REVITALIZATION OF FAMILY PLANNING PROGRAMS IN AFRICA

Ndola Prata, MD, MSc and Amita Sreenivas[1], MPH

School of Public Health | University of California, Berkeley

[1] Corresponding Author: *17-A University Hall | Berkeley, CA 94720-7360. Email: sreenivas@berkeley.edu. Ph: (510) 642-7315*

ABSTRACT

Many family planning programs in sub-Saharan Africa are weak and poorly functioning. Lack of leadership, resources and above all, political will, are the major issues being faced by currently existing programs. This paper reviews current population policies and family planning agendas in some of the fastest growing countries in Africa. We then assess the impact that rapid population growth is having on their maternal and child health, economy, equity, and poverty reduction strategies. Lastly, we outline four critical steps that governments can take which will benefit their populations now and in the long-term: a) increase general public knowledge about the safety of family planning methods; b) reduce fees to ensure contraception is genuinely affordable to even the poorest families; c) ensure supply of contraceptives by making family planning a permanent line item in national/state health budgets; and d) take immediate action to remove barriers hindering access to family planning methods.

INTRODUCTION

Too often, family planning programs in resource poor settings, such as sub-Saharan Africa (SSA), are frail, poorly functioning, dependent on international donor aide, and constrained by existing policies or lack thereof. Lack of leadership, resources and above all, political will, are the major issues being faced by currently existing programs. However, it is exactly in those types of settings where revitalization of existing family planning programs are urgently needed if governments wish to achieve their goals in poverty reduction, maternal and child health improvement, economic development, and sustainability. Through a human rights lens, this paper reviews current population policies and family planning programs in some of the fastest growing countries in sub-Saharan Africa. We assess examples of high fertility countries and the impact their rapid population growth is having on their health and development. Finally, we conclude with realistic and accessible solutions for African Governments on how to revitalize family planning programs for immediate impact on the health and well-being of their own citizens.

A Human Right

In Africa, the unmet need for contraception is staggering. Couples who wish to have fewer children, are unable to determine the size of their families as family planning funding continues to become scarce and existing programs fail to meet the concerns and desires of their users. In SSA, the proportion of married women (ages 15 to 49 years) who want to delay or stop childbearing and are *not* using contraception is the

highest globally—16% for birth spacing, and 9% for birth limiting). Consequently, this region also has the world's lowest contraceptive prevalence (CPR) at 18% (PRB 2008). There is also significant inequity in the distribution of unmet need by wealth quintile. The poorest of the poor tend to have not only the lowest CPR, but the highest total fertility rate (TFR) and the highest unmet need for family planning (Prata 2006, Prata 2007).

A large part of the burden of disease linked to maternal and child health faced by African countries is also reflective of undesired fertility. Unjustly, women are dying simply because of unmet need for family planning and yet this continues to be the case. Individuals living with HIV/AIDS (ages of 15 to 49 years) make up 5% of the total population of in SSA (PRB 2008). Among HIV-positive women, it is estimated that 25% have an unmet need for contraception (UNAIDS 2005). Yet, even though contraception is more cost-effective than Nevirapine to prevent mother-to-child-transmission (Reynolds et al. 2005), it is often not an integral part of HIV prevention programs (Prata et al. 2008).

Voluntary family planning is an effective way of controlling fertility within a human rights framework by giving couples the ability to have their desired family size (Prata 2007). This type of programming emphasizes the importance of not telling women how many children they should have, but rather that they have a right and the freedom to choose how to control their own fertility. In a documentation of family planning social

marketing programs that starts in Calcutta (now Kolkata), India, author Phil Harvey takes a comprehensive look into how family planning can reach even the poorest of the poor in even the most distant of places. Entitling his book, "Let Every Child Be Wanted," Harvey demonstrates that reaching low-income families can be achieved rapidly and within a human rights framework (Harvey 1999). To effectively control one's own fertility, women and couples need to have access to correct information about contraceptive methods and the ability to afford the method of their choosing. The end result of which will positively impact the health of women and children, easing pressure on natural resources, and increasing families' chances to escape the trap of poverty (Cleland et al. 2006).

Progressive Policies

Governments in SSA have recently taken many steps towards ensuring access to family planning. In fact, policies do exist in most African countries to reduce fertility (Cleland 2009). In 2001, the African Union Abuja Health Declaration was made by member states of the African Union (AU). The declaration was to commit 15% of national budgets (excluding foreign aide) to health. It was agreed, however, that in order to realistically leverage 15% of domestic resources towards health, African Governments should be free from external debt and member nations of the Organisation for Economic Co-operation and Development should make a minimum contribution of 0.7% of their GDP to official development assistance (Govender et al. 2008).

In September of 2006, The Maputo Plan of Action on Sexual and Reproductive Health and Rights was created in support of earlier efforts to increase commitment to health and in particular, to women's health. The ultimate goal of the Maputo Plan of Action is for African Governments, civil society, the private sector, and development partners to work together with renewed effort to ensure universal access to sexual and reproductive health by 2015 in all countries in Africa. Governments are encouraged to compare their national plans relating to nine 'action areas' to ensure sexual and reproductive health and rights and identify gaps and areas for improvement. Family planning and access to safe abortion—to the extent of the law, are key components of the Maputo Plan, which indicates that (i) family planning be repositioned as a key strategy for the attainment of the Millennium Development Goals (MDGs), (ii) incidence of unsafe abortion be reduced, and (iii) SRH commodity security strategies (e.g. methods of contraception) be achieved. In short, the policy is progressive. The Plan concludes that "African leaders have a civic obligation to respond to the Sexual and Reproductive Health needs and Rights of their people. This Action Plan is a clear demonstration of their commitment to advance Sexual and Reproductive Health and Rights in Africa" (AU 2006).

However, although the policies are progressive, implementation of both the Abuja Declaration and the Maputo Plan has been difficult, if not unrealistic. As of 2006, no sub-Saharan African countries reached the goal of allocating 15% of national budgets to health (Govender 2008). In fact, many finance ministers are opposed to the Abuja goal.

In Malawi, for example, during budget negotiations in 2006, the Secretary to the Treasury was quoted saying, "*We seem to have too many of these declarations. Health is asking for 15%, Education is asking for 20%, Agriculture, 25%. If we try to fulfill all these commitments we will end up allocating all our resources to a few sectors only. That's unrealistic"* (Zimbabwe Govt. 2007). Furthermore, external aide can be volatile and government spending on health in Africa tends to rise and fall with donor funds—with the exception of monies for HIV/AIDS. The challenge which makes the Abuja Declaration unrealistic for most African governments is their current dependency on funding that fluctuates, and thus is beneficial for the short-term, but undependable for the long-term.

Although every country in the African Union signed the Maputo Plan of Action, only 20 countries[2] ratified the plan since 2006. Many religious leaders, however, are pressuring governments against its implementation. This is in large part due to the plan's call to provide access to safe abortion services—although the document explicitly states to do so *where law allows*. The restrictive laws in SSA regarding abortion have not changed significantly in the last decade and it is unlikely that such laws will be amended in the near future (UN Pop Div. 1999, CRR 2008). Therefore, countries in SSA would benefit the most from implementing the sections of the Maputo Plan of Action which call for the revitalization of family planning programs.

[2] Zambia, Zimbabwe, Togo, Tanzania, Seychelles, Senegal, South Africa, Rwanda, Nigeria, Nambibia, Mauritania, Mozambique, Malawi, Mali, Liberia, Lesotho, Libya, Ghana, Gambia, Djibouti, Comoros, Cape Verde, Burkina Faso, Benin, Angola.

METHODS

In order to examine the level of implementation and reach of family planning programs in SSA, Ross et al's (2007) family planning effort scores across two decades were reviewed. For further information on current progress, CPR of modern method use and unmet need for family planning were also analyzed using data from Demographic and Health Surveys and Population Reference Bureau.

