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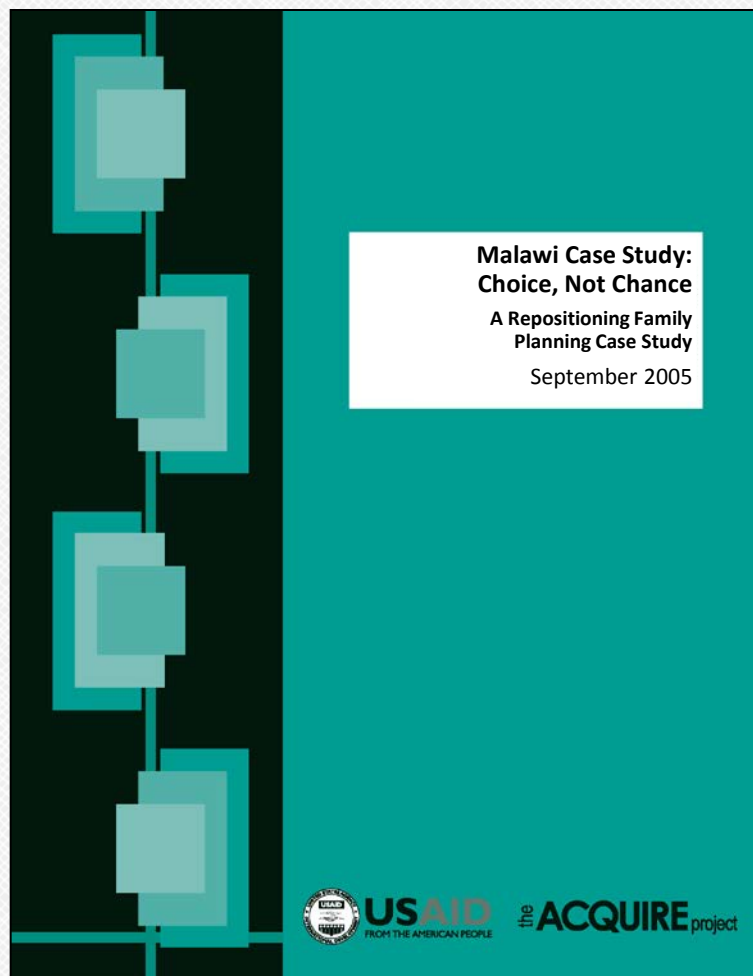
Don't Call Me Fragile: The Remarkable Performance of Malawi's FP Program and What It Teaches Us

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Managing Partner: EngenderHealth; Associated Partners: FHI 360; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council





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Commentary

Fragile, Threatened, and Still Urgently Needed: Family Planning Programs in Sub-Saharan Africa

Roy Jacobstein, Lynn Bakamjian, John M. Pile, and Jane Wickstrom

Many family planning (FP) programs in sub-Saharan Africa are fragile; recent performance has fallen off and future performance is challenged. Yet robust and well-functioning FP programs are still urgently needed if countries are to meet their health, equity, poverty-alleviation, and economic development goals. In support of these observations, we present data on FP parameters in sub-Saharan Africa overall and in eight of its countries, including Nigeria, the most populous African country; Kenya, a long-time leader in FP in the region; and Uganda, with fertility among the highest in Africa and a population projected to more than triple in the next 40 years to become sub-Saharan Africa's fourth-most-populous country. We also draw upon findings of individual case studies of the contraceptive programs of Ghana (Solo et al. 2005c), Malawi (Solo et al. 2005a), Senegal (Wickstrom et al. 2006), Tanzania (Pile and Simbakalia 2006), and Zambia (Solo et al. 2005b), as well as a synthesis of some of these case studies (ACQUIRE Project 2005).¹ All eight of these countries, which together comprise 40 percent of the population of sub-Saharan Africa, are facing the same difficult dynamics in terms of threat and need.

Trends and Current Status of Family Planning

The use of modern contraceptive methods² is very low in sub-Saharan Africa, far lower than it is in other regions

of the world. Only 18 percent of married women use a modern method of contraception, compared with 63 percent in Latin America and 61 percent in Asia (48 percent excluding China). This level of contraceptive use represents only a small rise in the contraceptive prevalence rate (CPR) for modern methods from the level of 13 percent seen in sub-Saharan Africa in the late 1990s to 2001 (PRB 2002 and 2008).

