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PERSPECTIVES

Making evidence matter in Africa's development

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25 years after Cairo: Accelerating Africa's promise

Fast-tracking progress in achieving good sexual reproductive health and rights outcomes and achievement of Sustainable Development Goals

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AFRICAN Development PERSPECTIVES

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Editorial

By Nyovani Madise

Twenty-five years ago, in 1994, 179 countries met in Cairo for the International Conference on Population and Development (ICPD). A major change from previous population and development conferences was the move away from a primary focus on demographic targets to the broader relationship between population and development, emphasising that "*increasing social, economic and political equality, including a comprehensive definition of sexual and reproductive health and rights... remains the basis for* ***individual well-being, lower population growth, sustained economic growth and sustainable development.***"

ICPD signalled the global commitment to sexual and reproductive health and rights (SRHR)[1]. The 179 members agreed that *"reproductive health and rights are human rights, that these are a precondition for women's empowerment, and that women's equality is a precondition for securing the well-being and prosperity of all people."* ICPD also called for an end to gender-based violence and harmful traditional practices, including female genital mutilation. Regionally, African countries have made further commitments to the ICPD agenda through the Maputo Plan of Action (2007-2030) and the Addis Ababa Declaration on Population and Development in 2013. Sustainable Development Goals (SDGs) reinforce the commitments to ICPD, for example, SDGs 1 (no poverty); 3 (ensure healthy lives and promote wellbeing for all ages); 4 (ensure inclusive and equitable quality education); and 5 (achieve gender equality and empower all women and girls).

Since its launch, there has been tremendous progress on the broader agenda of the ICPD Plan of Action (PoA). Countries have developed and implemented policies on SRHR, enabling millions to access SRHR services. According to UNICEF estimates, under-five mortality in Africa declined by 52% over a 20-year period between 1994 and 2014, while data from national demographic and health surveys (DHS) suggest that the transition to lower fertility is underway, with the average number of births by African women now around 4.4, down from around 6 in the 1990s. Over the same 20-year period, the maternal mortality ratio in the continent reduced from 987 deaths per 100,000 births to 546 deaths, while the percentage of married women using modern contraception methods increased threefold to nearly 30 per cent.

Notwithstanding these achievements, the progress on SRHR in Africa has been very uneven. In particular, trends in the desired number of children and actual achieved fertility are very uneven across the continent and between socio-economic sub-groups, as the article by John Cleland in this edition shows. Claire Jensen's article on child marriages provides some explanations for the persistently high fertility in Africa such as low female education, household poverty, and culture. The article on unmet need as an unfinished agenda in family planning argues for renewed focus on the quality of care and solutions to women's fear of side effects, in order to prevent premature discontinuation of modern contraceptives.

Another area that needs renewed focus is adolescent sexual and reproductive health and rights (ASRHR). A review of the first phase of the

Maputo Plan of Action (2007-2015) by the African Union showed that African countries had made inadequate progress in this area. Twenty-five years after Cairo, we are still having controversial debates on comprehensive sexuality education for adolescents and youth, and the examples from Rwanda and Uganda in the article by Emma Heneine highlight some of the challenges that African countries face in this field. Sarah Neal's article brings to focus a particularly vulnerable group—very young adolescent mothers— and the need to develop interventions tailored to their needs. Similarly, Monica Jamali and her co-authors highlight some of the challenges faced by another vulnerable group, people with disability, in accessing SRHR services.

Why are African countries still struggling with implementing commitments to SRHR? Across the continent, SRHR has been an uncomfortable topic in the policymaking spheres as leaders grapple with making good on commitments that they have made at a global level, in the face of strong opposition at home from religious and traditional leaders. Furthermore, most African governments do not assign sufficient funds for SRHR, leaving development partners to fund most of the SRHR and family planning budgets. SRHR policies reflect the tensions surrounding this topic: policy documents often give mixed messages, use contradictory language, and can be very ambiguous. There is also limited use of evidence on what works or doesn't work to aid decision-making in this space. As a result, some SRHR interventions are implemented without strong underpinning evidence; furthermore, scaling-up is done without knowing how the added component will affect the health system's effectiveness overall.

In this edition of *Development Perspectives*, we hope to refocus researchers, decision-makers, and practitioners to the role of evidence in addressing SRHR in Africa. What does the evidence say about the successes in SRHR over the past 25 years and where are the gaps in knowledge? Finally, how can we fast-track progress in achieving good SRHR outcomes which are fundamental human rights of all girls, boys, men, and women; and also the lynchpin to achievement of many SDGs?

We must not wait another twenty-five years to finish the ICPD agenda. This is a defining moment. We urge African decision-makers, researchers, and development partners to act now on the evidence to ensure that the continent achieves the ICPD goals of zero unmet need for family planning; zero preventable maternal deaths; and zero gender-based violence and harmful practices against women, girls and youth. The global community needs good, disaggregated SRHR data across socio-economic and geographical contexts so that we can monitor who is being left behind.

[1]Sexual and Reproductive Health and Rights (SRHR). We use SRHR to encompass efforts to eliminate preventable maternal and neonatal mortality and morbidity, to ensure quality sexual and reproductive health services, including contraceptive services, safe abortion and post-abortion services, and to address sexually transmitted infections (STI) and reproductive cancers, violence against women and girls, and sexual and reproductive health needs of adolescents.

Nyovani Madise, PhD, DSc is the Director of Research at AFIDEP and also heads the Malawi office. Nyovani has worked in the sexual, reproductive health and rights (SRHR) field for over 28 years and she has trained dozens of African scholars to PhD level and published widely on research from Africa and other low-income countries. She also advises many governments and UN agencies on SRHR issues. In 2017 she was profiled by The *Lancet* journal as an influential researcher in the field of SRHR.

Prof Nyovani Madise

Reproductive Change in sub-Saharan Africa

Is there any cause for optimism?

By John Cleland

Sub-Saharan Africa lags well behind other regions in the mass adoption of contraception and the transition to smaller families. Today, existing data from nationally representative demographic and health surveys shows that only about 32% of couples in the region are using some method of family planning, compared with 66% in Asia and 75% in Latin America. The average number of children born per woman in Africa has fallen slowly over time from seven to a little under five, whereas the fertility rate in Asia and Latin America is now close to two children. The Population Division of the United Nations Secretariat believes that reproductive change will continue to be slow in Africa. By 2030, it is expected that contraceptive prevalence will only be 42% and that by 2050 the fertility rate will still be above three births per woman. By then the region's population will have doubled from one billion today to two billion, according to the United Nations' projections. However, these projections are not cast in stone and there are sound reasons to believe that contraceptive adoption and reproductive change can undergo an unexpected acceleration, providing a cause for optimism. The following are the signals that trigger such optimism.