To describe the importance of revitalizing family planning programs in SSA, rising unmet need for family planning, changes in TFR over time and resulting population growth were taken into consideration. This was followed by an assessment of the impact that rapid population growth is having on health and development throughout the continent. Literature targeting the population growth factor on the environment, sustainability of natural resources, maternal and child health, as well as poverty reduction strategies was considered in detail.

To determine the amount of effort that would be necessary for the future progress and success of family planning programs, the number of new users of modern contraception needed to maintain current CPR and to double CPR in 5 years were calculated for seven sub-Saharan African countries. Data was obtained from the Population Reference Bureau and the US Census Bureau International Database.

Literature on successful strategies for revitalizing family planning programs was reviewed to determine those that would enable African Governments to make significant progress in improving access to contraception. The success potential of recommended strategies was verified also using data from available Demographic and Health Surveys.

REVITALIZING FAMILY PLANNING PROGRAMS

Current Effort

In analyses that span over 30 years, Ross J et al (1996, 2005, 2007) examine the intensity and types of effort exerted by national family planning programs in developing countries. The Family Planning Effort (FPE) score is intended to reflect the quality in policy positions, services, evaluation methods, and method availability. Authors found that efforts in family planning are continuing to increase across the developing world. However, the mean FPE score (out of 100) across the 30 program features analyzed was only 56[3] in Anglophone Africa[4] and 53 in Francophone Africa[5] in 2004 (Ross et al. 2007). This is only a modest increase from a score of 44 for SSA in 1994 (Ross et al. 1996).

Scores for service quality and access to contraceptive methods are particularly low in comparison to those for policy positions in SSA. Reasons for this discrepancy include a

[3] Family Planning Effort Score Index: Strong program = 80+, Moderate = 55-79, Weak = 25-54, Very weak/None = 0-20.
[4] Ethiopia, Gambia, Ghana, Lesotho, Liberia, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.
[5] Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Democratic Republic of Congo, Guinea, Guinea-Bissau, Madagascar, Mali, Mauritania, Niger, Repbulic of Congo, Rwanda, Senegal, and Togo.

loss of staff for family planning and inefficient delivery systems that become saturated quickly with more prioritized supplies, such as condoms. Inadvertently, this can threaten the availability of other contraceptives. The former can be attributed in large part to the increase in employment opportunities in HIV/AIDS programs, waning interest in family planning projects, an already overly strained workforce, shortage in human resources, and brain drain (Ross 2002). In fact, although Africa carries 24% of the global burden of disease, it has only 3% of the world's health workforce (WHO 2006). The latter can be attributed in part to a lack of political will to focus on family planning, as well as reliance on unreliable donor funds to ensure family planning supply lines. For example, international population assistance for family planning has declined from 30% in 2001 to less than 10% in 2004 (Leahy 2007, Ethelston et al. 2004).

Fortunately, there is strong international commitment to fighting the spread of HIV/AIDS, and condoms have the added benefit of protecting individuals from not just sexually transmitted infections but pregnancy as well (Prata et al. 2008). However, there is a 50% unmet demand for condoms worldwide (UNAIDS 2006). In countries like Zimbabwe and Mozambique, for example, the average number of male and female condoms donated annually between 2001 and 2004 per male aged 15 to 49 years was only 33 and 8, respectively (Chaya N and Haddock S 2006).

Current Access

Current trends in CPR are also a good proxy for a country's success in the implementation of and sustained efforts in family planning programs. At present, use of modern methods by married women is highest in Latin America (63%) and lowest in SSA (18%) (PRB 2008). The current contraceptive level in SSA represents only a modest increase from 13% registered nearly a decade ago (PRB 2002). Furthermore, the unmet demand for family planning has experienced little reduction on average over the last decade. Examples of seven sub-Saharan African countries[6] in Table 1 demonstrate not only the disparity in access across the continent, but also the minimal gains in CPR and in the reduction of unmet need for family planning over nearly two decades.

From around the 1990s, Demographic and Health Survey (DHS) data indicate that increases in CPR of modern method use in Ghana, Malawi, Senegal, and Tanzania have been modest, and in Kenya, Uganda, and Nigeria (which has yet to achieve double-digit levels of modern contraceptive use) have ceased altogether (Figure 1). Furthermore, according to recent DHS data from 31 countries, the region has an average unmet need for modern contraception of 30%. Nineteen of the 31 countries have a reported unmet need for family planning of up to 49%. As a result there are more women (25million) with an unmet need for contraception, than women currently using modern methods (18million) (Westoff 2006, PRB 2008).

[6] Kenya, Ghana, Malawi, Senegal, Nigeria, Tanzania, Uganda

Analysis of DHS data from 27 sub-Saharan African countries also indicate that current fertility does not match up with wanted fertility. Consistently, wanted fertility among women surveyed is lower than current fertility, further illustrating the inability of present national efforts in family planning to meet current demand for fertility regulation (Figure 2). In a recent study conducted by Gillespie et al. (2007), authors analyzed DHS from 41 different countries, finding that there is a strong relationship between socioeconomic status and level of unwanted fertility. Although there was wide variation among the countries, fertility in the poorest quintiles was more than twice that found in wealthier quintiles. Authors of this study conclude that higher fertility and lower CPR should be acknowledged as an inequity (Gillespie 2007).

The Rationale

It is a human rights violation when couples are unable to determine when and whether to have a child. As mentioned above, the unmet need for contraception in SSA, especially among the poor is staggering and this bears great significance on the importance of revitalizing existing, but very fragile family planning efforts. However, there are *many* reasons why it is important that African Governments take on the revitalization of their family planning programs. As Cleland et al. (2006) write, "Family planning is unique among health interventions in the breadth of its benefits—family planning decreases maternal and child mortality, empowers women, reduces poverty and it lessons stress on the natural and political environment."

Population Growth Factor

In sub-Saharan Africa the TFR is 5.5, considerably higher than the TFR of Latin America (2.5) and Asia (2.4 excluding China). Fifteen of the 31 Sub-Saharan African countries with a recent DHS have TFRs that exceed 6.0 (PRB, 2007). This level is essentially unchanged from the late 1990s, when the region's overall TFR was 5.6 (PRB 2002). It is estimated that the mid-year population in 2008 for SSA was 828 million. By the year 2050, the population is expected to rise by nearly one billion people (1,761 million) (UN Population Division 2007). This means that just to maintain current levels of education, with no level of improvement, the developing world must train 2 million additional teachers every year. With increasing levels of population, however, this will not even be enough (MSI 2007).

Very high fertility is directly associated with low contraceptive use and high unmet need for family planning. As a consequence of high fertility, most SSA countries are facing rapid population growth. The population growth factor has made international experts from all disciplines question the ability of developing countries to achieve any of the MDGs by 2015[7]. In 2007, the All Party Parliamentary Group convened to discuss the role of population on health and development, and concluded that "the MDGs are difficult or impossible to achieve with current levels of population growth in the least developed countries and regions, unless attention is paid to the population growth factor" (APPG 2007).

[7] With the exception of MDG no. 7 where links are still under investigation.

Poverty Reduction

Poverty and socio-economic disparities are closely linked to rapid population growth. Analysis comparing wealth quintiles in Kenya against CPR, unmet need for family planning, and TFR show telling results. As socioeconomic status decreases, so does CPR. In turn, TFR increases with socioeconomic group. Consequently, the unmet need for family planning increases, with the exception of the third and fourth wealth quintile—where they differ by only 1%. The increase in demand for contraception among the poor indicates that they do not necessarily want higher fertility and do experience significant barriers to accessing contraceptive methods (Figure 3). This has translated into Kenya's current and future population (Table 2).

In SSA, it is estimated that between 8% to 25% of young females drop out of school because of pregnancy. Furthermore, as education systems and families are put under strain, it is the younger females who tend to suffer the most in comparison to their younger male counterparts. Consequently, a decrease in CPR within a country is associated with lower attendance in school among girls. Without sufficient education, it is difficult to escape the barrier of poverty (UNFPA 2002).

