realising rights

RESEARCH SYNTHESIS

Population, fertility and family planning, with a focus on Sub-Saharan Africa

Realising Rights uses research to raise the profile of sexual and reproductive health rights in developing countries. We work in partnership to find innovative solutions to the challenge of universal access.

Raising the profile

Realising Rights staff have been at the forefront of efforts to revitalise the family planning agenda with evidence-based reviews. Papers have been published in high impact journals such as the *Lancet* and *Science* as well as in more policy-oriented journals (these are listed in the references provided at the end of this document). A series of evening forums in London to debate the issues was organised and a high profile one-day symposium on population was held to celebrate 2010 World Population Day. Numerous presentations in Europe, USA and Africa have been made.

Evidence of impact is starting to emerge, hugely assisted, of course, by the election of President Obama. The USA is set to raise its budget for family planning and reproductive health substantially. DFID allocations for family planning have increased. An internal review of the World Bank was heavily critical of the virtual disappearance of its population projects. This growing momentum now needs to be reflected in national budgets, policies and programmes.

The arguments used to raise the profile of family planning are encapsulated below. It should be emphasised that these arguments are not necessarily shared by all RPC members.

Promotion of family planning in countries with high birth rates and rapid population growth has the potential to reduce poverty and hunger, and avert 32% of all maternal deaths and nearly 10% of childhood deaths. It would also contribute substantially to women's empowerment, achievement of universal primary schooling, and long-term environmental sustainability. In the past 40 years, family planning programmes have played a major role in raising the prevalence of contraceptive practice among married couples from less than 10% to 60% and reducing fertility in developing countries from 6 to about 3 births per woman. However, in half the 75 larger low and lower-middle income countries (concentrated in Africa), contraceptive practice remains low and fertility, population growth and unmet need for family planning remain high. It is the cross-cutting contribution to the achievement of Millennium Development Goals that makes greater investment in family planning in these countries so compelling. Despite the

magnitude of this 'unfinished agenda', international funding and promotion of family planning has waned in the past decade.

The priority – both political and financial – accorded to family planning in the 1970s and 1980s was driven largely by the belief that high fertility and rapid population growth represented a serious barrier to socio-economic development. At the 1994 Cairo Conference this link was broken. As a consequence, the importance of family planning in international development has steadily eroded and it is unlikely that this decline will be reversed until the link is re-forged. The irony of the current situation is that continued rapid population growth poses a bigger threat to poverty reduction in most poor countries than HIV/AIDS. Consider sub-Saharan Africa, the region most affected by HIV. In Southern Africa, with very high levels of infection, the disease is correctly regarded as an economic disaster. These countries already have low fertility and population growth is not a problem. The priority here is to achieve a more effective synergy between HIV prevention and family planning, building on the fact that condoms are now the most common contraceptive method for single people. However, in most other African countries, HIV infections are at a much lower level and the disease shows few signs of rapid spread while fertility and rates of population growth remain high. Many countries will double or even treble in size in the coming decades.

Many of them already face serious problems of food security and a growing dependence on food imports. Increased volatility of world grain prices and the probable impact of climate change on agriculture in Africa, which is predominantly rain-fed, combine with demographic pressures to present a huge challenge to the achievement of reductions in poverty and hunger.

A convincing case can be made that investment in family planning should have a higher priority than investment in HIV prevention and therapy. Yet current priorities are the reverse. For instance, in Ghana, HIV/AIDS is sucking funds, staff and political energy from family planning and this is a country where women are more likely to die of unsafe abortion than of AIDS. In Uganda, with a moderately severe, longstanding HIV epidemic, population size is nevertheless projected to grow from 30 million today to 61 million by 2025 and further to 127 million by mid-century, posing huge problems for economic advance. Yet President Museveni's lack of concern over the burgeoning population goes unchallenged. Further signs abound of irresponsible neglect of family planning and grotesque distortion of priorities. In Niger, for instance, which faces possible catastrophe because of rapid population growth, more meetings have been held on sterility (a problem affecting about 3% of the population) and on sexuality among the elderly than on population or family planning.

