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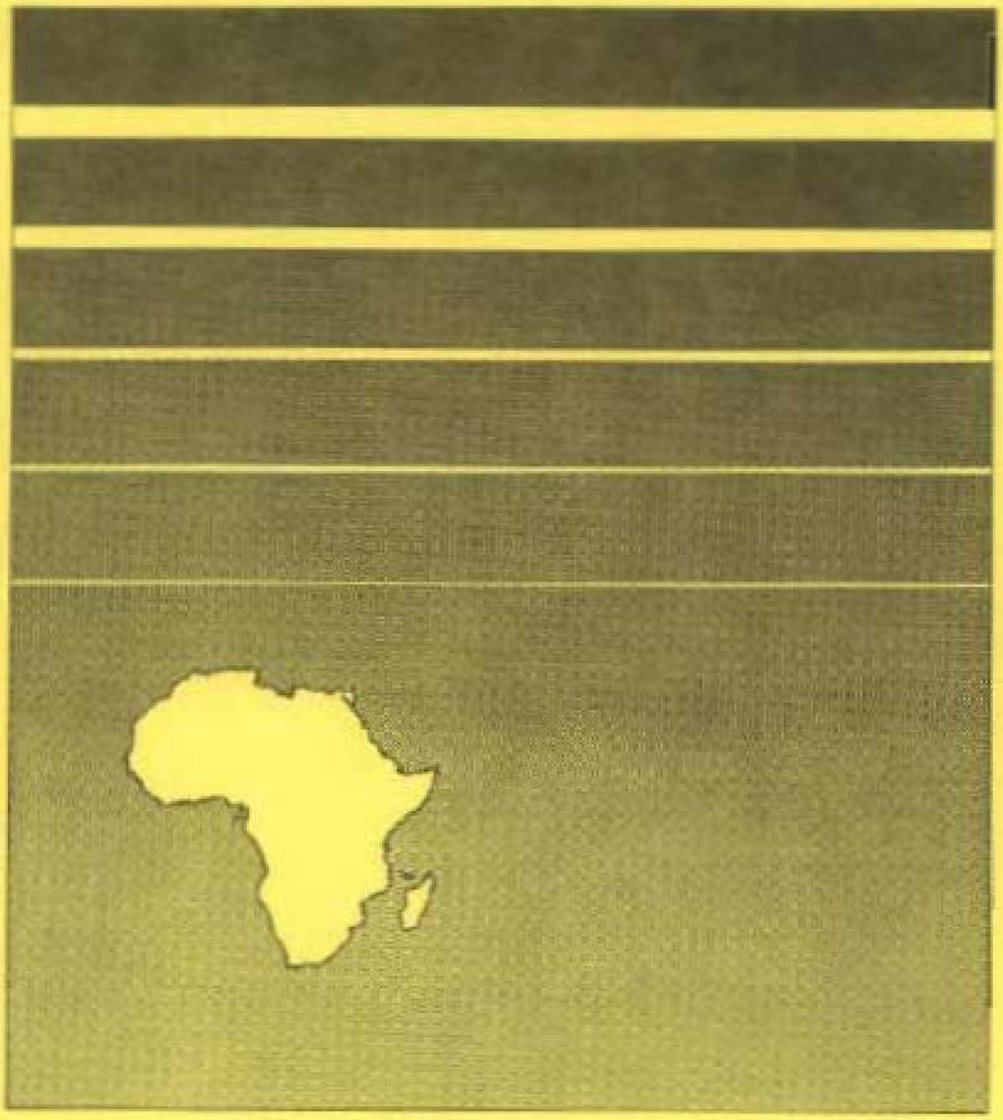
Alternatives to Traditional Approaches in the Formulation and Implementation of Family Planning Programmes in African Countries



United Nations
Economic Commission
for Africa

Addis Ababa
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CONTENTS

I. INTRODUCTION

Throughout the world for thousands of years, child spacing has been practised using various traditional methods. The religious authority of traditional Judaism, the Roman writings, as well as writings from Japan, China and Africa, all reveal of evidence of the "teas" made from roots, weeds, barks, and other substances that were given to women as protection against unwanted pregnancy 1/. Abstinence, prolonged breastfeeding, withdrawal, etc were among some of the other traditional methods used before modern methods of contraception were introduced. In some cases infanticide and abandoning of unwanted children have been used where unwanted pregnancies could not be prevented. Furthermore, abortion has always been one of the means used to get rid of unwanted pregnancies throughout the world. The incidence of abortion, mostly illegal abortion, in most African countries is on the increase. The various traditional methods of childspacing/birth control enabled total fertility to be below the biological maximum.

In the African context, cultural and traditional practices were very strong in the past in most societies to enforce childspacing for improving the health of mothers and children and not for limiting family size. Many African societies valued large family size in the past when land and other resources were not a constraint. Among the various reasons that have been advanced for large family sizes in Africa include: a source of labour and security in old age; continuation of family name; symbol of status for the mother and father who have a large family size; enabling mothers to continue having access to property through sons when a husband dies etc. The social and cultural values which encouraged early marriages and childbearing till the end of the reproductive period supported the regime of large family sizes.

Economic reasons were never advanced as a basis for childspacing. The changing economic situation whereby land resources and other natural resources on which life in most African countries depends, and, in the absence of technological innovations can no longer support large family sizes and increase productivity of consumer goods and services. Large families are no longer being viewed by most African countries as an asset in themselves. This was reflected in the Kilimanjaro Programme of Action for African Population and Self-Reliant Development (KPA) adopted by African Governments at the Second African Population Conference held in Tanzania in 1984 2/. Among the objectives of the KPA was the

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1/ Elizabeth M. Edmands, Concepts and Issues in Family Planning: Guidelines for Nurses, Midwives and Other Health Personnel, University of North Carolina, Chapel Hill, 1984, p.3.

2/United Nations Economic Commission for Africa, Kilimanjaro Programme of Action for African Population and Self-Reliant Development, 1984.

achievement of population growth rates that were compatible with the desired economic growth and social development goals.

The KPA addressed 14 recommendations on fertility and family planning to African governments; some of these recommendations called on African governments to: incorporate family planning services into the maternal and child health (MCH) services; ensure the availability and accessibility of family planning services to all couples or individuals seeking such services freely or at subsidized prices; consider setting up family planning outlets which included utilization of existing health facilities and community-based delivery systems; make necessary efforts to improve planning, funding and management for more effective implementation of MCH/family planning; ensure that national family planning programmes make available a variety of methods to ensure free and conscious choice by all couples.

The 3rd African Population Conference held in Dakar, Senegal, 7-12 December 1992, in preparation for the International Conference on Population and Development (ICPD) in 1994, adopted the Dakar/Ngor Declaration on Population, Family and Sustainable Development. The Declaration was endorsed by the ECA Conference of Ministers at its nineteenth meeting 3-6 May, 1993. That Declaration has reaffirmed the continued validity and implementation of the KPA. African countries have, in that Declaration, set specific targets to attain contraceptive prevalence rates of 20% by the year 2000 and 40% by 2010, and to reduce population growth rate from the present rate of 3% to 2.5% by the year 2000 and to 2% by 2010.

The targets cited above cannot be attained through the use of traditional birth spacing/family planning methods. There is therefore, urgent need to have alternatives to tradition approaches in the formulation and implementation of family planning programmes in African countries. Moreover, with modernization and social change, traditional methods of child spacing/family planning are no longer practised as much as they used to be in the traditional societies in African countries, and are not replaced fast enough by modern methods. Organized birth spacing/family planning programmes are alternatives to traditional approaches. Organized family planning programmes have contributed greatly to increasing contraceptive use and reducing birth rates in many countries. In addition, they have also contributed to improving the health of children and mothers.

The present study was undertaken as part of the ECA Population Division approved work programme for the biennium 1992 to 1993 under 2(b) as one of non-recurrent publications: "Alternatives to traditional approaches in the formulation and implementation of family planning programmes in African countries". This study is related to two previous publications by the secretariat namely: Guidelines on Improving Delivery of Population and Family Planning Programmes in African Countries, 1991; and Strategies to Improve

Contraceptive Use to Influence Demographic Trends in African Countries, 1992.

This study is in 5 sections including the Introduction in Section I. Section II reviews available literature on traditional approaches of birth spacing/family planning and their limitations. Section III deals with organized modern family programmes as alternative to traditional approaches. Detailed discussion on ingredients of successful organized births spacing/family planning programmes is presented in Section IV. A summary and conclusion are in Section V.

II. TRADITIONAL APPROACHES TO BIRTH SPACING/FAMILY PLANNING

1. A Review of Available Literature.

Child spacing has been practised in African countries for many ages using traditional methods. Social and a cultural values and norms helped to enforce child spacing. In many cases, children were in the past spaced between 2 to 3 years apart. This was achieved mainly through prolonged sexual abstinence after giving birth; prolonged breastfeeding; sexual taboos after giving birth; abortion; and other methods like rhythm; withdrawal; douche. Indigenous herbs and medicines have also been used in African countries to prevent conception. The World Health Organization has documented over 500 different plants and substances in Africa which have been used as traditional contraceptives and abortifacient up to 1983 3/. The literature review also includes magical methods which have been used in the belief of preventing pregnancy to ensure expected birth interval among the children. Birth spacing was practised in the past mainly for improving the health of the child and the mother, and not for limiting family size, as large family sizes were valued for many reasons. A brief review of the specific cases of traditional methods of child spacing that have been used in some of the countries in Africa is presented below.

(a) Egypt

It has been reported from North Africa that women, in the past, sucked the froth from camels' mouth and drank water that had been used to bathe the dead as a means to prevent pregnancy. 4/ First mention of contraception by Egyptians dates as far as 1850

3/Family Planning Methods and Practice: Africa, 1983, Center for Disease Control, Atlanta, Georgia, p.22.

4/Elizabeth M. Edmands, Concepts and Issues in Family Planning: Guidelines for Nurses, Midwives and Other Health Personnel, University of North Carolina, Chapel Hill, 1984, pp. 3-4.

B.C. Vaginal plugs formed from crocodile dung and honey wax used to prevent pregnancy. The plug was inserted into the vaginal prior to coitus. 5/ Some other works written 300 years later mention a vaginal persary of lint soaked in the juice from the tips of acacia shrubs, mixed with honey. The honey functioned to form a film that could be penetrated with difficulty by the spermatozoa while the acacia tips contained arabic gum which released lactic acid, a firm efficient spermicide. 6/ However, traditional barrier methods (sponges, leaves, etc), folk herbs, and breast feeding, were reported as most popular contraceptive methods till 1966 when the Egyptian Government launched an official programme on family planning 7/.

