

Drivers of Progress in Increasing Contraceptive Use in sub-Saharan Africa: Lessons from Eastern and Southern Africa

Family Planning (FP) has immense health, environmental and economic growth benefits. It is estimated that in 2008, FP 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. FP 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%. However, despite these known benefits, limited progress has been made in increasing contraceptive use in the region. Only 20% of married women in SSA are using a modern method of FP, compared to the global average of 56%. Of all married women who wish to delay or stop child-bearing altogether, about 60% of women (53 million) are not using modern contraceptives.

Despite this bleak outlook, recent experience from a few countries in the region, notably Ethiopia, Malawi, and Rwanda, has shown that barriers to access and use of contraception can be overcome. Between 2000 and 2010 the percent age of married women using modern FP increased from 4.3% to 45.1% in Rwanda, from 21.5% to 46% in Malawi, and from 6.3% to 27.3% in Ethiopia. In Kenya and Tanzania, progress in improving contraceptive use stalled in the 1990s, but has recently picked up with annual increases of 1.6 percentage points in the past five years.

This policy brief documents the policy and program drivers that have propelled the impressive progress in increasing or stalling contraceptive use in these five countries. Lessons from these countries can galvanize commitment to FP and propel similar progress in other countries in the region.

1. Drivers of Progress in Contraceptive Use in Countries making Progress

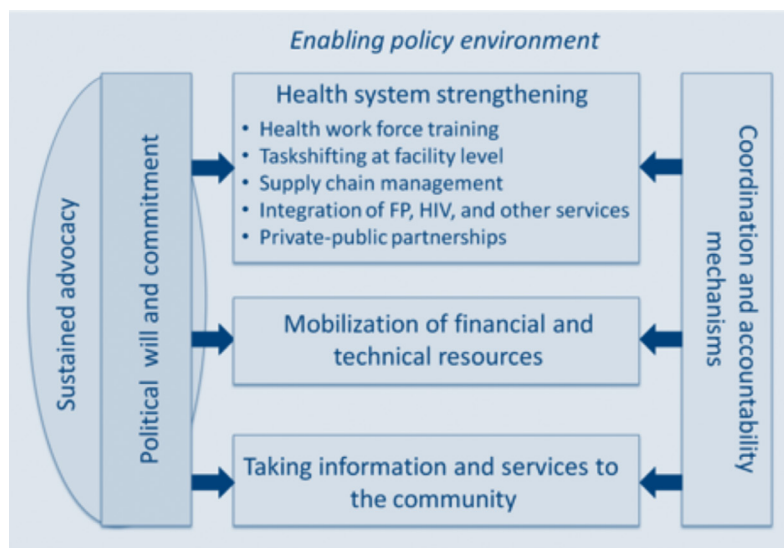


Figure 1: Policy and programmatic drivers of progress in increasing contraceptive uptake



1.1 Political will, leadership and commitment to FP

Historically, the agenda to manage population growth in the newly independent African nations in the 1970s and 1980s which was driven by the Global North faced strong opposition from African leaders who envisioned socio-economic development to be linked to a growing work force. However, this has changed, particularly in countries making good progress, where political will has been generated and sustained by **evidence-based advocacy**. Emerging research that demonstrated to leaders the major link between high population growth and development, and the impact of FP programming on steering development and improving the health of women and children, was instrumental in generating political will. The advocacy efforts were particularly successful in generating political will, leadership and commitment because they used **compelling research evidence and trusted, local and influential/powerful individual FP champions**. Political will has been the most critical factor to creating an enabling policy environment as African leaders have embraced, and in some cases, become champions for FP. This has culminated in FP policy adoption and the rolling out of a synergistic combination of drivers of progress to support FP program implementation and uptake that are discussed in this policy brief.

Rwanda stands out with strong leadership by the President who openly supports and promotes FP as a development tool. This traverses all levels of leadership in government

in Rwanda, and has been institutionalized by holding District Mayors and senior leaders in government accountable to the President for FP uptake through their performance contracts.

In Ethiopia, Malawi, and Tanzania, political will manifests at the Ministry of Health level, whereas in Kenya, this includes the Ministry of Planning. Although none of the Heads of State of these countries is publicly vocal about supporting FP, there is recognition of the enabling environment to implement the national FP programs. In Ethiopia, the FP program has been championed by the 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 Ministry of Health, while in Kenya the National Council for Population and Development in the Ministry of Planning are leading population pressure alleviation efforts in strong partnership with Ministry of Health's Division of Reproductive Health. Notably, advocacy efforts in Ethiopia, Kenya, and Malawi are led by the Ministry responsible for development planning, implying that a focus on managing population growth as a development issue is important in generating political support.