Several key steps towards the revitalisation of the family planning agenda can be identified.

Family planning proponents must first reassert the economic rationale that was muted at Cairo. This will require a break from the prevailing international discourse that cloaks family planning in the term "reproductive and sexual health", a habit that obfuscates rather than clarifies priorities. The priority due to family planning as a development intervention must be explicitly stated. The recent evidence fully justifies this stance, though it will arouse suspicions of a revival of the high pressure semi-coercive past tactics of some Asian family planning programmes. Such suspicions need to be addressed by emphasising that no contradiction exists between a respect for reproductive rights and a renewed sense of urgency in family planning promotion.

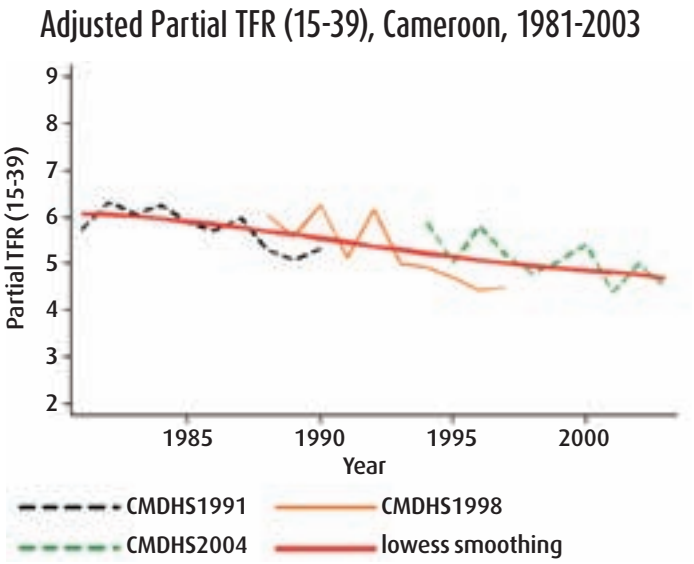
A further essential step is to press for a greater recognition that the demographic circumstances of low-and middle-income countries are increasingly diverse and that priorities for government actions and international assistance must be tailored accordingly. To reiterate, we are not arguing that family planning should be a top priority in all countries. Throughout much of Asia and Latin America, progress towards meeting people's family planning needs and population stabilisation is well advanced, though huge scope for improving the quality of services and for meeting the needs of the poor still exists. But in most of sub-Saharan Africa and a relatively small number of countries in other regions, family planning should return as a top priority.

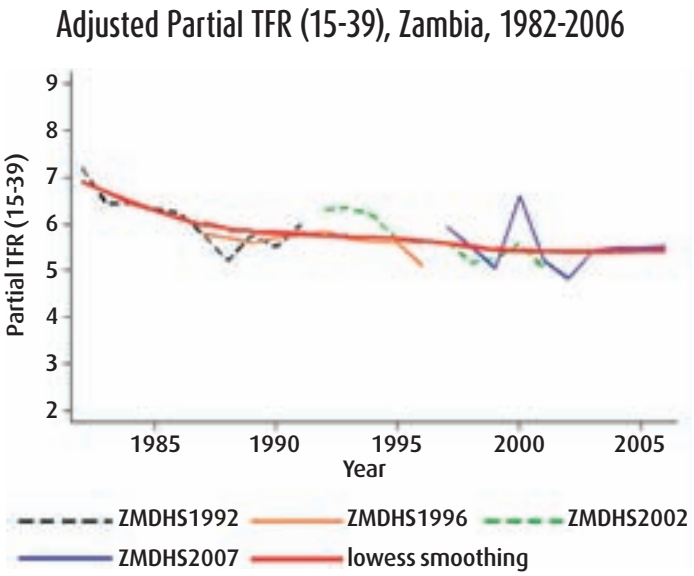
It is also necessary to protest against MDG hegemony in setting the development agenda, in particular against the myopia implicit in the 2015 deadline for their achievement. A major impact of family planning programmes in a mere five years is unlikely in those African countries where desired family sizes remain high. Even in Bangladesh, the paradigm of success in a very poor country, it took a decade of concerted effort to achieve an effect on fertility. While short term benefits of increased family planning practice on maternal and child health would be realised, the big pay-off in terms of poverty-reduction will take longer to unfold. But when populations are doubling in size every 25-30 years, as is the case in many of the poorest countries, a delay in the onset of fertility decline carries huge medium-term implications for future population size and economic prospects. It would be the utmost folly to sacrifice longer-term welfare considerations in the rush to show short-term impact.

