

Drivers of Progress in Increasing Contraceptive Use in sub-Saharan Africa

Case Studies from Eastern and Southern Africa

1. BACKGROUND

Family Planning (FP) has immense health, environmental, and economic growth benefits. For instance, it is estimated that in 2008, family planning averted 32% of maternal deaths in sub-Saharan Africa (SSA), and that such deaths would decline by a further 29% if all women who want to avoid pregnancy use an effective contraceptive method (Ahmed et al. 2012). Family planning also helps save the lives of children; spacing births of children by at least two years would reduce deaths of infants by 10% and deaths of children aged 1-5 years by about 20% (Cleland et al. 2012). By reducing unintended pregnancies, FP programs can reduce fertility by an average of about 1.5 children per woman (Ezeh et al. 2012). Sustained decline in fertility helps to reduce child dependency ratios and increase the number of working age people, which can boost investments in human capital and economic productivity if job-creating economic reforms are enacted (Canning and Schultz 2012).

However, despite these known benefits, limited progress has been made in increasing contraceptive use in the region. About 60% of SSA women (53 million) who need to use family planning are not using modern contraceptives, while 26% of women in all developing regions fall into this category (Singh and Darrock 2012). Consequently, SSA exhibits high levels of unintended pregnancies, which contribute to high maternal and child deaths, high fertility and rapid population growth. SSA's population is projected to more than double from 851 million in 2010 to nearly 2 billion in 2050 (United Nations Population Division 2011). This kind of rapid population growth negates socio-economic development and preservation of the environment and natural resources in the region (Mutunga et al. 2012).

In spite of SSA's general poor performance towards achievement of universal access to family planning envisaged under the Millennium Development Goal 5b and the 1994 International Conference on Population and Development (ICPD) Program of Action, a few countries in Eastern and Southern Africa (namely Ethiopia, Malawi, and Rwanda) have exhibited a new wave of optimism and made good progress in addressing barriers of access to modern contraception over the past decade or so. Use of modern contraceptives increased by 2.7, 2.8, and 7.0 percentage points per year in the past five years in Ethiopia, Malawi and Rwanda, respectively. In Kenya and Tanzania, progress in improving contraceptive use stalled, but has recently picked up with annual increases of 1.6 percentage points in the past five years (Figures 1 and 2). Lessons on how these countries have achieved such phenomenal progress over a relatively short period of time have not been systematically documented and disseminated.

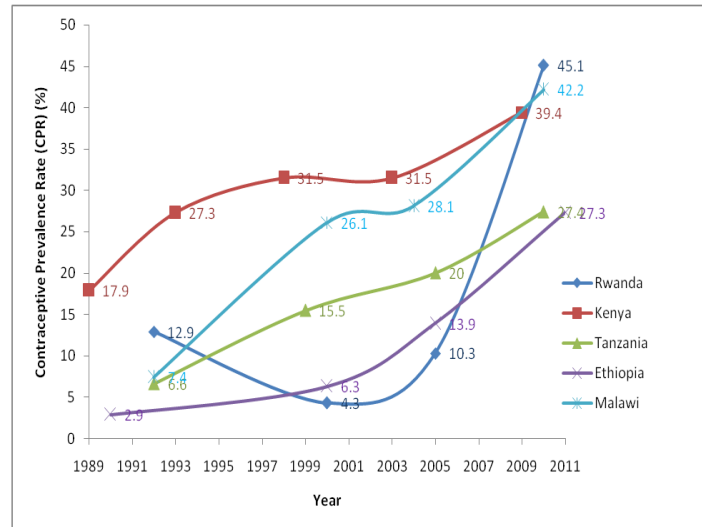


Figure 1: Trends in modern FP use amongst married women

This brief documents the policy and program drivers that have propelled the impeccable as well as stalled progress in increasing contraceptive use in these countries. Lessons from these countries could galvanize commitment to FP and propel similar progress in other countries in the region. Additionally, the study helps identify key policy and service gaps that need to be addressed for the study countries to achieve universal access to family planning.

