

Update on Family Planning in Sub-Saharan Africa

This brief provides family planning advocates with data and research findings on population and family planning in sub-Saharan Africa. It points to sources of useful information for advocacy purposes—presenting the rationale behind the messages and showing why family planning is still critically needed in Africa despite the high rates of AIDS deaths in some countries. Data on population, contraceptive use, and health for each country are found in the Appendix.

Demographic context

Sub-Saharan Africa has yet to complete its “demographic transition”—that is, to shift to low birth and death rates. Sub-Saharan Africa has the highest fertility rate in the world, averaging 5.2 births per woman. This rate is more than double that of Asia and almost four times that of Europe. The birth rates are so high that even in the face of high AIDS mortality in some countries, the region’s mid-2010 population of 865 million is projected to increase to 1.2 billion by 2025. A big factor underlying high birth rates is the low use of modern contraception: only 17% of married women in sub-Saharan Africa use modern methods of family planning (see Appendix for country-specific data), compared with 60% in Asia and 69% in Western Europe.¹

Increased use of family planning in sub-Saharan Africa would lead to large improvements in the health of the mothers and the children, the status of women, and economic development. For these reasons, health and development professionals in Africa are rededicating themselves to ensuring that family planning is available to all who need it.

Unmet need for family planning

Demographers and health professionals use the term “unmet need” to indicate the number or percentage of married women who say they prefer to avoid a pregnancy but are not using any method of contraception. Research confirms high unmet need for family planning among African women, whether for spacing births or limiting childbearing.

Table 1 presents the percentages of women with unmet need in 32 African countries where this indicator was measured, based on Demographic and Health Surveys. In 26 of these countries, at least one-fifth of married women aged 15 to 49 want to wait at least two years between births or to stop childbearing altogether, but are not using a family planning method. In five African countries, about one-third of women’s need for family planning is unmet, such as Rwanda with 38% and Uganda with 41%. Encouragingly, an analysis of survey data showed a significant level of women with unmet need who had never used family planning intended to do so.² For example, 43% of women with unmet need in Tanzania, fell into this category. This calls for renewed efforts to meet women’s needs for information and high-quality services. These data do not include unmarried adolescents or older women, many of whom also have an unmet need for family planning.

Factors associated with the failure to meet the family planning need vary from country to country. While access to affordable modern methods of contraception is sometimes a problem, many women reported other reasons for not using family planning,³ such as:

- They did not perceive themselves at risk of

Table 1: Unmet need for family planning in countries with demographic and health survey data

Percent of married women ages 15–49

Country (year)	Using any method of contraception	Having unmet need for family planning		
		Total*	Want to space births	Want to limit births
West & Middle Africa				
Benin (2006)	17	30	18	12
Burkina Faso (2003)	14	29	22	7
Cameroon (2004)	26	20	14	6
Chad (2004)	3	23	19	4
Congo (2005)	44	16	13	3
Congo, Dem. Rep. of (2007)	21	24	19	5
Cote d'Ivoire (1998/99)	15	28	20	8
Gabon (2000)	33	28	20	8
Ghana (2008)	24	35	23	13
Guinea (2005)	9	21	13	8
Liberia (2007)	11	36	25	11
Mali (2006)	8	31	21	10
Mauritania (2000/01)	8	32	23	9
Niger (2006)	11	17	13	3
Nigeria (2008)	15	20	15	5
Senegal (2005)	12	32	24	7
Togo (1998)	24	32	21	11
East & Southern Africa				
Eritrea (2002)	8	27	21	6
Ethiopia (2005)	15	34	20	14
Kenya (2008/09)	46	26	13	13
Lesotho (2004)	37	31	11	20
Madagascar (2008/09)	40	19	10	9
Malawi (2004)	33	28	17	10
Mozambique (2003)	17	18	11	8
Namibia (2006/07)	55	21	9	12
Rwanda (2005)	17	38	25	13
South Africa (1998)	56	15	5	10
Swaziland (2006/07)	51	24	7	17
Tanzania (2004)	26	22	15	7
Uganda (2006)	24	41	25	16
Zambia (2007)	41	27	17	9
Zimbabwe (2005-06)	60	13	8	5

Source: Demographic and Health Surveys (Calverton, MD: ORC Macro) *Total unmet need includes women who want to space births and those who want to limit births, but are not using any contraceptive method. Totals of those who want to space and those who want to limit births may not add up due to rounding.

pregnancy because they did not have sex frequently, were going through menopause, or were breastfeeding. But these situations do not offer protection against pregnancy in all cases.