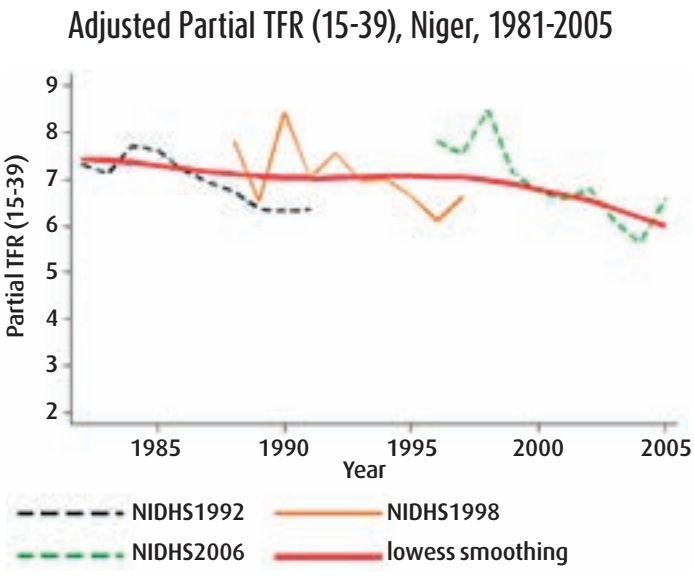
Monitoring Fertility and family planning in Africa

Confident estimation of fertility trends in Africa is not straightforward. The main source of data is the retrospective birth histories collected in Demographic and Health Surveys, which are not free of error. The most pernicious error stems from the questionnaire design: a long series of questions are asked of all children born in the past five (or three) years, an arrangement that provides an incentive for interviewers to displace dates of birth beyond the five year boundary, thereby removing the need to ask the supplementary questions. As part of a PhD thesis at LSHTM, Kazuyo Machiyama has adjusted for this type of error and smoothed erratic annual fluctuations to obtain reliable fertility trend estimates for 17 African countries that have conducted three or more Demographic and Health Surveys. Three main patterns have been identified: (1) continuous decline, moderate in the case of Ghana and very slight in the case of Cameroon; (2) an initial decline that has completely stalled (Kenya) or weakened (Tanzania, Zambia, Namibia); (3) constant high fertility (Niger). These patterns are illustrated in Figure 1. This analysis strengthens concerns that the fertility transition in Africa is faltering in many countries.