> **"... about 32% of couples in the region are using some method of family planning..."**

1. Increasing number of women want no more than three children

Ensuring a healthy interval between births has long been an important component of reproductive cultures in Africa. Most unmet need for contraception stems from the wish to delay the next pregnancy rather than stop childbearing altogether. So far, research shows that the fertility decline observed has been driven largely by increases in birth spacing. However, spacing by itself is insufficient to achieve small families. Even with a four-year gap between births, a woman marrying at the age of 20 will have five children by the end of her reproductive life. Until substantial numbers of couples are content to stop childbearing altogether after a few children, reproductive change is likely to remain sluggish in sub-Saharan Africa.

However, a shift towards family size limitation is already underway in many countries in Eastern Africa. In Kenya, for example, the demographic and health survey data show that the proportion of women with three children, who stated a desire for no more, has grown from 47% in the early 1990s to nearly 60% in 2014. In Rwanda, change over the same time period has been more dramatic, from 25% to 57%. The corresponding estimates for Zambia are 11% and 28%. However, the overall impression for countries in West and Central Africa is very different. Changes over time have been modest and in Burkina Faso, Mali, Nigeria and Senegal, where existing data show that little more than 10% of women

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with three children are content to stop childbearing. Even in Ghana, the forerunner of reproductive modernisation in West Africa, data shows that only 35% of women wish to stop at three children. The reason for this sharp sub-regional difference is one of the puzzles of social demography but the evidence suggests that in sub-Saharan Africa, increases in contraceptive use and decline in fertility will continue to be faster in the East than in the West.

2. Educated women are already having small families

One way of attempting to discern the future of family size is to examine the current reproductive behaviour and fertility preferences of well-educated women. Educated couples tend to be more receptive to new ideas and more likely to innovate than those with lower formal education, and therefore form the vanguard of change. Contraceptive practice and acceptance of smaller family sizes usually diffuse from the more privileged to less privileged sectors, and the behaviour of the well- educated today may well become the behaviour of the less educated tomorrow. On average, about 39% of women in sub-Saharan Africa have completed secondary or higher education but this percentage masks wide variation from around 9% in Niger to over 75% in Namibia and South Africa. Among these better-educated women, the average fertility rate is 3.8 births in West Africa and 3.5 in the Eastern region of the continent. Further declines are almost inevitable in the next 30 years to a level well below three births. Moreover, secondary school enrolments will continue to increase and, even more importantly, the less well educated are likely to follow the reproductive pathway of their better-educated counterparts.

3. Policies and programmes can have a large impact on fertility decline

For much of the past 50 years, most African leaders have given only lukewarm support to family planning. However, the political climate is changing rapidly, partly in response to evidence that fertility decline and consequent changes in population age structure can boost economic growth and reduce poverty. There is also strikingly positive evidence that government policies and programmes in Africa can make a big difference to fertility decline. In Kenya, in the early 1980s, the then-President Daniel arap Moi and Vice-President Mwai Kibaki launched a vigorous family planning programme, and contraceptive use by currently married women rose from 7% to 27% in only 10 years, as reflected in available demographic and fertility data. More recently, Rwanda has seen an astonishing rise in contraceptive use from 13% in 2000 to 53% 15 years later, in the context of a well-organised programme instigated by President Paul Kagame.

The most compelling evidence that policies and programmes really matter in achieving fertility decline comes from Ethiopia, one of the poorest countries in the world and with some of the highest illiteracy rates. Ethiopia is ethnically and religiously diverse and the terrain poses problems for the delivery of services. Yet contraceptive use rose from 8% in 2000 to 36% in 2016 and the fertility rate has fallen from its historic level of seven births to 4.6, according to multiple demographic and health surveys since 2000. It is almost impossible to believe that this change would have occurred without the strong government family planning programme, under which a cadre of over 30,000 community health and family planning workers were trained and deployed. The Ethiopia example shows that reproductive change can happen even in poor and largely illiterate populations.

Conclusion

Achievement of the huge benefits that mass adoption of contraception and having smaller families can bring depends largely on the willingness of African governments to promote family planning with energy and commitment. Rising levels of education and urbanisation also favour change but rapid progress requires determined government action.

John Cleland, MA is Professor Emeritus of Medical Demography at London School of Hygiene and Tropical Medicine (LSHTM), UK, where he has taught since 1998. John is well known for his diverse research on demography, with interests in fertility, family planning and child survival in South Asia and sub-Saharan Africa. He was elected a Fellow of the British Academy in 2003, and received a Commander of the Most Excellent Order of the British Empire (CBE) for his services to social sciences in 2008.

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Child Marriages

What the Evidence Tells Us

By Claire Jensen

Child marriage (defined as marriage of a person aged under 18 years) is a serious public health issue and violation of children's rights on the African continent. According to UNICEF data, 18 of the 20 countries with the highest prevalence of child marriage in the world are in Africa. The highest rates can be found in West and Central Africa countries such as Niger and Chad where more than 70% of women 20-49 years are married before 18 years of age (see m 1). Other countries with high rates include Guinea, Ethiopia, Mali, Burkina Faso, and Sierra Leone with over 50% of women married before 18 years. By contrast, the lowest rates are in Southern Africa, where South Africa and Namibia have the lowest rates of less than 10%. Most countries lie somewhere in between: Nigeria has a rate of 49%, Malawi's rate is 47% while Kenya is at 29%.

There are some signs of optimism. Since the 1990s, the percentage of African women married by 18 years has been declining according to DHS studies, from over 52% to 45% in the 2000s, to 39% between 2010 and 2018. Research on the drivers of child marriages in Africa show strong similarities across countries, with low female education, poverty, and traditional cultures as the recurring themes in many studies. This article illustrates the complexity of child marriages in Malawi and how society is responding to this challenge.