A Supreme Council for Family Planning was established in 1965 the same year when a national population policy was declared. Since then, Egypt has taken various measures to introduce alternative methods to traditional family planning methods. Data from the 1988 Egyptian Demographic and Health Survey showed that among the married women, 37.8% were using a method of contraception of which 35.4% were using modern methods and 2.4% were using traditional methods. The modern methods were dominated by use of the IUD (15.7%) and the pill (15.3%). This has contributed to reducing population growth from about 3% in 1985 to 2.3% in 1992 and total fertility from 7 in 1960 to just over 4 in 1992.

(b) Kenya

Prolonged sexual abstinence has been used in some parts of Kenya, like in many other parts of Africa, as one of the main methods of child spacing. In Siaya District, in Kenya, the cultural norms required that a woman was left alone and abstained from sex for 1 to 2 years after birth in order to recover fully from the effects of birth. In some other cases a woman abstained from sex until the child started to talk. It was believed that a woman was considered dirty after giving birth, and considered clean after 1-2

5/Derek Llewellyn- Jones, Human Reproduction and Society Faber and Faber, London, 1974, p.26.

6/Ibid.

7/ Dr. Nadia I. Atif " Child Spacing Practice in Egypt" in Report of the Regional Seminar on Traditional Practices Affecting the Health of Women and Children in Africa, 6-10 April, 1987, Addis Ababa, Organized by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, p.109.

years. 8/ In Busiya District similar findings were observed by Nderitu - Sexual abstinence was practised till the child was about to walk. Nderitu noted that the division of the house into 2 parts whereby one part of the house was exclusively for the wife and the other for the husband was more strictly observed after giving birth, and during lactation there was total sexual abstinence. 9/ Among the Maragoli people of Western Kenya, some of them have been reported to have used herbal medicine for contraception apart from sexual abstinence. 10/ The herbs were provided by traditional medicine men who kept the information on medicine used a secret. Children were spaced at an interval of 2 years.

In the 1980s, and especially after 1985, the Government of Kenya revitalized and intensified its efforts to improve the practice of family planning through organized family planning programmes so that the population use modern family planning methods, as opposed to traditional methods. Government provides family planning services through the Ministry of Health infrastructure: hospitals, dispensaries, and clinics. These services have been decentralized up to the district level. Moreover, the private sector and non-governmental organizations are all involved in providing family planning services in the country. The efforts of the organized family planning services are beginning to show results. The mean ideal family size which was about 6.2 according to the Kenya Fertility Survey of 1977/78 declined to 5.8 in 1984 as reflected in the results from the Kenya Contraceptive Prevalence Survey in 1984, and declined further to 4.4 children in 1989 according to the Kenya Demographic and Health Survey. In 1989, about 18% of married women were using a modern method of contraception while 9% were using a traditional method. While in 1977/78 only 17% of ever married women in Kenya wanted no more children, this figure rose to 32% in 1984 and 50% in 1989. The 1989

8/Mary Nderitu, "Literature Review: Demographic and Health Profiles and Cultural Practices that Affect Reproductive Health, 1993" prepared for the Family Planning Association of Kenya; and "Social Cultural Profile of Siaya District", Ministry of Planning and National Development and the Institute of African Studies, University of Nairobi, 1987.

9/Mary Nderitu, "Literature Review: Demographic and Health Profiles and Cultural Practices that Affect Reproductive Health, 1993", prepared for the Family Planning Association of Kenya; and "Social Cultural Profile of Busia District", by the Ministry of Planning and National Development and the Institute of African Studies, University of Nairobi, 1987.

10/ R. Sarah, M. Lukalo "The Maragoli of Western Kenya" in Angela Molnos, Cultural Source Materials for Population Planning in East Africa Vol. 3 Beliefs and Practice, Institute of African Studies, University of Nairobi, 1973, pp. 139-140.

Kenya Demographic and Health Survey has provided data which shows that fertility has started to decline in Kenya.

(c) Nigeria

In Nigeria, a lot more has been documented on some of the traditional methods of contraception. Tolushe has documented the following: 11/

- A concoction of herbs called tira is wrapped in a snake skin and is woven with a coloured thread. Women wear the object against the skin during intercourse, or keep it under the pillow to avoid conceiving.

- Use of igbadi - a bracelet woven from a leopard skin. It is worn during intercourse. The belief is that because children run away when they see a leopard, the leopard bracelet drives away the spirit of unwanted children.

- Use of ado- a pessary made from leather, thread and feathers. It is inserted into the vagina before intercourse.

- Use of omi oku which is an infusion made from the water used to bathe the dead. After intercourse, the woman recites an incantation and then drinks the liquid which is believed to render the man's sperm incapable of fertilization.

In a 1969 study among the Yoruba, Olusanya cited the following traditional methods of preventing pregnancy: abstinence (lactation taboo), charms (such as black iron ring or a leather belt stuffed with charms), drinking very salty water immediately after coitus, withdrawal, abortifacient as well as suppositories.12/ In another study in 1971 among the Yorubas the majority of women cited having ever used abstinence (66%) as a traditional family planning method, followed by breast feeding (25%), rhythm (15%), withdrawal

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11/ F.A. Tolushe, "Family Health Project in Kwara State", paper presented at the Conference on Reproductive Health Management, held in Sierra-Leone, 5-8 November, 1984; see also Deidre Wulf, "The Future of Family Planning in Sub-Sahara Africa" in International Family Planning Perspective Vol. 11, Number 1, March 1985. p.6.

12/P.O. Olusanya, "Nigeria: Cultural Barriers to Family Planning Among the Yorubas" in Studies in Family Planning, No.37, 1969.

(9%), douche (3%), and other methods (3%). 13/ Sexual abstinence after delivery averaged about 2 1/2 years. Yorubas believe that a sucking child gets sick if the mother has intercourse because the spermatozoa pollutes and poisons the milk. They also believe that sexual relations that are prematurely resumed soon before the expected interval, according to custom, after delivery are indecent and immoral and may be subject to punishment by the gods or ancestors spirits.

Overall use of family planning in Nigeria from available surveys is very low. The 1981/82 Nigeria Fertility Survey indicated that among married women, 4.8% were using a method of family planning, of which 0.6% were using a modern method. Results from the 1990 Nigeria Demographic and Health Survey did not show much change - 6.0% were using a family planning method, of this, 3.5% were using a modern method of family planning. In 1988, Nigeria adopted an explicit population policy to influence demographic trends. Specific targets relating to fertility, population growth rate, as well as use of contraceptives, were included. Organized family planning programmes will have to be implemented to assist the attainment of the objectives and goals of the national population policy.

(d) Tanzania

Among the Changa of North-Eastern Tanzania, custom does not allow a nursing mother to sleep with her husband. It is believed that the child gets a cold if that happens and the child will not grow strong. 14/ The child is suckled for 2-3 years according to custom. A woman considers it a misfortune if she bears children who are closely spaced. In such cases she is scorned and ridiculed by her neighbours. Other occasions of sexual abstinence were observed among the Changa during mourning of a dead child, dead parent, or wife. The period of abstinence varied depending on who died: a few days after the death of a child; a month after death of a parent, or wife; and for a widow until she had remarried according to the levirate, or returned to her father's home. 15/ It was taboo for a mother and a daughter to be both pregnant in many African societies. Among the Changa of Tanzania, once a son or

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13/Gyorgy T. Ascadi, "Traditional Birth Control Methods in Yoruba land" in Culture, Natality, and Family Planning edited by John F. Marshall and Steven Polgar, Monograph 21, University of North Carolina, Chapel Hill, 1976. p. 134

14/Otto F. Raum "The Changa of North- Eastern Tanzania" in Angela Molnos, Cultural Source Materials for Population Planning in East Africa Vol.3, Beliefs and Practice, Institute of African Studies, University of Nairobi, 1973, p.27.

15/ Ibid p.28.

daughter got married, the mother was expected automatically to stop having more children. 16/

Tanzania has recognized the importance of family planning. In 1990, the Ministry of Health formulated a National Family Planning Programme. This was followed by the adoption of an explicit National Population Policy in early 1992. Contraceptive prevalence in the country as a whole in 1992, was about 6%. There is a move towards organized family planning programmes to improve modern contraceptive use.

(e) Uganda

Studies done by Ntozi and Kabera in Uganda among the Ankole people of Uganda show that about 33% of women ever used traditional methods of contraception while only 10% reported ever having used a modern method. Traditional methods cited included the following: 17/

- drinking of certain herbs; herbs tied in a belt and the belt worn on the body; herbs infused into the body.
- wearing of the umbilical cord of the last born by the mother around the waist, and when she wants to conceive again she removes the umbilical cord.
- performing certain rituals
- inserting certain leaves of plants into the vagina before sexual intercourse.
- prolonged breastfeeding, withdrawal, and abstinence.

In another survey that focused on elders of Ankole, knowledge of traditional methods cited above was confirmed. However, there was not much information on the use of these methods: The study indicated that the population would prefer to use modern methods of contraception after having 4 to 6 children. 18/

16/John C.K. Kabagambe, "Family Planning Concepts: Myths and Realities" in Family Welfare and Development in Africa, Proceedings of the IPPF Africa Regional Conference held from 29 August to 3rd September 1976, p.55.

17/ James P.M. Ntozi and John B. Kabera, "Family Planning in Rural Uganda: Knowledge and Use of Modern and Traditional Methods in Ankole" in Studies in Family Planning, Vol. 22, No.2. March/April 1991.

18/ James P. Ntozi, John B. Kabera, Jackson Mukiza - Gapere, John Ssekamate- Sebuliba and Jovah Kamataeka, Some Aspects of Determinants of Fertility in Ankole, Uganda: Findings of Elders Survey, Makerere University, 1990.

Results of the 1988/89 Uganda Demographic and Health Survey showed that among all women of reproductive age, 5.5% were using a contraceptive method of which 2.7% were using a modern method and 2.9% traditional methods. The traditional methods were : periodic abstinence 2.2%, withdrawal 0.3% and other methods 0.4%.

(f) Zaire

In Zaire, it has been reported that the leaves of the Lutela plant could be boiled and the juice drunk to induce abortion. Furthermore, the juice extracted from the roots of the Dilenge plant could be drunk to cause abortion. 19/ Induced abortion was used when a nursing mother became pregnant. It was a taboo for a nursing mother to be pregnant.