Figure 1



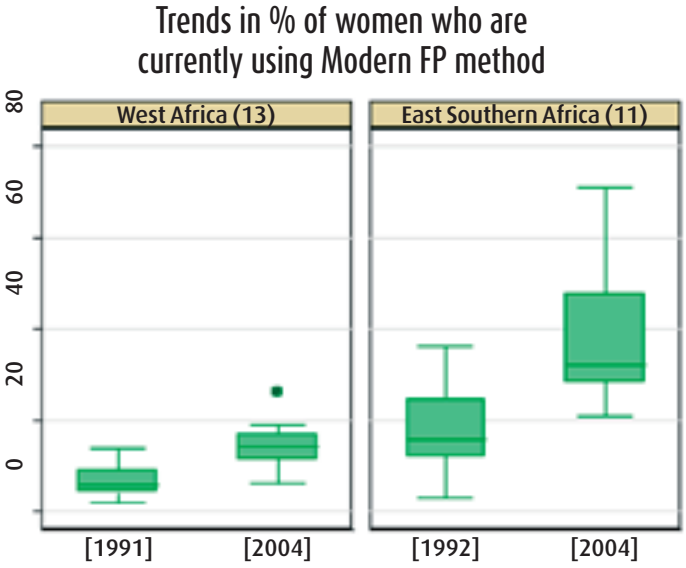




In Asia and Latin America, the dominant cause of fertility decline has been the use of effective modern methods of contraception by married women. Mass adoption of contraception depends on three factors: **demand** usually expressed as the percent of couples who wish to have no more children or postpone the next child for at least two years; **favourable attitudes** to the use of contraception; and **access to contraception** which is represented by the percent aware of key methods and of a source of supply. RPC staff have applied this framework to compare family planning progress between 1991 and 2004 in 13 West African and 11 East/Southern African countries.

In the West African countries, subjective demand for contraception remained unchanged, with about 46% of married women reporting a desire to postpone future childbearing for at least two years or to have no more children; the percent of couples who approved of contraception rose slightly from 32 to 39% and the percent who had access to methods rose from 8 to 29%. Current use of a modern method increased from 7% to 15%, equivalent to an average annual increase of 0.6 percentage points. In the East/Southern African countries, trends were much more favourable and current use increased at an average annual rate of 1.5 percentage points (see Figure 2).

Figure 2



Results are for fecund, currently married or co-habiting women (standardised by education and residence)

In West Africa, it is clear that progress towards mass adoption of contraception has been dismally slow; attitudinal resistance remains a barrier and access, though improving, is still shockingly low. If the pace of change is not radically transformed, the United Nations population projections for this sub-region are likely to be exceeded with potentially catastrophic consequences for those countries with fragile ecosystems and current problems of food security. In East/Southern Africa, the prospects for future fertility decline are much more positive, provided that funds and political will are favourable.

The reasons for the sub-regional divide are unclear. There is little difference in values of the Human Development Index between the two though educational advance has been more marked in East/Southern Africa. It is also likely that family planning services are more widely available in this sub-region than in the West, as evidenced by the big difference in reported access.

Sexually active single women in Africa represent an important component of overall of family planning need. Trends in contraceptive use were examined in 18 African countries among single women aged 15-24 years. Among those who were sexually active in the past three months, current use of condoms reported for pregnancy prevention rose significantly in 13 countries and median use increased from 5% to 19%. The median annual increase was 1.41 percentage points.

Use of modern non-barrier methods remained static and use of traditional methods declined with the net result that overall contraceptive protection changed little. In 13 countries with available data, condom use at most recent coitus also rose from a median of 19% to 28%. Most young people reported commercial outlets as their source of supply.

This increased uptake bears no relation to severity of national HIV epidemics: some of the sharpest increases were recorded in Western African countries where HIV prevalence is lower than in Eastern or Southern Africa. The annual increase of 1.4 percentage points per year—the median for all 18 countries—may appear modest but it matches the rise in overall contraceptive practice among married women in developing countries over recent decades and represents a much faster pace of change than, for instance, the decline in cigarette smoking in US adult men.

Sexually active, single women in Africa place themselves potentially at risk not only from HIV and other sexually transmitted infections but also from unwanted pregnancy. In nearly all African DHSs, fewer than 10% of sexually active, single women state the desire for a child in the next 12 months and thus the need for contraception is high, as is the likelihood of unwanted pregnancy. Induced abortion is illegal in most African countries, but nevertheless estimated to be common. The proportion of all unsafe abortions that occur among young women and abortion-related deaths are both higher in Africa than in other regions. In Ghana, it is thought that more women die of unsafe abortion than of AIDS and the same may hold for other countries in Western and Central Africa. Thus fear of pregnancy may be greater than fear of AIDS for many young women.