Ending child Marriages in Malawi

Malawi has made tremendous progress in recent years toward ending child marriage, including amending the Constitution in 2017 to close a legal loophole that allowed some children to marry under the age of 18 years. However, child marriage remains a key

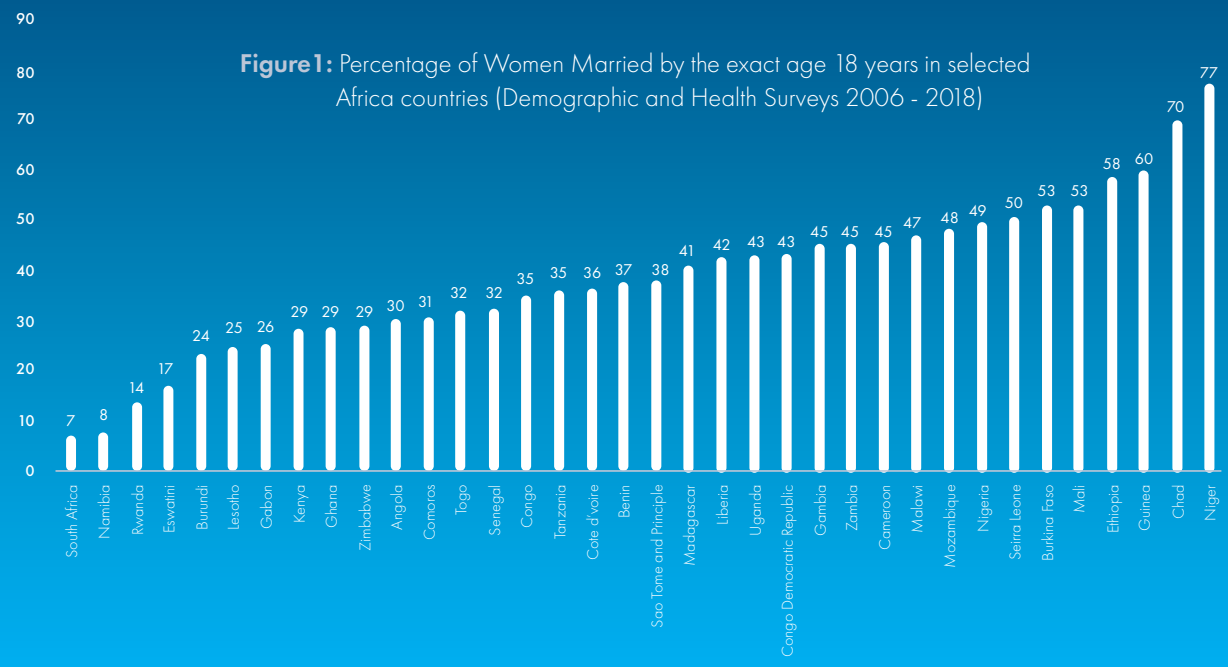


Figure 1: Percentage of Women Married by the exact age 18 years in selected Africa countries (Demographic and Health Surveys 2006 - 2018)

development challenge in Malawi. The 2015-16 Demographic and Health Survey found that 47% of all women in the country were married before the age of 18 years, and 9% before they turned 15 years. Among younger women aged 20-24 years, 42% were married before 18 years, reflecting a downward trend among younger cohorts. A direct consequence of child marriages is Malawi's very high teenage pregnancy rate where 29% of girls aged 15-19 years have already begun childbearing (see Map 1).

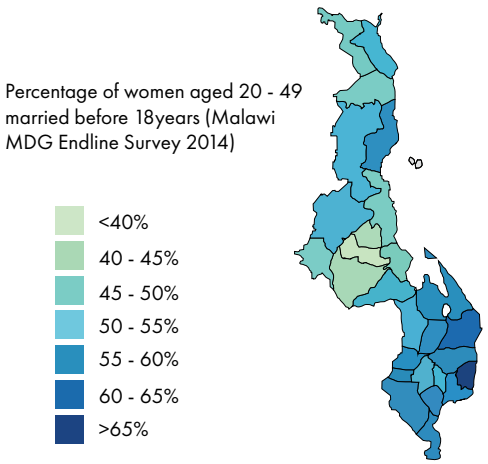
There is variation in the prevalence of child marriages and early pregnancy rates in the country. Rates are higher in the largely rural Southern and Northern regions, compared to the Central region. The higher prevalence in rural areas may be related to traditional lifestyles and lower levels of education, due in part to primary schools being incomplete (i.e. not offering all class levels) as well as secondary schools having low capacity to accommodate students.

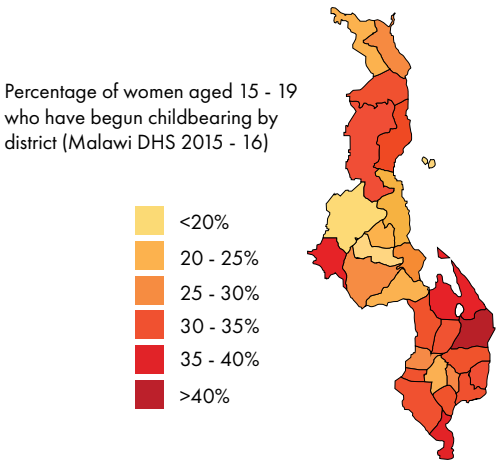
Factors associated with child marriage in Malawi

A Human Rights Watch study in 2014[2] concluded that many families in Malawi still see child marriage as a way to improve their economic status through the payment of a bride price (lobola) or other support from the groom, or by reducing the financial burden of raising a girl child. Girls may also view marriage as a way to improve their financial and social status. he Malawi MDGs Endline Survey in 2014 found that more than half the girls in the poorest wealth quintile were married by 18 years, compared to 33% of those in the highest quintile. The value of girls attending school is not always clear to girls and their families, as it may not improve finances in the short-run and in fact it is often a cost to families even with free primary and secondary education policies.

In addition, regional and cultural differences exist with regard to child marriage – for example, research by Malawi Human Rights

Map 1: Percentage of women in Malawi married before age 18 years and those who have begun childbearing, by district (Malawi Endline Survey 2014, DHS 2015-16)





[2]Odhiambo, A. (2014). I've never experienced happiness: Child marriage in Malawi. Human Rights Watch

Commission in 2006[3] found that in parts of Chitipa District in Northern Malawi, parents can traditionally give their daughters in marriage to pay a debt in a practice called 'kupimbila'. The study also found that in some parts of the country especially in the South, early sexual initiation for girls is encouraged as part of the rite of passage when a girl reaches puberty. However, out-of-wedlock pregnancies are stigmatised, and a girl who becomes pregnant is often expected (or forced) to marry, in some cases her abuser, to avoid damaging the reputation of her family. The school environment is sometimes viewed as "unsafe" in that there are opportunities for girls to interact with males either within the school or on the way to, and from school.