Unmet Need for Modern Contraception

Although the use of modern contraceptives is low in sub-Saharan Africa, unmet need for modern contraception is high. Twenty-nine of the 31 sub-Saharan African countries where a recent DHS has been conducted report levels of unmet need for modern-method use exceeding 20 percent; 19 countries report levels between 30 percent and 49 percent. In contrast with other regions, little or no reduction in unmet need for modern family planning has occurred during the past decade in sub-Saharan Africa. Unmet need for modern-method use is higher than current use (that is, met need) in many sub-Saharan African countries, in some cases substantially higher. Whereas 18 million married women in sub-Saharan Africa use modern contraceptives, 25 million lack modern means of managing their fertility (Westoff 2006).

Fertility and Population Growth

A concomitant to this low prevalence of use and high unmet need is very high fertility and rapid population growth: sub-Saharan Africa's total fertility rate (TFR) is 5.5 lifetime births per woman, substantially higher than the TFR of Latin America (2.5 births) and Asia (2.4 births [2.8 births, excluding China]). Fifteen of the 31 sub-Saharan African countries with a recent DHS have TFRs that exceed six births per woman (PRB 2007). This

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THE NATION

WEDNESDAY, SEPTEMBER 15 2010



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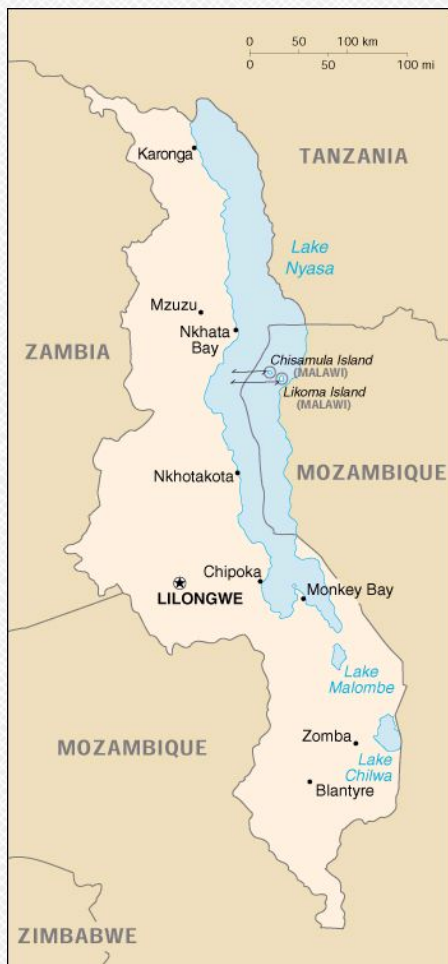
Roger Staubach once wrote; "Confidence does not come out of nowhere; it is a result of something...hours and days of constant work and dedication."

Management Sciences for

Malawi gets international credit for strides in family planning



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- One of the 10 poorest countries in the world
 - GNP per capita US\$810*
- Population: 13.1 million** (growth rate 2.8%/yr.)
- Mainly rural: 81.3% rural / 18.7% urban***
- Female literacy: 67.6% (9% completed primary)***
- Life expectancy at birth (years): 44 (M) / 51 (F)*
- Maternal mortality: 675 per 100,000 live births (984 per 100,000 in 2004)***
- HIV prevalence: 10.6% (12.9% women; 8.1% men) (was 15% in 2000; 11.8% in 2004)***

Sources:

*WHO Global Health Observatory

**2008 Malawi Population and Housing Census

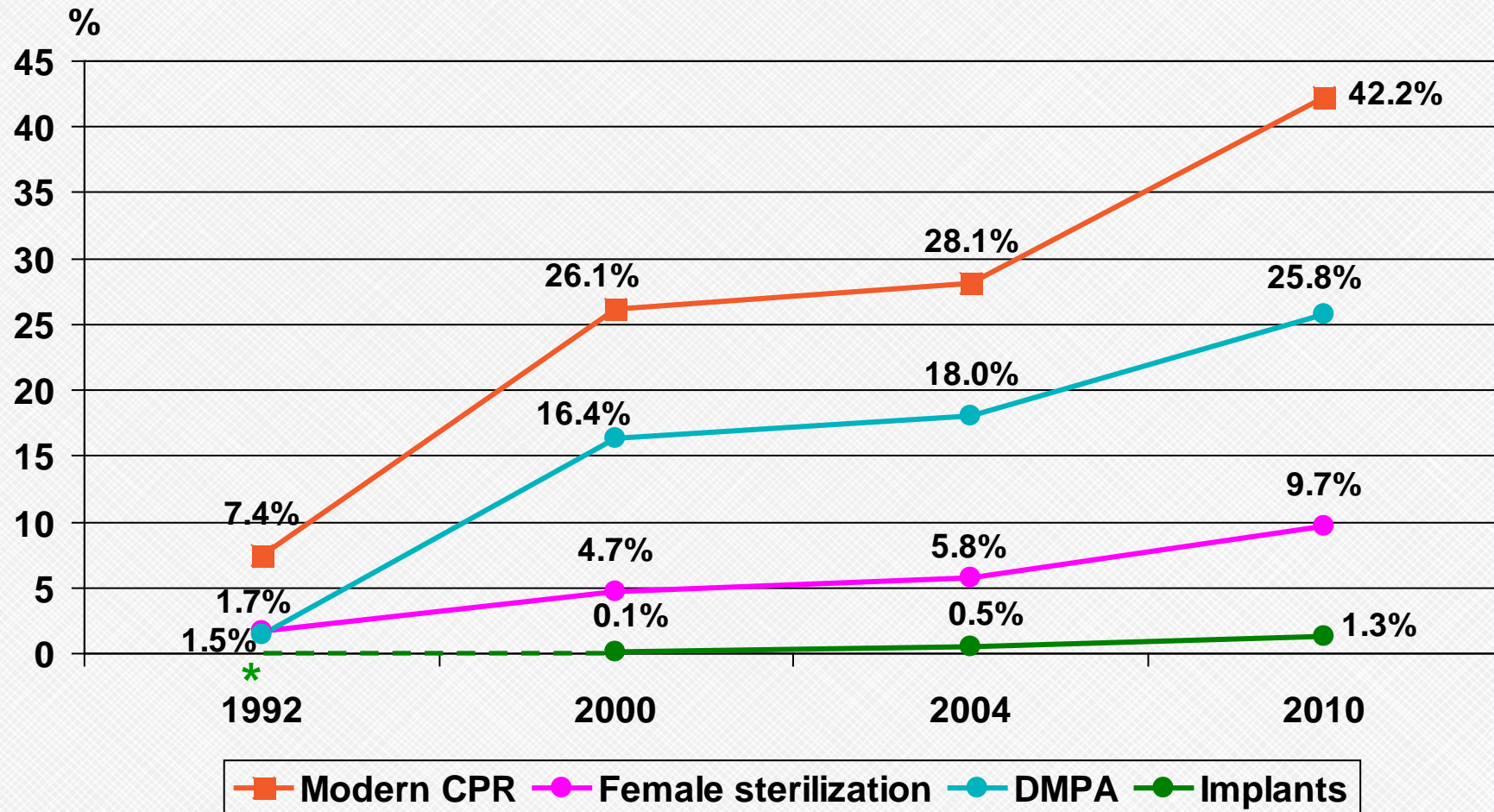
***MEASURE/DHS, Malawi DHS Survey, 2010.



- FP use rising: total CPR: 46% / modern CPR: 42%
(in 2004, modern CPR 28%; in 1992, 7%, & “family planning” a prohibited term)
- Fertility still quite high, fell only slightly, & higher than wanted fertility
 - Total fertility rate (TFR) 5.7 (was 6.0 in 2004; 7.3 in 1966)
 - Wanted fertility: 4.5
- Total demand for FP is high, and now the norm: 73%
- **Demand to limit greater than demand to space**
- Most commonly chosen methods:
 - Injectables: 26%
 - **Female sterilization: 9.7%**
 - **Implants: 1.3%**



Trends in modern CPR, and use of injectables, implants, and female sterilization



Source: Multiple DHS surveys; data is for married women (MWRA)

* In 1992, implants were included in "other methods".



