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COMPARATIVE STUDY ON FAMILY PLANNING AND BIRTH SPACING PROGRAMMES IN ECA MEMBER STATES

Contents

I INTRODUCTION

1. In the 1960s, 1970s and early 1980s, a few African countries had organized family planning/birth spacing programmes. Prior to 1984, most African countries, and governments had associated family planning with limiting of family size. The majority of countries in the African region were pronatalist. It was in 1984 that a general consensus on the usefulness and benefits of family planning/birth spacing programmes was reached among African governments. That change in perceptions on family planning was reflected in the Kilimanjaro Programme of Action on Population (KPA) adopted at the Second African population Conference held in Arusha, Tanzania, in 1984. The KPA had addressed a number of recommendations on fertility and family planning to African Governments in the context of socio-economic development.

2. Family planning and birth spacing issues were again given prominence at the third African Population Conference held in Senegal, Dakar, in 1992. The Dakar Conference adopted the Dakar/Ngor Declaration on Population, Family and Sustainable Development. This will form the African input and common position at the International Conference on Population and Development to be held in Cairo, Egypt, in 1994. The Dakar/Ngor Declaration includes specific targets to (a) increase contraceptive use for Africa as a whole to 20% by the year 2000, and to 40% by the year 2010; (b) decrease Africa's population growth rate from 3% in 1992 to 2.5% in the year 2000 and to 2% by 2010. Nearly all countries in Africa are now involved in family planning/birth spacing programmes in order to influence demographic trends and to improve the health of mothers and children. Further more, an increasing number of countries are involved in family planning programmes as a human right for individuals and couples to decide on the number and spacing of children.

3. The objective of the paper is to present a comparative analysis of family planning/birth spacing programmes in selected countries with organized programmes. Coverage is limited to the following countries: Botswana, Egypt, Ghana, Kenya, Morocco, Tunisia, and Zimbabwe. These countries were selected because there was adequate information on them. While more countries could have been included, it was felt that attention should focus on programmes which started before 1984 and for which relevant data was available. The source of data for this study is varied and includes survey reports, country reports presented at conferences as well as earlier studies carried out by the secretariat.
This study was requested by the Joint Conference of African Planners, Statisticians and Demographers at its 7th session in 1992.

4. The paper is organized into 4 sections. Section I is the introduction. Section II is an overview of socio-economic background of the countries selected for coverage. The comparative analysis based on a number of selected variables is presented in Section III. Summary and conclusion is in Section IV.

II SOCIO-ECONOMIC BACKGROUND

5. Table 1 shows selected socio-economic indicators. Among the seven countries under study, the 1992 population show that Egypt is the most populous with a population of 54.8 million at that time. Morocco's and Kenya's population for the same period were not very different at 26.3 million and 25.2 million respectively. The population in the other countries were: Ghana 16.0 million, Zimbabwe 10.6 million, Tunisia 8.4 million and Botswana 1.3 million. Regarding population growth rates for the period 1985 to 1990, the rates were below 3% in the North African countries of Tunisia: 2.1%; Egypt: 2.4; and Morocco: 2.6%. In 4 other countries the rates were: Zimbabwe 3.5%, Kenya 3.4%, Ghana 3.1% and Botswana 3%.

6. The three North African countries have more than 40% of their population living in urban areas. The figures for 1992 were: Tunisia 57%, Morocco 47% and Egypt 44%. In the other countries the figures range between 25% and 35% as follows: Ghana 35%, Zimbabwe 30%, Botswana 27% and Kenya 25%.

Table 1: Selected Socio-Economic Indicators

Country	1992 Population (million)	Population Growth rate 1985-1990 %	Percentage of Urban population 1992	Life expectancy at Birth, 1990-1995	Adult literacy M/F, 1990	GNP Per capita 1990 US.$	HDI, 1990 Rank
Botswana	1.3	3.0	27	61	84/65	2040	94
Egypt	54.8	2.4	44	62	63/34	600	110
Ghana	16.0	3.1	35	56	70/51	390	119
Kenya	25.2	3.4	25	59	80/59	370	114
Morocco	26.3	2.6	47	63	61/38	950	106
Tunisia	8.4	2.1	57	68	74/56	1440	87
Zimbabwe	10.6	3.5	30	56	74/60	640	108

HDI = Human Development Index
M = Male
F = Female

Source: *UNDP, Human Development Report 1992; United Nations Population Division, World Population Prospects: The 1992 Revisions; World Bank, World Development Report 1992; UNFPA, State of World Population 1993.*

7. Estimates of life expectancy at birth for 1990-1995 are highest for Tunisia at 68. This was followed by Morocco: 63; Egypt: 62; Botswana: 61; Kenya: 59; Ghana and Zimbabwe: 56 each.

8. Data on adult literacy for 1990 shows Botswana as having the highest literacy rate among the males with a rate of 84%. This was

followed by Kenya: 80%; Tunisia and Zimbabwe: 74% each; Ghana: 70%; Egypt: 63%; and Morocco which had the lowest rate of 61%. Literacy among women was also highest in Botswana with a rate of 65% followed by Zimbabwe: 60%, Kenya: 59%; Tunisia: 56%; Ghana 51%; Morocco: 38% and Egypt had the lowest rate of 34%.

9. With regard to GNP per capita for 1990 in US dollars, Botswana has the highest figure of $ 2040. Tunisia ranks second with a figure of $ 1440. Morocco's GNP was almost $ 1000. Egypt and Zimbabwe had GNP per capita which was almost the same at around $ 600 each. Ghana and Kenya also had GNP per capita which was about $ 400 each in 1990.

10. The last column of Table 1 shows the ranking of the Human Development Index (HDI), which is an index computed based on indicators of national income, life expectancy at birth and educational attainment to give a composite measure of human progress. It was computed for 160 countries (developed and developing) based on 1990 data only. Among the seven countries in Table 1, in terms of human progress for 1990, Tunisia comes first with a rank of 87 out of 160 countries. Botswana comes second with a rank of 94 followed by Morocco 106, Zimbabwe 108, Egypt 110, Kenya 114 and Ghana comes last with a rank of 119.

III COMPARATIVE ANALYSIS OF FAMILY PLANNING/BIRTH SPACING PROGRAMMES

11. The comparative analysis is based on selected variables which include: Evolution of programmes and policy framework; government commitment; institutional framework for implementation of programmes; targets related to programmes; demand for services; delivery of services and method mix; levels and recent trends in fertility; and programme effort.