Examination of the important roles that psychosocial, socioeconomic and cultural factors played in determining demand for children and contraceptive use in the study countries is beyond the scope of the study that is summarized in this brief. The purpose of the study was to understand the specific policy and program reforms that the progressive countries undertook in order to increase access to and use of modern contraception for the millions of women with unmet need for FP, as well as those aimed at generating demand for FP through educational campaigns. As evidence in Northern Nigeria and many other African settings has shown, provision of FP commodities does not lead to contraceptive use if couples are not ready to use it to manage their fertility (Pathfinder International 2008). These demand side barriers of contraceptive use include demand for big families or disapproval of FP for cultural or religious reasons, low female status and autonomy in decision-making processes, high child mortality, and economic vulnerability, which may influence some parents to have many children to ensure old age security or it may also influence others to have fewer children because they can not afford to take care of many children (Bonaccini 2012).

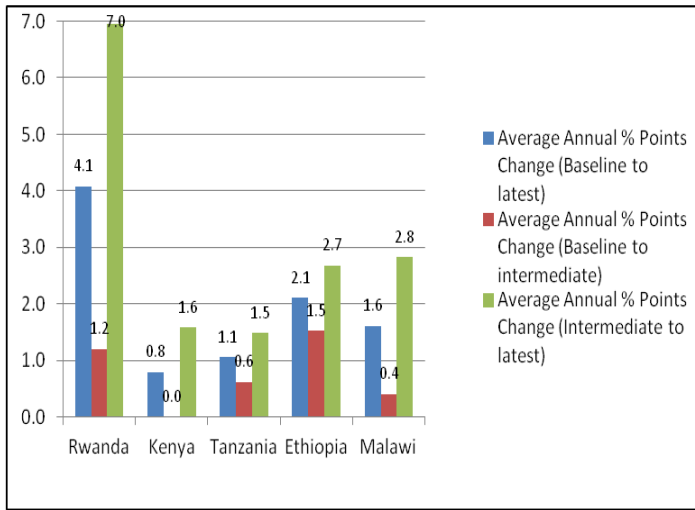


Figure 2: Trends in annual rate of increase of contraceptive use (from around 2000 to around 2010)

2. KEY POLICY AND PROGRAM DRIVERS AND LESSONS

The collective experience of these countries demonstrates that Family Planning Programs (FPPs) can play a key role in enabling couples access and use effective contraception, which empowers them to determine the timing and number of births that they would like to have.

The study revealed that a set of five common and synergistic factors contributed to the success of the FPPs as depicted in Figure 3. However, they manifested differently in achieving this common goal based on historical and current contextual circumstances (including political, health, culture, social systems, infrastructure, technical and human resource capacity) and sensitivity of population issues and family planning.

The most critical enabler of this progress is strong **political will and commitment** to family planning. Having top leaders in the country who embrace family planning helps create an enabling policy framework and program

implementation environment. It also facilitates **mobilization of financial and technical resources** from multilateral and bilateral development partners, and paves the way for increased local budgetary allocation for family planning programs. In Rwanda where political will is openly displayed and runs across all levels of leadership from the President to the community level, and FP is promoted as a central development intervention, phenomenal progress has been achieved. However, political leaders in Ethiopia and Malawi do not publicly advocate for family planning and political will has mostly manifested through full empowerment of the ministries of health to build strong FPPs premised on health benefits of family planning. Crucially, **sustained evidence-informed advocacy** conducted by local and international advocates for family planning helped to captivate political will and has remained key in sustaining it.

The five countries have also embarked on a range of **health system strengthening** initiatives, albeit at different levels and impact, in order to improve the quality and access to family planning services. These include training of health workers on family planning, performance-based incentives, enabling lower level health workers and community based volunteers administer widely popular contraceptives like injectables that were previously restricted to clinical staff (task shifting), expanded method choice, integration of family planning with other services such as HIV/AIDS, and improvement of supply chain management.