Use of female sterilization (FS) Selected countries and regions

Regional Prevalence of FS	Prevalence of FS, Selected Countries	
Worldwide: 18.9%		
Asia: 23.4%	Thailand: 26.6%	Nepal: 18.0%
South America: 23.1%	Colombia: 31.2%	Brazil: 29.1%
North America: 22.3%	United States: 23.6%	Canada: 11%
Oceania: 13.9%	Australia: 15.9%	New Zealand: 14.6%
Sub-Saharan Africa: 1.6%	South Africa: 14.3%	Malawi: 9.7%
	Kenya: 4.8%	Rwanda: 0.8%
	Ethiopia: 0.5%	Nigeria: 0.4%



Country	Demand to space (%)	Demand to limit (%)
Malawi (2010)	34.6%	37.7%
Kenya (2008/09)	30.4%	40.7%
Madagascar (2008/09)	29.3%	29.5%
Ethiopia (2011)	32.7%	21.2%
Senegal (2005)	31.5%	11.9%
Nigeria (2008)	23.8%	11.0%
Indonesia (2007)	29.5%	41.1%
Bangladesh (2007)	21.6%	51.3%
Dominican Republic (2007)	23.1%	61.2%



- Positive government policies
- Universal knowledge (of FP and FS)
 - “FP is on the road to becoming a norm, but where will the supplies come from?”
- Service delivery at community level
 - “We can’t have a medical approach to a social need.”
- **Task-shifting** of method provision to more cadres and sites
 - “We have a serious shortage of medical personnel.”



Photo by Staff / Banja La Mtsogolo (BLM)



Photo by Staff / MSH Malawi



Source of modern methods in Malawi

Effective public-private partnerships with strong NGOs

	<u>Total*</u>	Female <u>Sterilization</u>	<u>Implants</u>
Public sector	74%	54%	83%
Christian Health Association of Malawi (CHAM)	9%	10%	6%
Banja La Mtsogolo (BLM) (the Malawian MSI affiliate)	9%	33%	9%
Private sector	4%	4%	2%
Other source	4%	1%	0%



*"Total" = Female sterilization, Pill, IUD, Injectables, Implants, and Male condom
Source: MEASURE/DHS, Malawi DHS Survey, 2010.



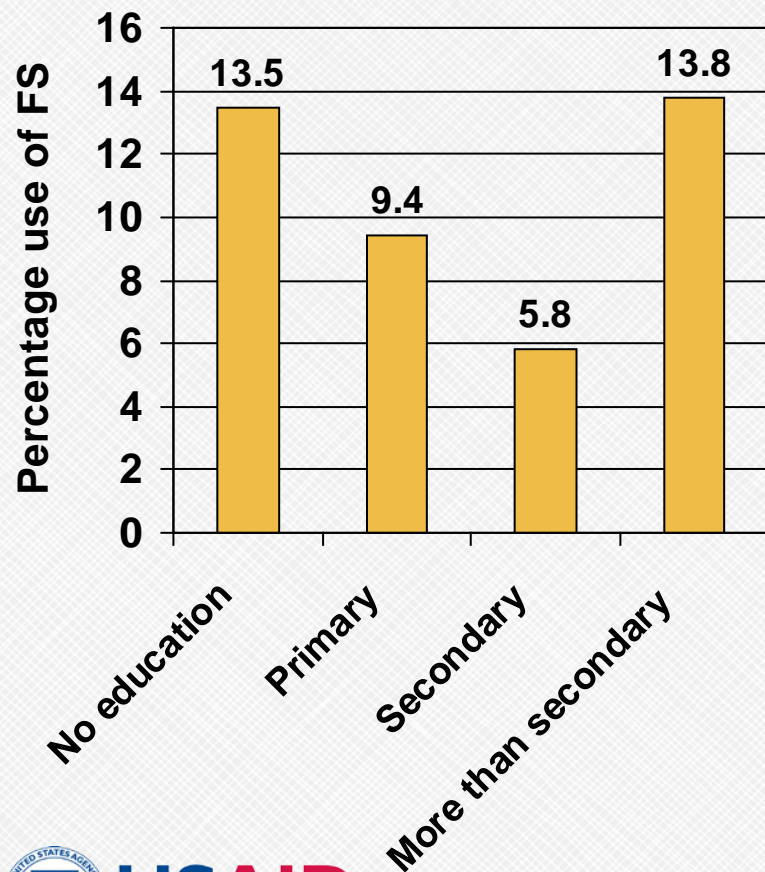
Public-private partnerships, mobile services, and provision of clinical FP methods