Among the Havu ethnic group in Zaire, Carael has documented the importance attached to child spacing to ensure physical and health development of the existing child. 20/ The next child should not be born until the existing child can eat and walk alone or fetch water. At the age of 3, it was felt that the child had gained enough physical strength. However, there are no well defined taboos, rules and regulations on child spacing apart from continued breast feeding till next pregnancy.

A study in 3 low-income zones in Kinshasa among married women 15-44 years old indicated that 72.8% were using a traditional method of contraception only, 4% were using a modern method only and 3.4% were using both a traditional and modern methods. More women were using withdrawal method (44%), followed by abstinence 31%, and rhythm 19%. 21/

In yet another study in the zone of Kintambo in Kinshasa, 35% of the married women aged 15-49 were using traditional methods of contraception (15.1% abstinence, 11% rhythm, 9% withdrawal, less

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19/John G. Kigondu "Traditional Checks on Fertility" in Family Planning Strategies in the 1980s Rolf Korte, Ricardo Keim, Petra Osinsiki, 1983, GTZ., p. 163.

20/M. Carael "Child Spacing, Ecology and Nutrition in the Kivu Province of Zaire" in H.J. Page and Ron Lesthaeghe eds. Child-spacing in Tropical Africa: Traditions and Change, New York, Academic Press, 1981.

21/ Jane T. Bertrand, W.E. Bertrand, and Miatudila Malonga, "The Use of Traditional and Modern Methods of Fertility Control in Kinshasa, Zaire" in Population Studies Vol. 37, Number 1, March 1983.

than 1% were using a traditional belt believed to prevent pregnancy) and 9% were using a modern method. 22/ The study revealed that the population was especially motivated to avoid pregnancy while the youngest child was less than 25 months old. This was achieved through mostly traditional methods which were available to them.

(g) Zambia

The Planned parenthood Association of Zambia has been involved in working with people in rural areas along the rail lines where villagers still follow traditional practices believed to prevent pregnancy. Some of the women tie herbs around their waist or insert them in the vagina to prevent pregnancy. 23/

Abortion, though not considered a contraceptive method, is used among traditional societies to get rid of unwanted pregnancies. Traditional drugs and herbs continue to be used in performing abortion. In Zambia, it has been noted that some of those seeking abortion approach midwives or traditional healers who usually insert into the cervix cassava and other roots that have been soaked in water and act as dilatory irritant to cause abortion. 24/ After several hours or days, the cassava dilates the cervix and stimulates uterine contractions. The method works sometimes and at other times it fails. Even where the method works, it is followed by excessive bleeding. Traditional healers also provide herbs that are claimed to be abortifacient. These are either eaten or taken as teas. About one fourth of women at the Zambia Teaching Hospital with abortion complications, when an investigation was made, were reported to have induced abortions themselves, generally by inserting objects such as plants, and twigs, in the cervix. However, the more desperate and isolated women, usually the youngest, were reported to drink detergents or gasoline or take overdoses of aspirin, chloroquine and other toxic substances in the hope that these would cause violent contractions to induce abortion. 25/ Although abortion is legal in Zambia, not many women who would need it make requests at health institutions.

22/Jane T. Bertrand et al. "Post-Partum Events and Fertility Control in Kinshasa, Zaire" in Journal of Biosoc. Sci, 22, 1990.

23/ Kondwani Chirambo, "Men Targeted for Family Planning in Zambia", in Network Vol.13 No. 1 August 1992, published by Family Health International, p.17.

24/ Mary Ann Castle, Rosemary Likwa, and Maxine Whittaker, "Observations on Abortion in Zambia", in Studies in Family Planning Vol. 21, No.4 July August 1990, p.233.

25/ Ibid.

In 1989 the Government of Zambia adopted a population policy which, among other things, has objectives of lowering population growth and fertility. The government wants to extend coverage of family planning to all adults. Among the efforts initiated so far include the integration of family planning into the health training curricula of all health personnel; increasing the number of nurses trained in family planning; information, education and communication (IEC) campaigns; population education in schools; programme of family life education has been extended to include provision of family planning in factories. The importance of organized family planning programmes in Zambia is reflected in the 1989 national population policy.

2. Limitations of Traditional Approaches.

Traditional methods of prolonged breastfeeding and abstinence in which there was separation between wife and husband during lactation till 2 or 3 years were 100% effective in child spacing. But under existing circumstances where emphasis among African governments are not only on child spacing, but going beyond to drastically reduce fertility and growth rate, there is need to use more effective modern methods of contraception. Social change through westernization and urbanization have contributed to shortening the periods of abstinence and breastfeeding resulting into shorter birth intervals. In many societies the custom of temporary separation of husband and wife during lactation to ensure abstinence, is no longer observed.

With regard to periodic sexual abstinence, some times referred to as rhythm or natural family planning methods, there is high failure rate of 10 to 30 pregnancies per 100 users in the first year. These methods cannot be used to control pregnancies until the user is able to identify correctly the fertile period when to abstain from sexual intercourse. These methods require up to 14 days per menstrual cycle of sexual abstinence. The user needs several months of practice to interpret symptoms of a fertile period correctly. Vaginal infection, fever or breasfeeding may alter symptoms for a fertile period and lead to inaccurate calculation of fertile period. There is need for accurate record keeping for some of these methods to be used accurately. In addition, these methods call for great commitment of both partners to practice periodic sexual abstinence.

The withdrawal method involves withdrawal of the penis from the vagina before ejaculation. The method has failure rates of 5-25 pregnancies per 100 users in the first year. Strict compliance with all sexual acts is very difficult.

Use of magical methods that use rings, belts, armlets, charms etc. to avoid pregnancies are based on beliefs and in practice do

not work. Native medicines including a variety of herbs, leaves, roots, fruit, juices and concoctions have all been used to prevent pregnancies or to induce pregnancies. There is no hard data on the effectiveness of these methods. There are no standards on doses to be taken. Rushwan has noted that traditional methods of birth control may introduce infection, or even lead to sterility. 26/ Some of these methods have killed women. 27/ Use of various substances to induce abortion are associated with high risk on the health of women: overdoses of aspirin can lead to haemorrhage; while overdoses of chloroquine can have a permanent cardiac and neurological impairment or cause death; detergents and gasoline can permanently cause damage to the oesophagus and gastro intestinal tract. 28/

In view of the Dakar/Ngor Declaration targets for African countries to increase contraceptive prevalence to 20% by the year 2000 and to 40% by 2010 so as to reduce Africa's population growth rates to 2.5% by the year 2000 and 2% in 2010, there must be a departure from the traditional approaches to child spacing/family planning to more effective methods for birth spacing and regulation. Modern contraceptives are the alternative in combination with socio-economic development efforts. Modern contraceptives are reliable and safer to use than traditional methods of birth spacing. Organized family planning programmes would help individuals and couples to have access to modern methods of fertility regulation.

III. ORGANIZED MODERN FAMILY PLANNING PROGRAMMES AS ALTERNATIVES TO TRADITIONAL APPROACHES TO BIRTH SPACING/FAMILY PLANNING

Family planning as an organized programme is relatively new in Africa. Family planning as a programme refers to deliberate efforts by governments to support, both financially and politically, family planning activities undertaken by governments, and by private organizations. Such activities include provision of information, services and supplies that enable individuals and couples to space and or limit births, given a choice of effective

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26/ Hamid Rushwan, " The Impact of Traditional Practices on Family Health Services", in The Non-physician and Family Health in Sub-Saharan Africa edited by Ronald S. Waife and Marianne C. Burkhart, Proceedings of a Conference, published by Pathfinder Fund, 1981.

27/ Elizabeth M. Edmands, Concepts and Issues in Family Planning: Guidelines for Nurses, Midwives, and Other Health Personnel, INTRAH, University of North Carolina, Chapel Hill, 1984, p.3.

28/ Mary Ann Castle, Rosemary Likwa, and Maxine Whttaker, in "Observations on Abortion in Zambia" in Studies in Family Planning, Vol.21, No. 4, July/August, 1990.

and acceptable methods and the means to do so. As noted earlier, organized family planning programmes use modern method which are effective at fertility regulations. However, organized modern family planning programmes are not only concerned with fertility regulation but also with the health aspects of the mother, child and the family as a whole.

It is well known that early family planning programmes in Africa were introduced by international organizations outside the continent who provided considerable funds on family planning in the 1960s and 1970s. These programmes put emphasis on controlling family size and population growth. These were taken from the Western standards without first understanding the social and cultural values of the African people on family size. In Ghana, for example, early family planning posters depicted an ideal family size of 3 children and in another African country a poster depicted an ideal family as one with 2 children - a boy and a girl. 29/ These early family planning programmes did not build on the African child spacing values which emphasized the health aspects of mother and child. Indeed, the health benefits of child spacing were not given adequate emphasis in the early organized family planning programmes. Thus, there was opposition to family planning programmes for a long time. Consequently, it took time for organized family planning programmes to advance significantly. Many African countries viewed these programmes with suspicion. Africans felt that these programmes were imposed on them by outsiders. The control and management of the programmes were in the hands of the donor agencies.

In 1984, as noted earlier, the perceptions among African countries changed in favour of family planning programmes to moderate demographic trends so that demographic growth is compatible with socio-economic development goals. Governments now recognize that reduction of fertility would lessen pressures in providing basic social and economic needs - employment, education, health, etc. Reduction in fertility and population growth would also lessen pressure on natural resources such as land, forests, water etc, on which the majority of the population depend for their survival. Although, initially, most of the governments supported family planning for spacing of children based on health reasons, they later also came to support family planning as a fundamental human right on fertility regulation. Organized family planning enables individuals and couples to have children by choice and not by chance through the use of modern contraceptive methods.

Table 1 shows the demand for contraception for spacing and limiting of births among married women according to estimates by Charles Westoff based on data from DHS surveys in some of the

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29/Florence Abena Dolphyne, The Emancipation of Women: An African Perspective, Ghana University Press, Accra, 1991, pp. 31-32

African countries. There is unmet need for contraction for spacing as well as limiting of births in all the countries. Ghana shows the highest unmet need for spacing of births 26%. Kenya and Egypt have the highest proportions of women with unmet contraceptive need for limiting of births, 15.5% and 15% respectively. If unmarried women including adolescent girls should be included, the unmet contraceptive need for fertility regulation would be much higher. The data in Table 1 supports the need for organized family planning programmes to offer modern contraceptive methods to help individuals and couples to regulate their fertility. The high incidence of abortions among adolescents, married and unmarried women is a further manifestation for the need of modern contraception.