Between 1990 and 2001, the percentage of individuals living in extreme poverty (< US $1.00/day) in SSA saw only what could be called a "modest" increase from 44.6% to 46.4%. However, because of very high fertility, the number of people living in poverty

grew substantially from 231 million to 318 million. This translates into a 38% increase or 87 million people living on less than one US dollar a day (UN Population Division). Today, 7 of every 10 Sub-Saharan Africans live in poverty (less than US$2 per day), with 4 of every 10 Sub-Saharan Africans living in extreme poverty (less than US$1 per day) (Chen S and Ravallion M 2007). Examples of sub-Saharan African countries where the vast majority of people live in poverty include Uganda with 97%, Nigeria with 91%, and Zambia with 87% (World Bank 2005).

Resource Scarcity

The result of rapid population growth can be devastating to a country's future health and development. In an environment of extremely scarce financial resources, investing in family planning can result in hundreds of millions of dollars in savings in national development work. In Zambia, for example, an investment of US$27million would save $111million dollars by 2015 in the areas of malaria ($4M), maternal health ($37M), water & sanitation ($17M), immunization ($17M) and education ($37M) (USAID 2006). The return on investment in family planning for other sub-Saharan African countries is as dramatic (Figure 4).

High fertility can also pose a significant barrier to reducing health disparities where food and water security is a distant scenario. Today SSA suffers from water scarcity, food shortages, and inadequate sanitation. Between the years 1990 and 2002 there were 34 million *additional* people living with hunger in this part of the African continent (UN

2005). On average, 5,000 children die every year in developing countries because a lack of access to clean water or proper sanitation (PAI 2007). A large proportion of these deaths occur in SSA. Kenya, for example, has actually seen a rise in child mortality since the 1980's in part because current supplies of vaccines—meant to protect children from dying from diseases that are spread through unclean water and poor sanitation—have been unable to keep up with the country's population growth (LSTMH 2007).

Furthermore, internal conflict has often been a direct result of desperation over the need for resources that continue to remain at crisis levels. Reduced farm supplies and water per capita have both been associated with civil unrest (Cincotta et al. 2003). Until African governments are able to address the large burden of unmet need for family planning, they will be unable to provide their citizens with even their basic human rights. Consequently, as populations begin to grow, so will the number of 20 to 24 year olds searching for employment. A lack of resources, a lack of opportunity, and a growth in what population experts have termed "the youth bulge", will all fuel political instability. There is growing evidence that countries with high fertility, high mortality, a more youthful and less-balanced age structure tend to be less stable (PAI 2007). Without an emphasis on family planning, countries in SSA will continue to fit this profile.

Maternal and Child Health

The consequence of a high unmet need for contraception is unintended pregnancy—the burden of which weighs unequally on the shoulders of the poor (Singh 2003, Gillespie et

al. 2007). In a recent study examining data from the latest Demographic and Health Surveys from 41 countries, researchers found that the number of unwanted births in the poorest quintile were more than twice that found in the wealthiest quintiles (Gillespie et al. 2007). The significance of this finding is that increased fertility is not only associated with unintended pregnancy, but consequently with poor maternal and child health outcomes.

In SSA, 95% to 98% of abortions are performed under unsafe conditions. This is the equivalent of 4.5million unsafe abortions as a result of unintended pregnancy and inadequate infrastructure for safe abortion care, including post-abortion services (AGI 2007, Sedgh et al. 2007). Consequently, unsafe abortions account for as high as 24% of all maternal deaths in the sub-continent (Hill et al. 2005).

Overall, an African woman has a 1 in 26 lifetime risk of maternal death (UNICEF 2009). And for every woman who dies from maternal death, studies indicate that as high as 30 additional women will suffer from severe morbidities that will last her a lifetime (Prual et al. 2000). These include infections, fistula, infertility, and incontinence (Fortney and Smith 1999). Furthermore, the loss of a mother can be detrimental to a child's health and wellbeing. Annually, nearly 220,000 children lose their mothers from abortion-related deaths alone (WHO 2007). Ensuring access to family planning would prevent hundreds of thousands of children from losing their mothers every year.

Unfortunately, SSA has not experienced a significant reduction in maternal mortality in recent years (Hill et al. 2005). Among the European and other industrialized nations where women have good access to family planning services and consequently, good access to maternal healthcare, fewer than one in 16,400 will die of complications during pregnancy and childbirth. By contrast, for every 109 births in SSA, a woman will die in pregnancy or childbirth—this is an almost 750-fold difference (Women Deliver 2006).

Africa is also faced by a severe shortage in human resources, including skilled healthcare personnel. Although some African countries do demonstrate a net increase in healthcare workforce, progress towards reaching the World Health Organization's target of 2.28 healthcare professionals per 1,000 individuals is severely restricted given the current trends in population growth. To reach the WHO target, a recent study suggests it could take 36 years for physicians and 29 years for nurses and midwives. Some countries in Africa would not even be able to make it. The study also indicates that only two of the twelve African countries analyzed[8] can maintain their current density of healthcare workers given the numbers of physicians and nurses/midwives being trained and current population growth (Kinfu et al. 2009).

Without access to emergency obstetric care, a skilled birth attendant, or a technology that can be self-administered for the prevention of direct causes of maternal death,

[8] Cote d'Ivoire and Ethiopia (Other countries analyzed are: Central African Republic, Democratic Republic of the Congo, Kenya, Liberia, Madagascar, Rwanda, Sierra Leone, Uganda, United Republic of Tanzania, and Zambia)

females living in SSA are at an inhumane disadvantage during pregnancy and childbirth. Therefore, improving access to family planning could avert thousands of maternal deaths. In SSA, alone, an estimated 2,200 to 16,400 potential maternal deaths could be averted by improving access to family planning with 20 to 80% program coverage (Prata et al. 2008).

As mentioned previously, high levels of fertility are also associated with low levels of infant and child survival (Prata et al. 2008). Nearly half of the world's under-five child mortality happens in Africa. This is mainly because larger families tend to have closely spaced births, and a baby that is born less than 18 months after its sibling is three times more likely to die than a baby born after 36 months (UNECA 2005, UK DFID 2007). Consequently, spacing births by greater than 2 years can result in saving the lives of an estimated one million infants (UNFPA 2007). Unfortunately, if current trends in population growth continue, SSA is estimated to see only a 13% decrease in infant mortality by 2015—much lower than the target of two-thirds (APHRC 2007).

In a region where HIV/AIDS is causing large-scale devastation, family planning is also important in the prevention of mother-to-child transmission of HIV (PMTCT). Currently, there is a 25% unmet need for contraception among HIV-positive women (UNAIDS 2005). Not only is family planning considered more cost-effective than Niverapine in PMTCT, family planning also prevents more MTCT than do antiretroviral drugs (USAID 2006).

There is a significant economic cost that should be taken into consideration as well. Worldwide, 5 million women are hospitalized each year for treatment of abortion-related complications, such as hemorrhage and sepsis. For developing regions, such as SSA, this translates into loss of productivity, and economic burden on public health systems that are already suffering from insufficient human and financial resources (WHO 2007).

The Strategy

The largest cohorts of people in sub-Saharan Africa's history are entering and moving through their reproductive years. Forty-three percent of sub-Saharan Africa's population is below the age of 15 (PRB 2007). Given the current population growth rate and the projected rise in female population 15-49 years old, family planning programs will have to run much faster, just to keep the current low modern contraceptive use. Using mid-year estimates for 2008 and mid-year projections for 2013, the number of new users necessary to maintain or double current CPR can be easily calculated. Table 2 references the seven sub-Saharan African countries examined in Table 1 by estimating just this. Among selected countries, the number of new users necessary for CPR to remain stable in 5 years time ranged from 238,000 (Ghana) to 1.6million (Kenya). To double contraceptive use in the same number of years, the number of new users needed ranged from 1.8 million (Senegal) to 15.4 million (Kenya).

