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PERCEPTIONS OF FAMILY PLANNING IN THE CONTEXT OF SOCIO-ECONOMIC AND CULTURAL VALUES IN ECA MEMBER STATES

I. INTRODUCTION

1. Family planning has long been practised in African countries to space births based on traditional, and cultural values. However, as an organized programme it is relatively new in many African countries. Cultural and traditional practices were very strong in the past in most African societies to enforce child spacing for improving the health of mothers and children and not for limiting family size. Modernization has led to some of those practices to be less followed and resulted in shorter birth intervals and high fertility rates. In the modern sense, family planning activities include the provision of information services and supplies to enable individuals and couples to realize their fertility preferences and to space births, given a choice of acceptable and effective methods and the means to do so. Emphasis is being put on informed choice, accessibility to quality services and the means to afford modern effective methods of family planning.

2. Large families have been valued overtime in most African societies in the past when land and other resources were not a constraint. Some of the reasons that contributed to attitudes

towards large family size in many African countries included the following:

- a large family size was a source of labour as well as source of social security in old age;

- a large family was encouraged in order to continue a family name;

- in some societies, a large family size was a symbol of status to the mothers and fathers of large family sizes;

- through a large family, mothers were sure to continue having access to property through sons after the death of husbands in some societies.

- Religion has not been favourable to modern family planning in many African countries.

3. The above perceptions and attitudes still prevail in many African countries, especially in rural areas. The social and cultural values favoured early marriages and continued child bearing till the end of the reproductive period of a woman. These attitudes have not changed much among most of the people at the grass-root level.

4. Overtime, socio-economic hardships started to have an impact on the well-being of the people in most African countries. Land and other natural resources started to be depleted and in the absence of technological innovations to produce adequate basic consumer goods and services for the population, attitudes towards large family size started to change in the 1980s in most African countries at government level and such changes are prevalent at present in nearly all African countries. Small family sizes are now being advocated by governments for (a) health reasons of the mother, child and the entire family; and (b) socio-economic reasons to ensure sustained and sustainable economic development for the present and future generations.

5. Better understanding of the interrelationship between population resources, environment and development has contributed to the changed attitudes on family planning and the need for small family size. Availability of improved population data, its dissemination and use in development planning has been instrumental in changing attitudes among governments. National workshops, seminars, conferences, as well as international meetings and conference have had significant impact on African governments' acceptance of population and family planning programmes as integral parts of socio-economic development planning and the over all goals to improve the quality of life of the population.

6. This paper on" Perceptions on family planning in the context of socio-economic and cultural values in selected ECA member States" has been prepared at the request of the 8th Session of the Joint Conference of African Planners, Statisticians and Demographers in 1994. The purpose of the paper is to analyse various factors that contributed to the general resistance to the acceptance of modern family planning in the 1960s and 1970s, the subsequent changing attitudes , and how to translate the observed changes into effective programmes, especialy at grassroots.

7. It appears appropriate and logical for the paper first to give a general overview of perceptions on population and family planning since the 1960s to the present and then move on next to some selected country examples before the discussion of obstacles in implementation of family planning programmes. A summary and recommendations are presented at the end of the paper.

8. This paper has benefited from various sources of data including: past research and publications by the Economic Commission for Africa, other United Nations organizations and non-United Nations organizations as well as publications by member States on population and development issues.

II. GENERAL OVERVIEW ON PERCEPTIONS ON POPULATION AND FAMILY PLANNING FROM THE 1960s TO THE PRESENT

9. At the time of independence in the 1960s, for most African countries, preoccupations were on socio-economic development. They were less concerned about population issues in development. In fact, the majority of countries were pronatalist. Thus, family planning issues in the context of regulating fertility was a taboo in most societies. Many African countries had adopted laws which did not permit the provision and advertisement of family planning. Thus, at the time of the first African Population Conference in Accra, in Ghana in 1971, family planning issues were not given serious attention. Even at the time of the 1974 World Population Conference in Bucharest, Romania, the general feeling among most African governments was that reduction in population growth rates would come with the attainment of socio-economic development. The International Conference on Primary Health Care in 1978 adopted the Alma Ata Declaration which, among other things, stressed the need to provide maternal and child health and family planning (MCH/FP) as part of primary health care.

10. It was only in 1984, at the second African Population Conference in Arusha, Tanzania, with the adoption of the Kilimanjaro Programme of Action (KPA) for African Self-Reliant Development that a general consensus emerged among African

governments on the role of population and family planning. It is important to note that the KPA indicated that population and development were interrelated and that population should be considered as a central issue in development strategies and plans.[1] Among the objectives of the KPA were the improvement of the quality of life of the people through effective programmes that would reduce the high levels of fertility and mortality, as well as the achievement of population growth rates compatible with the desired economic growth and social development goals.[2] Thus, the changing socio-economic situation did not support strong views held earlier that large family sizes were an asset in themselves.

11. The KPA recommendations on fertility and family planning addressed to African governments focused on: the need to incorporate family planning services into the MCH services; ensuring the availability and accessibility of family planning services to individuals and couples seeking such services freely or at subsidized prices; provision of various outlets to family planning including community based distribution (CBD) channels; programmes to make available a variety of methods and to ensure free and conscious choice by all; improving the funding and management of MCH/FP programmes.

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[1]. United Nations Economic Commission for Africa, Kilimanjaro Programme of Action for African Self-Reliant Development, p.6.

[2]. Ibid, p.7.