Table 1 Total Demand and its components for currently married women

Countries	Year of Survey	Demand for Contraception			Unmet Need			Current Use		
		Total	For Spacing	For Limiting	Total	For Spacing	For Limiting	Total	For Spacing	For Limiting
Botswana	1988	61.6	38.6	23.0	26.9	19.4	7.4	33.0	17.9	15.1
Burundi	1987	33.8	23.5	10.3	25.1	17.7	7.4	8.7	5.8	2.9
Ghana	1988	48.1	34.2	13.9	35.2	26.2	9.0	12.9	8.0	4.9
Kenya	1989	64.9	31.0	33.9	38.0	22.4	15.5	26.9	8.6	18.3
Liberia	1986	39.3	23.4	15.8	32.8	19.8	13.0	6.4	3.6	2.9
Mali	1987	27.6	21.2	6.4	22.9	17.2	5.7	4.7	4.0	0.7
Uganda	1988/89	32.1	22.0	10.1	27.2	19.9	7.3	4.9	2.1	2.8
Zimbabwe	1988	64.8	37.6	27.2	21.7	10.1	11.6	43.1	27.5	15.6
Egypt	1988	64.8	16.5	48.3	25.2	10.1	15.0	37.8	5.9	31.9
Morocco	1987	60.8	26.4	34.4	22.1	12.5	9.6	35.9	12.7	23.2
Sudan North	1989/90	34.8	22.2	12.6	26.1	17.5	8.5	8.7	4.6	4.1
Tunisia	1988	71.1	24.9	46.2	19.7	10.6	9.1	49.8	13.5	36.3

Note : Total demand includes method failure, current use and unmet need.

Source: Charles F. Westoff and Luis Hernancco Ochoa "The Demand for Family Planning: Highlights from a Comparative Analysis" in Vol.1 of the Proceedings of the Demographic and Health Surveys World Conference, Washington D.C. 5-7 August 1991, IRD/Macro International Inc., Colombia, Maryland, USA.

There is increased documentation on the impact of organized family planning on contraceptive use and on fertility. 30/ Many examples are found in Asian countries where fertility decline occurred mainly due to the adoption of modern contraceptive methods. The same was also true with Latin American countries. Recent trends are becoming evident in many African countries-Tunisia, Egypt, Botswana, Kenya and Zimbabwe are among some of the examples. Implementation of integrated family planning programmes and projects in most African countries is in itself a testimony for the usefulness of organized family planning programmes as alternatives to traditional family planning approaches.

IV INGREDIENTS OF SUCCESSFUL ORGANIZED BIRTH SPACING/FAMILY PLANNING PROGRAMMES

The impact of organized family planning programmes throughout the world varies from country to country. In some countries the results have been impressive within a short period. In others the results have not been encouraging. In some African countries, there is now emerging evidence that organized family planning is showing its impact in increasing contraceptive use and in reducing fertility rates as reflected in recent data on Botswana, Kenya, and Zimbabwe. It is extremely difficult and complex to organize for effective family planning programmes, especially in developing countries confronted with so many socio-economic problems.

Many factors affect the success of organized family planning programmes. These include: the role of strategic planning; family planning programmes being implemented as an integral part of socio-economic development; programmes to address the health needs of all population sub-groups: children, women and, adolescents; government policy, commitment and support to family planning programmes; role of information, education and communication (IEC) to support programmes; involvement of various population segments and communities in various aspects of programmes; involvement of non-governmental organizations (NGOs) and the private sector in programmes; programmes to give special attention to quality services; the role and status of women; programmes to reach the unserved and undeserved population, especially in rural areas; management of programmes. This list is not exhaustive. However, for the purpose of this paper the elements listed above form the basis for the discussion that follows. Some of these were discussed adequately in an earlier publication in 1991 by ECA entitled Guidelines on Improving Delivery of Population and Family Planning

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30/ Robert J. Lapham and George B. Simmons, editors, Organizing for Effective Family Planning Programmes National Academy Press, Washington D.C. 1987.

Programmes in African Countries. In an another ECA publication - Strategies to Improve Contraceptive Use to Influence Demographic Trends in African Countries, 1992, references were also made to some of these factors. Wherever possible, this publication draws on these earlier studies.

1. Application of Strategic Planning.

Lessons from past experience in family planning programmes indicate that there must be change in approaches in which organized family planning programmes are planned and managed at national as well as at every level of any institution involved in the provision and delivery of family planning services. Strategic planning offers a possibility to improve the effectiveness of organized family planning programmes. Strategic planning must deal with long-term goals and strategies of an organization.

What strategic plan should contain and reflect should be related to the mission statement of the organization. The organization broadest statement of purpose; and the general goals to be achieved. 31/ The general goals would then, in the process of strategic planning be refined to specific objectives and targets to be attained at a given point in time. The Strategies needed to attain the objectives and targets have to be specified. Thus financial, material, and human resources requirements should all be conponents of strategic planning. Management of logistics, and the programme as a whole through management information system (MIS) and evaluation on a continuous basis are all important components of strategic planning to be carried out.

In strategic planning the first step should be to fully understand the current situation of the organization through detailed situation analysis of available data on the organization. Such an analysis should examine various factors external and internal which affect positively or negatively organizations' activities. The situation analysis should guide the planning process in making realistic changes wherever possible in the goals, objectives, targets, resources and management of the programmes. Sometimes even the mission statement of the organization may have to be modified.

31/James A. Wolff, Linda J. Suttenfield, Susanna C. Binzen, eds. The Family Planning Managers Handbook Kumarian Press, 1991; James A. Wolff, Robert Cushman, Jr., Florida A. Kweekeh, C. Elizabeth Mc Grory, Susanna C. Binzen, Beyond The Clinic Walls: Case Studies in Community-Based Distribution, Kumarian Press, 1990; Micheal H. Bernhart, Strategic Management of Population Programs, World Bank Policy Research Working Papers, WPS 996, 1992; Thomas W. Merrick, Strategic Planning for the Expansion of Family Planning, Policy Paper Series No.2, The Futures Group, 1993.

2. Family Planning as an Integral Part of Overall Socio-Economic Development and Not Only Aimed at Reduction of Fertility

The Dakar/Ngor Declaration has set specific targets to increase contraceptive prevalence and to reduce population growth rates for the years 2000 and 2010 as mentioned in the introduction. Family planning alone cannot achieve the desired targets. In fact, past experience of family planning programme efforts in Africa proved this. Apparently development efforts alone too, have failed to bear fruit to reduce fertility and population growth. Both family planning programmes and development have an independent effect on influencing demographic trends. However, their combined effect has more impact than their individual sums. Moreover, the emphasis should not only be on reducing fertility but to addressing the overall well being of the population. Family planning programmes should, therefore, be implemented as integral part of overall socio-economic development to improve the quality of life of the people in general.

It was in view of the above that the African governments, as reflected in the Dakar/Ngor Declaration, called for the integration of population policies and programmes in development strategies. These focus on strengthening social sectors with a view of influencing human development and working towards the solution of population problems by setting demographic targets. The goal is to attain sustained economic growth and development. Thus family planning should be integrated into health, education, rural development programmes and projects.

Family planning programmes are now being integrated into employment activities of many organizations in some countries e.g. Kenya. A number of countries eg. Ethiopia, the Gambia, Ghana, Tanzania, and Zambia, are undertaking Integrated Projects (IP) as alternative to providing family planning. The Gambia IP, which initially focused on promotion of family planning integrated with parasite control was later expanded to include other components like environmental sanitation, health and nutrition promotion and women's development activities eg. soap making. Family planning in the Gambia has become more accessible through the IP in the pilot project areas. Moreover, women reached through the project feel that they are now more confident to discuss family planning with their partners. 32/ The IP pilot projects in Ghana have been successful and a conference held in Ghana, 11-13 January 1993, recommended that the achievements of the IP be widely publicized to promote replication of experiences in other areas. 33/

32/JOICFP News, No.226, April 1993, p.4

33/Ibid p.4.

Experience from the family planning activities of Chogoria in Kenya has shown that when family planning was provided separately, it was counter-productive and was received with suspicion and hostility in some communities. When family planning was offered within an integrated programme of health, education and other health services, it became more acceptable. 34/ It is logical therefore, to integrate family planning with health services as the two are directly related to the health of both mothers and children and that most family planning methods need the health personnel and facilities for their administration. Among the factors which have been attributed to the success of the Chogoria family planning programmes in reducing fertility include the complete integration of family planning with other services. 35/ Family planning activities should also be integrated into other activities like education and agriculture extension. In Kenya, the government,through the Ministry of Agriculture,is integrating family planning into the work of agricultural extension workers.In Lesotho,the 1991 to 1996 Fifth Year Plan indicated that the Ministry of Agriculture should introduce population education in its training institute and college and make efforts to motivate farm population on small family norm through its extension workers.

There are problems in the integration of family planning with other health services and with socio-economic activities. But the problems should be reviewed along the lines of how best the goals of integration can be achieved. For organized family planning programmes to assist in achieving integration of its activities with health and socio-economic activities, it must address issues that have bearing on integration and these must include- decision making, responsibilities, management, supervision, attitudes of those involved in service delivery, manpower quality, resources and infrastructure for integration. Where integration may not work it should not be forced just for the sake of integration.

3. Addressing the Health Needs of Children, Women and the Adolescents

Family planning programmes should address the health needs of children, mothers, adolescents and the family as a whole. A planned family is generally a happy family. Nearly all African countries are involved in the implementation of primary health care

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34/Cornelis N. De Boer and Malcolm Mc Neil, "Hospital Outreach Community-Based Health Care: The Case of Chogoria, Kenya" in Soc. Sci Med Vol.28, No.10, Pergamon Press plc, 1989, p.1010.

35/Howard I. Goldberg, Malcom Mc Neil and Alison Spitz, "Contraceptive Use and Fertility Decline in Kenya" in Studies in Family Planning Vol.20, No.1, January/February 1989.

programmes of which maternal and child health care and family planning are integral components.

(a) Addressing the Health Needs of Children

Family planning contributes to the health of children through adequate spacing of births. It is generally known and established that mortality among children are higher where children are closely spaced and among children to women below the age of 20 as well as among children to women above the age of 35 years old. Family planning programmes should therefore promote adequate birth spacing through IEC activities and make available services for practice of family planning.