In the 1993 World Development Report entitled "Investing in Health", the World Bank considered family planning a highly cost effective public health intervention (WB 1993). Recent modeling to assess the relative cost-effectiveness of implementing safe motherhood interventions in SSA has suggested that family planning is the most cost-effective strategy for averting maternal deaths in low-resource settings (Prata et al. 2008 presentation). However, to make any progress in reducing the unmet need for family planning, efforts must have the ability to reach millions. The task set upon African Governments to revitalize family planning programs must take this into consideration.

There are four critical steps that governments can take that will lead to immediate and long-term benefits for its population. These steps are a) increase knowledge among the general public about the safety of family planning methods; b) reduce the costs of contraception to ensure that it is genuinely affordable to even the poorest families; c) ensure contraceptive supply is not disrupted by making family planning an integral and permanent line item in national/state health budgets; and d) take immediate action to remove barriers that are hindering access to family planning methods

Increase Family Planning Knowledge

Misinformation is highly associated with choosing to stop or not use contraception. In a paper examining barriers to fertility regulation, authors found that fear and misinformation surrounding possible side effects or long-term consequences to one's health inhibit women from controlling their own fertility (Campbell et al. 2006).

Although most contraceptives have side effects, the degree to which they will have a harmful impact on one's health is often severely exaggerated. A study of 8 developing countries showed that 50-70% of women thought the use of oral contraceptive pills was a considerable health risk, even though in a low-resource setting, having a baby can be up to 1,000 times as dangerous as taking oral contraceptives (Grubb 1987).

In situations where families are not aware that a safe method of fertility regulation exists, recent theoretical discussions on fertility transition suggest that women have a latent desire for controlling their own family size and will only act upon their desire when they perceive costs of using contraception to be lower than the benefits *and* when they recognize that options for contraception are available (Campbell 2009). In what economists call 'normal consumer behavior', demand for a new product often arises when consumers become aware that the product exists. This holds true even in the case of contraception (Campbell 2006).

Analysis of DHS data on the trends in family planning prevalence and lack of knowledge in 19 countries in SSA[9] shows striking results. An increase in CPR for many of the countries has yet to reach double digits, let alone 50% (Figure 5a). Analysis of the percent change in lack of knowledge and in fear of side effects among non-users gives a clear illustration of why CPR remains largely unchanged for many sub-Saharan African

[9] Benin, Burkina Faso, Cameroon, Chad, Eritrea, Ghana, Kenya, Namibia, Madgascar, Malawi, Mali, Niger, Nigeria, Rwanda, Senegal, Tanzania, Uganda, Zambia, Zimbabwe (Ethiopia and Mozambique showed in graph but not included in calculations because DHS data was collected too close together).

countries (Figure 5b). Although knowledge of contraception has been growing (slightly) over the past decade, fear of side effects has been rising dramatically—ranging from a 22% increase in Mali between 1995-1996 and 2006, to a 93% increase in Madagascar between 1992 and 2003-2004. On average, among the 19 countries analyzed, there has been a 64% increase in fear over side effects in using family planning among non-users. This finding indicates that current non-users have knowledge of contraceptive methods, but lack correct information about them. It may also mean that as new cohorts of young individuals enter their reproductive years they are becoming more aware of contraception, but are not yet receiving accurate information. Family planning programs must directly tackle the problem of incorrect knowledge. They can do so by using simple, single messages that empower women and families such as "Family Planning is Safe" or "Family Planning is Safe and Works."

According to Frost and Dodoo (2009), there continues to exist opposition to contraceptive use among African men, restricting dialogue on birth spacing and limiting between African couples. Efforts to improve reproductive health should thus try to involve men to mitigate this issue. However, family planning is not an insurmountable obstacle to those who wish to determine their own fertility. It is important to recognize that women often do not know that there are many methods of family planning, including those that do not require negotiation with one's partner. This can be significant in partnerships where use of a contraceptive method requires negotiation with one's partner.

Make Family Planning Affordable

Given current and rising levels of people living in poverty, it cannot be expected that consumers will pay the increasing costs of family planning services. Current costs of family planning commodities should be critically examined and prices should be adjusted making affordability and necessary subsidies a primary concern. The poorest quintile of the population suffers from the highest unmet need for family planning and shoulders the largest burden of maternal and child mortality. Importantly, the poor are also extremely sensitive to price changes and the results could be a decline in contraceptive use (Prata et al. 2001).

Research on the experiences of social marketing programs for condoms demonstrate that when the annual cost of condoms is greater than 1% of the gross national product, condom-use declines dramatically. Therefore, it is important to ensure that contraception is genuinely affordable to the poorest families. Research suggests that condoms be no more than 1%, but preferably 0.7% of the GNP in each country. Oral contraceptive pills should be priced no higher than 1% of the GNP. Long-term methods, such as injectables and intrauterine devices should be priced lower since the total cost is incurred at the time of uptake (Harvey 1999).

Today, those living in SSA are under the greatest threat, where 77% of the population is unable to pay for contraception (Figure 6). In comparison to other aid-dependent

nations, SSA has the greatest percentage of individuals who cannot afford the cost of family planning (Green 2002). To reduce rising inequalities that place a high burden on society as a whole, family planning methods must be supplied to the poor at a cost they can afford. The overall, long-term burden for any country is ultimately higher if a large proportion of the poor cannot afford to determine the size of their own families.

Ensure Family Planning Supplies

Contraception security is a third essential area where far-sighted government policy has been shown to make a difference. Steady flow of family planning commodities is the responsibility of every government – it cannot allow the supply of products, which are so essential to protecting the health of the population, to get disrupted. This means that governments must include family planning as a line item in their national and regional health budgets. Currently, most governments are relying on donors to provide funding for family planning costs, but donor supply is unsteady and unpredictable. For example, in 2007, the estimated cost of contraceptives was US $873 million. However, donor support for that same year was only $223 million, nearly 75% less than what developing countries needed for contraceptive commodities (Figure 7)**.**

Outside funding should be sought as a supplement to a government's commitment but should never be the sole source. Figure 7 illustrates the volatility of donor funds as well as the insufficiency of those funds to meet the needs in developing countries with respect to securing contraceptive commodities. Therefore, it is important to ensure

supply of contraceptives by making family planning a **permanent line item** in health care system budgets. To supplement vulnerable financial infrastructure for health, governments in Africa may also consider the promise of "south-south" supply for ensuring contraceptive security.

Remove Barriers to Access

Immediate action must be taken by governments in Africa to remove barriers which are currently hindering access to family planning methods. Although barriers experienced by women interested in having fewer children include misinformation, expense, and inadequate supply, there are many more which deserve the public sector's full attention (Campbell 2006). Governments committed to reducing unmet need can take concrete steps to remove obstacles to family planning that are legal, facility-based, and provider based, to improve access within their own country.

Legal barriers include formal laws and restrictions which deny females of reproductive age access to family planning services. For example, keeping oral contraceptive pills on prescription disallows the ability to socially market them – an important distribution and financing mechanism in low resource settings. Other restrictions include what level of provider can/should provide certain contraceptive methods. For example, rural women in many part of Africa receive services from community-based distributors, who are legally only allowed to provide oral contraceptives or even condoms. However, in the majority of African countries with recent DHS data, women intending to use

contraception in the future prefer injectables—ranging from 24% (Cameroon) to as high as 72% (Ethiopia). More than 45% of women would choose to use an injectable in more than half of those countries where it is the method of choice. In countries where injectables are not the first choice, it is often the second and only rarely the third.

Pilot projects in Uganda, Madagascar, and Ethiopia have also demonstrated that injectable contraceptive provision by community-based workers is safe and effective in reaching women who do not have ready access to public health facilities. Unfortunately, provision of injectables is restricted to skilled providers in much of Africa despite the evidence (FHI 2007, Stanback 2007). Similarly, the satisfactory provision of IUD insertion by non-physicians has been established since the early 80's (Eren et al, 1983; Farr et al, 1998), but today these services are provided most often by physicians and less often by select mid-level providers such as Clinical Officers.