12. In November 1984, a Conference on Reproductive Health Mamagement in Sub-Saharan Africa was convened at Freetown in Sierra Leone. That Conference adopted the Sierra Leone Declaration which reflected a resolve to (a) include family planning as a component of public health and maternal-child health services,and (b) increase the acceptability of family planning in Sub-Saharan Africa.

13. The All - Africa Parliamentary Conference on Population and Development held at Harare in Zimbambwe, 12 to 16 May in 1986 also added its support to family planning. The Conference adopted a Declaration in which the parliamentarians of the 31 African countries pledged themselves to introduce and strengthen programmes of family planning information and services, including those of governments, non-governmental organizations and the private sector.

14. In 1986, the African governments position on fertility was as follows:[3]

- out of 51 countries, three countries (Congo, Equatorial Guinea and Gabon) perceived their fertility levels as too low and wanted to increase them;

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[3]. United Nations, World Population Trends and Policies, 1987 Monitoring Report, New York, 1988, p. 104.

- 17 out 51 countries (Angola, Benin, Burkina Faso, Cape Verde, Chad, Côte d'Ivoire, Djibouti, Guinea Bissau, Libyan Arab Jamahiriya, Mali, Mauritania, Mozambique, Sao Tome and Principe, Somalia, Sudan, Togo and Zaire) indicated that they were satisfied with their fertility levels;

- 31 countries perceived their fertility rates as too high and of these, 21 had policies to reduce their fertility rates.

15. However, in 1993 as shown in Table 1, only in one country government considered its fertility level as too low; in 11 countries governments were satisfied with their fertility levels; and in 41 countries, governments indicated that their fertility levels were too high. Of these 41 countries, 36 governments were intervening to lower their fertility levels while in 5 countries there was no government intervention (see Table 2).

16. In most African countries, family planning programmes are being integrated into the MCH programmes. There has been a lot of discussion on the pros and cons for the integration of FP and MCH. Among the reasons that have been advanced for the integration of FP into MCH programmes, include the following:[4]

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[4]. ECA, "Health and Family Planning", paper by WHO presented at the Expert Group Meeting on National Population Policies and Programmes in Africa, 11-15 November 1974, doc. E/CN.14/POP/128 of

- where infant and childhood mortality rates are very high, isolated family planning programmes are unlikely to convince unresponsive or resistant individuals or couples to accept family planning. Parents give positive reaction to programmes which include family planning among other family health care measures aimed at reducing child morbidity and mortality than they do to programmes concerned solely with family planning;

- many field workers have found that when family planning programmes are not integrated with or based on family health care provided in health services, it is difficult to sustain the initial impact;

- the nature of modern contraceptive methods requires supportive health services for their proper administration to couples who use them;

- many aspects of family planning care require the personnel, skills, techniques and facilities of health services;

- for logistic reasons, integrated MCH/FP programmes enable the pooling of funds; strengthening of supervision;

November 1974; and United Nations, the Population Debate: Dimensions and Perspectives, papers of the World Population Conference, Bucharest 1974; vol. 2, New York, p. 416.

better use of facilities, and health workers can relate family planning to many of the reasons for which mothers visit the health centres.

The above reasons for integrating MCH and FP were confirmed by a study carried out by ECA in 1987.[5]

17. At the Third African Population Conference held in Dakar, Senegal, in 1992, in preparation to the 1994 International Conference on Population and Development, African countries adopted the Dakar/Ngor Declaration on Population, Family and Sustainable Development. That declaration affirmed the continued validity of the KPA. The recommendations of the declaration on fertility and family planning emphasized the implementation of programmes to address unmet family planning needs including the needs of adolescents. Furthermore, contraceptive prevalence targets for Africa were set at 20 percent for the year 2000 and 40 percent by 2010. Issues on improving the status of women through education and information, education and communication (IEC), as well as male involvement in family planning are emphasized in the Dakar/Ngor Declaration as essential to the success in family planning programmes to achieve the goals and targets of the declaration. The

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[5]. Economic Commission for Africa, "Report on Integrated Maternal and Child Health/Family Planning Programmes in Africa", ECA/POP/WP/3 [1.3 (ii)], August 1987.

concerns on population and family planning expressed in the Dakar/Ngor Declaration in the context of socio-economic development are fully reflected in the 1994 ICPD Programme of Action.

TABLE 1: Government views on fertility level as of 1993

Country	Government's view		
	Too low	Satisfactory	Too high
Algeria			x
Angola			x
Benin		x	
Botswana			x
Burkina Faso			x
Burundi			x
Cameroon			x
Cape Verde			x
Central African Republic			x
Chad		x	
Comoros			x
Congo			x
Côte d'Ivoire		x	
Djibouti		x	
Egypt			x
Equatorial Guinea		x	
Eritrea			x
Ethiopia			x
Gabon	x		
Gambia			x
Ghana			x
Guinea			x
Guinea Bissau			x
Kenya			x
Lesotho			x
Liberia			x
Libya Arab Jamahiriya		x	
Madagascar			x
Malawi			x
Mali			x
Mauritania		x	
Mauritius		x	
Morocco			x
Mozambique			x
Namibia			x
Niger			x
Nigeria			x
Rwanda			x
Sao Tome and Principe			x
Senegal			x
Seychelles			x
Sierra Leone			x
Somalia		x	
South Africa			x
Sudan			x
Swaziland			x
Togo		x	
Tunisia			x
Uganda			x
United Republic of Tanzania			x
Zaire		x	
Zambia			x
Zimbabwe			x
Total	1	11	41

Source: Compiled from United Nations, Global Population Policy Data Base 1993, New York, 1995.