A third critical feature has been **educational campaigns and mobilization of community leaders and members** in championing FP, which has been matched with provision of FP services to meet this created demand. Educational campaigns help increase acceptance of family planning as a tool for enabling couples to decide the timing and number of children they should have. Taking FP to communities helps to address a number of the key barriers of access including transportation costs, and helps FPPs reach out to overlooked population subgroups such as men and youth.

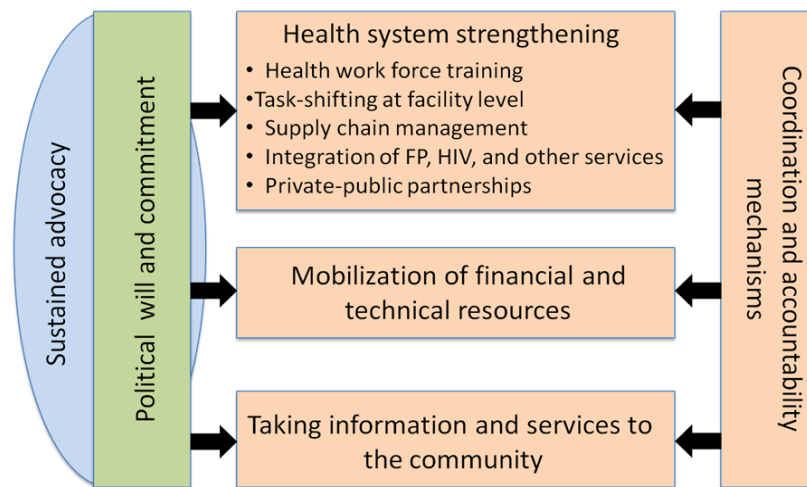


Figure 3: Policy and programmatic drivers of progress in increasing contraceptive uptake

These countries have also adopted various forms of public-private partnership in promotion and provision of FP services. Social marketing of FP services has been expanded and the religious leaders and health providers have been mobilized to support family planning.

Finally, the countries have had **strong coordination and accountability mechanisms**. Reproductive health and family planning technical working groups have played key roles, not only in sustaining political will through evidence-informed advocacy, but also in monitoring performance and enforcing accountability of the service delivery machinery, and improving coordination of financial and technical inputs from development partners and governments. They have also improved management of procurement and distribution of family planning commodities through clinics and community based systems. Each country has also had various family planning champions who have taken on the role of mobilizing support for family planning within government and in the public domain.

The main lessons from the stalled progress that was experienced in Kenya and Tanzania is that sustained efforts are required from all stakeholders to ensure that funding and technical inputs for improving the quality and outreach of FP services is maintained. Progress stalled in Kenya and Tanzania when program effort and financial and human resources shifted to address HIV and AIDS challenges. In addition, Tanzania's program was adversely affected by the challenges associated with the decentralization of the health sector during that period. Both countries have gone a long way in addressing these challenges and are revitalizing their FPPs.

Methodology

*This brief is based on the full report **Drivers of Progress in Increasing Contraceptive Use in Sub-Saharan Africa: Case Studies from Eastern and Southern Africa**. The report is based on case studies of the policy and program landscape and changes that Ethiopia, Malawi and Rwanda have undertaken in order to make good progress in increasing contraceptive use. The study also includes case studies from Kenya and Tanzania; countries that experienced stalled progress during the past decade, in order to understand what needs to be done to sustain progress. The African Institute for Development Policy (AFIDEP) conducted the study between October 2011 and June 2012. The study involved a literature review of policy and program documents and the literature, analysis of demographic data, and interviews with key stakeholders, including policymakers, program managers, and donors, in order to identify policy and program gaps in the five countries. The full report may be obtained from www.afidep.org.*

3. FACTORS CONTRIBUTING TO THE SUCCESS OF FP PROGRAMS

Below we summarize the key similarities and differences across the five countries on how the set of factors contributed to the success of the family planning programs:

3.1 Political will and commitment to FP and an enabling environment

Political will, which is initiated and sustained with evidence-informed advocacy, has been the most critical factor to FP policy adoption and program implementation. Rwanda stands out with strong leadership by the President who openly supports and promotes family planning as a development tool. This has been institutionalized in Rwanda, and traverses all levels of leadership in government. District Mayors and senior leaders in government have performance contracts to hold them accountable to the President for FP uptake. Informal contracts are also encouraged at the family level.