(a) Evolution of programmes and policy framework

12. Tunisia's national family planning programme is the oldest among the seven countries under study. It was formally adopted in 1964. The national family planning programmes in the other 6 countries were launched as follows: Egypt and Morocco 1966, Kenya 1967, Ghana 1970, Botswana 1973 and Zimbabwe 1981. The late adoption of a national programme in Zimbabwe is related to the fact that the country became independent in 1980.

13. Since independence in 1956, the Government of Tunisia has considered population and development as greatly interrelated and family planning has been an integral part of socio-economic development and this has been reflected in its various development plans. Preparations for the national family planning programme

started in 1962 and took 2 years before the programme was formally launched. The Government started providing free family planning services in 1966. Throughout, the government's population policy has been to: lower fertility and population growth; improve family planning and health care, particularly in rural areas. The government has always emphasized the need to moderate population growth rate so as to alleviate socio-economic problems including unemployment.

14. In Egypt, the establishment of a National Commission on Population in 1953 gave rise to the need to provide family planning services, in fact, family planning clinics started providing services in 1955. A Supreme Council for Family Planning was established in 1965. Like Tunisia, Egypt's population policy, first declared in 1965 and revised in 1973, 1975, 1980, and 1986 has consistently been geared at reducing fertility and population growth rates. Provision of family services have always featured in the government population policy.

15. Family planning centres have been in operation in Morocco since 1966 when a High Population Commission and a Local Population Commission were established. However, family planning has been reflected in development plan since 1968. Although the government of Morocco has not formulated a comprehensive and explicit population policy, specific policies exist to reduce fertility and population growth rates through provision of family planning. However, emphasis is on child spacing. The national family planning programme is integrated into the primary health care system.

16. Voluntary family planning programmes in Kenya began in 1955. These were merged into the Family Planning Association of Kenya in 1961. Concerns about population issues in Kenya have been reflected in development plans since 1964. In 1967, Kenya National Family Planning Programme was launched within the Ministry of Health to provide family planning services and information to all who needed them in government hospitals and health centres throughout the country. Thus, family planning was integrated into the health services. A population and family planning policy was launched in 1967. In 1982, a six year Integrated Rural Health and Family Planning Programme was launched. In 1984, Population Policy Guidelines were published. Government Population Policy has been to reduce fertility and population growth rates so as to improve the well-being of the people.

17. Between 1961 and 1965, a number of clinics, through the Christian Council of Ghana, started making available contraceptives advice to those who were interested to limit or space their pregnancies in centres like Accra, Kumasi and Ho. In 1967, the Ghana Planned Parenthood Association was founded. Among its

objectives was to encourage the proper spacing of children and to ensure that families have children when they are ready and when they want them. In 1969, Ghana adopted a national population policy. The Ghana National Family Planning Programme was established in 1970 with the objective of reducing Ghana's population growth rate, through, among other things, offering of family planning services and information.

18. Some women in Francistown in Botswana requested for the provision of contraceptive in 1968 to regulated their fertility. 1/A pilot project on family planning started in 1969. But it was not until 1973 that a national family planning programme was adopted in the context of the Maternal and Child Health/Family Planning Programme in the Ministry of Health. There is as yet no government policy on population. However, various measures are taken on provision of family planning services and information which influence demographic trends including fertility and population growth rates.

19. Although family planning activities in Zimbabwe (then Rhodesia) started in 1953 under colonial rule, the services were restricted to the white population. In 1965 a Family Planning Association of Rhodesia was launched. The African population, till independence in 1980, had considered the family planning services run by the colonial government with suspicion. However, after independence these attitudes changed. The Zimbabwe government took over the Family Planning Association in 1981 and named it the Child Spacing and Fertility Association. It was later renamed the Zimbabwe National Family Planning Council (ZNFPC) and became an autonomous body within the Ministry of Health. The 1985 Act on ZNFPC empowered the Council to implement family planning activities throughout the country. Although the Government has not adopted a national population policy, the activities of the ZNFPC are directly influencing population trends.

(b) Government commitment

20. Government commitment to family planning programme can be demonstrated in several ways including: political support, financial support, preparation of guidelines, use of mass media, involving private sector in programmes, provision of free services, and passing of relevant legislation to support programmes.

21. Great political support has been given to family planning programmes since their formulation in Tunisia, and Zimbabwe. Tunisia received the United Nations Population Award in 1987 for

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1/ Report of the Launching of the Botswana Family Planning Welfare Association, Botswana, 1988.

the work of the National Office of Population and the Family. In Zimbabwe, this political support is from the President at the top down to the government and the party structure. In Kenya, the political support gained momentum since 1984 when a National Leaders Seminar on Population called on Kenyans to adopt a small family size norm. A series of similar seminars have been held since then. The President has personally appealed to the people of Kenya to have only 4 children. Beginning 1977, the Government of Egypt put emphasis on direct measures such as upgrading family planning services in health units throughout the country and enabled pharmacies to make available family planning services and methods. However, political commitment to family planning programme was enhanced since 1985. 2/ Some of the principles reflected in the 1986 revised population policy document of Egypt were 3/: recognition of the rights of each family to decide on the appropriate number of children and the right to obtain information and the means for achieving their decisions on family size; and local participation in implementation of programmes. In Ghana, although various governments endorsed the 1969 Population Policy which was to be implemented by the National Family Planning Programme, political commitment was weak to the family planning programme and the population policy as a whole. 4/ However, the late 1980s saw renewed efforts to strengthen political support. In Botswana, Members of Parliament and Members of the House of Chiefs commited themselves to improve and strengthen programmes of family planning information and services. 5/ The process was initiated in the late 1980s to formulate a national population policy.

22. There is no readily available data on government expenses on family planning. All the countries have had external support to their family planning programmes especially at the beginning of the programmes. In some cases this support was discontinued at some point in time but the late 1980s have shown that support has been resumed eg. in Ghana. Egypt, Kenya, Tunisia and Zimbabwe seem to have benefited most in the past from external donor support to

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2/ Hussein Abdel-Azizi Sayed, "Population Policy in Egypt" in Population Policies in the Third World: Issues and Practice, Cairo Demographic Centre, 1988.

3/ Ibid.