TABLE 2: Government which indicated that their fertility was too high in 1993 by intervention view on fertility

Country	Type of intervention on fertility	
	To lower fertility	No intervention
Algeria	x	
Angola		x
Botswana	x	
Burkina Faso	x	
Burundi	x	
Cameroon	x	
Cape Verde	x	
Central African Republic		x
Comoros	x	
Congo	x	
Egypt	x	
Eritrea	x	
Ethiopia	x	
Gambia	x	
Ghana	x	
Guinea	x	
Guinea Bissau		x
Kenya	x	
Lesotho	x	
Liberia	x	
Madagascar	x	
Malawi	x	
Mali	x	
Morocco	x	
Mozambique	x	
Namibia		x
Niger	x	
Nigeria	x	
Rwanda	x	
Sao Tome and Principe		x
Senegal	x	
Seychelles	x	
Sierra Leone	x	
South Africa	x	
Sudan	x	
Swaziland	x	
Tunisia	x	
Uganda	x	
United Republic of Tanzania	x	
Zambia	x	
Zimbabwe	x	
Total	36	5

Source: Same as Table 1.

Note: 34 of 36 countries intervening to lower fertility indicated that they provide direct support to contraceptive use; Cameroon and Sierra Leone provide indirect support.

18. Most of the countries have adopted explicit national population and development policies while others are in the process of formulating such policies. As noted earlier, most of the change on perceptions from pronatalist views to acceptance of population and family planning happened since 1984. Some of the factors that prompted the change, as observed earlier was related to economic, and health reasons.[6] Workshops, seminars and conferences on national, regional and international levels on the interrelationship of population and development have contributed to the adoption of comprehensive population and development policies in African countries. Most of these policies have demographic targets on population growth, fertility, infant, child and maternal mortality rates and on family planning in terms of increasing contraceptive prevalence levels.

III. SPECIFIC EXAMPLES ON THE EVOLUTION OF ATTITUDES ON POPULATION AND FAMILY PLANNING IN SOME AFRICAN COUNTRIES

19. By 1969, family planning programmes had been introduced in eight African countries while these programmes had been introduced

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[6]. International Conference on Population and Development, National Perspectives on Population and Development (synthesis of 168 national reports prepared for the International Conference on Population and Development, 1994), p. 84, March 1995.

in 25 countries between 1970 and 1981.[7] The early family planning programmes were mostly introduced through the influence of donors from outside Africa with emphasis on controlling population growth through fertility reduction. Such an approach ignored to put equal emphasis on the health and welfare benefits of the mother, child and society as a whole. Moreover, the cultural values and customs of the people were not taken into account when introducing family planning programmes. Consequently, there had been opposition to family planning programmes for a long time till the early 1980s.

20. Among the countries which had explicit policies on population and/or family planning before 1984 included: Egypt, Kenya, Ghana, Mauritius, Morocco and Tunisia. Since 1984, comprehensive population policies which include family planning have been adopted in the following countries: Burkina Faso 1991, Cameroon 1992, Ethiopia 1993, Gambia 1992, Guinea 1992, Lesotho 1994, Liberia 1988,Madagascar 1990, Malawi 1994, Mali 1991, Niger 1992, Nigeria 1988, Tanzania 1992, Rwanda 1990, Senegal 1988, Sierra Leone 1992, Uganda 1995 and Zambia 1989. In most of these, demographic targets on fertility reduction and contraceptive prevalence rates have been included in the policies. In many other countries including Botswana, Namibia and Zimbabwe, arrangements are underway to adopt explicit population policies.

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[7]. Economic Commission for Africa, "Report on Integrated Maternal and Child Health/Family Planning in Africa", ECA/POP/WP/87/3 [1.3 (ii)], August 1987.

21. Selected examples on the evolution on perceptions on population and family planning in some African countries is presented below. These should give a general representation of the other countries.

22. **Cameroon**: Cameroon, over the past years, had been pronatalist. During the period 1960 to 1976, the law prohibited the sale and advertisement of contraceptives. Large families were subsidized. However, between 1976 and 1985, the government started awareness programmes on the interrelationship between population and socio-economic development and the need to moderate population growth. The law prohibiting the sale and advertisement of contraceptives was later repealed. Government then emphasized education on responsible parenthood. In 1985, a National Population Committee and a Population Planning Unit were set up. A national population policy was finally adopted in 1992. Among the areas emphasized in the policy include population education to all the population, especially adolescents so as to enable them assume responsible parenthood.

23. **Egypt**: Family planning clinics started providing services in Egypt in 1955. The 1962 National Charter stated that population constituted the most dangerous obstacle that faced the Egyptian people in their desire for raising the standard of production in an effective and efficient way. The Charter further stated that attempts of family planning deserved the most sincere efforts by

modern scientific methods.[8] In 1965, a Supreme Council for Family Planning was established when Egypt's population policy was first declared. The policy was revised in 1973, 1975, 1980, and 1986.

24. The reduction of population growth rate has consistently been one of the objectives of the population policy and family planning has been one of the means to help achieve fertility reduction. The national report to the International Conference on Population and Development in 1994 reiterated that Egypt's population growth rate was too high and undermined the socio-economic development of the nation. Among the government response to the effects of population growth rates include governments stress for greater investment in health, economic and social programmes with special emphasis on increasing family planning, and raising the general status of women and the youth. Contraceptive prevalence among married women has risen from 24 percent in 1980 to 47 percent in 1992. Total fertility in 1960 was 7 and declined to 4 in 1992.