In Ethiopia, Malawi, Tanzania and Kenya, political will manifests at the Ministry of Health level (and Ministry of Planning in Kenya). Although neither of the Heads of State of these countries is vocal about supporting FP, there is recognition of the enabling environment to implement the national FPPs. In Ethiopia, the FPP has been championed by the current Minister of Health. In Malawi and Tanzania, the leadership has been apparent at the level of the heads of the Reproductive Health departments of the MOH, while in Kenya the Ministry of Planning is leading population pressure alleviation efforts with strong partnership with the FP service provider, the Division of Reproductive Health. Of note, the Ethiopian Ministry of Health is structurally different to the Ministries of Health in Malawi, Kenya and Tanzania, and may explain the difference in level of support at the Ministry level. Whereas, the Ethiopian Ministry of Health is structured on the basis of place of residence (urban, rural and pastoral), the Ministries in the other 3 countries have disease-oriented departments. Notably, advocacy efforts in Ethiopia, Kenya, and Malawi are led by the Ministry responsible for development planning, implying that managing population growth is central to development planning.

Political will and commitment to FP leads to an enabling environment for development of FP policies and guidelines, and implementation of national FP programs, which are supported by implementing agencies. Top level leadership in many sub-Saharan African countries are keen on advancing development and poverty reduction in their countries. Through sustained evidence-based advocacy, the governments of Ethiopia, Rwanda and Kenya have come to understand the link between FP and development. They have included FP in national development policies and aligned key health sector and national development policy instruments with the MDGs, which emphasizes FP as key to improving maternal health under MDG 5. The close scrutiny on performance of countries towards achieving the MDGs creates a global policy framework in support of FP in all

developing countries.

In addition, Rwanda, Ethiopia and Kenya have a multisectoral approach to implementing FP programs, which demonstrates their understanding of FP as more than a health issue. The explicit institutionalization of FP, with an acknowledged link between population growth and socio-economic development is strongest in Rwanda. Malawi's policy and program guidance for FP has historically been limited to the health sector. However, recently the government has started to move in this direction of addressing FP using a multisectoral approach.

The origin of political will

It is important to note that political will and commitment has not always been this strong in the five countries. In Malawi, for instance, family planning was banned in 1969 because the political leaders then wanted to have a big population and they felt family planning was a western imposition that was not in line with the country's reproductive culture (Chimbwete et al. 2005). In 1982, the country launched a national Child Spacing Program following intense advocacy by local health practitioners, politicians, and development partners. The program was labeled as such in order to align it with long-held traditional child spacing values. These values appear to have persisted since Malawi's impeccable progress in increasing contraceptive use has not been accompanied by expected declines in fertility. The persistence of high fertility has opened the door for government officials and some political leaders to start talking openly about the need to reduce fertility and slow the country's rapid population growth.

Ethiopia is another case where the country's leadership, specifically the late Prime Minister (Meles Zenawi), was not supportive of family planning when he came to office in 1995. Prime Minister Zenawi was later convinced (possibly after he understood value of family planning in development), and empowered the Ministry of Health to develop what has turned out to be one of the most successful African FPPs between 2000 and 2010. While government officials and political leaders appear to appreciate the adverse effects of rapid population growth for the country's development, FP is largely promoted as a child and maternal health intervention.