It is important that family planning and birth spacing programmes be implemented in combination with other child survival activities such as: immunization, oral rehydration for diarrhoeal diseases, and breastfeeding. Similarly, when health workers attend to the women and mothers and children' needs, they should take advantage to discuss the benefits of good child spacing and contraceptive use.

The importance of breast feeding need to be given special importance in the survival strategy of children. Among the advantages of breastfeeding are the following:

- Breastfeeding provides intimate relationship between the mother and the child;
- It provides all the nutrients a baby needs for the initial months of its life;
- It reduces the incidence of diarrhoeal and other diseases among breast fed infants;
- It prevents malnutrition caused by dilution of bottle feeds;
- Breastfed babies have lower risks of deaths than bottlefed babies;
- Breast milk is not contaminated unlike bottle feeds;
- Breastfeeding provides immunities during the first few months of the baby's life;
- Breastfeeding provides about 98% protection from pregnancy during the first 6 months postpartum if the mother is "fully" or nearly fully breastfeeding and has not experienced vaginal bleeding after the 56th day

postpartum according to the 1988 Bellagio Conference in Italy. 36/

The Bellagio Conference gave breast feeding the importance it deserves when it concluded that: 37/

- Breastfeeding should be regarded as a potential family planning method in all maternal and child health programmes in developing and developed countries.

- Pospartum women should be offered a choice of using breastfeeding as a means of family planning, either to achieve optimal birth spacing of at least 2 years, or as a way of delaying the introduction of other contraceptives.

Declining lengths of breastfeeding in most developing countries endangers infant health and would lead to higher births unless contraception is used. Where beastfeeding cannot be prolonged as a contraceptive method, other contraceptive methods should be used to prevent unplanned births.

(b) Addressing the Health Needs of Women

Family planning programmes should address the needs of women as individuals as well as women as mothers without any discrimination. In some cases, mothers, especially unmarried women are not provided with family planning services. Women in Africa face a 1 in 21 chances of dying from pregnancy related causes in their life time. This compares with a 1 in 9,850 chances for women in Northern Europe. 38/ Pregnancy related mortality are higher among women below the age of 20, older women above the age of 35 and among higher parity women, and women with short birth intervals.

Worldwide, estimates show that there are between 36 to 53 million induced abortions and that as many as 200,000 women die each year due to unsafe abortion. 39/ Some available data show

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36/Family Health International, Lancet 11 (8621): 1204-1205, 1988

37/ Ibid

38/Ann Starrs, Preventing the Tragedy of Maternal Deaths: A Report on the International Safe Motherhood Conference, Nairobi, Kenya, 1987.

39/Creating Common Ground: Womens' Perspectives on the Selection and Introduction of Fertility Regulation Technologies, Report of a Meeting Between Womens' Health Advocates and Scientists, Organized

the following proportions of maternal deaths due to illegal or clandestine abortions in some African countries in the mid 1980s: Ethiopia 54% (refers to Addis Ababa); Zimbabwe 28%; Nigeria 25%; Tanzania 21%.40/ It has been noted that most women seeking abortion in developing countries are married, or living in stable unions, and have several children. 41/ Use of family planning and contraception to prevent unwanted pregnancies can reduce maternal death and improve womens' reproductive health. Deborah Maine et al., have estimated that satisfying the unmet needs for family planning among married women alone could reduce maternal deaths in Africa by 17%.42/ Although some contraceptives have some side effects on womens' health, research show that womens' health risks related to pregnancy are much higher than risks associated with contraceptive use.43/

In view of sexually transmitted diseases (STDs) and the increasing pandemic of the human immunodeficiency virus (HIV) causing AIDS, family planning programmes should also provide educational information on prevention of the disease for which there is as yet no cure. Promotion of the use of condoms for both as a contraceptive means of family planning as well as a means to prevent transmission of STDs including AIDS should be emphasized.

(c) Addressing the Health Needs of Adolescents

All African countries are experiencing an increasing problen of unwanted pregnancies among adolescents. These have far reaching social, economic and health consequences on the adolescents and societies concerned. In Nigeria, it has been noted that 50% of maternal deaths are due to criminal abortions especially among adolescents.44/ In Rwanda, a study among young married women

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by WHO and the International Womens' Health Coalition, 1991.

40/ Jodi L. Jacobson, "The Global Politics of Abortion", Worldwatch paper 97, July 1990, p.41.

41/ WHO, "Papers in Human Reproduction Research, No.21, 1992.

42/ Deborah Maine et al., "Prevention of Maternal Mortality in Developing Countries", paper presented at the Safe Motherhood Conference, in Nairobi, Kenya, 10-13 February, 1987.

43/ Lettenmaier, Cheryl, and others, Mothers' Lives Matter: Maternal Health in the Community, Population Reports. Series L, No.7, September 1988; WHO, The Health of Youth. A42/Technical discussion/2 Geneva, 1989

44/ African Health, Vol. 14, No.3 March 1992; IPPF Open File of May 1992.

indicated that 11% of the births were unwanted in rural areas compared to 22% in urban areas.45/ In the case of Kenya, many of the unmarried youth start sexual relations at ages 13 and 14, according Ajayi et al, and that more than 50% of those aged between 12 and 19 are sexually active.46/ In 1987 over 8000 primary and secondary school girls dropped out of school due to pregnancy in Kenya.47/ In Senegal, more than 12% of teenage students have abortions each year.48/ These abortions are performed illegally under unhygienic conditions.

The above examples illustrate the general problems of unwanted adolescents fertility in most African countries. When adolescents are expelled from school due to pregnancy, that is the end of their educational opportunity. Curtailment of their education means the end of their potential possibility of meaningful future employment. For fear of being expelled from school, adolescent girls resort to clandestine abortions. Most of them end in serious complications as well as death. Even without abortions, pregnancies among adolescents have higher chances of maternal deaths. Adolescents have little or no knowledge of contraceptive use to prevent unwanted pregnancies. Moreover, they have no access to family planning services. They are denied family planning services because they are adolescents.

It is unacceptable for governments and family planning activities to ignore the reproductive health needs of adolescents by denying this group family planning needs in view of awareness of the socio-economic and health consequences of adolescents fertility. It is paradoxical that governments are promoting policies to increase contraceptive use in order to moderate demographic trends and at the same time deny adolescents access to family planning services. Kenya is an example of this. African governments need to follow the example of governments like that of

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45/ Peter Weis and Ulrike Muller, "Unwanted Pregnancies in Unmarried Young Women in Rwanda" in Family Planning for Life: Experience and Challenges for the 1990s, edited by Bouzidi and Korte, IPPF/GTZ 1990 (Papers presented at the Conference on Management of Family Planning Programmes held in Zimbabwe, 1-7 October 1989).

46/ Ajayi et al. "Adolescent Sexuality and Fertility in Kenya" in Studies in Family Planning Vol. 22, No.4, 1991.

47/ Kenya Ministry of Health, Division of Family Health and GTZ Support Unit, Schoolgirl Pregnancy in Kenya: Report of a Study of Discontinuation Rates Associated Factors, March 1988.

48/ URTNA Newsletter on Family Health and Communication No. 19, July 1992, p.1

Burkina Faso whose policy change in recent years allow contraceptive to be made available to unmarried adolescents.

Organized family planning programmes by governments and private organizations are not complete if they continue to ignore the reproductive need of adolescents. The following need to be given priority in dealing with family planning services for adolescents:

- Governments' policies on family planning should include provision of family planning services to unmarried adolescents. Governments should encourage delay in marriage and the start of childbearing among adolescents. Government policies to expel pregnant students from school only work as an obstacle to improving the status of women; such policies need to be changed.

- Problems of sexually transmitted diseases including AIDS among the adolescents, most of whom are sexually active, should be addressed through family planning methods such as the condom.

- Long term problem of population, sustained economic growth and sustainable development cannot be resolved when problems related to reproductive health of adolescents are completely ignored. There is need for governments and private organizations to ensure that adolescents (both boys and girls) receive adequate education, including population education, family life education, sex education and suitable family planning information and services.

- Adolescents are a special group for which special services including counselling as well as contraceptive supplies need to be made available as part of organized family planning programmes. Pilot programmes in Ethiopia and Kenya on family planning needs for the youth confirm this.49/ In Uganda, YWCA has started a family planning and health promotion project in Kampala targeted at the youth. The YWCA of Ghana also has family planning programmes for the youth.

4 Government Policy and Commitment to Support Family Planning Programmes

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49/ IPPF Youth Programme Review: Family Guidance Association of Ethiopia (Review Done in May 1992); and Youth Programme Review: Family Planning Association of Kenya (Review carried out in August 1991), Regional Office Nairobi, Kenya and Programme Department, London, UK.

Organized family planning programmes to be effective need to be supported by government policy and commitment. Policies should clearly support the provision of family planning services to all who need them. Policies should be consistent with desired socio-economic goals. In 1984 African governments adopted the KPA which supported family planning programmes. In 1992, the same governments reaffirmed the continued validity for implementation of the KPA. The adoption of the Dakar/Ngor Declaration with specific targets on contraceptive prevalence levels and population growth rates to be attained by African governments by the year 2000 and 2010, indicates the commitment of African governments to family planning. However, they have to translate this commitment into concrete terms by supporting family planning programmes and activities.

Governments can show that commitment in many ways including the following: (a) The governments should, in their socio-economic development plans emphasize the use of modern family planning methods, and take the first initiative to ensure that they provide family planning services in all health institutions and to all who need them. Governments should also encourage local leadership to be involved in family planning activities.In Kenya,at grassroot level, the government encourages local chiefs to include family planning issues when they hold meetings with the people.(b) Governments should encourage private organizations to be involved in the provision of family planning services. (c) Governments need to develop the institutional mechanisms to co-ordinate the activities of all involved in the provision of family planning services. (d) Governments must provide financial support to family planning programmes. (f) Governments should provide the necessary support to IEC programmes that aim at educating the population on the benefits of family planning and small family size. To this effect, religious and local leaders should be involved in supporting government policies including those related to family planning programmes. (g) Governments should enact relevant legislation supporting the promotion and implementation of population and family planning programmes. At the same time, existing laws which act as obstacles to the implementation of family planning programmes should be repealed. (h) Governments should also strengthen social sectors like health and education, which would facilitate the implementation of effective family planning programmes.