25. **Ethiopia**: During the 1960s and 1970s, attitudes on population issues was laissez-faire and pronatalist. Some changes came in the late 1980s. After a process on sensitization on the interrelationship between population and development, a national

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[8]. Sayed, Hassein Abdel-Aziz, "The Population and Family Planning Programme in Egypt, Structure and Performance", paper presented to the seminar on Egyptian Population Policy organized by the Egyptian Population and Family Planning Board and the International Union for the Scientific Study of Population, held in Cairo, in October 1983, p.7.

population policy was adopted in 1993. The policy states that high fertility and rapid population growth rates exert negative influences on economic and social development

26. The national population policy objective and targets focus on reducing mortality, fertility and population growth rates; increase in contraceptive prevalence rates (contraceptive prevalence rate among married women was 4.8 percent in 1990); removing all legal and customary practices militating against the full enjoyment of economic and social rights by women; mounting an effective country wide population information and educational programme to address issues pertaining to small family size and its relationship to human welfare and environmental security. Some of the strategies for the implementation of the policy include amending all laws that hinder women's access to all social, economic and cultural resources and control over them including the ownership of property and business. Some initiatives have started in Ethiopia to involve artists, through dramas, theatres, writings and music to promote the implementation of the policy.[9]

27. **Ghana**: The 1969 national population policy was to address population related problems which affected socio-economic development. Thus, the objectives of the policy included reduction of mortality, fertility and population growth rates through, among other things, implementation of the national family planning

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[9]. The Ethiopian Herald of 6 July, 1995, p. 3.

programme which was launched in 1970. Due to socio-economic crisis in the 1970s and 1980s, the policy could not be implemented sufficiently. The policy was thus revised in the early 1990s. The revised policy focuses on ensuring systematic integration of population and family planning in all aspects of development planning and programming; providing information and education on the value of a small family size and responsible parenthood; providing easy access to and ensuring affordability of, family planning services for all couples and individuals who need to regulate their fertility. Some of the specific targets of the Ministry of Health by the year 2000 include: increase of contraceptive prevalence rate by 25 percent (in 1993, contraceptive rate was 20 percent among married women); to increase awareness of the dangers of teenage pregnancy. In December 1994, the Ghana Parliament passed an act establishing a National Population Council (NPC) to co-ordinate, monitor and evaluate all population programmes and activities in the context of the revised population policy.

28. **Guinea**: In the 1950s and 1960s, the Government was strongly pronatalist. The most commonly held views then included the following: the larger the family size was, the richer the family was expected to be; the more populous the country was, the stronger it was expected to be. However, the socio-economic difficulties of the 1970s and 1980s led the Government to change its population perceptions. In 1984, the Government declared that a large

population size per se did not necessarily lead to development. Increased availability of demographic data and better awareness of the interrelationships between population and socio-economic development contributed to government change in attitudes. This led to the process of formulating a comprehensive national population policy which was adopted in 1992. Population education programmes in schools and out of school programmes are being implemented. Both government and non-governmental organizations (NGOs) promote and support the provision of family planning services. Radio and television coverage is given to promotion of family planning including use of condoms as a main means to prevention of the spread of AIDS/HIV.

29. **Kenya**: In 1966, the Government made known its intention to adopt policies to help reduce its population growth rate through voluntary family planning. In 1967, a National Family Planning Programme was launched by the Ministry of Health to provide family planning information and services to those who wanted them in all Government hospitals and health centres throughout the country. High population growth rate and its accompanying problems prompted the Government of Kenya to encourage and support family planning in the country.[10] The 1970-1974, 1974-1978, 1979-1983 and subsequent Development Plans all reflected Government concern regarding the adverse effects of the rate of population growth on socio-economic

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[10]. J. Mugo Gachuhi, "Who needs Family Planning?")A preliminary appraisal of the service in Kenya) in Population in African Development edited by Pierre Cantrelle, vol. II, no date.

development. Government then concentrated on changing attitudes of the people on family size. In the 1979-1983 Development Plan, the Government hoped that when the parents understood the concerns of very rapid rates of population growth in terms of its effects on family welfare and quality of life, they would adjust their decisions in favour of smaller families.[11]

30. In 1982, a National Council for Population and Development (NCPD) was established to co-ordinate population activities by government and those by NGOs. Among its goals was to encourage Kenyans to have a small family size and to motivate males to adopt and practice family planning. There has been strong political leadership support to population and family planning activities. The private sector is greatly involved in the provision of family planning services. Although for a long time the impact of population and family planning programmes did not seem to show any positive results, there is evidence to show that perceptions towards a small family size are showing desired results: contraceptive prevalence among married women has increased from 7 percent during 1977/1978 to 17 percent in 1984, 27 percent in 1989 and 33 percent in 1993. Total fertility has declined from 7.7 percent in 1984 to 6.7 percent in 1989 and 5.4 percent in 1993. In 1984, ideal family size was 5.8 percent and it declined to 4.4 percent in 1989 and declined further to 3.7 percent in 1993.

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[11]. Kenya Development Plan, 1979-1983, Part I, pp. 61 and 62.