Due to the high population density, Rwanda's leaders have been concerned about high fertility and rapid population growth for a long time, as shown by the establishment of the National Office of Population in 1982 and the enactment of a landmark law to increase the minimum age at marriage to 21 years in 1992. With the genocide in 1994 that led to the death of close to 10% of the population, one would have expected the Rwandese leaders to sun away from FP. However, the post genocide government of president Kagame did the contrary and prioritized FP as a key development intervention. The primary champion of this policy position was the then Minister of Health (currently President of the Senate), Dr. Ntawukuriryayo. Asked to

explain how he convinced people who were sceptical about this policy direction, Dr Ntawukuriryayo said he armed himself with evidence from Futures Group's RAPID advocacy tool to convince the cabinet and parliamentarians that Rwanda had no option but to prioritize FP if it was to achieve its medium and long term development goals.

“After looking at all the data and closely examining our situation, we came to the conclusion that we can not develop into a middle income country without addressing high population growth and prioritizing family planning. Family planning is a key tool for developing the quality of our population, improving the health of mothers and children, and to address the poverty challenges that we face.”

- Dr. Ntawukuriryayo, President of the Senate, Rwanda.

Kenya also went through a similar process whereby its reputation as the first sub-Saharan African country to approve a population policy in 1967 was not matched with notable increases in contraceptive use until the late 1980s after President Moi and his government explicitly made FP a priority for Kenya's development. The waning of the political will that characterized Kenya's success story and ensuing shift in the attention of leaders and programs from FP to HIV/AIDS led to the stalled progress in FP use between 1998 and 2008. Efforts to revitalize the FPP in Kenya after 2005 involved intensive multi-actor evidence-based advocacy and resulted in the creation of a budget line for FP commodities and commitment to strengthen the community-based component of the FPP.

3.2 Health Systems Strengthening

Various reforms in the health systems of the study countries have contributed to increased access to FP services. These include:

- Decentralization of health services,
- Integration of RH/FP services with other essential health services (e.g. MCH and HIV),
- Task-shifting (i.e. expansion of the pool of health workers able to provide FP and/or integrated health services),
- Infrastructure development,
- Creation of innovative service delivery models (e.g. community-based distribution, public-private partnerships, social franchising and performance-based financing).

3.2.1 Decentralization of health services

Transferring decision-making power to the sub-national level means that resource allocation is responsive to the priority health needs of the community. However, it also

means that there is need for advocacy at this level to ensure demand is created for FP, and concurrent financial and human resources to meet this created demand for FP, including commodities and skilled workers. In Ethiopia, advocacy targeted to the regional governments (at sub-national level) has been successful, and regions have allocated resources from their budgets for FP. Nevertheless, competing health priorities against limited resources remains a challenge in all the study countries, including in Ethiopia where there have been some successes. In Malawi, some district health administrators have had to prioritize curative supplies over FP because of limited resources. Limited resources were also responsible for a backlog of debt from health facilities at the Central Medical Stores (the agency in charge of procuring, storing and distributing FP commodities), which led to its eventual restructuring and change in management.

3.2.2 Integration of RH/FP services with other essential health services, task-shifting, and infrastructure development

In the last decade or so, integration of HIV and maternal and child health (MCH) and sexual and reproductive health (SRH) in all countries has led to increased access to FP services. Increasing the number of trained health care providers who can provide a wider scope of services (task shifting) has been extremely beneficial. In Malawi, the Health Surveillance Assistants (HSAs) who are the lowest cadre of government-employed health workers administer injectables. In Ethiopia, as part of the primary care services, health extension workers (HEWs) can administer injectables and health officers can conduct surgical procedures (tubal ligation and vasectomy). In line with the expanded workforce was the need to expand infrastructure. In Ethiopia, there has been a rapid increase in development of additional health infrastructure at community level (health posts) over the last decade. Rwanda has established secondary posts next to Catholic-run health facilities to enable access to FP services for clients who want to use modern contraceptives.