Impact on girl children and their families

> **child marriages are violations of children's rights and the practice is now legally banned**

Not only is child marriage a violation of human rights of children, it can also adversely impact girls' physical and mental health, as well as the health of their children. Child marriage exposes girls to marital rape, domestic violence, and labour exploitation. It also increases their risk of sexually transmitted diseases, cervical cancer, obstetric fistulas, and maternal death. Numerous studies in both developing and developed countries highlight the adverse birth outcomes for teenage mothers such as prematurity, birth complications and higher Caesarean sections[6]. There can be psycho-social consequences to child marriages as well. A study published in 2009[7] provided evidence that girls who marry early are at heightened risk of isolation and depression. Child marriage also leads to girls terminating their education prematurely which negatively impacts their future earnings. In sub-Saharan Africa, research shows that for each year that early marriage is delayed, there is an additional half-year of schooling[8], but on the other hand, each additional year of early marriage reduces the likelihood of literacy by 5.7 percentage points[9].

The fight against child marriages: leadership from community leaders and the state

In Malawi, there has been strong support from some traditional leaders in upholding the law against child marriages. Some have created local by-laws to enforce the national law, which bans marriage involving anyone under the age of 18 years. Many leaders, including the internationally recognised female Senior Chief Theresa Kachindamoto, have instituted programmes to rescue girls from early marriages and to ensure that they are enrolled back in school. Most leaders have imposed stiff penalties to families who allow their children to marry and the media constantly reports of the "sacking" of village leaders by their paramount chiefs because of allowing child marriages in their villages. A number of development partners are actively supporting these grass-root initiatives including facilitation of girls' re-entry into the school system, making the school environment safe from sexual violence, and monitoring and evaluation.

In addition to passing laws banning child marriages, the government of Malawi increased the age of consent to sexual intercourse from 14 to 16 years and strengthened the monitoring of the Gender Equality Act which was enacted in 2013 *"to promote gender equality, equal integration, influence, empowerment, dignity and opportunities for men and women in all functions of society; to prohibit and provide redress for sex discrimination, harmful practices and sexual harassment; and to provide public awareness on promotion of gender equality"*.

In 2017, the then Minister of Gender, Children, Disability and Social Welfare, Dr Jean A. N. Kalilani, committed the government to ending child marriages within a decade. While this is a very ambitious target, it nevertheless communicates the Government's seriousness in implementing the law banning child marriages.

Conclusion

Child marriages are a violation of children's rights and the practice is now banned by law in Malawi. Both the state and community leaders have intensified efforts to end the practice. Given the strong relationship between girls' educational attainment and early marriage and the fact that child marriage is more common among the poor, it is important to implement programmes that keep girls in school longer as well as alleviating the economic burden of schooling for girls and their families.

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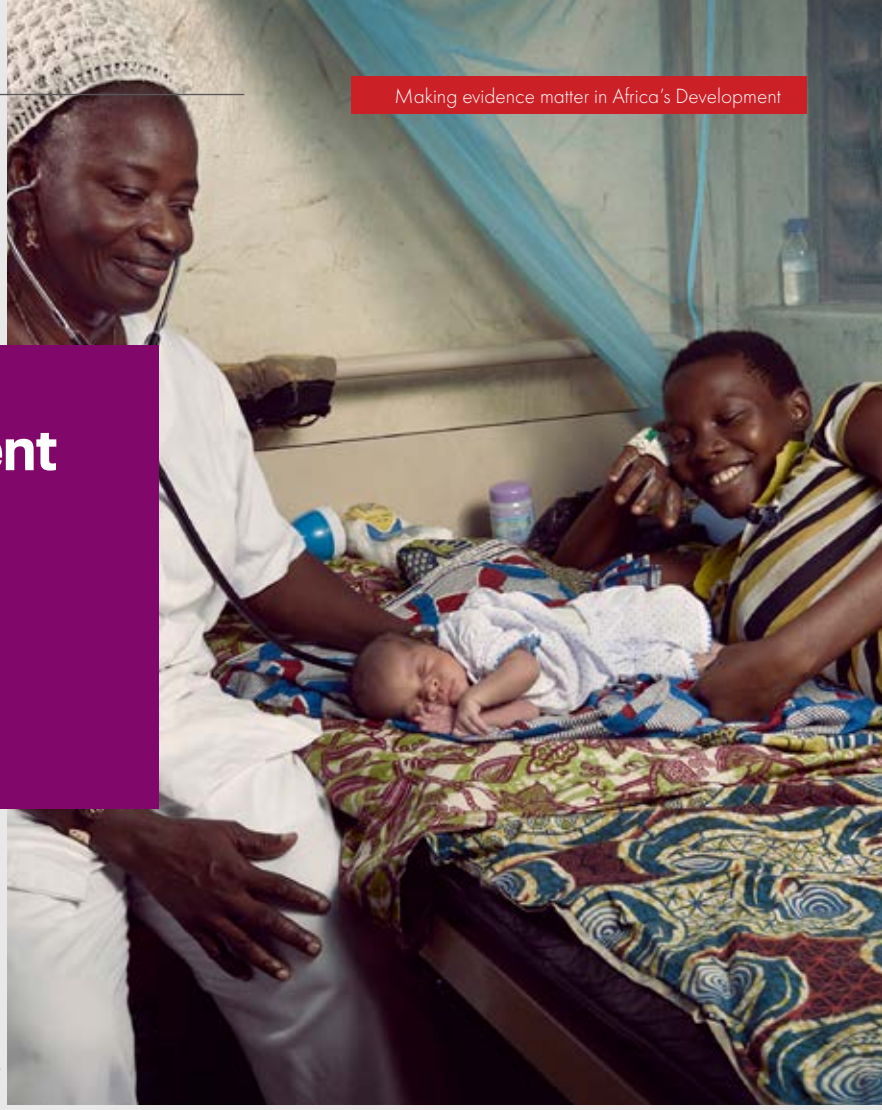

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Very early adolescent motherhood

A neglected issue

By Sarah Neal

Each year, around two million girls give birth in sub-Saharan Africa before the age of 16 years with around half having their first birth before their 15th birthday. Although these young girls face very specific risks and disadvantages to their health and wellbeing, current statistics on adolescent childbirth are rarely disaggregated by age. As a result, very early adolescent motherhood is often a hidden problem, which has failed to gain the attention it deserves.