4/ T.K. Kumekpor, Z.K.M. Batse, and Kwaku Twum-Baah, "Formulation, Implementation and Impact of Population Policy in Ghana" in Developments in Family Planning Policies and Programmes in Africa, Regional Institute for Population Studies, University of Ghana, 1989

5/ Republic of Botswana, Report of the Conference on Population and Development for Members of Parliament and House of Chiefs, 4-6 September 1986.

family planning programmes. In Tunisia, the Government has been providing substantial financial support to family planning activities in recent years. In 1990 for example, the support to the "Office National de la Famille et de la Population" was 73% of direct costs and nearly 90% of overall costs. 6/ In Zimbabwe too, in recent years, there has been government increase in funding the activities of the ZNFPC up to 50% of overall budget while donors meet the other half. 7/ It has been indicated that the family planning programme in Egypt is well-financed and strongly supported at the highest level of Government. 8/

23. The Government of Kenya decentralized the implementation of population and family planning programme to the district level. In 1988, the Ministry of Health published A Guide for Managing MCH/FP Activities at District level. The Government of Botswana also published Botswana Family Planning: General Policy Guidelines and Service Standards, in 1989. The Guidelines cover a wide range of activities towards provision of good services to users. They include: information, education and communication (IEC), provision of different contraceptive methods, counselling etc.

24. In terms of government commitment with regard to mass media on family planning, Tunisia seems to have better facilities and wider coverage. The radio has 4 channels which disseminate messages on family planning. Television has regular messages too on family planning. In Egypt, between 1985 and 1989, it has been noted that there were 4,805 programmes that had been broadcasted on radio and television; 1,554 articles had been in the press; over 5000 meetings and conferences were convened; 38 training courses and workshops in population IEC were conducted. 9/ Television and radio programmes and other forms of media exist in the other countries included in this study but their coverage and frequency vary from country to country.

25. There has been private sector involvement in family planning programmes in Egypt, Ghana, Kenya and Morocco. In Kenya, the

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6/ Office of Population Bureau for Science and Technology AID, Tunisia: Population Strategy for 1990s, Washington D.C. 1990.

7/ Population Action International, Population Picks and Pans, 1992.

8/ United Nations, World Population Policies, Volume 1, Afghanistan to France, 1987.

9/ Maher Mahran, " Strategy of Quality Service Delivery in the Egyptian Population Programme" in Strategy of Quality Services in Population Programmes: Country Papers, edited by Ellen Sattar, International Council on Management of Population Programmes (ICOMP), 1991, Vol. XI.

employment based family planning programme started assisting the private sector to provide family planning programmes in 1984 through the Family Planning Private Sector (FPPS) project. In Morocco, the private sector is involved in the contraceptive social marketing (CSM) programme by the private sector in provision of contraceptives. In Tunisia, CSM were managed by the government. However, strategies for the 1990s in Tunisia call for more involvement of the private sector in provision of family planning services.

26. The Government of Tunisia passed a series of legislation to help implementation of its family planning programme as will be shown later. Some of the other countries also passed some legislation but not to the extent of what Tunisia did.

(c) Institutional framework for implementation of programmes

27. The institutional framework for implementing population programmes vary in many respects from country to country and have some similarities. In both Botswana and Morocco the institutional framework of implementing the programme is within the umbrella of the ministries of health. In Kenya this was the case at the time of adoption of the family planning programme until 1981. Since 1982, the institutional framework was under the National Council on Population and Development (NCPD) in the Office of the Vice-President and Ministry of Home Affairs and National Heritage. In both Tunisia and Zimbabwe, semi-autonomous bodies- the National Office for Family and Population (ONFP) and the Zimbabwe National Family Planning Council (ZNFPC) form the institutional framework for implementation of the programmes. Both bodies are within the context of the ministries of health. In Ghana, the National Family Planning Programme, in the Ministry of Finance and Economic Planning, was responsible for implementation of the programme. In Egypt, the family planning programme is currently implemented under the institutional framework of the National Population Council (NPC) created in 1985. In some countries, especially Egypt, the institutional framework has undergone through several changes. Some brief details on some of the individual country institutional framework for implementation of the family planning programme are presented below.

28. In Egypt, the first institutional framework for family planning programme was the Supreme Council for Family Planning which was created in 1965. Then a technical Executive Board for Family Planning was established to implement the family planning programme. In 1977, the Council's name was changed to the Supreme Council for Population and Family Planning (SCPFP). Similarly, the Board's name was changed to the Population and Family Planning Board. The SCPFP was chaired by the Minister of Health. Another change came in 1985 when the SCPFP was renamed the National

Population Council (NPC) and was chaired by the President. However, the NPC chairman became the Prime Minister since 1988.

29. The Ghana National Family Planning Programme had a National Family Planning Council which consisted of representatives of public and private organizations whose activities were related to family planning. Then there was an Executive Committee composed of representatives from various government departments. The Executive Committee was responsible for monitoring the development and progress of the programme. There were three standing committees, namely, A Medical Advisory Committee, An Information and Education Advisory Committee and An Evaluation and Research Advisory Committee. These were to advise the Council and Executive Director on technical policy issues. The Programme had two Divisions, Services Division and the Information and Education Division. Finally, there were three support units to deal with (a) the administrative, fiscal, purchasing and supplies; (b) training; and (c) the evaluation and research. Due to the economic crisis of the 1970s and early 1980s, the programme was badly affected in its implementation.

30. In Kenya as noted earlier, the Ministry of Health had the initial responsibility for the co-ordination and implementation of the National Family Planning Programme when it was launched in 1967. The National Council on Population and Development became responsible for population policy development and co-ordination of governmental and non-governmental activities on population education, research and training, analysis and evaluation of population programmes in 1982. Thus, the National Family Planning Programme came under the co-ordination of the NCPD.

31. The government of Tunisia established institutional structure for the implementation of the family planning programme. This included the creation of the Directorate of Family Planning and Maternal and Child Health in the Ministry of Health in 1969; the creation of the Institute for Family Planning and Maternal and Child Health in the Ministry of Health in 1971, which was changed in 1973 to be the Office for Family Planning and Population; creation of the Higher Council for Population and regional councils in 1974; establishment in 1983 of a new ministry of family and promotion of women charged with the responsibility of implementation of the national population policy and supervision of the Office for Family Planning and Population. This office promotes and provides family planning services in many health centres throughout the country. Furthermore, the Office works closely with many governmental and private organizations. There is also adequate institutional arrangements for monitoring and evaluation of the impact of the family planning programme.