3.2.3 Innovative service delivery models

In Kenya, Tanzania and Malawi, public-private partnerships and social franchising are helping to meet the gaps in public sector health service provision, including access to FP services. In all countries, mobile health services, implemented through public-private partnerships, has been instrumental in increasing access to long acting and permanent methods. In Rwanda, the community health insurance program has increase utilization of essential health services, which has contributed to the increased uptake of FP services. In addition, the implementation of performance-based financing (at health facility level) has also increased demand for and access to FP services in Kenya (pilot program to be scaled up nationally) and Rwanda.

In all countries, a persistent challenge is the limited access to FP information and services for the youth. This has recently

been made a priority agenda in Ethiopia, Kenya and Malawi and efforts are underway to meet the need. In Rwanda, a national training of trainers program has been launched to build the capacity of health workers to provide services to young people. Additionally, the government is establishing youth corners within existing health facilities across the country. Kenya uses a multisectoral approach to addressing youth SRH challenges. The Ministry of Health engages the Ministry of Youth Affairs and Sports (MoYA) and the Ministry of Education (MoE) to implement youth-focused SRH activities. After years of opposition from religious leaders and concern from parents, Kenya has recently rolled out a national life skills education program that now incorporates age-appropriate sexuality education. Efforts are underway to equip existing youth empowerment centers established under Kenya's MoYA to provide SRH information and link youth to services in addition to other youth development activities. Ethiopia's urban health extension workers reach out to urban youth with SRH information and services.

3.2.4 Improved supply chain management

Evidently, in Ethiopia, Rwanda and Malawi, improved efficiency in supply chain management systems have been central to FP commodity security. Nevertheless, as shown in all the countries, lack of efficient logistics systems, a skilled human resource pool to manage and operate the commodity supply chain, as well as inadequate financial resources can compromise commodity security. Common problems cited in study countries include poor capacity of health workers at the primary care level to manage stocks and place orders for commodities within the pull system, and deficient transportation. In some cases although timely requisitions for contraceptives are made by health facilities, priority for transportation is given to curative supplies. Adequate warehouses at sub-national level and storage at health facility level are additional challenges that these countries constantly grapple with. Ethiopia is currently transitioning from an efficient parallel system to an integrated logistics system. It will be interesting to learn about the challenges experienced and how they are overcome with relation to contraceptive supplies. The supply chain management system in Malawi, on the other hand, is currently undergoing a major overhaul to improve its efficiency.



3.3 Improved mobilization of financial and technical resources

A key consequence of having strong political will and commitment to family planning has been increased mobilization of financial and technical resources to support the design and implementation of programs. A common feature of the funding situation in all the five countries has been an over-reliance on development partner's financial and technical assistance for design and evaluation of various intervention programs, procurement and distribution of contraceptive commodities, and training of health workers. Key informants in all the countries expressed concern over their FPPs' over-dependency on finances and technical assistance from donors, but were also proud of the fact that it was their commitment to prioritize FP and use the financial resources effectively that attracted the donors to invest in their countries and FPPs.

Nevertheless, the danger of over-dependence on donors is well demonstrated by the stalled progress in the Kenyan and Tanzanian FPPs, which was occasioned by shifting donor priorities and reduced funding for FP in both countries. Although the Ethiopian government contributes around half of the required funding towards contraceptive the FP program, only 5% is from internally generated revenue, while the rest is from basket funds (budget support from external sources). Rwanda's program on the other hand is predominantly funded with external funds on the basis that government resources are best directed to other competing development priorities with less support. In comparison to Ethiopia and Rwanda, the Kenyan government is contributing a much larger share of the budget towards procurement of commodities, around 60%, implying that Kenya has learned from the negative impact to the FP program as a result of the change in donor priorities and funding in the late 1990s.

