tr>
<th>Country</th>
<th>Unmet Need for Family Planning</th>
<th>Contraceptive Prevalence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uganda</td>
<td>18</td>
<td>41</td>
</tr>
<tr>
<td>Tanzania</td>
<td>25</td>
<td>38</td>
</tr>
<tr>
<td>Sudan</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td>Somalia</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>Rwanda</td>
<td>26</td>
<td>38</td>
</tr>
<tr>
<td>Kenya</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>14</td>
<td>34</td>
</tr>
<tr>
<td>Eritrea</td>
<td>5</td>
<td>27</td>
</tr>
<tr>
<td>Djibouti</td>
<td>17</td>
<td>27</td>
</tr>
<tr>
<td>Burundi</td>
<td>8</td>
<td>29</td>
</tr>
</tbody>
</table>

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

Percent of women using contraception and with unmet need for FP

- **DRC**: Unmet need for FP - 24.4%, CPR - 5.8%
- **Mozambique**: Unmet need for FP - 18.4%, CPR - 11.8%
- **Zambia**: Unmet need for FP - 26.5%, CPR - 26.5%
- **Tanzania**: Unmet need for FP - 25.3%, CPR - 27.4%
- **Madagascar**: Unmet need for FP - 18.9%, CPR - 28.2%
- **Mauritius**: Unmet need for FP - 3.5%, CPR - 18.9%
- **Botswana**: Unmet need for FP - 24%, CPR - 24%
- **Malawi**: Unmet need for FP - 27.6%, CPR - 42.1%
- **Lesotho**: Unmet need for FP - 23%, CPR - 42.2%
- **Swaziland**: Unmet need for FP - 24%, CPR - 45.6%
- **Namibia**: Unmet need for FP - 6.7%, CPR - 53.5%
- **Zimbabwe**: Unmet need for FP - 12.8%, CPR - 57.9%
- **South Africa**: Unmet need for FP - 13.8%, CPR - 60.3%

Legend:
- **Unmet need for FP**: Orange
- **Contraceptive prevalence rate**: Green
Key Barriers to Contraceptive Use

- Lack of access
- Limited method choice
- Medical and legal restrictions
- Provider bias
- Financial costs
- Opposition to FP (religions 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.
Mistimed or unwanted births in EAC and SADC are close to 2 out of 5 births (40%)

Percentage of recent births that were mistimed and unwanted

<table>
<thead>
<tr>
<th>Region</th>
<th>Mistimed births</th>
<th>Unwanted births</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECOWAS</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>EAC</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td>SADC</td>
<td>22</td>
<td>16</td>
</tr>
<tr>
<td>Eritrea</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Tanzania</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Rwanda</td>
<td>22</td>
<td>13</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>Kenya</td>
<td>26</td>
<td>17</td>
</tr>
<tr>
<td>Uganda</td>
<td>33</td>
<td>13</td>
</tr>
</tbody>
</table>

Mistimed births | Unwanted births
Considerable proportions of births in SADC countries are either mistimed or unwanted. The percentage of mothers who had a mistimed and unwanted pregnancy in the 36 months preceding the survey is shown in the diagram. The data is as follows:

- Madagascar: Wanted later (mistimed) 5%, No more (unwanted) 8%
- Mozambique: Wanted later (mistimed) 4%, No more (unwanted) 16%
- Tanzania: Wanted later (mistimed) 22%, No more (unwanted) 9%
- DRC: Wanted later (mistimed) 13%, No more (unwanted) 21%
- Zimbabwe: Wanted later (mistimed) 20%, No more (unwanted) 21%
- Malawi: Wanted later (mistimed) 16%, No more (unwanted) 23%
- Zambia: Wanted later (mistimed) 26%, No more (unwanted) 24%
- South Africa: Wanted later (mistimed) 31%, No more (unwanted) 21%
- Lesotho: Wanted later (mistimed) 27%, No more (unwanted) 27%
- Namibia: Wanted later (mistimed) 27%, No more (unwanted) 27%
- Swaziland: Wanted later (mistimed) 37%, No more (unwanted) 27%