32. In Zimbabwe, the ZNFPC has a good organizational structure. It has an Executive Committee which has representatives from various

ministries. The Committee is the policy organ of the ZNFPC and it controls the operations and administrative matters of the Council. The organizational structure of the Council include the following units: the medical/clinical unit; the community based distribution (CBD) programme unit; training unit; youth advisory services unit; the information, education and communication unit; research and education unit; and the management and administration unit.

(d) Targets related to programmes

33. Targets related to family planning programmes include those on fertility, contraceptive use and population growth rates. Data on these are presented in Table 2.There is no assessment of the targets as this was done in a paper on "A review of assessment of population policies in selected African countries" presented at the Third African Population Conference in Dakar, Senegal, in December 1992.

34. In Botswana, targets in relation to the family planning programme were only in connection with increasing of contraceptive prevalence from 12% during 1981-1983 to 15% in 1985. Since then no reference has been made to contraceptive targets. There has been no targets in relation to fertility and population growth rates. In the Zimbabwe National Family Planning Programme, there has been no targets set on fertility, contraceptive prevalence and on population growth rate. In Morocco, there has been no targets in relation to contraceptive use while targets in relation with fertility and population growth rates have ever been set. In Egypt, Ghana, Kenya and Tunisia, there have been targets on fertility, contraceptive use and population growth rate in the implementation of their family planning programmes. Tunisia and Egypt used targets more than the other countries.

Table 2: Targets Related to Family Planning Programmes

Country	Fertility	Contraceptive prevalence	Population growth
Botswana	-	The 1979-1985 MCH/FP targets were to increase contraceptive prevalence from 12% during 1981-1983 to 15% in 1985 among married women.	-
Egypt	1973 Population Policy had target of lowering crude birth rate from 33.7 per 1000 in 1973 to 23.6 in 1982.	1973 Population Policy included target of increasing contraceptive use to 25% in rural areas and to 35% in urban areas by 1982.	- 1973 Policy included target of reducing population growth rate from 2.06% per annum in 1973 to 1.06% in 1982.
	Since 1973 other targets were: reduce crude birth rate from 40 per 1000 in 1980 to 20 per 1000 live births by the year 2000; decrease total fertility rate from 4.6 in 1988 to 3.7 in 1996 and to 3.1 by the year 2001.	Increase contraceptive prevalence rate from 38% in 1988 to 51% in 1996 and to 60% by the year 2000 among married women.	- Reduce population growth rate to 1.6% per annum between 1977 and 1985. - Attain a population growth rate of between 1.0% and 1.3% by the year 2000.
Ghana	- Reduce total fertility from between 7 and 8 in the late 1960s to 5 in 1985 and 4 by the year 2000.	- Attain a contraceptive prevalence rate of 10% between 1970 and 1975, 40% in 1990 and 65% by the year 2000.	- Reduce population growth rate from 3.9% in 1970 to 1.75% by the year 2000. A later revision was to reduce growth rate from 3.2% to 2.5% in 1985, and to 1.3 by the year 2000.
Kenya	- Target from the 1974-1978 Family planning programme was to reduce crude birth rate from 48 per 1000 live births to 43 per 1000 live births in 1979.	-	- Reduction of population growth rate from 3.5% per annum in 1974 to 3.25% per annum in 1978, to 3% in 1980 and 2.5% by the year 2000.
	-Target for the 1990s: reduce crude birth rate to 42 per 1000 live births in 1995 and to 35 per 1000 live births in the year 2000.	- Target for the 1990s: increase contraceptive use among married women from 27% in 1989 to 30% in 1995 and to 40% by the year 2000.	- Target by the NCPD in 1982 after its establishment was to reduce population growth rate from 3.8% to 3.3% in 1988. - Targets for the 1990s: reduce population growth rate from 3.5% to 2.5% by the year 2000.

Table 2: (Cont'd.)

Country	Fertility	Contraceptive prevalence	Population growth
Morocco	- 1968 to 1972 Development Plan for the first time included a target of reducing crude birth rate from 50 per 1000 live births in 1968 to 45 per 1000 in 1972 and to 35 during 1980 to 1985. - The 1973-1977 Plan revised the crude birth rate to be attained during that period to 43 per 1000.	-	- The 1988-1992 Development Plan targets were reduction of population growth rate from 2.8% to 2% by the year 2007.
Tunisia	1966 Family Planning Programme: - To reduce crude birth rate from 46 per 1000 in 1966 to 34 per 1000 in 1975	-	1966 Family Planning Programme: -Attainment of population growth rate of 1.8% per annum between 1971 and 1976 and 1.1% between 1996 and 2001
	1977-1981 5th Developoment Plan: - Reduction of crude birth rate from 35.3 in 1976 to 29.9 in 1986; - Reduction of fertility rate from 155.5 per 1000 in 1976 to 135.3 per 1000 in 1981 and to 120 per 1000 in 1986.	1982 to 1986 6th Development Plan: - To increase contraceptive use from 27% in 1980 to 40% in 1986 for the country as a whole; and from 18% to 36% for rural areas; and from 35% to 45% in urban areas	1982 to 1986 6th Development Plan: - Attainment of a population growth rate of 2.5% between 1982 and 1986.
Zimbabwe	-	-	-

(e) Legislation related to programmes

35. Although nearly all African countries are in favour and are involved in family planning programmes to moderate fertility and population growth rates and to improve the health of mothers and children, most of them have not repealed existing laws affecting family planning and population programmes. There is need to enact legislation that facilitates the availability, sale and distribution of contraceptives as well as on improvement of women's status. These would go along way to support effective implementation of family planning programmes. In Africa, Tunisia is exemplary in this as will be seen below.

36. As early as 1961, Tunisia passed Law 61 which permitted sale and distribution of contraceptives. That law repealed the previous anti contraceptive laws which were adopted during the French Occupation. Morocco also repealed, in 1967, the 1920 French Law which prohibited the advertizing, sale, and distribution of contraceptives. Both Egypt and Tunisia eased the import requirements of contraceptives. The government of Kenya enacted two laws in 1984 which eliminated sales tax on contraceptives and also removed duty on the importation of contraceptives. Both Kenya and Tunisia have established legal basis for voluntary sterilization.