3.4 Taking Information and Services to the Community

At the core of the success of FP Programs in Ethiopia, Malawi, Rwanda and Kenya, is the expansion of service delivery by bringing FP information, services and products to the community, which in all cases are predominantly rural. 85% of Ethiopia's population is rural, and FP is one of the essential health services delivered through the successful, nationally implemented Health Extension Program (HEP). The difference between the HEP and other community-based service delivery models in Malawi, Rwanda, Tanzania and Kenya is that the health extension workers (equivalent to community health workers (CHWs) in other countries) are the lowest paid health cadre of the health system. Ethiopia's HEW model is therefore more sustainable due to retention of the HEWS.

In addition, 'demedicalization' of injectable contraceptives and implants (i.e. administration of injectables by these non-clinically trained volunteer CHWs and lower cadre health



workers) has increased the availability of contraception methods. Malawi, Rwanda and Kenya, despite not yet having well established community-based distribution (CBD) programs are now allowing CHWs to provide injectable contraceptives. Notably, this is a new policy change in Kenya, which is limited to underserved areas. It is worth mentioning that resistance to demedicalization is justified. Malawi and Kenya underwent years of resistance for this policy change from medical and nursing professionals who are knowledgeable of the potential health risks, and this continues to be the case in Tanzania. Policy change in both cases (Malawi and Kenya) was informed by feasibility studies and knowledge sharing study tours to countries in the region with successful programs, including Madagascar and Uganda. Notably, the recruitment criteria and training curricula for CHWs vary greatly across these countries. It may be useful to identify optimal factors to create a standardized CBD model. Information, Education and Communication (IEC) campaigns have increased demand for and utilization of FP in Ethiopia, Rwanda, Malawi, Tanzania and Kenya. Crucially, CHWs have been critical to mobilizing and educating the community. Further, engaging civic, faith-based and traditional leaders to be FP champions in their communities is another key strategy used by all countries. Rwanda has been particularly successful in working with Catholic Church leaders and getting their buy in to allow health service providers in their facilities to provide counseling on modern FP commodities and refer clients to an adjacent health facility that is strategically built to provide modern FP methods (secondary post). The Rwandan government also increases demand for contraceptives through monthly community meetings (known as *Umuganda*), which engage community members in discussions on development-focused issues. In Kenya and Ethiopia, innovative use of popular media (e.g. radio, TV), mobile technology and social media are being used

as major strategies for increasing demand for FP services and commodities. However, with the persistently high levels of teenage pregnancy and related unsafe abortions, the remaining challenge is to reduce stigma associated with provision of FP services to sexually active youth.

3.5 Coordination and accountability mechanisms

A key feature of the success that the five countries have witnessed is presence of strong coordination and accountability mechanisms for FPPs. Improved financial and technical coordination of public, not-for-profit and private sector health service providers, through the FP and Commodity Security Technical Working Groups has resulted in increased harmonization of the FP financing and coordination of programs in the five countries. Such forums have been critical at both national and sub-national level since the health systems in these countries are decentralized. The basket funding mechanism (which mobilizes development assistance for the health sector based on the government's health sector priorities) has been effective in mobilizing funding for the FP programs in Rwanda, Kenya, Ethiopia, and Malawi. However, there is still some funding which is allocated directly to programs at community level by development agencies such as USAID and UNFPA. These funding and associated programs are often not documented and create a challenge in assessing the full impact and gaps of the FP program. Rwanda stands out among the five countries for having a rigorous mechanism for coordinating donor funding. Through insistence that donors should support programs within the established government priorities, the Rwandese government is able to monitor all donor inputs and ensure that program areas of highest need are actually prioritized.

Another key role that Commodity Security Technical Working Groups play is to coordinate technical input in the design, monitoring, and evaluation of programs. In Ethiopia, for example, the technical working group has been instrumental in shifting the focus of the program towards long-term methods. These working groups provide a useful platform for building accountability frameworks that will ensure that FP services continue to be managed within the human rights framework agreed upon at the 1994 ICPD. The groups can also hold service providers, governments, and donors accountable to the commitments that they have made through protocols such as the London Family Planning summit in July 2012. A key shortcoming of the frameworks as currently composed is that they do not have civil society representation and the focus is heavily on the supply side of FPPs.