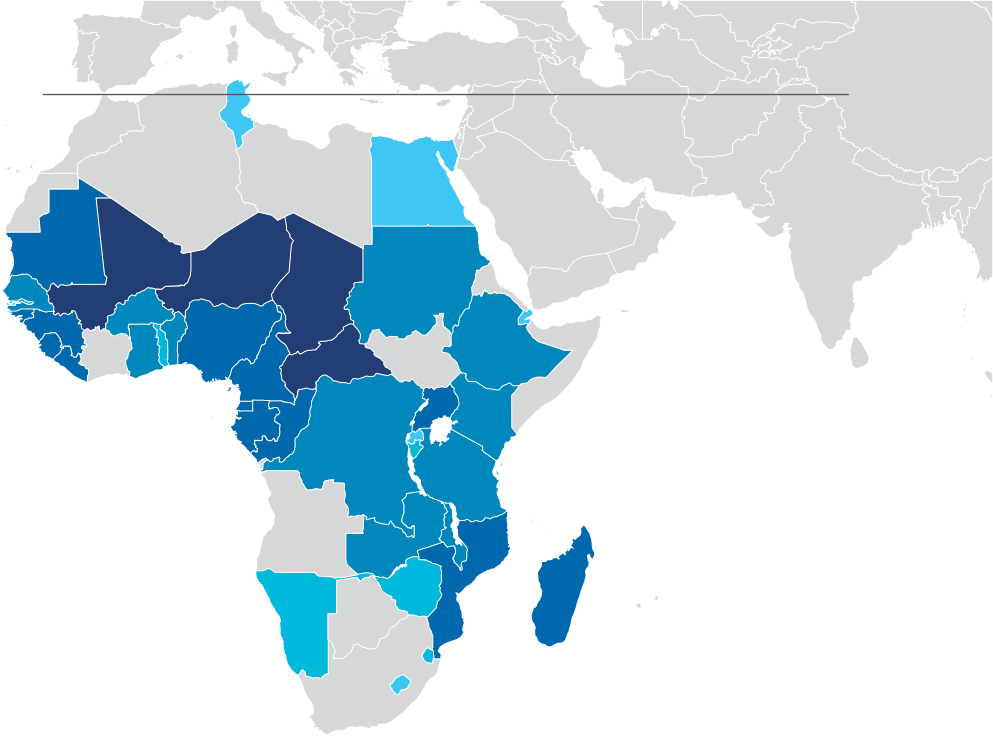
While the percentage of early first births varies markedly between countries, available data show that in many countries within the sub-Saharan Africa region, births before 16 years of age are common and that in several countries, over 10% of women have become mothers by age 15 years or younger (Map 2). Prevalence is particularly high in countries within West and Central Africa, with four countries (Chad, Mali, Niger and Central African Republic) reporting more than 20% of women having their first birth before 16 years. The prevalence tends to be somewhat lower in East Africa.

Very few countries in sub-Saharan Africa have made any significant progress in reducing births in this younger age group. Instead, in several countries (e.g. Benin and Mali), births to younger teens have increased, despite some evidence of modest declines among older adolescents. Because very early motherhood often reflects local cultural norms and practices, there are often geographical "pockets" where rates are very high, even in countries where the overall aggregate rate is quite moderate.

> **"young mothers will have much older partners, leading to a potential imbalance of power**

These younger adolescent mothers will face very different experiences and risks compared to older adolescents. A number of studies have shown that the negative health consequences of adolescent motherhood are more severe in very young mothers and maternal mortality is markedly higher for girls who give birth before 16 years of age, compared to older adolescents. Health outcomes for the children of very young mothers are also particularly poor, with new-born mortality increasing as maternal age reduces. The younger a woman gives birth, the more severely her life chances will be curtailed due to loss of education and economic opportunity. In addition, many very young mothers will have much older partners, leading to a potential imbalance of power within the relationship and a lack of autonomy. Very young adolescent mothers are also likely to be concentrated among the poorest, least educated rural populations, further adding to their disadvantage. In most countries, they are less likely to be married or in a union at the time of birth, compared to older adolescents, which in many contexts increases their risk of being stigmatised or ostracised from their families and communities.

Map 2: A mother before 16 years:
Percentage of women aged 20-24 who had their first birth before 16 years, 2017
(source: www.atlasofbirth.org; www.atlasofbirth.org)



The relatively large number of very early adolescent births, coupled with the potential increased risks faced by both mother and baby, strongly points to the need for efforts to address this pervasive but hidden issue. In some countries, more than a quarter of young people become sexually active before the age of 15 years, putting them at risk not just from pregnancy, but from other poor sexual health outcomes such as HIV and other STIs. Yet attempts to provide sexual health information and services for younger adolescents in these settings are often met with resistance from families, communities and opinion leaders.

There is a pressing need to develop sexual health interventions tailored to the needs of younger adolescents. Different approaches may be needed due to the cognitive and emotional differences between younger and older adolescents, to ensure that information matches the level of understanding of younger girls and boys. As younger adolescents may be less focused on reproductive health issues, a holistic approach may be more appropriate to engage them more broadly on their transition to adulthood, but further research is needed to identify what works best for younger adolescents. Because early age of first sex and childbearing is often associated with a lack of education, school-based programmes may fail to reach those most at risk.

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In many countries, the high prevalence of early adolescent births is associated with widespread child marriage, and there is a clear link with programmes and interventions to prevent early marriage. However, it must also be recognised that early adolescent births may also drive and underpin early marriage, meaning that a more nuanced discourse on the link between the two issues is needed. In addition, effective legal frameworks to protect girls from early marriage and sexual abuse and exploitation are vital components of any efforts to reduce births to this vulnerable group. Strong support for and investment in girls' education and promotion of livelihood opportunities for marginalised young women are also important factors.

Finally, a greater focus on this issue requires better measurement. Indicators used in national and international efforts to monitor progress in reducing adolescent pregnancy and other negative sexual health outcomes are rarely disaggregated by age-groups, and some of the most common (e.g. age-specific fertility rate aged 15-19) actively exclude those aged 14 years or younger. Disaggregated indicators that enable policymakers to track progress in pregnancy for this vulnerable younger group will be important in ensuring that this issue receives both the attention and interventions it requires.

Sarah Neal RGN, PhD, is Associate Professor Lecturer in Global Health at the University of Southampton, UK. Her research interests are in maternal, neonatal, child and reproductive health in low and middle income countries. She has also worked on a number of public health programmes and conducted research on motherhood in very young adolescents (under 16 years) in developing countries. The information in this article is based on existing research data, including data from national demographic and health surveys.