In Morocco, sterilization is restricted to women over 28 years of age with at least 4 children. In Egypt, sterilization is not prohibited, however, the government does not promote it. In Botswana and Ghana, sterilization is legal, but with conditions. The same is true in Zimbabwe but the factors taken into account are age, marital status and number of children a women has.

37. In most countries abortion is permitted only on certain cases. In Egypt and Morocco it is illegal except to save the life of a woman. In Botswana, abortion is permitted on broad medical grounds. In Ghana, the 1985 Law on abortion was changed to permit abortion on broad health, eugenic and juridical indicators. Abortion is legal in Zimbabwe on condition that life or health of the woman is at risk or in case of rape, incest, or serious physical or mental impairement of the foetus. Between 1961 and 1965 among the legislation enacted in Tunisia was one which legalized abortion for women with 5 or more children. A new legilsation was enacted in 1973 which made abortion free within the first 3 months.

38. It is essential to have legislation empowering the institution that co-ordinates and provides family planning services. In Zimbabwe, the ZNFPC, through the 1985 Act, was empowered to execute family planning activities throughout the country. In Ghana, for example, the Ghana Natiional Family Planning Programme (GNFPP) lacked legal status and this affected its authority. 10/ The organization was established by an administrative directive. The GNFPP was later changed into an advisory body without executive power. The government decree NRCD 171 in 1973 included a clause which stated that the Manpower Board would " co-ordinate population policy activities in the country generally. 11/ This was contrary to earlier power given to the GNFPP to co-ordinate the 1969 National Population Policy.

(f) Demand for services

39. Table 3 shows data on demand of family planning services in terms of contraception and current use of contraception. The demand is shown for reasons of spacing births and for limiting family size. Demand refers to the sum of contraceptive prevalence and the unmet need for family planning. The unmet need refers to the proportion of women or couples who are not using contraception but who wish to regulate their fertility - either to postpone the next wanted birth or to prevent unwanted childbearing after having achieved the desired number of children.

10/ Kumekpor, Batse and Twum-Baah, op.cit.

11/ Ibid.

40. The overall demand is highest in Tunisia at 71% among the currently married women at the time of the survey. Overall demand in Egypt, Kenya and Zimbabwe was 65% in each country followed by Botswana, 62%, Morocco 60 and Ghana shows the lowest demand at 48%. The data on overall demand in Table 3 imply that more than half of the demand is for spacing of births in Ghana (71%), Botswana (63%), and Zimbabwe (58%). The figures for the other countries are: Morocco 43%, Tunisia 35% and Egypt 26%. Thus Egypt has the highest of the overall demand for limiting the family size (74%), followed by Tunisia (65%), Morocco (57%), Kenya (52%), Zimbabwe (42%), Botswana (37%) and lastly Ghana (29%). There is the same general pattern of demand for family planning for spacing and limiting of births among the currently married women currently using contraception as follows: Botswana, 55% and 45%; Egypt, 16% and 84%; Ghana, 62% and 38%; Kenya, 33% and 67%; Morocco, 36% and 64%; Tunisia, 28% and 72%; Zimbabwe, 64% and 36%. In each of the set of figures, the first is for spacing and the second for limiting.

Table 3: Demand and Current Use of Contraception
Among Currently Married Women (Percent)

Country	Year of Survey	Demand for Contraception			Current Use		
		Total	For Spacing	For Limiting	Total	For Spacing	For Limiting
Botswana	1988	62	39	23	33	18	15
Egypt	1988	65	17	48	38	6	32
Ghana	1988	48	34	14	13	8	5
Kenya	1989	65	31	34	27	9	18
Morocco	1987	60	26	34	36	13	23
Tunisia	1988	71	25	46	50	14	36
Zimbabwe	1988	65	38	27	44	28	16

Source: *Charles F. Westoff, Luis H. Ochoa, "The Demand for Family Planning: Highlights from A Comparative Analysis" paper presented at the DHS World Conference, Washington D.C. 1991.*

41. In terms of satisfying the demand for family planning services for contraception, more than half of the demand is met in the following countries: 12/ Tunisia 70%; Zimbabwe 66.5%; Morocco 59.1%; Egypt 58.4%; and Botswana 53.6%. In Kenya, 41.4% of the total demand is satisfied while in Ghana 26.8% of the demand is satisfied.

(g) Delivery of Services and method mix

42. In Morocco, service delivery relies on (a) an approach that has integrated the family planning programme with the health sector; (b) the mobile outreach service delivery "visite à Domicile de Motivation Systematique" (VDMS) which has served to strengthen the primary health system. Through this system service providers visite clients at home and provide family planning services. The VDMS started in 1981 on a pilot project; it covers the whole country since 1986. About 33% of women using contraceptives receive their supplies from VDMS - agents, 40% from other public outlets, and 25% rely on the private sector providers.

43. As for Egypt, the national family planning programme depends strongly on the private sector for provision of services: 75% of users obtain their services from pharmacies where supplies are sold at nominal subsidized prices or from private physicians. The 1980 National Stragegy for Population and Family Planning Programme emphasized upgrading family planning services and integrating them into relevant health and social activities; instituting community based socio-economic programmes conducive to family planning; strengthening population education IEC.

44. Tunisia has had a vertical delivery system for family planning services through the ONFP in each of Tunisias 23 Governorates, a Regional Centre for Education and Family Planning. ONFP provide family planning services on an on going basis in 240 public health facilities. This is complemented by some 67 mobile teams and 10 mobile clinics which provide outreach servies to 25% of Tunisias population living in dispersed rural areas. The government has been offering family planning information, educaiton and services free of charge in over 1000 facilities throughout the country. More than 75% of contraceptive users in Tunisia obtain their supplies from public sector outlets, the remainder obtain their supplies from pharmacies or private physicians or nurse - midwives. The 1990s strategy is to involve private sector more in service delivery. The quality of services in Tunisia is given great importance - contrceptives are easily available, counselling services are also made available. Efforts are made to improve

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12/ Charles F. Westoff and Luis Hernando Ochoa. Unmet Need and the Demand for Family Planning, Demographic and Health Surveys Comparative Studies No. 5, Institute for Resource Development/Macro International, Inc. 1991.

skills and competence of staff delivering services. Clients are treated with respect and are given information on side effects of each method. A survey conducted in 1988 showed that more than 60% of the clients reported that the quality of services was satisfactory.13/ In another study done in 1990, it was indicated that over 70% of the population reported the media advertisement on family planning as good.14/

45. In Botswana like in Morocco, the family planning programme services are delivered mainly through the Ministry of Health facilities. In 1988 there were over 400 health facilities providing family planning services throughout the country. Due to favourable economic situation, the family planning programme has expanded recently and it provides services to farms and industrial work places where men are also reached. All persons of reproductive age, regardless of marital status, have a fundamental right to determine for themselves the number and spacing of births. Family planning methods are available without the consent of relatives or partner with the exception of sterilization which is provided to clients who feel they have achieved their desired family size.