One main policy implication of these results is that promotion of condoms for family planning should be strengthened. This strategy might be more effective than their promotion for HIV prevention because it is no doubt easier for young people to negotiate condom use for contraceptive purposes than for disease-prevention. The results also support continued support for condom social marketing.

Trends in condom use by married or cohabiting couples are much less positive despite the fact that a substantial minority (probably about 30%) of HIV infections in mature generalised epidemics are caused by an infected cohabiting partner. However, results emerging from a WHO-funded study in South Africa and Uganda indicate that barriers to condom use within marriage are not immutable. Between 1998 and 2008, attitudes towards use of condoms within marriage became more favourable and concern about HIV infection from the spouse became more widespread. Consistent condom use by cohabiting couples rose appreciably, from under 5% to about 10%. These results are encouraging and should serve to direct attention to the protective needs of cohabiting couples, which have been badly neglected.

Unsafe abortion contributes to increased maternal mortality and is known to be used as a form of birth control in Ghana and other West African countries. Research on the role of emergency contraception confirmed its potential to make an important contribution to reducing unwanted pregnancies and unsafe abortions if it is better marketed and formed part of the standard family planning method mix, especially in West Africa where the use of ineffective traditional methods is high.

Contraceptive Discontinuation and Method switching

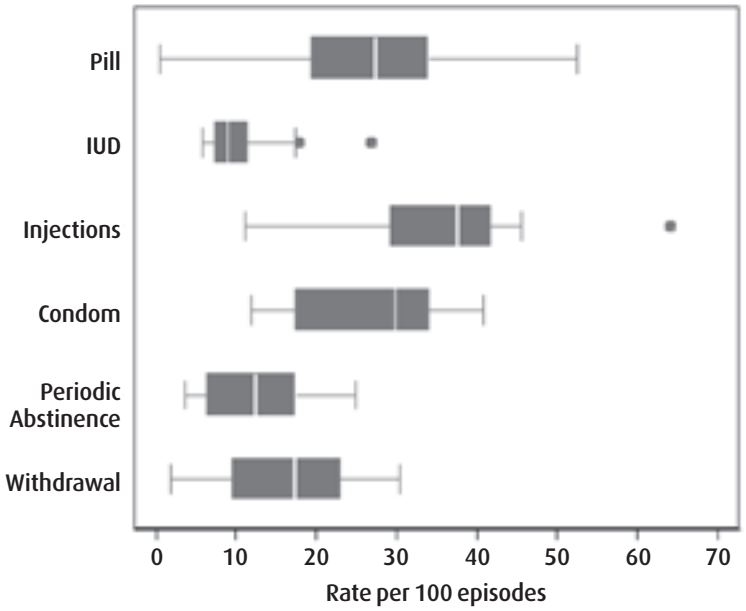
As contraceptive practice in a society becomes more widespread, the avoidance of unintended pregnancies becomes less dependent on rates of initial adoption and more dependent on the ability and willingness of couples to use methods with maximum effectiveness, to use them persistently and to switch quickly to alternative methods as and when the need arises. In populations where most couples have never tried any method of contraception, the vast majority of unintended pregnancies inevitably stem from avoidance, or never-use of contraception. Conversely, in populations where most adults have tried one or

more methods, the majority of unintended pregnancies are the result of the use of less effective methods, incorrect use of effective methods and abandonment of use. Thus the study of use-dynamics, and its relevance to an understanding of the ability of couples to achieve their reproductive intentions, has steadily grown in importance over the past 50 years, in line with the spread of contraceptive practice in developing regions.

In all countries—rich or poor—adopters of contraception have a high probability of stopping use of their chosen method within 12 months for reasons that imply dissatisfaction with the method. Discontinuation is more likely for methods that require no provider-involvement with cessation of use (e.g. pills, injectables, condoms) than for other methods such as IUDs and implants (Figure 3).