31. **Malawi**: Although family planning services were first introduced in Malawi in the early 1960s, it has been noted, according the Malawi National Report for 1994 ICPD, that the approach, philosophy and rational were not clearly articulated. This led to misconception on the intent of the family planning and family planning services were abandoned. It was in the late 1970s and early 1980s, through workshops, that a National Child Spacing Programme was established in 1982. Seminars and workshops for senior government officials, and parastatal organizations on population and development in 1989 and 1991 recognized the gravity of the demographic situation and made specific recommendation to formulate a national population policy as part of the overall development strategy. Even the then only political party (Malawi Congress Party) at the time, felt the need for the formulation of a national population policy.

32. The policy was formulated and adopted in 1994. Among the objectives of the policy include: achieving lower population growth rates compatible with the attainment of the country's social and economic objectives; improving the status of women; improving information, education and communication on the use of contraception and the benefits of small family sizes. Demographic targets to be achieved by 2002 include: the reduction of population growth rate, fertility, infant mortality rate, reduction of the number of adolescent pregnancies by 50 percent, increase contraceptive rate to 28 percent (the 1992 CPR among married women

was 13 percent), changing the negative attitude of at least 80 percent of men towards family planning and use of modern contraceptive methods. The Government issued new contraceptive guidelines liberalizing the provision of reproductive health and family planning services in 1992. The requirement of obtaining spousal consent before contraceptives supplies can be offered to a client has been abolished. There is a social marketing programme for the distribution of contraceptives.

33. **Mali**: From the time Mali became independent in 1960 till the beginning of the 1980s, population and its growth were perceived as advantageous for socio-economic growth in view of the vast land area that was under exploited. However, changed attitudes among government authorities on population issues started at the beginning of the 1980s when population was also viewed as a constraint to socio-economic development.

34. Better knowledge of the interrelationship between population and development, persistent economic crisis, continued poverty among the population, the effects of structural adjustments on the population, are among the factors that led the government to change its perceptions on population from a pronatalist view to one of controlling demographic growth. In 1991, the Government adopted a national population policy. Among the major objectives of the

policy include the reduction of population growth, mortality and morbidity. Programmes to convince the population on the advantages of a small family size are underway.

35. **Niger**: It was a taboo to talk of population issues, particularly those relating to family planning or birth spacing before the 1980s in Niger. When demographic data started to be available and the awareness of the interrelationships between population and development were understood, Government perceptions on population and family planning started to change. The first seminar on population and development was held in 1981. This was followed by several awareness creation activities on population and development and MCH/FP. MCH and FP activities were integrated in 1984. Regulations authorizing contraceptive service supplies were adopted in 1988, these were reviewed and further amended in 1992. A National Population Policy was adopted in 1992. Lowering of high maternal and infant mortality rates is seen as a prerequisite for fertility reduction and the well-being of the family. In 1993, a national policy for the promotion of women was adopted. It focuses on the improvement of the position of women in politics, economy, social and cultural life.

36. **Lesotho**: Lesotho was pronatalist for a long time. This was supported by religious and cultural justifications. As in many countries, a large population size was viewed important and desirable for the economy. An interim National Population

Commission was established in 1973. It convened a population symposium in 1974. The symposium made several recommendations requiring intervention on population and development issues. Unfortunately, there was little follow-up. The increased socio-economic pressures led to the convening of a workshop in 1988 on the need to prepare and adopt a population policy. In 1990, a workshop on Population Policy drafted a population policy which was presented to ministers, government officials, NGOs and donors. The Government adopted the policy in 1994. It includes demographic goals, programme targets and policy strategies. MCH/FP services are provided through several channels - clinic-based services, community based services, services in the organized sector and through social marketing.

37.**Tunisia**: From the attainment of independence in 1956, the Government has consistently considered population and development as greatly interrelated and family planning has been an integral part of socio-economic development. A National Family Planning Programme was formally adopted in Tunisia in 1964. Throughout, government population policy has been to lower fertility and population growth rate; improve family planning and health care, particularly in rural areas. Reduction of population growth rate was, among other things, intended to alleviate socio-economic problems including unemployment.

38. The Government has provided strong political support to the provision of family planning through financial support to programmes, enacting relevant legislation to support family planning programme, and the advocacy role through the various mass media channels including the radio and television. The following serve as examples of government commitment to family planning and population issues:

- the government passed law 61 in 1961 which permitted the sale and distribution of contraceptives. That law repealed the previous anti contraceptive laws which were adopted during the French occupation;

- between 1961 and 1965, other legislations were enacted including legalizing abortion for women with 5 or more children. In 1973, a new legislation made abortion free within the first three months;

- in 1983, a new ministry of family and promotion of women was established to be responsible for the implementation of the national population policy.

39. Contraceptive use among married women in Tunisia has increased from 31 percent in 1978 to 41 percent in 1983 and to 50 percent in

1988, it reached 54 percent in 1992. This has contributed to reduction of fertility and population growth rates in the country. Total fertility rate in 1988 was 4.3 percent.

IV. OBSTACLES TO IMPLEMENTATION OF FAMILY PLANNING PROGRAMMES

40. The previous section has already shown trends indicating that member States have moved from pronatalist attitudes to those that now favour moderation of demographic trends through family planning programmes and socio-economic development. Population policies which include family planning programmes have been formulated or are being formulated in most African countries. The existence of these policies per se does not guarantee the success of family planning programmes. Policies should be translated into action oriented programmes and implemented. Some of the problems that have to continue to be overcome which affect family planning programmes include: cultural and social norms affecting the status of women and general attitudes on birth spacing and family planning at grassroots (In Lesotho for example, according to the country report prepared for the 1994 ICPD in Cairo, women are legally treated as minors under the guardiaship of husbands. Furthermore, socio-cultural and religious attitudes favour large families and oppose family planning.Men's attitudes to family planning are negative.); policies not being translated into action programmes; problems related to administration and management of programmes;

and lack of adequate resources. These are briefly highlighted below.