The provision of non-surgical long term methods of contraception should be an integral part of pre-service training for all levels of health workers, not only those working on higher level facilities. The reproductive rights of all women of reproductive age, regardless of age and marital status, need to be protected and facilitated by such non-restrictive laws.

Facility-based barriers are not codified in law, but their de-facto practice creates unnecessary barriers to accessing family planning services such as clinics refusing to see

adolescent patients or only providing contraceptive services on specific days of the week. In addition, provision of services of poor quality, including limited contraceptive choice and inability to switch methods if unsatisfied with the prescribed one, are all facility restrictions imposed on clients that hinder access. Such facility-based barriers provide further rationale for the importance of making family planning more accessible, by allowing community outreach workers—who are trusted members of their own community and often women themselves—to provide all family planning methods except tubal ligation and vasectomy.

Finally, ***provider-based barriers*** prevent women from accessing certain methods of contraception through discouragement or non-evidence based clinical "diagnoses" that emerge from personal biases and beliefs. Providers have been widely documented to discourage individuals from accessing hormonal methods by insisting on costly and medically unnecessary blood tests, or making it difficult (or impossible) for women to obtain the method of their choice if they are nulliparous, have recently had an abortion, or are of a certain age. Moreover, women using oral contraceptives are often required to visit the provider every month or refused access to a method simply because they are not on the first day of their menstruation (Campbell 2006).

Role of the Private Sector

Governments should not have to carry out these strategies alone. Engaging the private sector to relay the information about what methods of family planning are available,

where you can access those methods, and the cost-benefit of using different methods can be very fruitful. Among private sector strategies for the finance and delivery of health services, many have been found to have impact while still being cost-effective. These examples including social franchising, social marketing, community-based distribution of socially marketed goods such as contraceptives, performance-based aide such as a voucher system, and contracting out services such as training or health delivery (Harvey 1999, IHSD 2004, Peters et al. 2004, Prata 2005). With assistance from the private sector, governments can revitalize their role within family planning programs by taking primary responsibility for health systems management, including the dissemination of accurate information and the correction of misinformation (Musgrove 1996).

CONCLUSIONS

African governments are in a position to demonstrate strong leadership by taking on the important policy commitment to pave the way for improved health and prosperity in future generations. African governments should consider family planning an urgent priority as it is both a feasible and achievable intervention that can be implemented *now*. To ensure that African women have not only the freedom but the choice to control their own fertility, current family planning programs will benefit from focusing on the four steps we have proposed. Addressing the unmet need for contraception in Africa can only be done when program planners consider the revitalization of current family

planning programs. It is important to know that family planning programs can be implemented within a human rights framework.

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TABLE 1: Fertility indicators for selected sub-Saharan African countries

Country	DHS year	Total Fertility Rate	Wanted Fertility Rate	Unmet Need for FP (%)	Met need for FP (%)
Ghana					
	2003	4.4	3.7	34	18.7
	1998	4.6	3.7	24.3	13.3
	1993	5.5	4.2	38.6	10.1
	1988	6.4	5.3		5.2
Kenya					
	2003	4.9	3.6	24.5	31.5
	1998	4.7	3.5	23.9	31.5
	1993	5.4	3.4	36.4	27.3
	1989	6.7	4.4		17.9
Malawi					
	2004	6	4.9	27.6	28.1
	2000	6.3	5.2	29.7	26.1
	1992	6.7	5.7	36.3	7.4
Nigeria					
	2003	5.7	5.3	16.9	8.2
	1999	5.2	4.8	17.5	8.6
	1990	6	5.8	20.8	3.5
Senegal					
	2005	5.3	4.5	31.6	10.3
	1997	5.7	4.6	32.6	8.1
	1992–1993	6	5.1	27.9	4.8
Tanzania					
	2004	5.7	4.9	21.8	20
	1999	5.6	4.8	21.8	16.9
	1996	5.8	5.1	23.9	13.3
	1992	6.2	5.6	30.1	6.6
Uganda					
	2006	6.7	5.1	40.6	17.9
	2000–2001	6.9	5.3	34.6	18.2
	1995	6.9	5.6	29	7.8
	1988	7.5	6.4	53.7	2.5

***Source** : Respective national DHS final reports. CPR data refer to women aged 15 to 49 who are currently married or in union and are currently using modern contraception.*

Table 2: Projections of the number of new users necessary given current population growth n selected sub-Saharan African countries

Country	CPR*	Population mid-2008 (millions)*	# Current modern method users (millions)	Projected Population mid-2013 (millions)**	# of new users to *maintain* CPR in 2013	100% increase in CPR	# of new users needed to *double* CPR by 2013
Ghana	14%	23.9	3.3	25.6	238,000	28%	3,822,000
Kenya	32%	38	12.2	43.0	1,600,000	64%	15,360,000
Malawi	39%	13.6	5.3	15.7	819,000	78%	6,942,000
Nigeria	8%	148.1	11.8	161.2	1,048,000	16%	13,944,000
Senegal	10%	12.7	1.3	15.2	250,000	20%	1,770,000
Tanzania	20%	40.2	8.0	44.5	860,000	40%	9,760,000
Uganda	18%	29.2	5.3	37.2	1,440,000	36%	8,136,000

***Source:** *Population Reference Bureau (2008). World Population Factsheet.*

****Source:** *US Census Bureau, International Data Base (Dec 15, 2008)*

FIGURE 1:

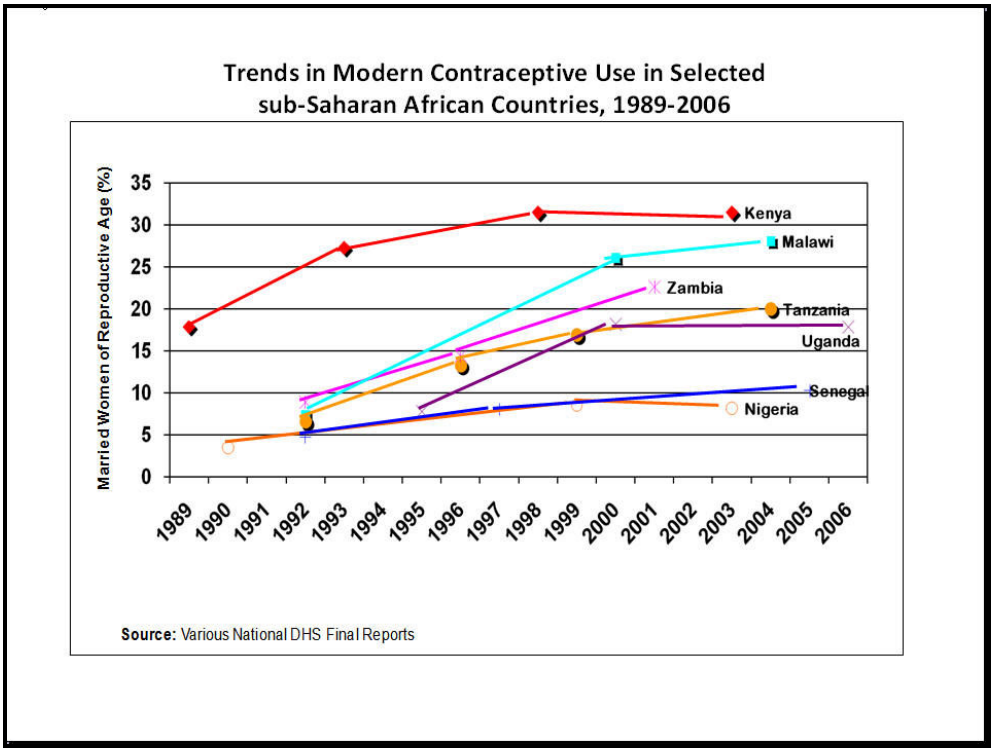
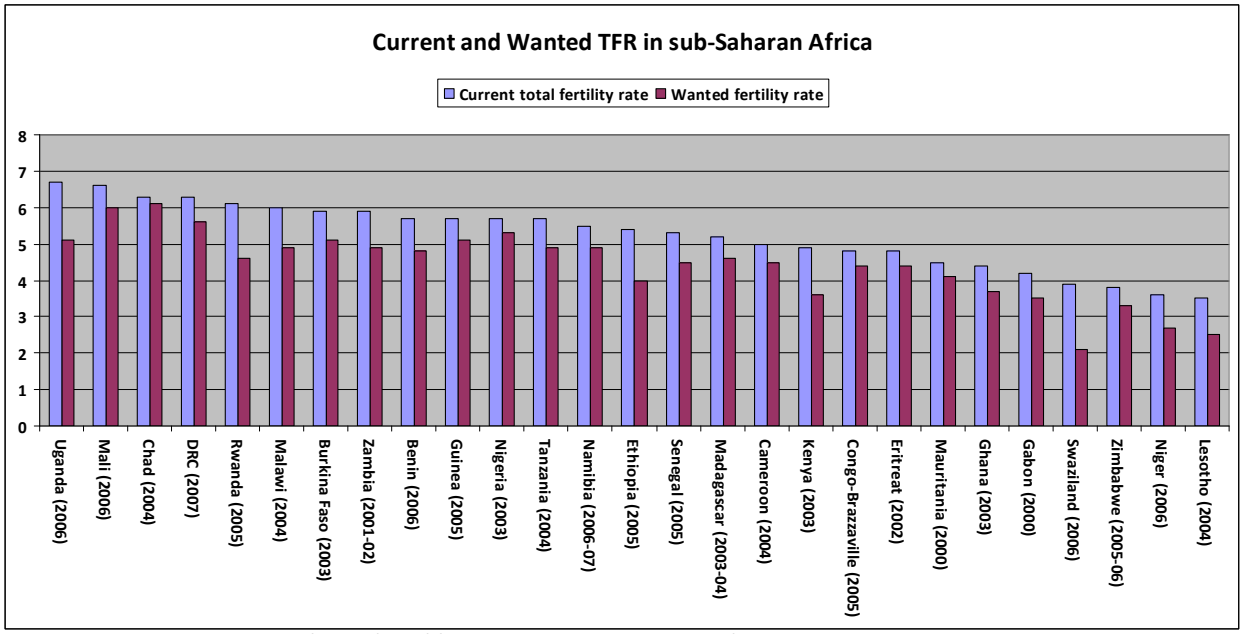

Trends in Modern Contraceptive Use in Selected sub-Saharan African Countries, 1989-2006
Married Women of Reproductive Age (%)
35
30
25
20
15
10
5
0
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
Kenya
Malawi
Zambia
Tanzania
Uganda
Senegal
Nigeria
Source: Various National DHS Final Reports

FIGURE 2:



Source: Respective Demographic and Health Surveys. Macro International.