5. Appropriate Information, Education and Communication (IEC) to Support Programmes

The importance of appropriate and strong information, education and communication to support family planning programmes was stressed in the 1984 KPA and the 1992 Dakar/Ngor Declaration on Population, Family and Sustainable Development. The various aspects of IEC programmes should address the following:

- IEC programmes should cover all target groups - men, women, adolescents, policymakers, planners, people the grass roots, communities, local leaders and religious leaders.

- IEC programmes should focus on changing attitudes of the population to accept the health, socio-economic and demographic benefits of small family size. Thus, those who are influential in making decisions on family size in society (husbands, uncles, mother-in-laws etc.) should be among the target groups of IEC message on family size.

- Where governments have set a minimum legal age at marriage, and where cultural practices do not conform to that, it is essential for governments to initiate action to educate the population on the disadvantages of early parenthood.

- It is important that IEC messages are culturally accepted. This can be achieved by involving local leaders and communities in designing IEC messages as well as making necessary pilot tests on the messages before using them on a large scale. The messages should be in languages that could be easily understood by the target groups. For example, youth drama groups in Ethiopia have been touring the country bringing messages on family life eduction to youth and adults. This has been found to be effective.50/ In Kenya, the Family Planning Private Sector has successfully used folk media to promote and disseminate family health, family planning, nutrition, environmental health messages. The approach used entertainment in the form of: poetry and verse speaking; story telling; sayings and idioms; drama; skits and role play; song and dance; choral music; and pop songs.51/

- IEC messages should cover all available methods of family planning. Advantages, disadvantages as well as side effects of each method should be clearly explained to users. IEC should dispel rumours that are not correct regarding side effects of various methods. Consequently, those staff involved in delivery of family planning services should be properly trained to advise users on contraceptives side effects of each contraceptive method.

- Where there is significant opposition from religious leaders to family planning, IEC messages need to be developed with

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50/ IPPF, Youth Programme Review: Family Guidance Association of Ethiopia, Africa Regional Office, Nairobi, Kenya, and Programme Department, London, UK. n.d.

51/ Family Planning Private Sector (FPPS), The Use of Folk Media for Community Motivation: A Process and Experience in Promotion of Family Planning and Health, 1988

care to resolve the problems. These religious leaders together with health leaders should be involved in designing the messages. In the Gambia, for example, sensitization of the people through the leaders were undertaken to convince them that family planning activities were not against Islam by making reference to specific verses from the Koran which do not contradict the welfare of the family.

- IEC messages should encourage exclusive breastfeeding without supplementary feeds at least for the first 6 months after delivery wherever possible. Proper information, education, and advice need to be provided on contraceptive use when breastfeeding is relaxed or stopped completely. Relevant advice on prenatal health care for the mother and child should be provided to mothers.

- Family life and sex education related to responsible parenthood should be provided in schools. The dangers to the health of adolescents and socio-economic consequences regarding early sexual activity should be explained to adolescents. Similarly, programmes should be developed to reach out of school adolescents. Contraceptive and counselling should be made available to adolescents to reduce abortion related problems. In Botswana, as an example, there are programmes providing family life education to school children to motivate them to assume responsibility for their choices and actions.

- All possible channels of communication and information dissemination should be used - radio, television, video, news papers, seminars, workshops, conferences etc. Video, television and film shows to promote family planning have been used in some countries including Congo, Ghana, Kenya, Mali, Zaire, Zimbabwe. Some of the countries which have regular programmes scheduled to educate the population on family planning include Zimbabwe and Tunisia. Other countries using the radio to spread information on family planning include: Burkina Faso, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Mauritius, Nigeria, Sierra Leone, Swaziland, Zambia. In this connection, it is worth mentioning that the Union of National Radio and Television Organization of Africa (URTNA) is involved in helping African broadcasters to develop effective family planning and health related broadcast programmes. Programmes can take various forms - interviews, music, drama, news item, tales, commentary etc. Since these mass media are either unavailable or not readily available in rural areas, special programmes emphasizing the use of educating communities through local leaders-chiefs, village headmen, religious leaders as agents of change in the adoption and delivery of population and family planning programmes must be given special attention. In Botswana, again as an example, seminars and workshops have been used on family life education

for teachers, parents, health workers, parliamentarians, chiefs and senior civil servants. Folk media should be encouraged as much as possible in rural areas and communities.

- Focus group discussions and one to one counselling should be encouraged as these have been proved to be more effective than mass media approaches in changing attitudes.

- Libraries, documentation centres and family planning organizations should improve the collection by making available printed information on family planning to all interested in such information.

- Conservative health personnel reluctant to deliver family planning programmes in existing health systems need to be educated and convinced through appropriate IEC messages that family planning is an important service which would attract women to MCH centres.

- IEC programmes should give special attention to dispel rumours and misconceptions which act as obstacles to the adoption of family planning by many people. The FPPS of Kenya in 1992 published a booklet "Understanding Family Planning Facts and Misconceptions" as part of its efforts to educate people on false rumours and misconceptions regarding family planning.

- There should be a continuous assessment of how IEC messages are received by users to evaluate their effectiveness and make necessary modifications. To this effect, all those involved in designing of IEC programmes and messages should be well trained.

6. Involving Men, Women, Youth, and Communities

Family planning programmes concern men, women, youth and communities. Each of these groups should therefore be involved in various aspects of family planning programmes to ensure that their needs are taken into account.

(a) Involving Men

Since the 1980s, family planning programmes in Africa started to involve men. Benin, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Mauritius, Morocco, Nigeria, Sierra Leone, Swaziland, Togo, Zambia, and Zimbabwe have involved men in family planning programmes. Many other countries need to take concrete action on male involvement in family planning.

As part of their involvement, men should increase their knowledge and understanding of family planning, population issues and their impact on the health of children, mothers and communities

as a whole. Furthermore, they should be made to understand that family planning is the responsibility of both men and women, youth and the communities. Information on family planning collected from men through an interview of residents in Ouagadougou, Burkina Faso, in 1986 showed that 80% of the men wanted more information on family planning and 76% said they wanted the information for their wives. Some men in Burkina Faso, as in most African countries, link use of condoms to the prevention of sexually transmitted diseases outside marriage rather than fertility regulation within marriage.52/

It is essential that reaching men should be part of family planning programme strategy. Unfortunately, men cannot be reached through the health system regarding family planning. Therefore, there is need to make effort to reach them elsewhere like at place of work or through clubs. For the sake of illustration, references are made to cases of male involvement in some countries.

Male involvement in family planning in Ghana started in 1980 through a project called Male Motivation and Responsible Parenthood which used three channels: (a) Daddies Clubs at Pretsea Oil Palm Plantation Workers and at Tafo Cocoa Research Institute of Ghana. During weekly meetings of Club members, the staff of the Planned Parenthood Association of Ghana (PPAG) and other resource persons arrange discussions on responsible parenthood, film shows and lectures. (b) National Vocational Training Institute with a number of centres, organize lectures and film shows for trainees on responsible parenthood. Contraceptives are available through volunteers who act as agents of various communities. (c) Industrial workers - for which the PPAG arranges lectures for organized groups on responsible parenthood. In some parts of Ghana, husbands and wives with ten or more children are traditionally given honours. It is essential, therefore, for IEC programmes to change the attitudes of both men and women towards favouring large families to favouring small family size. Men should not only be involved in motivation but all aspects of formulating and implementing family planning and population programmes.

The Planned Parenthood Association of Zambia (PPAZ) has since 1987, been involved in making men to be interested and to take an active part in family planning programmes. PPAZ initiated motivational campaigns for industrial employees targeted at men. The Association encourages companies to include family planning services in the clinics at work places. The Association has also been invited at times by the labour and social security ministry to give talks at union meetings. Furthermore, PPAZ has sponsored male

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52/ Therese MC Ginn, Azara Bamba and Moise Balma, "Male Knowledge and Attitudes Regarding Family Planning in Burkina Faso" in International Family Planning Perspectives, Vol. 15, Number 3, September 1989.

counselling along the rail lines from Ndola, Kitwe and Chingola in the Copperbelt to urban areas in the southern region of Zambia. The result of the PPAZ campaign has been the incorporation of family planning services in the company clinics by companies along the rail line. PPAZ promotes all methods of family planning including the pill, condoms, vasectomy, female sterilization and diaphragm.53/

In Zimbabwe, a three year national male motivation project was undertaken at the end of the 1980s to (a) increase knowledge and use of family planning methods among the males of reproductive age; (b) improve men's attitudes towards family planning; and (c) to promote joint family planning decision making between men and women.

The DHS data has clearly shown lack of communication between wives and husbands on family planning issues. The various surveys revealed that among the married women knowing a contraceptive method, the proportion of women who never discussed family planning issues with husbands were as follows: Liberia 65%, Togo 63%, Uganda 60%, Ghana 58%, Burundi 40%, Kenya 34%, Botswana 29%. This is one area where IEC could assist to encourage open discussion on family planning among couples.

(b) Involving Women

Women's needs in family planning and population programmes have not been adequately taken into account in formulating, and implementing these programmes because women themselves have not been involved in designing the programmes. It was in relation to this that the 42nd World health Assembly in 1989 adopted resolutions WHA 42.42 and WHA 42.2 which called for actions to enhance women's leadership and participation in family planning and MCH activities.

Women's full involvement and participation in family planning requires governments' leadership to make the necessary guidelines and directives in all relevant socio-economic development sectors where women's concerns should be taken into account. In addition, governments should review their legislation which discriminate against women and modify it accordingly or enact legislation to enhance the role and status of women so that they can meaningfully participate in developing their countries rather than confine their activities to child bearing and food production. In Nigeria, for example, the Nigeria Population Policy makes provision that "all employers of labour shall actively promote family planning as a labour code and voluntary social contracts".

53/ Kondwani Chirambo, "Men Targeted for Family Planning in Zambia" in Network Vol. 13 No.1 August 1992, published by Family Health International.

It is necessary that women's organizations, wherever they exist should be used as a means of encouraging women to participate in various activities eg. population and family planning programmes. In some African countries, eg. Kenya and Tanzania, women's organizations are involved in providing information on family planning methods. Where women's organizations do not exist, there is need to establish them.