(i) Attitudes

41. There has been considerable change in perceptions on family planning and population issues among governments. However, such perceptions have not changed much among the greater majority of the people at grass roots where religion, social and cultural values still favour large families in many countries. This is clearly reflected in Table 3 where 33 percent to 83 percent of the married women not using contraception indicated that they did not intend to use it in the future. In Cameroon, Guinea, Madagascar, Namibia and Niger, 50 percent to 66 percent of the women stated the reason for non-use of contraception as desire for children. In 12 countries, 27 percent to 47 percent of non-users of contraception stated desire for children as reason for not using contraception.[12] Lack of knowledge is also major reason for non-use of contraception.

42. From Table 3, it is observed that among the women not using contraception, over one-third to nearly half of the women stated that they intended to use contraception within the next twelve months after the survey in ten countries: Algeria, Botswana, Kenya, Madagascar, Malawi, Morocco, Rwanda, Tunisia, Zambia and Zimbabwe.

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[12]. United Nations Economic Commission for Africa, Statistical Compendium on Contraceptive Prevalence and Practice in ECA Member States, Addis Ababa, November 1995.

In the other fifteen countries, the women who indicated intention to use in the next twelve months ranged from 8 percent in Cameroon to 32 percent in Ghana. In ten countries: Algeria, Burundi, Cameroon, Egypt, Ghana, Kenya, Malawi, Rwanda, Togo and Zambia, over 10 percent to 17 percent of married women indicated intention to use contraception later while in the other fifteen countries the percentages ranged from 1 percent to 10 percent. Proportions of the married women who were unsure of the timing as to when to use contraception were below 6 percent in all the countries shown in Table 3. Those married women who were unsure about intention on future use of contraception ranged from 2 percent to 17 percent.

43. In view of the high proportions of married women not using contraception and those not intending to use contraception in the future, policy measures need to be taken to influence change in attitudes. Thus, IEC programmes should be strengthened and be targeted at changing the attitudes of the population at the grass roots in favour of family planning. Moreover, programme formulation and implementation should also involve population at the grass-root level.

TABLE 3: Percentage distribution of all currently married women not using contraception by future intention to use contraception

Country	Year of survey	Future intension to use contraception							Number of women
		Total	Intends to use in next 12 months	Intends to use later	Unsure as to timing	Unsure as to intention to use	Does not intend to use	Missing	
Algeria	1992	100	33.0	17.1	-	3.6	54.6	0.1	2314
Botswana (a)	1988	100	47.3	4.9	3.2	4.7	39.9	0.1	2740
Burkina Faso	1993	100	20.5	5.4	4.4	15.1	54.0	0.6	4001
Burundi	1987	100	11.5	16.8	4.1	11.6	55.9	0.2	2436
Cameroon	1991	100	7.9	15.3	0.0	5.2	71.6	0.0	2408
Egypt	1992	100	28.7	11.2	5.6	8.3	46.2	0.0	4843
Ghana	1993	100	31.7	15.9	3.2	7.4	41.6	0.2	2555
Guinea	1992	100	8.5	5.7	0.3	10.5	74.6	0.4	5004
Kenya	1993	100	44.2	11.0	3.0	7.8	33.7	0.4	3113
Madagascar	1992	100	36.0	4.3	0.9	5.2	53.4	0.0	3111
Malawi	1992	100	42.3	13.4	2.1	8.6	33.4	0.2	3038
Mali	1987	100	11.0	1.2	0.7	3.6	83.3	0.1	2811
Morocco	1992	100	36.5	7.6	1.0	2.9	51.4	0.6	2994
Namibia	1992	100	25.9	4.0	0.5	8.8	60.3	0.4	1606
Niger	1992	100	14.4	4.6	1.3	10.4	69.1	0.2	5314
Nigeria	1990	100	12.2	9.4	0.0	10.2	68.2	0.0	6465
Rwanda	1992	100	49.8	11.6	0.6	1.6	35.9	0.5	2984
Senegal	1992/93	100	18.2	6.3	3.5	9.5	62.2	0.3	4171
Sudan	1989/90	100	13.1	4.0	1.3	4.7	76.8	0.1	4932
Tanzania	1991/92	100	19.0	6.6	1.6	16.5	55.9	0.3	5409
Togo	1988	100	25.6	11.9	2.3	3.5	55.0	1.7	1623
Tunisia	1988	100	36.3	8.8	5.1	5.1	44.7	0.0	2015
Uganda	1988/89	100	11.9	6.9	2.6	7.8	70.8	0.0	3025
Zambia	1992	100	34.5	12.2	1.4	6.9	44.8	0.2	3780
Zimbabwe	1988	100	35.2	9.4	5.9	8.2	40.1	1.2	1504

(a) Data refers to all women who have had sexual intercourse and were not using contraceptive methods at time of survey.

\- means no data.

Source: Compiled from various DHS country reports.