46. Early efforts at providing family planning services in Kenya were clinic based but changed later to involve the private sector and voluntary private organizations in provision of services starting 1984. Provision of family planning has been decentralized to district level. There is also the community-based distribution programme involved in the delivery of family planning services and non-governmental organizations are involved in this. The 1989 Demographic and Health survey of Kenya indicated that 71% of married women who were using modern methods of contraception, at the time of the survey, obtained their supplies from government; 10% obtained their supplies from the Family Planning Association of Kenya facilities; 9% from private sources (private doctor/ pharmacy); 8% from other hospitals/clinics and 2% from other sources. Regarding quality of service, the Kenya Family Planning Programme was assessed as "moderate to moderately high."15/

13/ Mohamed Moncef Boukhris, "Quality of Family Planning in Tunisia" in Strategy of Quality of Services in Population Programmes: Country Papers Op.cit. 1991.

14/ Ibid.

15/ Robert A. Miller, Lewis Ndhlovu, Margaret M. Gachara and Andrew A. Fisher, "Situation Analysis Study of Kenya's Family Planning Programme" in Managing Quality Care in Population Programmes, edited by Anrudh K. Jain, 1992, Kumarian Press, Inc.

47. In Ghana the family planning programme delivery was to be clinic-based. Because of lack of adequate staff at health centres and clinics to handle family planning, family planning delivery was seriously affected. Planned Parenthood Association of Ghana and the Christian Council had fixed clinics in addition to those by the government. Available clinics where family planning services could be obtained were mostly located in urban areas. As noted earlier, the economic crisis in Ghana in the 1970s and early 1980s made it difficult for the family planning programme to be implemented effectively. However, in 1986, a contraceptive social marketing programme was established for distribution of contraceptive supplies. At present, family planning services are also being provided through Integrated Family Planning, Nutrition and Parasite Control Projects which involve community participation. Midwives in private practice have received training and other support to initiate family planning services. The 1986 Ghana Demographic and Health Survey showed that, among the married women using modern contraceptive methods at the time of the survey, 35% obtained their supplies from government, 23% from pharmacies, 18% from the Ghana Planned Parenthood Association, 14% from friends/relatives, 2% from private sources, and 8% reported other sources.

48. In Zimbabwe, the ZNFPC supplies the Ministry of Health and other familities with contraceptives and is the sole source of IEC. Community - based deliveyr system is the main outreach for services in rural areas where 33% of the rural contraceptive users depend on the CBD for supplies. About 90% of the family planning acceptors in Zaimbabwe obtain supplies from government sponsored service providers; 2% get them from the private sector.

49. With regard to proximity of services, it has been shown that:16/ 86% of rural women in Zimbabwe live within 15 kilometers of a facility providing the pill; 76% live within 15 kilometers of a facility that distributes condoms. In Egypt, almost all rural married women live within 15 kilometers of a facility providing the pill, IUD and condom. In Tunisia, over 80% of rural married women live within 15 kilometers of a facility providing the pill, IUD and condom.

50. Concerning modern method mix among married women using contraceptives, the Botswana 1988 DHS data showed that the method mix was dominated by the pill 14.8% followed by the IUDs 5.6%, injectables 5.4% and female sterilization 4.3%. The condom was used by 1.3% of the women. Thus 47% of all married women using modern methods of contraception were using the pill. The 1988 DHS data on Egypt indicated that the pill and IUD were equally popular among married women - 15.3% and 15.7% respectively; the condom was

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16/ Marilyn I. Wilkinson, Noureddine Abderrahim, Wamucii Njogu, "Availability and Use of Contraception: A Comparative Analysis" Paper presented at the DHS World Conference, Washington D.C. 1991.

used by 2.4% of the women while 1.5% reported female sterilization. In Ghana, according to the 1988 DHS data, only 1.8% of the married women were using the pill, 1.3% vaginal methods, 1% female sterilization, 0.5% IUD, 0.3% condom and 0.3% injectables. Total use of modern methods among married women in Ghana was only 5.2%. In Kenya, in 1988, 17.9% of married women were using modern contraceptive methods distributed as follows: the pill 5.2%, female sterilizaiton 4.7%, IUD 3.7, injectables 3.3%, condom 0.5% and vaginal methods 0.4%. In Morocco, in 1987, 28.9% of married women were using modern methods of contraception distributed as follows: the pill 22.9%, IUD 2.9%, female sterilization 2.2%, condom 0.5%, injectables 0.3%, vaginal methods 0.1%. Thus almost 80% of married women using modern contraceptive methods rely on the pill, and 10% rely on the IUD. As for Tunisia, the 1988 DHS data indicated 40.4% of married women use modern methods distributed as follows: IUD 17%, female sterilization 11.5%, the pill 8.8%, condom 1.3%, and injectables 0.8%. Thus of all the married women using modern contrception , 42% rely on IUD, 28% on female sterilization and 22% on the pill. In Zimbabwe, 36.1% of the married women were using modern methods distributed as follows: 31% the pill, 2.3% female sterilization, 1.2 condom, 1.1% IUD and 0.3% vaginal methods. Thus the pill was used by 86% of women using modern methods, and IUD by 6%.