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Living with disabilities affects uptake of sexual and reproductive health services among women in Malawi

By Monica Jamali, Nyovani Madise, Allan Hill and Vicky Hosegood

Addressing the sexual and reproductive health needs of women with disabilities has been one of the development challenges confronting the global community since the 1994 International Conference on Population and Development (ICPD). While the ICPD Programme of Action recognised the vulnerable position of all persons with disabilities, and required states to prioritise their sexual and reproductive health needs through appropriate policies and programmes, 25 years on, women with disabilities continue to face structural, financial, physical, social and attitudinal barriers when accessing services.

Although the 2018 report by Arne Eide and Alister Munthali on "Living conditions among persons with disabilities in Malawi" reports that a high proportion (77%) of persons with disabilities can access health services in Malawi, it is hardly known what proportions are accessing sexual and reproductive health services. Available data points to the poor socio-economic status of women with disabilities and limited knowledge of their sexual and reproductive health needs among health service providers. For example, Gubela Mji and her colleagues in their 2008 report, "The Call on HIV/AIDS and Reproductive Health Care amongst Disabled People" reported that disabled women in the Chingale area of Zomba District in Malawi failed to access sexual and reproductive health services because they could not afford payment for the services. Limited access to sexual and reproductive health services among persons with disabilities may predispose them to various sexual and reproductive health problems, such as sexually transmitted infections, including HIV/AIDS, and reproductive health issues such as child-bearing complications, which may or may not arise as a result of their disabilities.

There are different ways of measuring disability during population censuses and surveys including measuring impairment and functional limitation. Impairment refers to problems in body function or structure, such as a significant deviation or loss of a limb, vision or memory. Functional limitation measures, on the other hand, relate to difficulties that an individual may experience when executing activities, or problems they may experience in life situations, such as difficulties in dressing or climbing stairs. Some people have both impairments and functional disabilities and these may hinder them from accessing sexual and reproductive health services.

Combining the 2003 Malawi World Health Survey (which has measurements on disability) and the 2004 Malawi Demographic and Health Survey (with data on SRHR outcomes) using a statistical matching technique, enabled us to show how impairment and functional measures of disability relate to the uptake of modern contraception, HIV counselling and delivery under skilled care. The findings showed that 42% of women with impairment had severe or extreme difficulties in functioning and that the more severe a person's level of functional disability, the less likely they were to use HIV counselling services. The presence of impairment alone was not associated with less utilisation of modern contraceptive methods or HIV counselling services. The findings indicate that utilisation of sexual and reproductive health services differs, depending on the type of disabilities that the women have.

> **"it is necessary to intensify the provision of HIV counselling information to this vulnerable population group**

Low use of HIV counselling services among women with severe functional limitations implies that most such women may not be aware of their HIV status, and it is therefore necessary to intensify the provision of HIV counselling information to this vulnerable population group in Malawi. Community-Based Rehabilitation (CBR) Officers can be trained and deployed to provide information on sexual and reproductive health services to women and their partners.

By far, the most challenging aspect of our research was finding data that measured disability, socioeconomic status, and SRHR outcomes from the same individual. Not having these data limited our ability to conduct thorough investigation on how people with disability are disadvantaged when accessing and utilising SRHR services. If we are to monitor SRHR outcomes of people with disability and ensure that they are not "left behind", we need good data on which robust research can be conducted.

Monica Jamali is a Lecturer in Demography at the University of Malawi. She obtained her PhD from the University of Southampton in 2019, and works on measuring disability and universal access to SRHR.

Nyovani Madise, PhD, DSc* was, at the time when this research was conceptualised, Professor of Demography and Social Statistics at the University of Southampton.

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Unmet Need for Family Planning in sub-Saharan Africa

The unfinished agenda

By Nyovani Madise

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In July 2012, efforts to increase access to quality family planning methods for African couples received a boost with the launch of a global initiative, FP2020, led by the United Kingdom's Department for International Development and the Bill and Melinda Gates Foundation at the Family Planning Summit in London, UK. The goal of this initiative is to provide contraception to an additional 120 million women in developing countries by 2020.

Seven years later, there is no doubt that FP2020 has contributed to increasing the prevalence of modern methods of contraception in the countries where the programme is being implemented. However, other indicators of quality of care and fertility rates are not going in the desired directions fast enough. For example, while the Malawi Demographic and Health Survey of 2015-16 estimated that the prevalence of modern contraception among married women had risen from about 42% in 2010 to 58% in 2015-16, the fertility rate of 4.4 children per woman is considered quite high for the level of contraceptive use. Women in Lesotho, which has similar rates of modern contraceptive use, have on average, one birth fewer than Malawian women. In part, this situation of increased contraception use but relatively high births can be attributed to use of contraceptives for spacing on the one hand, and premature discontinuation of modern methods on the other.

To accelerate the demographic transition to lower fertility in sub-Saharan Africa, the region and global partners should pay attention to couples who have 'unmet need' for contraception. Unmet need

for contraception is usually calculated from survey data as the percentage of women who do not want to become pregnant but are not using any form of contraceptive method. Unmet need for 'spacing' and 'limiting' refer to women who wish to space the next birth and those who do not want to have any more births, respectively. In surveys, the definition also includes responses from women on whether their births in the last five years were wanted 'then', 'later' or 'not wanted at all'.

The 'unmet need' indicator, first described by Charles Westoff in the 1970s, has had considerable political traction since the 1994 ICPD in Cairo, when it became no longer acceptable to speak in terms of demographic targets in family planning. 'Unmet need' allowed numerical goals to be set that were presumably based on what women themselves wanted. This common ground is well articulated in a 1994 article written by Steve Sinding, John Ross, and Allan Rosenfield[10] .

> "pay attention to couples who have 'unmet need' for contraception

However, the measure is not without its critics. Some have argued that retrospective questions may elicit responses that underestimate unmet need for contraception, because although a pregnancy may have been unwanted at the time of conception, women may rationalise and claim that the timing was right.

According to the Guttmacher Institute, it is estimated that 222 million women in the developing world have an unmet need for contraception. While the ICPD Program of Action helped in raising awareness of modern contraceptive methods, it is clear that even when access is improved, there will still be 'unmet need' for some women. The 2017 Guttmacher report, *Adding It Up*, indicated that 58 million women in Africa have an unmet need for modern contraception, and that these women contribute to 90 percent of all unintended pregnancies in the region. Many of these women use unsafe abortion methods to terminate these unintended pregnancies due to restrictive abortion laws.