FIGURE 3

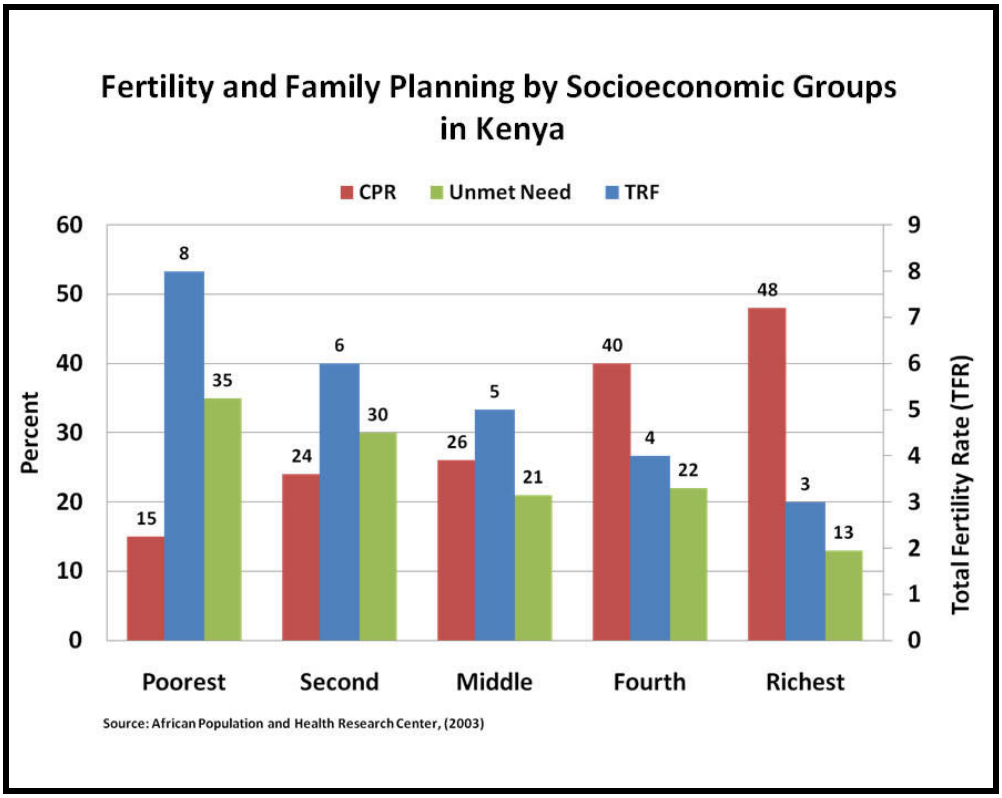
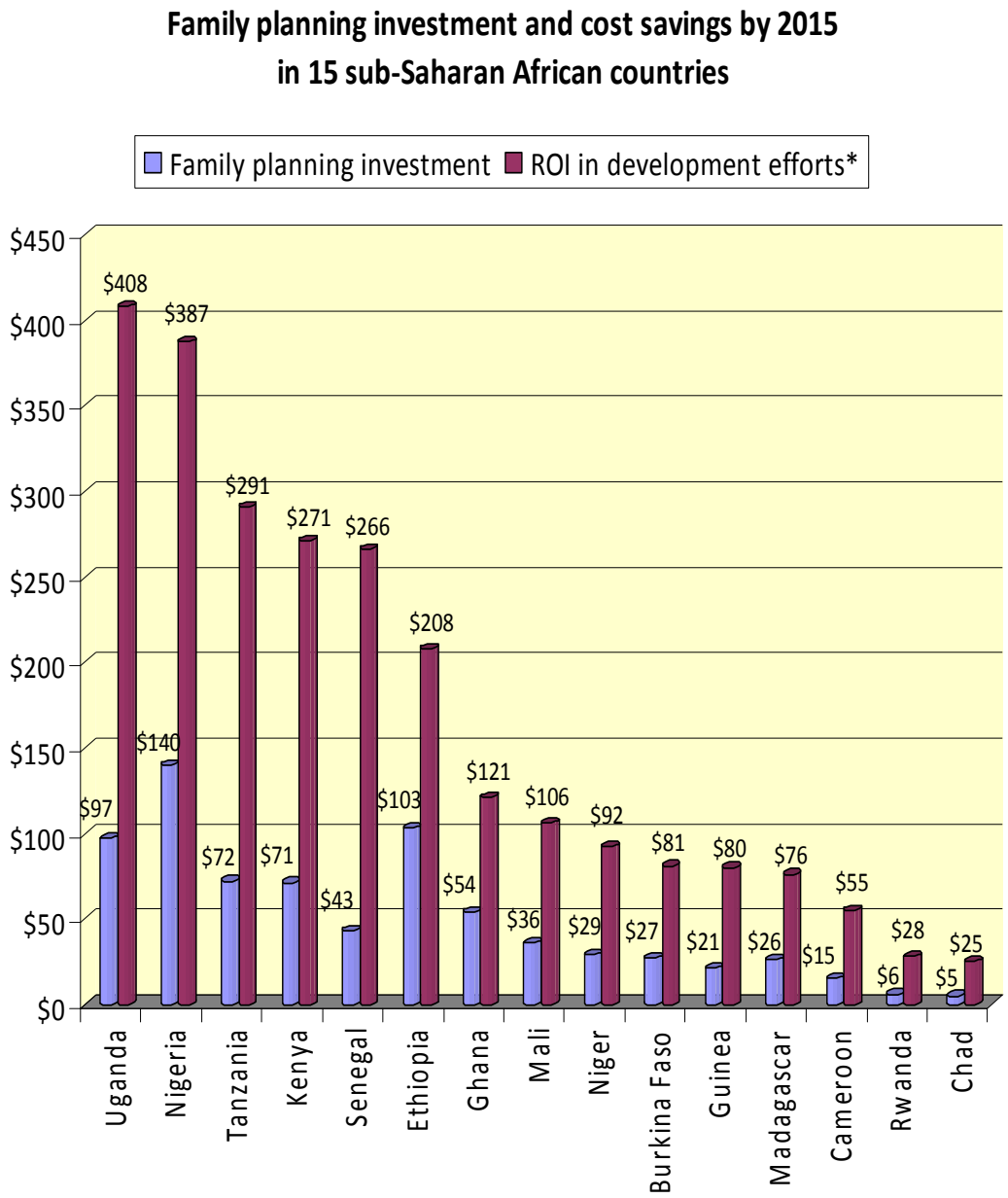
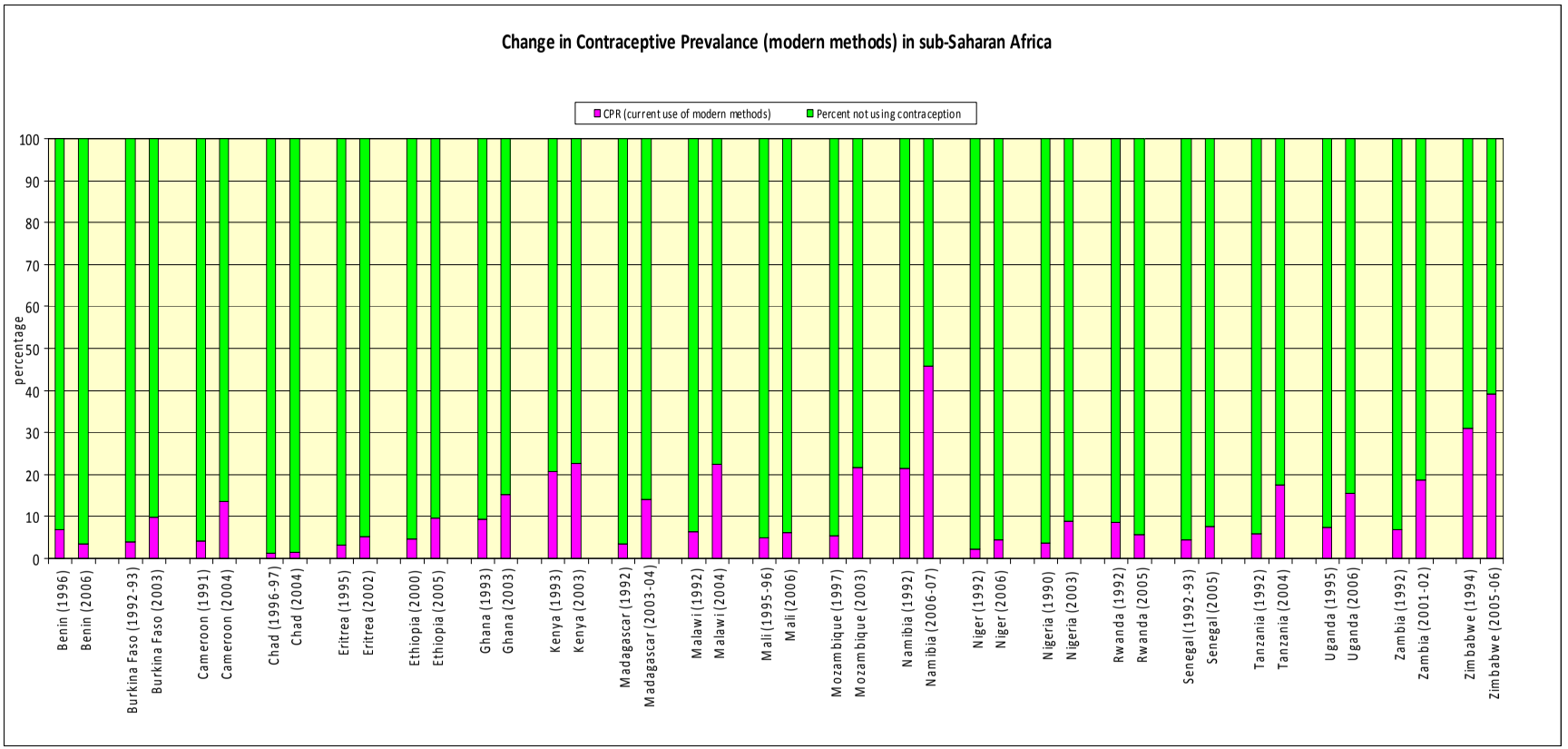

Fertility and Family Planning by Socioeconomic Groups in Kenya
CPR
Unmet Need
TRF
Percent
Total Fertility Rate (TFR)
60
50
40
30
20
10
0
9
8
7
6
5
4
3
2
1
0
15
8
35
24
6
30
26
5
21
40
4
22
48
3
13
Poorest
Second
Middle
Fourth
Richest
Source: African Population and Health Research Center, (2003)