Figure 3

12-months method-related discontinuation rate by method



Little convincing evidence exists that improvements of service quality, such as more intensive counselling, improves continuation of use. Family planning providers need to anticipate that 30-40% of women will not persist with their method. Following discontinuation of a modern method in low and middle-income countries, only 30-40% switch promptly to another modern method and the remainder are at moderate or high risk of an unintended pregnancy. Switching is lower among less privileged strata (e.g. poorly educated women). Switching is also less common in settings where alternative methods are not commonly used; thus method-mix is an important consideration in identifying countries where poor

switching is likely to be a severe problem. In conclusion, low continuation and low switching is a neglected issue in family planning services. It needs a higher profile and perhaps operations research to identify effective ways of improving the situation.

Impacts of antenatal HIV diagnosis and contraceptive counselling on postpartum reproductive behaviour in Mwanza, Tanzania

In a region where over a quarter of married women do not want a child in the next two years but are not using contraception, meeting contraceptive needs will help women prevent unwanted pregnancies, which in a context of high HIV prevalence can also help reduce the number of HIV-positive births. Antenatal care is a valuable opportunity for contraceptive counselling: women are sexually active, of reproductive age, and contraceptive counselling can be integrated into routine antenatal HIV testing in order to offer family planning information tailored to HIV status. To do this, a better understanding is needed of postpartum reproductive behaviour, and of the impacts of HIV diagnosis and contraceptive counselling on this behaviour.

A baseline survey of pregnant women in 17 antenatal clinics collected information on reproductive history and intentions prior to routine HIV testing. HIV results were then linked anonymously to the survey results. In the second half of the baseline survey, an intervention offered contraceptive counselling as part of the post-test HIV counselling (with women in the first half of the survey acting as the control group).

Fifteen months later, a follow-up survey of the baseline respondents enquired about their postpartum reproductive behaviour.

Unmet need for contraception in the postpartum period was particularly high, despite over 70% of respondents intending to use it in the future. However, condom use was much more popular than at other times. Major reasons for not using contraception included not having resumed menses (even after a year postpartum), fear of side-effects, negative community attitudes, and partner's disapproval. With regards to the role of HIV, HIV-positive women had half the odds of wanting another child ($p=0.006$), a smaller ideal

family size ($p<0.001$), lower unmet need at follow-up ($p=0.018$), and were non-significantly more likely to have used contraception (especially condoms) in the postpartum period, than their HIV-negative counterparts. In in-depth interviews, HIV-positive women overwhelmingly desired to stop childbearing (in contrast to much of the recent literature), mainly due to dissuasive advice from health providers and worries about health deterioration during pregnancy. However, they also had to consider the heavy stigma of childlessness, which emerged as stronger than HIV-related stigma. Women who received antenatal contraceptive counselling were more likely to intend to use contraception ($p=0.006$), and less likely to want a short next birth interval ($p=0.030$), but no more likely to have actually used contraception postpartum.

The different reproductive needs of HIV-infected and uninfected women, both before and after testing, call for integrated contraceptive and HIV counselling which is person-centred, tailored to HIV status, and respectful of reproductive rights. While offering this counselling antenatally has the potential to reach a large proportion of women with much needed contraceptive information and help meet the high postpartum unmet need for contraception, the impact of antenatal counselling would be greatly increased if reinforced by postpartum counselling and better continuity of care.

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Who are we?
The Realising Rights Research Programme Consortium is a partnership of five organisations. The consortium brings together epidemiologists, demographers, clinicians, social scientists, development specialists and service delivery organisations. You can find out more about our work by visiting our website **www.realising-rights.org**

Our partners
African Population and Health Research Center (Kenya), BRAC (Bangladesh), INDEPTH Network (Ghana), Institute of Development Studies (UK) and the London School of Hygiene and Tropical Medicine (UK).

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