According to our own analyses of the demographic and health surveys conducted in Africa, the reasons given by sub-Saharan Africa women with an 'unmet need' for not using contraception include fear of side effects (17%) and opposition to their use (11%). Only less than one per cent cite lack of access or cost as reasons for non-use, and only seven percent cite lack of knowledge of the available methods. In comparison, in the 1990s, only 8 percent of women cited health concerns or side effects as the main reason for not using modern contraception, and more than 20% cited lack of knowledge. Thus, it would appear that on addressing health concerns and fears of side effects, African countries are not making good progress.

Another important aspect to consider if African countries are to reduce unintended pregnancies is the provision of a wide choice of methods to meet the varying needs of couples. When women (or couples) experience side effects or are unhappy with a method, it is important that they are offered alternative methods to switch to, in order to prevent unplanned pregnancies. However, this is not always the case. Demographic and health surveys from countries in sub-Saharan Africa show that more than 30% of all women discontinue using modern contraception within 12 months of starting and the most important reason for discontinuing a method, after wanting to get pregnant, is the fear of side effects or health concerns (25%).

There is wide variation in discontinuation statistics. For example, in Ethiopia, more than 70% and 38% of women discontinue using the pill and the injectable, respectively, within 12 months of starting. In Lesotho, the discontinuation rates are between 20% and 27%, respectively, for both methods. Family planning programs that rely on one or two methods limit the choices available to men and women. Where legally permitted, access to safe abortion services should be improved to prevent unwanted births and the dangers associated with unsafe abortion practices.

It is clear that addressing the unmet need for family planning and providing a range of quality, voluntary methods remains an unfinished agenda. While FP2020 and other bilateral aid commitments have helped to improve access for millions of women, it is time to go the extra mile by improving the quality of care and access to the full range of sexual and reproductive health services. The following ICPD Program of Action's major strategies are still as valid today as they were 25 years ago:

1. Making good quality voluntary family planning and reproductive health truly accessible to all women, especially the most vulnerable;

2. Enhancing reproductive rights, including the right to safe abortions as permitted by the laws of the country; and

3. Making complementary investments in women, especially in adolescents' health, girls' education and strengthening legal protections.

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[10]Steven W. Sinding, John A. Ross and Allan G. Rosenfield (1994). Seeking Common Ground: Unmet Need and Demographic Goals. International Family Planning Perspectives, Vol. 20, No. 1 (Mar., 1994), pp. 23-27+32

Implementing Comprehensive Sexuality Education in Rwanda and Uganda

Progress or Regress?

By Emma Heneine

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In 2018, the United Nations Educational, Scientific and Cultural Organisation (UNESCO) revised its International Technical Guide for Comprehensive Sexuality Education (CSE), based on evidence from decades of previous sexual and reproductive health (SRH) efforts. Defined as "a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality," CSE aims to equip learners with knowledge, skills, attitudes and values that will empower them to make healthy and safe life choices. To achieve this, CSE goes beyond the limited scope of traditional sex education and instead, takes a nuanced and inclusive approach to SRH. In fact, to be considered comprehensive, a CSE curriculum must include eight key topics: relationships; values, rights, culture and sexuality; gender; violence and staying safe; skills for health and well-being; the human body and development; sexuality and sexual behaviour; and SRH.

Programme evaluations affirm that CSE is an effective and indispensable component of young peoples' education, contributing to positive SRH behaviours and healthier populations. UNESCO's *International Technical Guidance on Sexuality Education (2018)* points out that CSE has been found to contribute to increased knowledge about different aspects of sexuality, behaviours and risks of pregnancy or HIV and other STIs. It also leads to beneficial SRH behaviours, including delayed initiation of sex, decreased number of sexual partners, and increased use of condoms and contraception. In recent years, numerous African countries, including Rwanda and Uganda, have

developed national CSE frameworks and curricula. However, despite their similar underlying goals—to empower youth to make safe and healthy SRH decisions —Rwanda and Uganda's CSE curricula have little in common. While Rwanda's 2015 CSE mostly aligns with UNESCO's framework in content and approach, Uganda's 2018 framework opposes it.

Rwanda's CSE curriculum, which takes a rights-based approach, reflects national goals of unity and equitable development, embracing "respect, acceptance, tolerance, equality, empathy and reciprocity." Overall, Rwanda's perspective on sex-related matters in the CSE is similar to UNESCO's—sex is normalised, intersectional, and addressed with nuance. For instance, the biological, emotional and sociocultural components of sex and related matters are acknowledged in the topics ranging from puberty to stigma and gender. Learners are taught objective, non-stigmatising information about sexuality, allowing them the freedom to make informed decisions based on facts as well as their values.

Critically, information on how to engage in sexual relations safely and in a healthy manner is provided, as the curriculum explores different methods of preventing pregnancy and STIs/HIV, explains safe sex and how human rights apply to SRH. This differs from traditional sex education, which often employs judgment, shame, and/or fear rather than providing factual information to influence SRH decision-making. There are some context specifications even with the Rwanda's CSE framework. At variance with the UNESCO framework, Rwanda approaches the topic of 'sexuality' from a conservatively, religious angle. For example, the curriculum encourages self-control over one's sexuality to prevent unfavourable behaviours like promiscuity, adultery, and deviances.

Uganda's National Sexuality Education Framework (NSEF), on the other hand, tells a different story. In an attempt to address perceived negative effects of globalisation, technology and the media, including exposure to "uncensored sexually-explicit and obscene material," the NSEF aims to propagate a traditional, religious-based approach to sexuality. One of its guiding principles, for example, is "Uganda as a God-fearing nation." Similarly, its goal is "to increase young people's resilience to reject and resist the temptation of engaging in risky sexual relationships and behaviours," and "to promote healthy behaviours such as sexual abstinence".

Uganda's curriculum focuses on abstinence. In fact, information promoting premarital sexual abstinence, sexual purity, and marital faithfulness is included as a key area of learning under all of the NSEF's four main topics and in 10 of the 22 subtopics. As a result, the framework conveys sexual activity as a negative or shameful indulgence that should be conquered by upholding a common moral standard. Unlike UNESCO and Rwanda's individual rights-based approach, Uganda's NSEF prioritises familial, marital, societal, cultural and national values and stability. Moreover, the curriculum focuses on the dangers associated with being sexually active rather than how to mitigate such risks. Ultimately, this fear-provoking and stigmatising approach fails to empower learners with the relevant skills they need to engage in sexual activities safely and in a healthy way.