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1.2 Health Systems Strengthening

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

1.2.1 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 are allocated. 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 remain 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.

1.2.2 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, and sexual and reproductive health in all five 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 has been extremely beneficial. In Malawi, the Health Surveillance Assistants who are the lowest cadre of government-employed health workers administer injectable contraceptives. In Ethiopia, as part of the primary care services, health extension workers can administer injectable contraceptives 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.

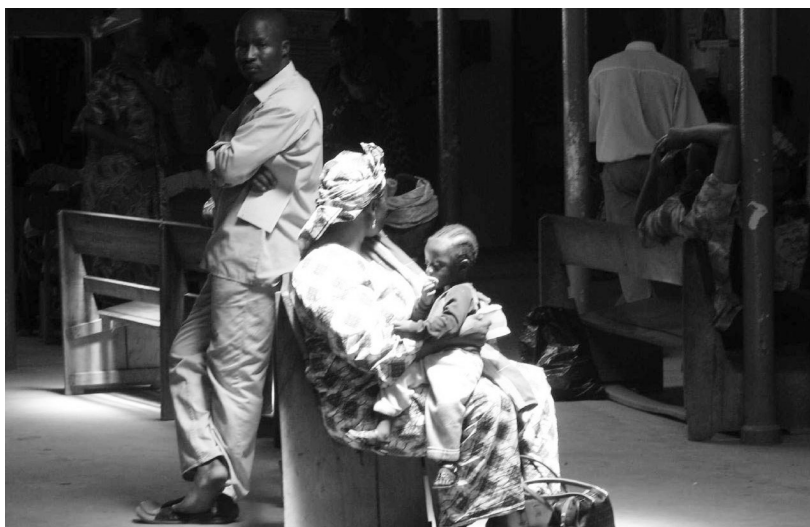
1.2.3 Innovative service delivery models

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 increased 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.

1.2.4 Improved supply chain management

In Ethiopia, Rwanda and Malawi, improved efficiency in supply chain management systems have been central to FP commodity security. However, 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 in relation to contraceptive supplies. The supply chain management system in Malawi, on the other hand, is currently undergoing a major overhaul to improve efficiency.



1.3 Improved mobilization of financial and technical resources

A key consequence of having strong political will and commitment to FP 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 countries' 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 effective use of financial resources that attracted the donor funding.

1.4 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. The difference between the health extension program and other community-based service delivery models in Malawi, Rwanda, Tanzania and Kenya is that the health extension workers

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(equivalent to community health workers in other countries) are paid health workers employed by the ministry of health. Ethiopia's health extension workers model is therefore more sustainable due to retention of the health extension workers.

In addition, 'demedicalization' of injectable contraceptives and implants (i.e. their administration by non-clinically trained volunteer lower cadre health workers – task-shifting) has increased the availability of contraception methods. Malawi, Rwanda and Kenya, despite not yet having well established community-based distribution programs, are now allowing community health workers 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 to 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.

1.5 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 FP programs. 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

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

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. Rwanda stands out among the five countries for having a rigorous mechanism for coordinating donor funding. By insisting that donors support programs within the established government priorities, the Rwandese government is able to monitor all donor funding to 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 FP 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 FP 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 FP programs.

2. Recommendations

None of the five factors outlined in Figure 1 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 FP programs in increasing use of modern contraceptives in the countries that have made good progress, as well as the ones that are lagging behind. Based on the lessons from the five countries, other countries not making good progress need to:

- a. **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.
- b. **Position the population agenda**, which includes access to FP services, **at the centre of development planning**. This alongside recommendation a. will ensure a multi-sectoral approach to implementation of population activities.
- c. **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.
- d. **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.

- e. **Strengthen the capacity of the health system** in providing quality FP services by enhancing the health management information system 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.
- f. 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 FP programs.
- g. **Increase public awareness on the benefits of FP**, and simultaneously break cultural, religious and other barriers to FP uptake.
- h. **Increase access to and utilization of youth-friendly FP** and reproductive health services.

This policy brief is derived from an AFIDEP research report:

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