44. Data from Demographic and Health Surveys conducted in some African countries show that from 30 percent to 81 percent of married women never discuss family planning with their husband as reflected in Table 4. A safe Motherhood Survey conducted in 8 districts in Uganda during 1990-1991 focused on social economic and cultural factors influencing women's use of family planning and maternal health services. It revealed that (1) many women thought that their husbands might be opposed to using family planning; (2) men, especially those with several wives, desire large families; (3) those men with wives who wanted few children did so because of economic reasons.[13]

45. There is need for couples to be encouraged to discuss family planning issues among themselves. In Zimbabwe, the Zimbabwe National Family Planning Council undertook national campaigns in 1988-1989 and 1993-1994 to encourage joint decision-making by wives and husbands on contraceptive use and family size using various mass media and entertainment groups. Results of the 1993-1994 campaign showed an increased number of men and women who talked regularly with their partners about family planning, they also agreed that decisions on the use of family planning should be made together.[14] Other countries where programmes have been conducted to involve males in family planning activities include: Benin, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Malawi,

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[13]. UNFPA, Uganda Programme Review and Strategy Development Report. (The Review was undertaken from 10 August to 11 September 1992), p. 18.

[14]. UNFPA, The State of World Population, 1995, p. 36.

Mauritius, Morocco, Nigeria, Sierra Leone, Swaziland, Togo and Zimbabwe. The International Planned Parenthood Federation and family planning associations, in various African countries, have been instrumental in these programmes. However, male motivational programmes and involvement in family planning should be strengthened.

46. Decisions on family size are generally influenced by relatives - mothers, mother-in-laws, sister-in-laws, uncles,aunts,etc. Even if a couple may want a small size, these other relative exert pressure on the couple to have as many children as possible. This is particulary very common in the rural areas. It is therefore important that IEC messages on family planning should also be targeted to change the attitudes of the extended family members.

TABLE 4: Percentage distribution of currently married women who know a contraceptive method by number of times family planning was discussed with husband in the year preceding the survey

Country	Year of survey	Number of times family planning discussed					Number of women
		Never	Once or twice	Three times or more	Missing	Total	
Botswana	1988	28.5	43.1	27.2	1.1	100.0	1619
Burkina Faso	1993	75.1	10.4	14.3		(a)100.0	4359
Burundi	1987	39.5	28.8	28.9	(b)2.7	100.0	2095
Cameroon	1991	63.0	12.0	25.0	0.0	100.0	1963
Ghana	1993	53.1	20.1	25.9	0.8	100.0	2895
Guinea	1992	77.9	6.5	15.2	0.0	100.0	1387
Kenya	1993	33.9	30.1	35.7	0.1	100.0	4500
Liberia	1986	64.8	18.6	16.3	0.0	100.0	2470
Madagascar	1992	41.0	22.2	36.6	0.2	100.0	2454
Malawi	1992	42.7	32.4	24.1	0.7	100.0	3242
Niger	1992	81.2	10.9	7.8	0.0	100.0	4293
Nigeria	1990	58.1	24.0	17.0	1.0	100.0	2999
Rwanda	1992	30.5	16.9	51.6	1.0	100.0	3722
Senegal	1992/93	70.9	14.1	14.9	0.1	100.0	3359
Sudan	1989/90	52.8	27.0	20.1	0.1	100.0	3856
Tanzania	1991/92	56.0	25.6	18.1	0.3	100.0	4746
Togo	1988	62.9	19.1	17.8	0.1	100.0	2350
Uganda	1988/89	59.6	26.5	13.8	0.0	100.0	2670
Zambia	1992	41.8	31.3	26.6	0.2	100.0	4083
Zimbabwe	1988	30.9	21.6	47.5	0.0	100.0	2609

(a) Includes cases that were not stated.
(b) Includes 2.4 percent of women in marriage for less than one year.

Source: Compiled from various DHS country reports.

ii) Policies not translated into concrete programmes

47. Many policies indicate the various priorities to be addressed, eg. improving the status of women through education and enacting relevant legislation to facilitate policy implementation. Generally, little is done to formulate specific action programmes. Sometimes action programmes may be formulated but not implemented. Similarly, relevant legislation to facilitate implementation of policies may be passed but not follwed on to enforce its implementation. For example, women have no direct access to credit facilities in most countries. What is worse, women are denied ownership of property. In most cases, women's ownership to property, especially after the death of the husband, would be through male children. Hence, women are encouraged to have large family sizes in the hope that they may inherit property through male children in the event of death of the husband. In such context, it implies that women are treated as minors and yet most countries in their policies indicate they want to improve women's status.

48. Any changes in women's status should put emphasis on improving the education of girls as a priority. With education, women's opportunities in socio-economic activities would be easier to attain. Educated women are more likely to be receptive to: improve their health and that of their families; use family planning and hence adopt a small family size norm; participate more effectively in contributing to the national socio-economic development efforts.

49. Policies on reproductive health care and family planning tend to discriminate against adolescents in some countries regarding access to information and services. Such descrimination should be eliminated. In Ghana, the representatives of various church groups seem to opose family planning services to be provided to adolescents as observed by Dr. Fred Sai, " ... many representatives of church groups of all types seem to feel that while adolescents may be given counselling, they should not be offered services, even if they are sexually active".[15] It should be recalled that both the Dakar/Ngor Declaration and the ICPD.PA recommend that adolescents should have access to information, and services on family planning and reproductive health care.