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The implications for Rwanda and Uganda's CSE frameworks are notable. Both countries have large youth populations, and efforts that can contribute to favourable population demographics—such as increased use of contraception, delayed initiation of sexual intercourse, and gender-equitable norms—are timely and urgently needed. Evidence shows that UNESCO's CSE framework has remarkable value and success in achieving such outcomes, if implemented as intended. With Rwanda's CSE well-aligned with UNESCO's, Rwandan youth receive education correlated with improved SRH knowledge, trends and behaviours. By contrast, evidence[11] published in 2017 from an expert review of sexuality policies and programs promoted by the United States government suggests that abstinence-based curricula such as Uganda's will not lead to the intended positive SRH behaviours. In effect then, Rwanda's CSE casts a promising future that would enable the country's youth to contribute to national socio-economic development, while the Ugandan curriculum has the potential to retard Uganda's development by its failure to promote young people's SRH and to give them the right knowledge and skills in an increasingly progressive and global world.

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[11] Santelli, John S. et al. (2017). Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact. Journal of Adolescent Health, Volume 61, Issue 3, 273 - 280

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Progressing the agenda

AFIDEP's Impact on SRHR in Africa

By Victory Kamthunzi

The African Institute for Development Policy (AFIDEP) seeks to promote a culture of evidence use in policies and programmes in all sectors, and including sexual reproductive health and rights (SRHR). AFIDEP works to ensure that policymakers and programmers have evidence to support decision-making. SRHR gives fundamental rights and freedoms that enable all people to fully participate in society, benefit from social and economic advancements and live a decent life.

AFIDEP has over the years undertaken projects on the protection of the dignity and rights of women and girls to eradicate harmful practices such as Gender-based Violence (GBV) and early (and forced) marriage. Most notable of these is the study in 2017 on GBV in Kenya and the Gender Policy dialogue in Malawi in the same year. The GBV study identified major reporting gaps that have stifled GBV monitoring, and developed data visualisation tools (scorecards and dashboards). The Kenyan government has adopted these tools to track performance for reproductive health and HIV programmes and strengthened reporting of GBV through the Sexual and GBV Information System at the National Gender and Equality Commission. The Gender Policy dialogue in Malawi highlighted gaps in the enforcement of the gender laws at community level, prompting the government to commit to spearheading efforts to end child marriages in the country within a decade. In 2015, AFIDEP provided the evidence to the Kenya Parliamentary Committee on Health which led to their successful lobbying for an increase in the health budget and provision in the budget for family planning. AFIDEP has also supported Malawi government in reviewing its progress on the Addis Ababa Declaration on Population and Development, reviewing the draft 2019 Population Policy, and highlighted SRHR in the media and high-level fora.

In 2019, AFIDEP has been at the forefront of the discussion on teen pregnancy in Kenya and Malawi. Under the project Initiative for Learning and Evidence to Address Teen Pregnancy among Girls in School in Malawi (I-LEARN), AFIDEP has conducted a study to better understand the causes of school dropout attributed to pregnancy in Malawi, as well as best practices to prevent teen

pregnancy and keep girls in school. The preliminary findings shed light on drivers of pregnancy among girls in school, which included but was not limited to poverty, child marriages, family-related issues and culture and harmful practices, and indicated that some of the most effective interventions to prevent teen pregnancy were those that took a holistic approach and sought to keep girls in school by addressing economic barriers to school attendance. In Kenya, AFIDEP and UNFPA hosted a policy dialogue to discuss effective approaches to end teen pregnancy. The meeting, attended by 70 participants from the government, development partners, the youth, academia, think tanks, civil society, faith-based organisations and the media made a call for action with key recommendations for ongoing approaches and interventions to decisively end the problem of teen pregnancies. These included active involvement of youth and parents, age-appropriate sexuality education, resource mobilisation, mutlisectoral approach, use of evidence and innovations.

In a follow up to the policy dialogue, in June 2019, AFIDEP in collaboration with Youth in Action (Y-ACT), hosted a 2-day write-shop for 100 youth in Kenya to brainstorm a one-year action plan for the youth-led campaign "StepUP the Fight on Teenage Pregnancy: An accelerated multi-sectoral action and disruption in addressing the adolescent pregnancy crisis in Kenya". The campaign involves stakeholders including government staff, development partners, political leaders, celebrities, social influencers, religious leaders, media practitioners, service providers, private sector and civil society organisations. It hinges on disruption as a concept that challenges the norm, questions agency and encourages learning and scaling up of interventions.

Through the institute's governance work in Malawi, which is currently focused on the Malawi Parliament Enhancement Project (MPEP) and Malawi Parliament Support Initiative (M-PSI), AFIDEP has contributed extensively to strengthening strategic leadership and the capacity of Parliament to contribute to often neglected development issues such as SRH and GBV. In 2017, AFIDEP supported the Malawi Parliament to form a Parliamentary Caucus on Population and Development. Likewise, the institute's Demographic Dividend (DD) work in over 15 countries has successfully translated into the adoption and domestication of the paradigm into national development plans and led to policy prioritisation for issues like GBV.

Victory Kamthunzi, M. A provides effective and innovative communication for the African Institute for Development Policy (AFIDEP), leading the implementation of the Institute's communications programme in Malawi and the Southern Africa region.

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Summary of some of AFIDEP's achievements

1

In 2017, AFIDEP in collaboration with UNFPA assessed and mapped existing capacity for evidence use to **strengthen monitoring and accountability for gender-based violence** (GBV), reproductive health, and HIV/AIDS in Kenya.

2

We partnered with the Malawi Ministry of Gender, Children, Disability and Social Welfare to convene a **gender policy dialogue on ending child marriage in October 2017.**

3

The **Malawi Parliament Enhancement Project** combines political and technical interventions that engage and shape power relations to address challenges hindering parliament's performance.

4

The **Malawi Parliamentary Support Initiative** seeks to institutionalise a culture of evidence-informed decision-making by strengthening skills in budget analysis, financial scrutiny and legislative research in Parliament.

5

An analysis of 15 African countries looked at prospects of harnessing the demographic dividend. AFIDEP conducted participatory workshops with senior government officials and other stakeholders to identify actionable recommendations, and engage with the public using a range of communication tools.

6

Initiative for Learning and Evidence to Address Teen Pregnancy Among Girls in School in Malawi (I-LEARN) seeks to better understand the causes of school dropout due to pregnancy in Malawi as well as best practices to prevent teen pregnancy and keep girls in school. In order to shed light on these issues and possible solutions, the initiative explored drivers of pregnancy among girls in school through an analysis of secondary data, effective interventions to prevent teen pregnancy among girls in school through a review of the literature, and perspectives of teens, teachers, health workers, and other community members in two districts in Malawi – Dowa and Mangochi – through key informant interviews and focus group discussions.

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