(c) Involving the Youth

The KPA (1984), the ICP (1984), Sierra Leone Declaration by the Conference on Reproductive Management in Sub-Saharan Africa in 1984, the All-African Parliamentary Conference on Population and Development Declaration in 1986, the International Conference on Better Health for women and Children through Family Planning in 1987, the Dakar/Ngor Declaration in 1992, all recognized the need for programmes to address health and family planning needs of the adolescents (youth). It is reiterated here as was emphasized in the above documents that family planning services and information should be made available to these young people to enable them prepare for responsible parenthood. Withholding services and information makes the problems of unwanted pregnancies, illegal abortion, and infant and maternal deaths worse. Family life education, reproductive health information and family planning as well as population education should be part of curriculum in schools and vocational training centres; and similar programmes should be developed for out of school youth. Wherever possible, the youth should be involved in designing, implementation and evaluation of programmes that affect their lives. In Senegal, a pilot project involving adolescents with regard to family planning activities was indicated to have been successful.54/

The rights of individuals and couples to information and family planning services should also be respected with regard to adolescents. Regulations that do not permit pregnant school girls from continuing with their education even after delivery should be revised as such regulations impair permanently the educational and potential opportunities for employment for these young people. Since adolescents find it difficult to obtain family planning and reproductive health services, it is suggested that mechanisms should be made within existing health systems so that adolescents can freely seek and obtain the services without fear and discrimination.

(d) Community Involvement

The involvement of communities in population and family planning programmes is important. Community participation should extend to all aspects of programmes - assessing needs, making

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54/ IPPF Open File of July 1992

decisions on programmes, formulation, evaluation, financing as well as in sharing of benefits. Community participation enhances the chances of programmes reflecting the needs of the communities; it fosters self confidence and self-reliance; it also ensures that programmes will be supported by the communities concerned. Indeed, results from operations research have emphasized the importance of community participation in planning, implementation, and evaluation of programmes. Acceptance by the community that the programme is geared to respond to their needs is of paramount importance; without this, the programme would be faced with problems from the outset.55/

Community participation in programmes is ensured if the programmes objectives are within the context of improving the lives of the people in the community. For example, family planning programmes should be introduced with the objective of improving the health of mothers and children as well as the family as a whole in connection with other social needs eg. education. To encourage community participation in programme, there is need for government policy to address that issue and also ensure that mechanisms are established for community representation at local government level through which community participation will be expressed to programme staff.

Within the communities, it is important to sensitize the various leadership - political as well as religious, regarding the programmes' objectives, implementation, and benefits to the community. In the Gambia, a largely moslem country, sensitization campaigns among the people through their leaders were undertaken to convince them that family planning programmes were not against Islam. This was done by making reference to specific verses from the Koran which do not contradict the welfare of the family. The Chogoria health and family planning programme referred to earlier has demonstrated the importance of community involvement in delivery of services. The Community Health Department (CHD) was established in 1970 to strengthen delivery of services through a network of outreach to various delivery points. Area Health Committees (AHC) were then established in all service delivery areas to help with identification of needs and implementation of programmes.

In Ghana, there has been considerable community participation in the implementation of the Integrated Family Planning, Nutrition and Parasite Control Project and the Integrated Family Planning Services. The Communities provided labour, premises and in some

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55/Allan Rosenfield, M.D.; Regina Mc Namara, Dr. PHD, Community-Oriented Health, Nutrition and Family Planning Services: Overview and Lessons From Operations Research, Working paper 1, October 1985, Centre for Population and Family Planning Health, Columbia University, New York.

cases funding to start some of the projects.56/ Similar results were observed at the Integrated Project on Family Planning, Nutrition and Parasite Control in Tanzania at the Tanganyika Sugar Plantation Company (where family acceptance rose from 27% in 1984 to 64% in 1988) and at Masama rural area (where family planning acceptance rose from 9% in 1984 to 47% in 1988).57/ In Zambia it has been indicated that through community participation and involvement, the Integrated programme on Family Planning with Nutrition and Parasite Control contributed to increasing knowledge on family planning in the communities and in changing attitudes towards acceptance of family planning. Furthermore, these programmes helped to encourage husbands and wives to discuss family planning issues regarding family size. 58/ In many African countries community-based distribution programmes are being pursued in delivery of family planning services which involve communities.

7. Involvement of the Private Sector and Non-Governmental Organizations (NGOs)

The Dakar/Ngor Declaration has emphasized the involvement of the private sector and non-governmental organizations in promoting community participation in programme planning, implementation and financing. The Declaration also called on the private sector and NGOs to enhance collaboration and coordination with multilateral and bilateral organizations, and other organizations and government agencies.

The private sector and NGOs will have to play a greater role in assisting governments achieve the contraceptive prevalence rates and population growth rates set in the Dakar/Ngor Declaration. Family planning associations have to expand their family planning activities, and improve the quality of services to assist in implementation of the Dakar/Ngor Declaration. Private sector activities in social marketing to enhance availability of contraceptives need to be encouraged for certain contraceptives like pills and condoms.

Governments should encourage the private sector to provide family planning servies at work places. Employment based family planning programmes benefit women who must work to stay on the job;

56/ Annual Report of the Planned Parenthood Association of Ghana, 1991.

57/ The Proceedings of the Second Pan African Conference on Integrated Family Planning, Nutrition and Parasite Control Project, held in Lusaka, Zambia, 7-13 March 1989, organized jointly by UNFPA, IPPF, and JOICFP, pp. 35-36.

58/ Ibid. p.54

it also helps men and women gain access to family planning. It benefits the employer as healthier workers are more productive. Moreover, fewer pregnancies mean less maternity leave benefits, less expenses on education, housing and general health care allowances the business would be expected to provide to its employees.

In Kenya, employment based family planning programmes have been provided at various employment organizations since 1984. The Family Planning Private Sector (FPPS) project has assisted more than 60 organizations in introducing family planning servies at their place of work. These include large companies and plantations, parastatals, NGOs, private maternity homes and self help community projects. Some of these companies have done very well, for example, the Sulmac Flower Company. Acceptance and increased use of family planning at Sulmac Clinic (Sulamc Flower Company is in Naivasha Town some 90 kilometres north of Nairobi) is due largely to 59/: (a) the company's policy and (b) the IEC activities. The policy demands that all new employees be counselled about family planning and preventive services before being issued an employee number. Moreover, at every contact with a patient at the clinic, the physician or nurse discusses with each patient, his or her current contraceptive status. In 1986, clients at the clinic were reluctant to discuss contraception with clinic staff or with each other. However, during 1987-1988, IEC materials, group discussions, community leader involvement activities and folk media activities were intensified. This led to the present open and relaxed environment regarding discussion of family planning. The overall results showed a 700% increase in contraceptive distribution between 1986 and 1992. Contraceptive prevalence rate was high, for example, among women employees with proven fertility employed in the carnation grading hall, 96% were using contraception. There was an increasing number interested in surgical contraception, 12% in 1992, while 50% intended to use it in the future.

8. Programmes to Give Special Attention to Quality of Services

The quality of family planning services is of paramount importance to the success of programmes aimed at improving acceptance and the continued use of family planning methods. Clients need quality services. There is need to provide clients with adequate information on advantages and disadvantages of each family planning method. A study in Mexico showed a strong relationship between receipt of accurate information on methods, including possible side effects, continued use, and the

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59/ Melinda Wilson: "Family Planning in the Private Sector Success at Sulmac Clinic: A Case Study", FPPS, Kenya, May 1992.

clients'ability to resist rumours about the methods.60/ In Zimbabwe, Stamps observed at one time regarding the use of "depoprogestrone epidemic", that women were given a dose of the long-acting contraceptive without sufficient information to enable them make a choice. Moreover, the side effects were not clearly explained.61/ Programmes should ensure that counselling and follow-up on the use of family planning methods are provided. There should be referral services for complications and their management. In the Gambia and Niger, it has been indicated that counselling about side effects improves the continued use of contraceptive methods. 62/

The availability of a broad mix of family planning methods is an important indicator of the quality of services to enhance the choice of an appropriate method. For instance, sterilization would not be appropriate for those who want to space births but appropriate for those who want no more children. Clients may have to try several methods before finding a method that is considered suitable and convenient. In some cases, however, the method mix may have to be kept to a reasonably manageable number in order to avoid confusing clients. The availability of the method mix should be continuous so that clients do not lose confidence. Adequate skills and management capability of those providing family planning is an essential aspect of the quality of services. In particular, it is important that personnel providing services be adequately trained and retrained. A situation analysis of the Nairobi City Commission's 46 clinics offering family planning services found substantial problems related to training and supervision - only 15% of the nurses who had initial family planning training had been provided with refresher training; about half of the clinic staff had no external supervision.63/

Clients at family planning or health centres should be treated with respect, feel welcome; and there should be confidentiality.

60/ A.B. Keller, "Patient Attrition in Five Mexico City Family Planning Clinics" in J.M. Stycos, ed., Clinics, Contraception and Communications 1973, New York, Meredith Corp.

61/ Timothy Stamps, "Six Imperatives for the Success in Community-Based Family Planning Services in Africa : The Programme Managers' Perspectives edited by Bouzidi and Fisher, IPPF and GTZ, (Proceedings of a Workshop, held in Zimbabwe, 2-6 September 1991).

62/ Network Vol. 12, No.2, 1991, by Family Health International.

63/ A Family Planning Situation Analysis of the Nairobi City Commission Clinics. Conducted by the Nairobi City Commission, the Population Council Africa OR/TA Projet and the Pathfinder Fund, December 1991.

There should be adequate time to attend to the problems of individual clients. Too long waiting time should be avoided. To avoid boredom while waiting for services, programmes may be developed, e.g watching video on family planning or attending lectures on family planning. Services provided should be comprehensive as most clients may not afford to visit family planning or health centres frequently.

9. Improved Role and Status of Women

Improved role and status of women is important in improving the acceptance of family planning, and, in the final analysis, to the reduction of fertility, and population growth. Furthermore, improved status of women contributes to improving their health and that of children and the entire family. Education and employment are indicators for improved status of women.

Women who are educated up to secondary level and beyound are more likely to accept family planning than those with less than secondary education. Improved women's education increases knowledge and practice of family planning. It also enables women get better employment opportunities outside the home.

Employment of women per se may not, especially in Africa, facilitate adoption of family planning. Here the type of employment is more important. For example, it is clear that women's employment in traditional and agricultural sectors in Africa does not have much impact on the acceptance and use of family planning. However, employment outside the home and out side the agriculture sector provides an environment for the adoption of family planning.

In developed countries, eg. Denmark, Japan and Sweden, only 1% of the women marry before the age of 20 while in Africa the majority marry before the age of 20. In developed countries women generally complete secondary education while a significant portion complete University or college education. A study by the Population Crisis Committee confirmed that age of marriage, contraceptive use and total fertility were closely linked with women's educational attainment and with paid employment in the modern sector.64/ The study cites examples of Canada and Finland where family planning is practised by most women, as having at least 50% of all adult women in the formal paid labour force and at least 15% of them are in the professional or managerial positions.