4. FACTORS CONTRIBUTING TO THE STALLED PROGRESS AND REPOSITIONING OF FP PROGRAMS IN KENYA AND TANZANIA

The main cause of the stall in the FP program in Kenya in the

late 1990s was the shift in top leadership prioritization of FP, which was compounded by the shift in donor priority and funding. In the late 1990s, when the country's economy was at its worst, HIV was declared a national disaster. Political attention shifted away from FP to address these challenges. At the same time, development assistance shifted to focus to supporting HIV/AIDS prevention and treatment efforts. The shift in development assistance is also blamed for the slow-down in the FPP in Tanzania. Because, development partners heavily financed the FPPs in the two countries, a heavy burden was bestowed upon the two governments, which were unprepared for the responsibility. The resulting stagnation in the FP uptake in Kenya, and retardation in the Tanzania was characterized by a decline in contraceptive commodity security, reduction in the number of trained health workers as they shifted to vertical HIV programs. The community-based distribution of FP information and services also collapsed.

Additionally, Tanzania's general slow progress in increasing contraceptive use was as a result of well-intended but premature health service reforms. The FPP was integrated with 6 other programs into a broader health program, which resulted in a loss of visibility for FP, and consequently reduced prioritization and allocation of government funds.

The repositioning of FP in Kenya and Tanzania by its integration into their development blueprints (Vision 2030 and Vision 2025 respectively), demonstrates the recognition of FP beyond its health benefits, and the importance of managed rapid population growth, as a critical measure for the countries to achieve their development objectives. There was also a concurrent global shift in attention to prioritise RH, as well as sustained evidence-informed advocacy to galvanize government commitment to FP.

“The mistake we made was that we focused on these higher levels where we have the facilities but it doesn't matter how many service providers you train, it doesn't matter how many of them are youth friendly or whatever it is you have decided for them to be trained in, especially if in the community people don't know”.

- International NGO representative.

5. RECOMMENDATIONS

The following recommendations have been derived from the lessons drawn from assessment of the study countries. As noted above, none of the five factors outlined in Figure 3 operate independently and have had synergistic effects in increasing contraceptive uptake in the five countries. Reinforcement of these factors with particular focus on meeting the needs of underserved populations will help enhance the impact of FPPs in increasing use of modern contraceptives in the countries that have made good progress, as well as the ones that are lagging behind.

1. Galvanize political will and commitment for FP at top leadership and all levels of government, as this will increase its profile as a health and development priority, through evidence-informed advocacy.
2. Position the population agenda, which includes access to FP services, at the centre of development planning. This alongside recommendation 1 will ensure a multi-sectoral approach to implementation of population activities.
3. Increase government and external funding for FP commodities and community oriented educational campaigns. Over-reliance on external sources of funding undermines the sustainability of FPPs, as exemplified by the experiences in Kenya and Tanzania.
4. Harmonize FP activities through strong technical and financial coordination and accountability frameworks, including enhancing local technical capacity in program design, evaluation, and research to feed into the accountability systems.
5. Strengthen the capacity of the health system in providing quality FP services by enhancing the health management information system (HMIS) and health worker skill base through pre-service and in-service training, introducing performance-based incentives and task shifting; integrating FP with HIV and other reproductive health services; strengthening the supply chain management; and expanding public-private partnerships through social franchising.
6. Address financial and geographical barriers through sustainable community-based information and service delivery initiatives. Complimenting this effort with empowerment of community-based public health workers and volunteers through task shifting and demedicalization of clinical FP commodities will optimize impact of FPPs.
7. Increase public awareness on the benefits of FP, and simultaneously break cultural, religious and other barriers to FP uptake.
8. Increase access to and utilization of youth-friendly FP and reproductive health services.

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