(h) Trends in contraceptive use

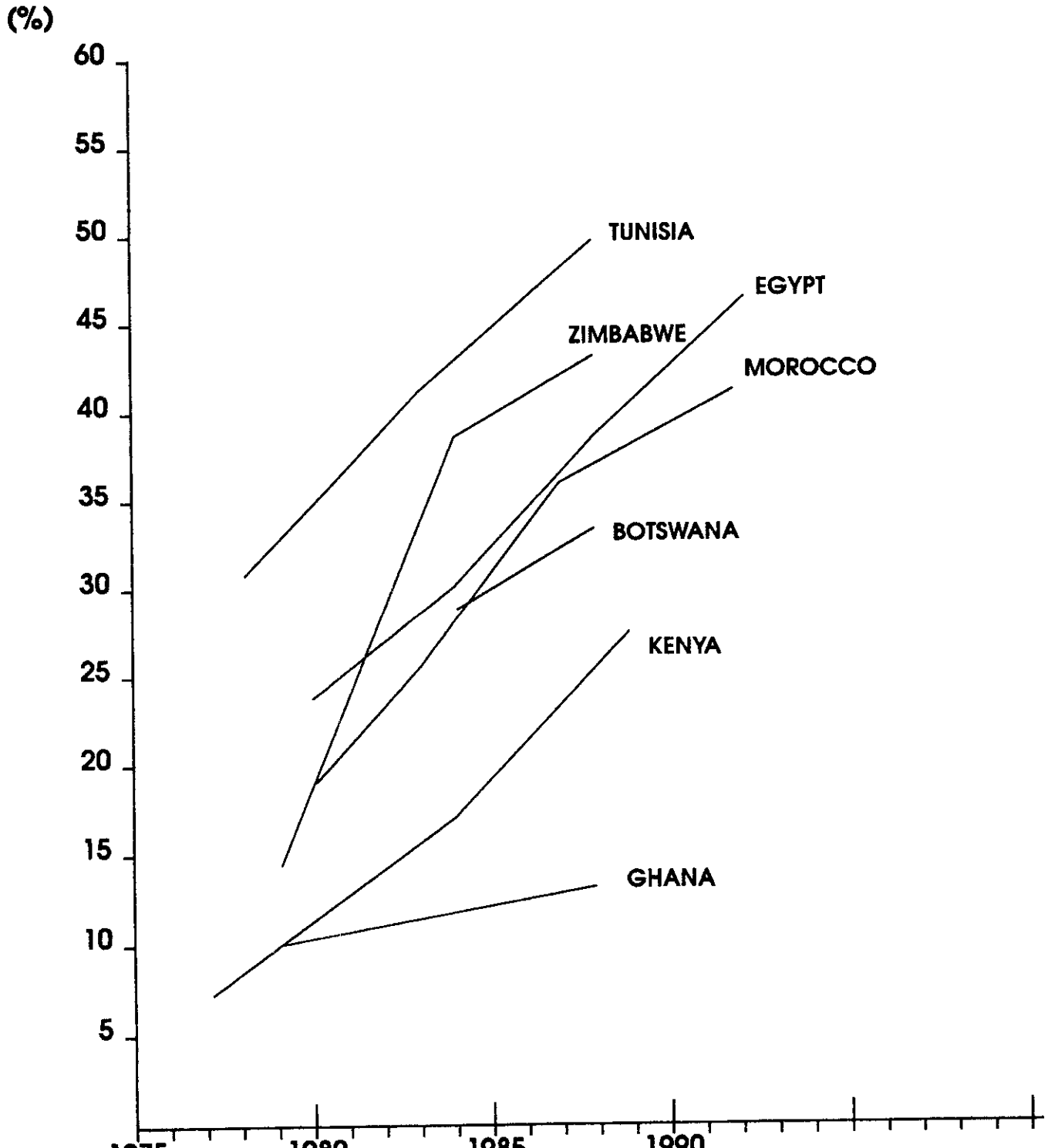
51. Data in Table 4 and Figure 1 show the general trends in contraceptive use in the 7 countries under study. All the seven countries show an upward trend with Tunisia having a most pronounced trend and Ghana shows the least change.

Table 4: Data on Contraceptive Trends (%) Among Married Women

Country	Year	Contraceptive Use
Botswana	1984	28
	1988	33
Egypt	1980	24
	1984	30
	1988	38
	1992	47
Ghana	1979	10
	1988	13
Kenya	1977/78	7
	1984	17
	1989	27
Morocco	1983/84	26
	1987	36
	1992	42
Tunisia	1978	31
	1983	41
	1988	50
Zimbabwe	1979	14
	1984	38
	1988	43

Source: Various reports on WFS, CPS, DHS and country reports presented at the Third African Population Conference held in Dakar, Senegal in December 1992.

FIG 1
Trends in Contraceptive Prevalence Among Married Women



52. Among the factors which have contributed to increasing trends in contraceptive prevalence in Kenya include:17/ the impact of population density on arable land; cost of raising children (paying for school fees, health, feeding); increased availability of family planning services (through governmental and non-governmental organizations); impact of education; increased government commitment etc. The 1989 DHS data on Kenya indicated that 30% of the married women reported that they had already more children than they desired while half of them indicated that they did not want any more children. In Botswana and Zimbabwe 33% of the married women wanted no more children while in Ghana 23% wanted no more children.

(i) Levels and recent trends in fertility

53. Table 5 shows current levels of fertility and recent trends. Total fertility levels are lowest in Tunisia (4.4) for 1988 while Kenya has the highest level at 6.7 in 1989. Egypt and Morocco total fertility rates were almost the same. There have been declines in fertility in all countries except in Ghana where the levels between 1979 and 1988 have remained the same. In Botswana total fertility declined from 6.5 in 1984 to 5.0 in 1988. This represents a 23% decline in 4 years. Between 1980 and 1988, total fertilty decliend by 11% in Egypt. In Kenya total fertility declined by 15% between 1979 and 1989. As for Morocco there was a decline of 19% in total fertility between 1979/80 and 1987. In Tunisia total fertility had declined by 24% between 1978 and 1988. In Zimbabwe there was a 15% decline in total fertility between 1984 and 1988.

17/ World Bank, Population and World Bank: Implications from Eight Case Studies, 1992.

Table 5: Levels and Recent Trends in Fertility

Country	Year	Total Fertility
Botswana	1981	7.1
	1984	6.5
	1988	5.0
Egypt		
	1980	5.3
	1988	4.7
Ghana	1979	6.5
	1988	6.4
Kenya	1977	8.0
	1977/78	7.9
	1979	7.9
	1984	7.7
	1989	6.7
Morocco	1979/80	5.9
	1987	4.8
Tunisia	1978	5.8
	1988	4.4
Zimbabwe	1982	5.6
	1984	6.5
	1988	5.5

Source: Various including WFS, CPS, DHS and Country Publications.