Data on Tunisia also confirm the importance of improved status of women in relation to use of family planning. Among married women

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64/ Population Crisis Briefing Paper No.20, "Community Rankings of the Status of Women: Poor, Powerless and Pregnant" June 1988.

with secondary education or over, 68% were using family planning compared with 36% for illiterate women in 1988. In another study in Tunisia, it was revealed that women with jobs have on average 2 children while those without jobs have more than 4 children.65/ However, recent research shows that even in areas with low socio-economic conditions, provision of family planning, education and health services can increase use of family planning as demonstrated by Kerala State in India, Sri Lanka and Bangladesh.

Apart from improving the status of women especially in education, employment and health, women should be involved in planning and management of programmes that affect their reproductive health. It is also important that family planning activities are integrated into other activities of concern to women for example, home economics, agricultural extension services, environmental problems etc.

10. Programmes to Reach the Majority of the Unserved Population, Especially those in Rural Areas.

As seen earlier, there is considerable need for family planning services to space or limit the number of children as shown from DHS data. Unfortunately, problems of access to and availability of services are a hinderance to use of modern family planning methods. DHS data revealed that many women who were not pregnant but sexually active were not using any contraceptive method and yet they were aware of the dangers associated with frequent pregnancies. The proportions of these indicating problems of access to and availability of contraceptive methods and supplies as the main reason for non-use of contraception were as follows: Kenya 12%, Liberia 11%, Uganda 9% and Zimbabwe 18%.66/

Those greatly affected by problems of accessibility and availability of family planning services are those in rural areas, the adolescents and those living in slum areas. There is need to make modern methods of family planning available at a free or affordable prices to the rural populations, especially as they are the majority. In countries like Egypt, Tunisia, and Zimbabwe, there is clear evidence that availability of modern contraceptive methods have had positive impact in increasing contraceptive use even among women with no education. Among the strategies that can contribute to the use of family planning, especially in rural areas, should include: use of community-based distribution (CBD)

65/ IDRC Reports, Vol.16, No.3, July 1987; IPPF Open File of 11 September 1987, p.18.

66/ United Nations Economic Commission for Africa, Statistical Compendium on Contraceptive Prevalence and Practice in African Countries, 1990.

systems and provision of family planning services in all health centres in the rural areas.

Delivery of family planning services through CBD system have been found to be culturally acceptable in African countries. These are being implemented in Gambia, Ghana, Kenya, Nigeria, Rwanda, Senegal, Sierra-Leone, Sudan, Swaziland, Tanzania, Zaire, Zambia, and Zimbabwe. For illustrative purposes, the Kenyan CBD is described briefly below.

Lewis, Keyonzo and Mott in their paper on CBD outlined the activities of the Kenya CBD.67/ These activities started in 1983 mainly through NGOs, church affiliated organizations, women's groups, private clinics, and some government clinics. There were more than 10,000 CBD agents in 37 of the 41 districts in Kenya in 1992. Each CBD project trains community members who work within their own communities by visiting potential clients at home, receiving clients in their own homes or meeting clients at community gathering. Clients are provided with pills, condoms, and foaming tablets by CBD workers. There is high level of community involvement in the Kenyan CBD. Most CBDs have support of community leaders and encourage the formation of village health communities prior to initiation of training and provision of services. In nearly all cases, the community suggests candidates for CBD training. This has enabled co-operation from the communities and minimized resistance to projects. Problems of several brands on CBD workers and logistics of stocks were observed.

In Mali where training was provided to traditional birth attendants, midwives, and "Animateurs" to provide information on birth spacing and modern contraception, the results were beyond initial expectation and led to national policy change on service delivery to include non-medical personnel, and to extend the project to 2 other areas.68/ An example from outside, Khartoum, in Sudan showed that contraceptive use rose from 11% in 1980 to 34% in 1987 when village midwives provided family planning services.69/ A CBD project in Bas Zaire showed that use of modern contraceptive increases significantly if the methods are more readily available and accessible to the population, and that

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67/ Gary L. Lewis, Nelson A. Keyonzo and Polly Mott, "Community-Based Family Planning Services: Insights from the Kenyan Experience" paper presented at the Population Association of America Annual meeting held in Colorado, Denver, 28 April to 2 May 1992.

68/ USAID, Population Assistance to Sub-Saharan Africa: Program Accomplishments and Challenges in the 1990s, Washington D.C., 1991, p.13.

69/ Ibid.

women abandon traditional methods in favour of modern contraceptive methods.70/

The above illustrations show that the rural undeserved population could be served with family planning services at relatively lower costs through CBD delivery services. However, all other channels that can reach the rural areas in delivery of family planning services should be explored and used, eg. the social marketing.

11. Programme Management

As noted earlier, management of programmes in relation to strategic planning should be ensured as it is an important component of organized family planning programmes. Effective management makes maximum use of available human and material resources to realize the objectives of an organization. There are a number of aspects that contribute to effective management. Some of these are referred to below.

There should be good and adequate management information system to help management - client records, service statistics should be maintained, and baseline data should be collected at the beginning of programmes. Periodic evaluation and continuous monitoring of performance of programmes should be ensured. It is important that adequate personnel are trained in management of service statistics, data collection and analysis, and presentation of information in usable form by management. Management should encourage adequate communication at all levels of the organizational structure and between users of services and providers. Both formal and informal channels of communications within the organizations should be encouraged. Lines of authority should be clear.

Adequate supervision of staff delivering services should be maintained. Staff should be motivated and inspired by management leadership. Thus, supervision that seem to serve as policing activities of staff should be avoided. Training of the staff delivering services should be task oriented and should be continuous.

Efforts should be made to improve organizational capability development. Limited financial resources should be used and managed rationally and effectively. There should be accountability of use of funds by all involved in use of such funds.

70/ Jane T. Bertrand, Nlandu Mangani, Matondo Mansilu, Mark E. Mc Bride and Jeffry L. Tharp "Strategies for Family Planning Services Delivery in Bas Zaire" in International Family Planning Perspectives Vol. 12, Number 4, December 1986.

Management should give special support to management of logistics of contraceptive supplies so that adequate supplies are available at all times. It should also ensure that adequate facilities and equipment for delivery of clinic-based family planning services are available.

V. SUMMARY AND CONCLUSION

The paper has shown that over the years, childspacing has been valued and practised in most African countries in order to improve the health of the mother and the child. This was achieved through traditional methods of birth spacing which included: prolonged sexual abstinence after birth, prolonged breastfeeding, sexual taboos, rhythm and withdrawal methods, use of indigenous herbs and medicine to prevent pregnancy. Even magical methods were used in the belief that they could prevent pregnancy.

Large families were valued as a source of labour and security in old age; continuation of family name; symbol of status for the mother and father who have a large family size; as a means to enable women to have continued access to property through sons when a husband dies. The social and cultural values encouraged early marriages and early childbearing. These contributed to the high fertility regimes in African countries. The traditional methods of childspacing/birth control, however, enabled total fertility to be below the biological maximum, where births were spaced 2 to 3 years apart.

For illustrative purposes, the paper reviewed some of the traditional methods of birthspacing in Egypt, Kenya, Nigeria, Tanzania, Uganda, Zaire, and Zambia. It has noted a number of disadvantages of traditional methods of birthspacing/family planning. Use of magical methods including rings, belts, armlets, charms etc to avoid pregnancies are based on beliefs and there is no proven evidence that they work. Native medicines including a variety of herbs, leaves, roots, fruit, juices and concoctions to prevent pregnancy or induce abortions, have detrimental effect on women's lives as there are no standards on doses and there is no scientific research on safety of the methods. Consequently, most women have had permanent health problems from the use of traditional herbs and medicine to prevent pregnancy or to induce abortion. Many have lost their lives from use of such methods. Although some methods like prolonged abstinence and prolonged breastfeeding were 100% effective in spacing births 2 to 3 years, westernization, urbanization and social change in general (modernization) have made it difficult for these methods to be practised as in the past.

It is important to note that perceptions on family planning and birthspacing are changing too . This change has been clearly demonstrated with the adoption of the KPA in 1984 and the Dakar/Ngor Declaration in 1992, both of which express African governments' concern to reduce population growth rates that will be compatible with desired socio-economic goals. Family planning is currently given a more prominent role in socio-economic development plans than in the past. Many people in Africa are interested to

regulate their fertility given the harsh socio-economic conditions. In the Dakar/Ngor Declaration, African countries set targets to: increase contraceptive prevalence to 20% by the year 2000, and 40% by 2010; decrease population growth rate to 2.5% by the year 2000 and 2% in 2010. In view of these targets, there must be a departure from the traditional approaches to family planning/birthspacing to more effective methods of birth regulation. Modern contraceptive methods are the alternative in combination with socio-economic development efforts. Modern contraceptive methods are reliable, effective and safer to use than traditional methods of birth spacing. Organized family planning programmes would help individuals and couples to have access to modern methods of fertility regulation.

The paper has given considerable attention to various ingredients that contribute to the success of organized birth spacing/family planning programmes. These include - the role of strategic planning; family planning programmes to be implemented as an integral part of socio-economic development; family planning programmes to address the health needs of children, women and adolescents; government policy, commitment and support to family planning programmes; the role of information, education and communication to support programmes; involvement of various population segments and communities in various aspects of programmes; involvement of NGOs and the private sector in programmes; programmes to give special attention to quality of services; the role and the status of women; programmes to reach the unserved and undeserved population; especially those in rural areas; management of programmes.

Africa has come to realize and accept the adoption and implementation of effective family planning programmes at a time when resources required for such programmes are hardly available given the socio-economic crisis affecting nearly all the countries on the continent. Even the structural adjustment programmes which affect social sectors like health and education militate against family planning programmes in most African countries. In this context it may not be easy to take into account some of the factors the paper dealt with which are considered essential for organized family planning programmes to succeed. It is gratifying to observe that recent research shows that even in poor developing countries, improvements in social sectors like health and education are having considerable impact to increase contraceptive use and lowering of fertility. Thus, if the social sectors are improved and strengthened, there would be hope that organized family planning programmes would have an impact in attaining the targets in the Dakar/Ngor Declaration. With the genuine commitment by African countries to adopt and implement population and family planning policies and programmes, supported with resources from international donor agencies/governments, Africa can expect to achieve better results in organized family planning programmes.

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