- Longstanding GOM public-private partnership with CHAM and **BLM**
- **National network:**
 - 33 BLM clinics, in 22 of Malawi's 28 districts
 - BLM outreach teams from clinics to rural areas in 27 of 28 districts
- **Mobile outreach services**
 - Mainly for LA/PMs; often provided in MOH or CHAM facility
 - Provided **free of charge** (fees charged in clinics)
 - > *90% of BLM services provided via mobile teams*
- **All female sterilizations done by clinical officers, not doctors**
- Large and increasing service volume:
 - **115,000 female sterilizations in past 2&1/2 years**
 - 9,000 implants in first 8 months of 2011 (versus only 2600 in 2010, and all to outreach/rural clients)
 - 4,000 in past four months -- **rapid ↑ in implants with cheaper implant**

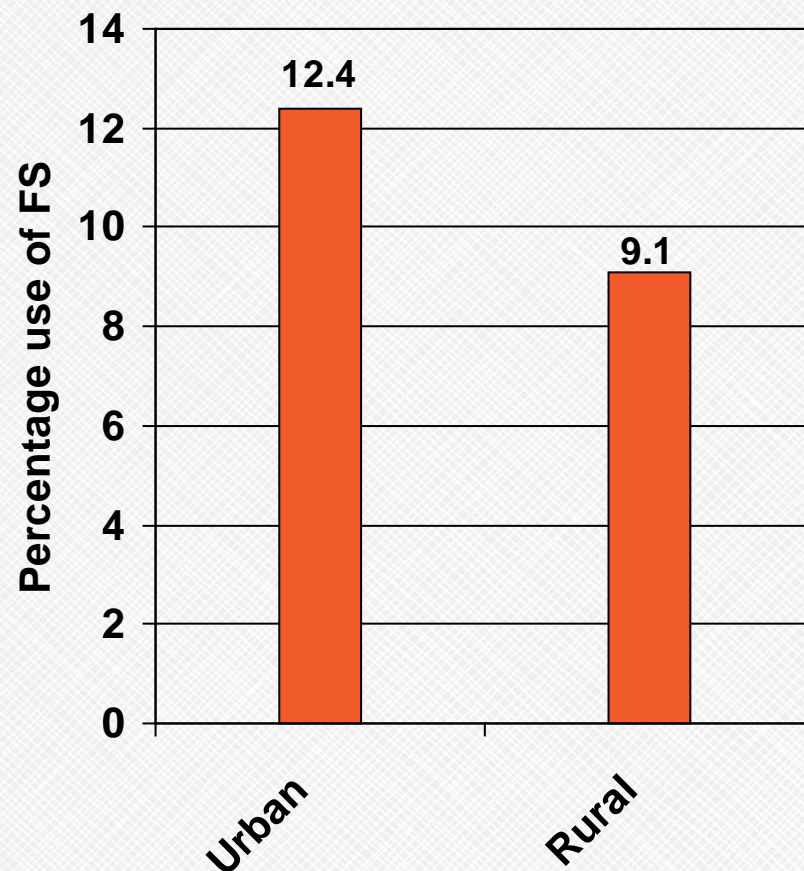


Wide and equitable FS access and use

**Use of FS
by education level**



**Use of FS
by residence**





- **Rapid increases in contraceptive use, including of female sterilization, can be generated and provided equitably** in sub-Saharan Africa despite severe shortages of health personnel, other disease burdens, and poverty
- **Contraceptive security** is critical and fragile, and needs constant attention and prioritization: **“No provider, no program”**
- **Task-shifting** is key to meeting reproductive intentions and growing demand for FP in general and LA/PMs in particular
- **Community-level services** are critical for widespread FP and LA/PM access and use



“Takeaway messages” (cont.)

- **Don’t forget the limiters:** A sizeable and growing proportion of women in Africa want to limit births -- **this will increase** as TFR falls (as it has in other regions, and notwithstanding the “youth bulge”)
- **Mobile services**, in **public-private partnerships**-- with FP-dedicated providers and free services -- can greatly increase access to LA/PMs.
“Dedicated, mobile, free”
- **Female sterilization** will be widely chosen when it is made affordable and accessible
- **Implants** use is **likely to continue rising** in Malawi and in Africa as a **much less expensive implant** (Zarin) is more widely introduced



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Zikomo kwambiri!



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