(j) Programme Effort

54. Among the research done to assess family planning programme effort are those by Lapham and Mauldin done for the year 1982 18/ and that by Mauldin and Ross for 1989.19/ The methodology in both cases was the same and focused on the following 4 main groups and items in each groups: (a) Policy and stage - setting activities: policy on fertility reduction and family planning; statements by leaders; level of programme leadership; policy on age at marriage; import laws and legal regulations; advertising of contraceptives; involvement of other ministries and public agencies; percent of in-country funding of family planning. (b) Service and service-related activities: involvement of private sector agencies and groups; civil bureacracy involved; community-based distribution; social marketing; postpartum programme; home visiting workers; administrative structure; personnel carry out assigned tasks; logistics and transport; supervision system; mass media for IEC; incentives and disincentives. (c) Record keeping and evaluation: record keeping; evaluation; management's use of evaluation findings. (d) Availability and accessibility of fertility - control supplies and services: male sterilization; female sterilizaion; pills and injectables; condoms, spermicides, foam, diaphragms; IUDs; and abortion.

55. The result of the 1982 assessment showed that family planning programme efforts were moderate in Tunisia and weak in Botswana, Egypt, Kenya, Morocco and Zimbabwe. In the case of Ghana, programme effort was rated as very weak or none. However, for 1989, both Botswana and Tunisia were rated as strong while the other countries were rated as moderate. The percentage scores for 1989 were: Botswana 72%, Tunisia 68%, Egypt 65%, Kenya 57%, Zimbabwe 56%, Morocco 55%, and Ghana 50%. The percentage programme effort scores for 1989 was based on a maximum of 120 and divided as follows: Strong: 67% and over; moderate: 46-66; weak: 21-45% and very weak or none: 0-20%. For details on methodology of assessment, please refer to the references given.

18/ Robert J. Lapham and W. Parker Mauldin, "Family Planning Programme Effort and Birth rate Decline in Developing Countries: in International Family Planning Perspective Vol. 10, Number 4, December 1984; see also "Contraceptive Prevalence: The Influence of Organized Family Planning Programmes", by the same authors, in Studies in Family Planning Vol. 16, Number 3 May/June 1985.

19/ W. Parker Mauldin and John Ross, "Family Planning Programmes: Efforts and Results, 1982 to 1989: in Studies in Family Planning Vol. 22 Number 6 November/December 1991.

IV SUMMARY AND CONCLUSION

56. The paper has attempted to present a comparative analysis of the family planning/birth spacing programmes in Botswana, Egypt, Ghana, Kenya, Morocco and Zimbabwe. The programmes in Egypt, Ghana, Kenya and Tunisia were formulated and implemented in the context of explicit population policies to moderate fertility and population growth rates. In Botswana, Morocco and Zimbabwe, the programmes were formulated and implemented without explicit population policies. However, there were specific policies implemented on family planning programmes which have had an impact on fertility and population growth rates.

57. Among the factors which contribute to effective family planning programmes include: adequate government commitment; putting in place requisite institutional framework and infrastructure; use of targets to facilitate evaluation of programmes and to take remedial action; passing of relevant legislation that enhance programme implementation; making available quality services with a wide variety of family planning methods. ECA has in the recent years focused on family planning programmes and published some relevant materials useful to improvement of family planning programmes. The publications include: Guidelines on Improving Delivery of Population and Family Planning Programmes in African Countries, (1991); Strategies to Improve Contraceptive Use to Influence Demographic Trends in African Countries (1992); Alternatives to Traditional Approaches in the Formulation and Implementation of Family Planning Programmes in African Countries (1993). These publications are relevant in view of the Dakar/Ngor Declaration targets to increase contraceptive prevalence and to reduce population growth rates through family planning programmes and socio-economic development.

58. The institutional framework for the implementation of programmes vary among the countries. In Tunisia and Zimbabwe there exist autonomous bodies which co-ordinate the programmes while in Morocco and Botswana the programmes are implemented as integral components of the health activities by the Ministry of Health. In Egypt, after several changes in the evolution of the programme, the National Population Council in 1985 was given the overall responsibility of family planning programme co-ordination. In Kenya it is the National Council for Population and Development that co-ordinates family planning programmes.

59. Tunisia and Egypt have used targets related to programmes more than other countries. In Botswana they were used once,while in Zimbabwe they have never been used. Tunisia has also passed a lot of relevant legislation to support programme implementation. The other countries did not do as much as Tunisia in this respect.

60. Data on overall demand for family planning services imply that more than half of the demand is for spacing of births in Ghana (71%), Botswana (63%), and Zimbabwe (58%). Egypt has the highest of the overall demand for limiting family size (74%), followed by Tunisia (65%), Morocco (57%), Kenya (52%), Zimbabwe (42%), Botswana (37%), and Ghana (29%). In terms of satisfying the demand for family planning services for contraception, more than half of the demand is met in Tunisia (70%), Zimbabwe (66.5%), Morocco (59.1%), Egypt (58.4%) and Botswana 53.6%). In Kenya, 41.4% of the total demand is met while in Ghana 26.8% of the demand is satisfied.

61. Regarding modern method mix for contraception among married women, Tunisia has the best method mix while in Zimbabwe 86% of the women using modern methods rely on the pill, a corresponding figure for Morocco is almost 80%. Current contraceptive prevalence rates are above 40% in Egypt, Morocco, Tunisia and Zimbabwe; 33% in Botswana; 27% in Kenya; and 13% in Ghana at the time of the last surveys. There have been increase in contraceptive prevalence rate in recent years in all countries which are associated with fertility decline except in Ghana.

62. The paper has indicated that family planning programme efforts have improved in all the countries covered in the paper between 1982 and 1989. In 1982 only Tunisia's family planning programme was rated as moderate while the programmes in the other countries were weak. By 1989, the programmes in Botswana and Tunisia were rated as strong and the other countries had moved from weak in 1982 to moderate in 1989.

63. In conclusion, an appeal is made to encourage African governments to continue implementation of organized family planning programmes. Governments need to involve non-governmental organizations to complement government efforts in provision and delivery of family planning services. The international donor community need to step up their assistance to family planning programmes in African countries. Family planning programmes need to be formulated and implemented as an integral part of overall socio-economic development in order for them to have maximum impact.