FIGURE 4



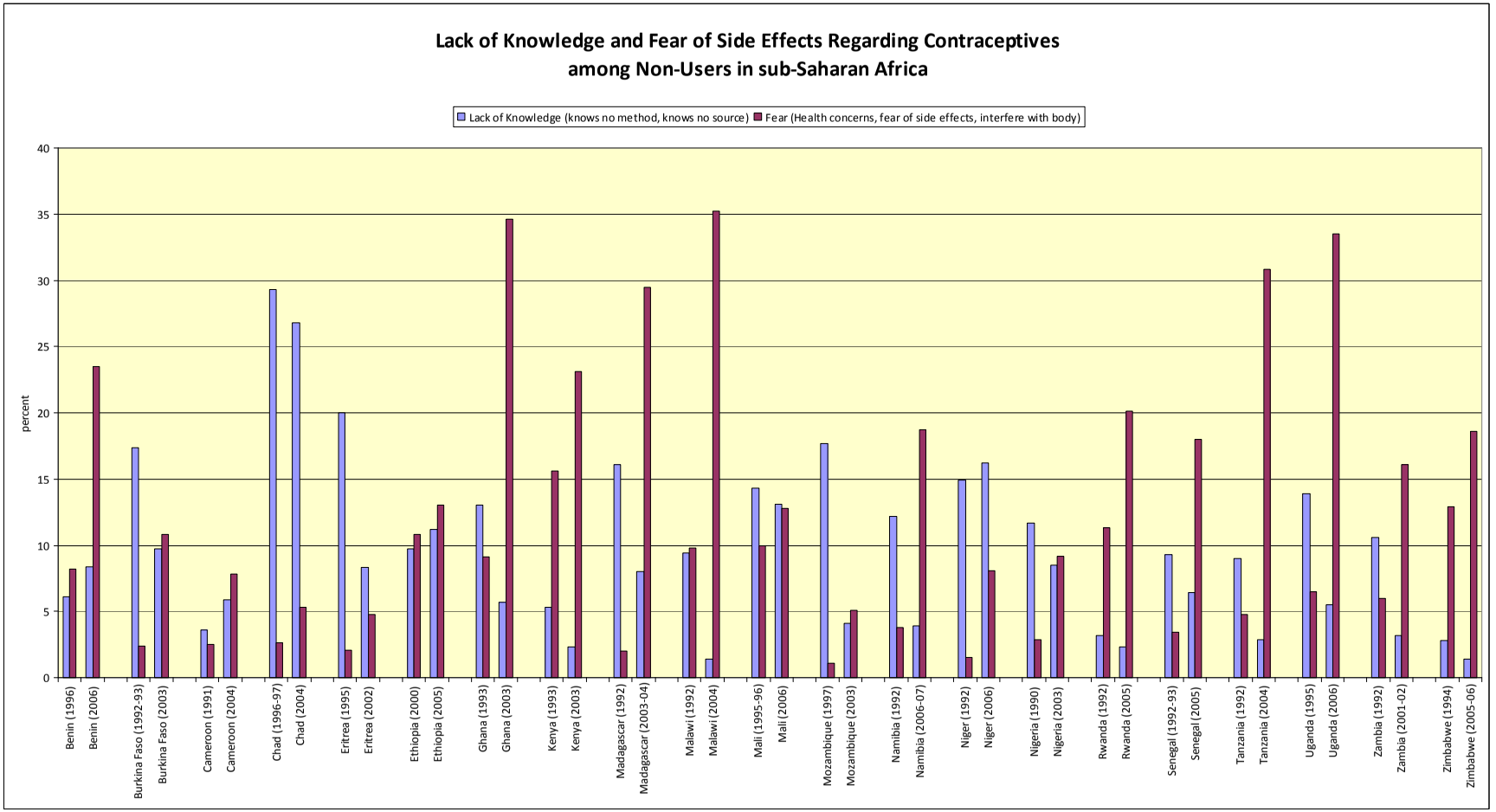
*...in malaria, maternal health, water sanitation, immunization, and education.
Source: USAID (2006). Achieving the Millennium Development Goals: The Contribution of Family Planning [Case studies in sub-Saharan Africa countries]. Repositioning Family Planning Health Policy Initiative.

FIGURE 5a:



Source: Respective Demographic and Health Survey data

FIGURE 5b :



Source: Respective Demographic and Health Survey data

FIGURE 6:

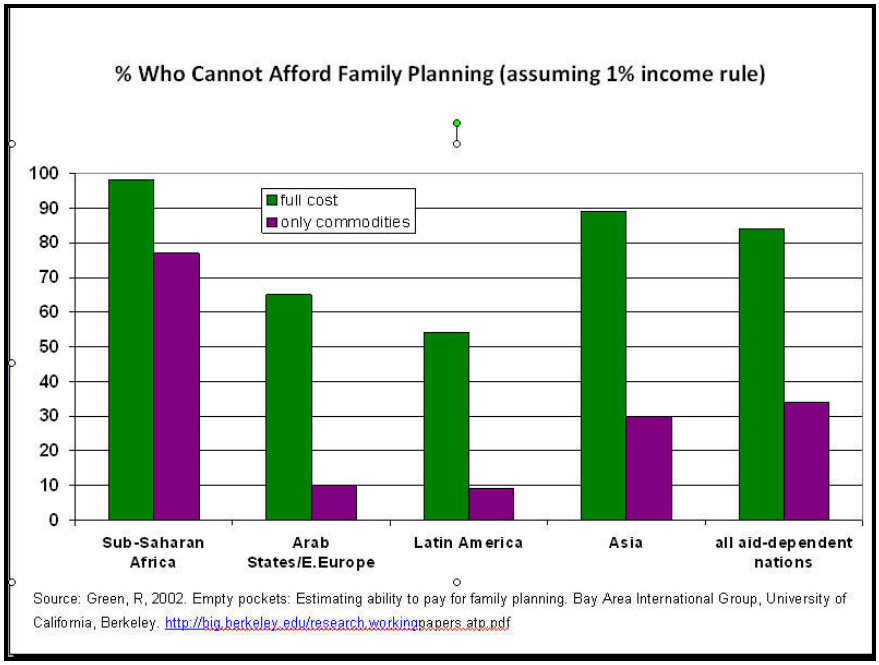
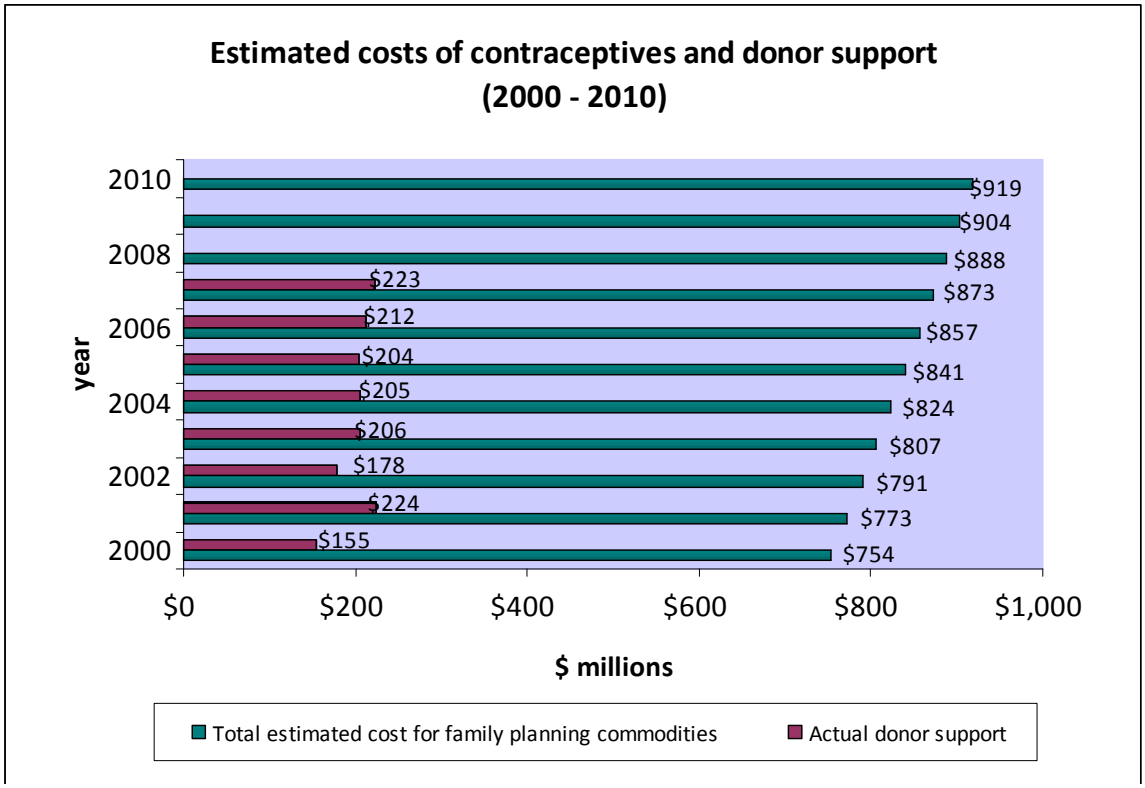

% Who Cannot Afford Family Planning (assuming 1% income rule)
100
90
80
70
60
50
40
30
20
10
0
full cost
only commodities
Sub-Saharan Africa
Arab States/E.Europe
Latin America
Asia
all aid-dependent nations
Source: Green, R, 2002. Empty pockets: Estimating ability to pay for family planning. Bay Area International Group, University of California, Berkeley. http://big.berkeley.edu/research.workingpapers.atp.pdf

FIGURE 7:



Source: Spiedel J, Sinding S, Gillespie D, Maguire E, Neuse M (2009). Making the case for US international family planning assistance REPORT. Available at:www.jsph.edu/gatesinstitute, p1-20.