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Population Size (‘000)</th>
<th>Growth factor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2050 (projected)</td>
</tr>
<tr>
<td>Burundi</td>
<td>8,383</td>
<td>13,703</td>
</tr>
<tr>
<td>Djibouti</td>
<td>889</td>
<td>1,620</td>
</tr>
<tr>
<td>Eritrea</td>
<td>5,254</td>
<td>11,568</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>82,950</td>
<td>145,187</td>
</tr>
<tr>
<td>Kenya</td>
<td>40,513</td>
<td>96,887</td>
</tr>
<tr>
<td>Rwanda</td>
<td>10,624</td>
<td>26,003</td>
</tr>
<tr>
<td>Somalia</td>
<td>9,331</td>
<td>28,217</td>
</tr>
<tr>
<td>Sudan</td>
<td>43,552</td>
<td>90,962</td>
</tr>
<tr>
<td>Tanzania</td>
<td>44,841</td>
<td>138,312</td>
</tr>
<tr>
<td>Uganda</td>
<td>33,425</td>
<td>94,259</td>
</tr>
<tr>
<td>Total</td>
<td>25,441</td>
<td>58,801</td>
</tr>
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</table>
By 2050, population size will at least double in 7 out of 15 SADC countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Population Size ('000)</th>
<th>Growth Factor 2010 -&gt; 2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>19,082</td>
<td>2.2</td>
</tr>
<tr>
<td>Botswana</td>
<td>2,007</td>
<td>1.2</td>
</tr>
<tr>
<td>DRC</td>
<td>65,966</td>
<td>2.3</td>
</tr>
<tr>
<td>Lesotho</td>
<td>2,171</td>
<td>1.3</td>
</tr>
<tr>
<td>Madagascar</td>
<td>20,714</td>
<td>2.6</td>
</tr>
<tr>
<td>Malawi</td>
<td>14,901</td>
<td>3.3</td>
</tr>
<tr>
<td>Mauritius</td>
<td>1,299</td>
<td>1.1</td>
</tr>
<tr>
<td>Mozambique</td>
<td>23,391</td>
<td>2.1</td>
</tr>
<tr>
<td>Namibia</td>
<td>2,283</td>
<td>1.6</td>
</tr>
<tr>
<td>Seychelles</td>
<td>87</td>
<td>1.0</td>
</tr>
<tr>
<td>South Africa</td>
<td>50,133</td>
<td>1.1</td>
</tr>
<tr>
<td>Swaziland</td>
<td>1,186</td>
<td>1.4</td>
</tr>
<tr>
<td>Tanzania</td>
<td>44,841</td>
<td>3.1</td>
</tr>
<tr>
<td>Zambia</td>
<td>13,089</td>
<td>3.4</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>12,571</td>
<td>1.6</td>
</tr>
</tbody>
</table>
Only 5 countries in EA and SA had met the Abuja declaration to commit 15% of the national budget towards health in 2009

<table>
<thead>
<tr>
<th>SADC Countries</th>
<th>Eastern Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>18.1 Tanzania</td>
</tr>
<tr>
<td>DRC</td>
<td>17.0 Rwanda</td>
</tr>
<tr>
<td>Botswana</td>
<td>16.7 Djibouti</td>
</tr>
<tr>
<td>Madagascar</td>
<td>15.1 Burundi</td>
</tr>
<tr>
<td>Mozambique</td>
<td>12.6 Uganda</td>
</tr>
<tr>
<td>Namibia</td>
<td>12.1 Ethiopia</td>
</tr>
<tr>
<td>Malawi</td>
<td>12.1 Sudan</td>
</tr>
<tr>
<td>Seychelles</td>
<td>11.4 Kenya</td>
</tr>
<tr>
<td>Zambia</td>
<td>10.8 Eritrea</td>
</tr>
<tr>
<td>Swaziland</td>
<td>9.3</td>
</tr>
<tr>
<td>South Africa</td>
<td>9.3</td>
</tr>
<tr>
<td>Angola</td>
<td>8.4</td>
</tr>
<tr>
<td>Mauritius</td>
<td>8.3</td>
</tr>
<tr>
<td>Lesotho</td>
<td>8.2</td>
</tr>
</tbody>
</table>
Per capita RH expenditure on women of reproductive age is quite varied.
How much of the Health Budget is for RH and how much of the RH Budget is for FP?

RH expenditures as percentage of total health spending and FP expenditure as % of RH spending

- **Kenya**: FP as % of RH Spending: 24%, RH as % of Total Health Spending: 13%
- **Tanzania**: FP as % of RH Spending: 15%, RH as % of Total Health Spending: 11%
- **Rwanda**: FP as % of RH Spending: 22%, RH as % of Total Health Spending: 6%
- **Malawi**: FP as % of RH Spending: 26%, RH as % of Total Health Spending: 14%
- **Liberia**: FP as % of RH Spending: 21%, RH as % of Total Health Spending: 7%

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Where is the money for RH coming from?

Sources of RH Funding

- Ethiopia: Private 37, Government 19, External 44
- Kenya: Private 41, Government 43, External 24
- Tanzania: Private 34, Government 22, External 28
- Rwanda: Private 14, Government 14, External 71
- Malawi: Private 20, Government 29, External 51
Zimbabwe, Namibia, and Swaziland have made the most progress in increasing FP use in SADC

Trends in the Percentage of Married Women Using Modern Contraception, SADC

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

**Trends in the Percentage of Married Women Using Modern Contraception, Eastern Africa**

- **Somalia**
- **Sudan**
- **Burundi**
- **Ethiopia**
- **Djibouti**
- **Uganda**
- **Rwanda**
- **Tanzania**
- **Kenya**

What are the drivers of progress in FP uptake in East and Southern Africa?
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
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
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
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
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)
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)
Recommendations for the Governments of Eastern and Southern Africa
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
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**
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.
THANK YOU

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