(iii) Weak administrative, management and institutional infrastructure

50. Data from the Demographic and Health Surveys shows total demand for family planning ranging from 26 percent to 69 percent among married women in some countries for which relevant data is available. However, of the total demand for family planning, 7 percent to 71 percent is met in the various countries.[16] The administrative and management arrangements of population and family planning programmes are not adequate and weak. The same is true with the infrastructural framework for the implementation of programmes. This is reflected in logistics problems,

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[15] IPPF Annual Report 1994 to 1995, London, P.2

[16] United Nations Economic Commission for Africa, Statistical Compendium on Contraceptive Prevalence and Practice in ECA Member States, Addis Ababa, November 1995.

inadequate service delivery points, inadequate supervision, poor morale of personnel, poor quality of services rendered to clients. There is need to improve capacity building of infrastructure and personnel as well as administration and management of programmes. It is essential that programmes should be monitored and evaluated periodically. Results of evaluation should be used to improve the administration and management of programmes.

(iv) Inadequate financial and material resources for programmes

51. Population and family planning programmes are affected by structural adjustment programmes and inadequate financial and materials support from governments. In the past, these programmes were supported mostly by donor governments and organizations. Continued outside assistance has declined over the years. The only chance for population and family planning programmes to succeed would be for member States themselves to increase financing of these programmes. There should be maximum and efficient use of limited available resources. However, donor governments and organizations need to complement member States efforts. Communities,the private sector and NGOs should all be encouraged and involved in resource mobilization as well as in planning ,implemention,and evaluation of the programmes.

V. SUMMARY AND RECOMMENDATIONS

Summary

52. The paper has reviewed the general trend in perception on population and family planning issues in Africa from the 1960s to the present highlighting positions at major conferences including : The first African Population Conference in 1971, the second African Population Conference in 1984, and the third African Population Conference in 1992. Specific illustrations on selected African countries have also been presented.

53. What is clear is that few governments had accepted population and family planning programmes as integral components of socio-economic development in the early 1960s and the 1970s. At that time, most countries held pronatalist views that did not encourage family planning programmes. In fact, many countries had inherited laws which were against the provision and advertisement of family planning services. Overtime perceptions changed from pronatalist views to acceptance of family planning due to: (a) availability of demographic data, and better understanding of the interrelationships between population and development; and (b) the difficult economic and social conditions especially since the 1980s.

54. Change in perception on population and family planning has been evident on government level as reflected in the increased number of countries that now have explicit population policies which include family planning. Unfortunately, change in

perceptions has not quite filtered down to the majority of the population at grass-roots level in rural areas in most countries. In Burkina Faso for example, the 1993 Demographic and Health Survey showed that 24 per cent of couples approved of family planning in rural areas compared to 48 per cent in urban areas. Positive attitudes to family planning is one of the key elements towards the implementation of successful population policies and programmes.Thus continued efforts have to be made to change attitudes at the grassroots . Other obstacles that affect family planning programmes which have been referred too in the paper are : policies not being translated into concrete programmes for implementation; weak administrative, management and institutional infrastructure; and inadequate financial and material resources for programme implementation. All possible efforts should be made to address these obstacles to family planning programmes.

55. The paper has stressed the need: for governments to translate population and family planning policies into concrete action programmes and to implement those programmes in the light of the Dakar/Ngor Declaration and the ICPD Programme of Action; to improve administrative, management and institutional infrastructure; and to increase financial and material support to population and family planning programmes.

Recommendations.

56. There is no need to come up with new recommendations on the implementation of population and family planning programmes. These recommendations are already clearly presented in the Dakar/Ngor Declaration and the ICPD Programme of Action. The main recommendation made here is to appeal to member States and those concerned with population and family planning programmes to implement those recommendations contained in the Dakar/Ngor Declaration and the ICPD Programme of Action. In addition, recommendations by the Experts/NGOs Workshop on the Implementation of the Dakar/Ngor Declaration and the ICPD Programme of Action, held in Abidjan, 6-9 June 1995 (organized by ECA/OAU/ADB and IPPF) should be taken into account.

57. Particular emphasis in the implementation of population and family planning programmes should be put on:

(a) improving the education of girls and women and their status - a woman's education is a catalyst to the adoption and use of family planning, improving her health and that of her family, improving her reproductive health, and opening her opportunities for employment in the modern economic sector outside the home;

(b) ensuring that family planning is based on informed free and voluntary choice whereby the population have access to information, a variety of methods and that services are of high quality. In relation to informed choice, IEC programmes should

be sensitive to cultural values and seek to change attitudes through persuasion without coercion. In addition, IEC programmes need to pay special attention to convey appropriate messages on family planning and HIV/AIDS prevention targeted at all population groups at risk.

(c) ensuring that family planning is not targeted at women alone - men should also play a greater role and involvement and assume joint parenthood responsibility

(d) involving the participation of users of family planning programmes, private sector and NGOs in provision of family planning services as governments cannot adequately provide all the services;

(e) intergrating population and family planning programmes into socio-economic development programmes of various ministries or departments,as well as into the activities of the private sector and the NGOs ;

(f) monitoring and evaluating the implementation of programmes and using the results of the evaluation to improve programme implementation;

Perception on Family Planning in the context of Socio-Economic and Cultural values in ECA member States.

The paper reviews various factors that contributed to the general resistance to the acceptance of modern family planning in the 1960s and 1970s and the subsequent changing attitudes; it then presents some of the obstacles to the implementation of family planning programmes. It makes some suggestions on how to translate the observed changes in attitudes into effective programmes.