- They lacked sufficient knowledge of family planning to make informed choices and, in particular, feared that modern contraceptive methods could cause health problems.
- Their husbands or they themselves were opposed to family planning for religious or cultural reasons.

Family planning education programmes should reach out to both men and women and provide accurate information on the risks of pregnancy, the benefits of birth spacing, and the safety and possible side effects of contraception, and encourage positive attitudes toward family planning.⁴

Family planning and the health of women and children

Not meeting the need for family planning, combined with the occasional failure of contraceptive methods, causes millions of unintended pregnancies each year in sub-Saharan Africa.⁵ Unintended pregnancies (accounting for about 30% of all births in sub-Saharan Africa) result in either abortion or births, both of which can have severe health consequences.

Abortion

Some women who do not want to become pregnant but do not use contraception may resort to abortion whether it is legal or not. But the associated risks are high in developing countries, as demonstrated by these key facts:⁶

- Most abortions in developing countries are unsafe because they are performed in unsanitary conditions or by unskilled providers, or both, which can cause death or long-term disabilities.
- Unsafe abortions account for 13% of all maternal deaths globally, and African women have the highest risk of abortion-related deaths in the world.
- The risk of abortion-related death is four times

greater for an African woman than for an Asian woman, and 650 times greater than for a North American woman.

Access to quality family planning services can significantly reduce abortions. Research in various countries demonstrates that women with access to good family planning services are more likely to use contraception, are less likely to have unintended pregnancies, and thus have fewer abortions.⁷ Where family planning services are introduced and promoted, abortion-related deaths decline as contraceptive use rises.⁸

Complications associated with pregnancy

By averting unintended pregnancies, family planning reduces the number of women who are at risk of death from complications of pregnancy and childbirth. Globally, more than half a million women die from pregnancy and childbirth complications, but the death toll is not equally spread throughout the world (see Table 2).⁹

Table 2: Women's lifetime risk of dying of pregnancy-related causes

Developed Countries	1 in 4,300
Developing Countries	1 in 120
Sub-Saharan Africa	1 in 31

Source: WHO/UNICEF/UNFPA/The World Bank, *Trends in Maternal Mortality: 1990 to 2008*.

Lack of family planning is not the only contributing factor to pregnancy-related deaths. Poverty, gender inequality, undernourishment, and low levels of education also play a large role and must be addressed. Obstetric or newborn emergencies may result in death if there are delays in seeking care, reaching care, or receiving appropriate care within the health-delivery system.

Adolescent pregnancies

Adolescents suffer a number of health consequences from unintended pregnancies. For example, they may be at a higher risk of high blood pressure, anaemia, excessive bleeding, obstructed labour, premature delivery, or death. In addition, children born to adolescent mothers have higher incidence of low birth weight (associated with neurological problems or retardation), premature birth, stillbirth, and neonatal mortality. Africa's adolescent pregnancy rates are the highest in the world: 10% of African women aged 15–19 give birth each year, compared with 5% globally and 2% in developed countries.¹⁰

Birth spacing

Unintended pregnancies are often associated with short between-birth intervals, which can have deadly consequences for infants and children. Short birth intervals (<27 months) are associated with an elevated risk of infant, neonatal and perinatal mortality; low birth weight; small size for gestational age; and preterm delivery.¹¹ Women should wait at least two years after giving birth before getting pregnant again. Family planning education, counselling, and contraceptive services can help in spacing births at intervals recommended for the health of the mother and the baby.

Family planning and AIDS

While HIV/AIDS and family planning programmes share the common goal of sexual health, family planning has been largely overlooked as a vehicle for preventing HIV infection or identifying those who are infected.¹² But, HIV/AIDS services provide an opportunity and important entry point for family planning in several ways:

- **Preventing unintended pregnancies and reducing HIV transmission—achieving dual protection.**

The term “dual protection” means protection against pregnancy and sexually transmitted infections, including HIV/AIDS. Hormonal implants and injectables, intrauterine devices, or sterilisation provide the greatest protection against pregnancy, but condoms (male or female types) are the only method known to provide protection against HIV, other sexually transmitted infections, and pregnancy.¹³ Dual protection can be achieved

through either condom use alone or condom use combined with another contraceptive method.

The primary goal of dual protection—whether to prevent pregnancy or infection or both—will influence the dual protection strategy adopted. Promoting dual protection is particularly important among young people and groups at high risk of sexually transmitted infections, such as sex workers or their clients. Innovative strategies are needed to ensure that the dual-protection approach routinely features in family planning and HIV/AIDS prevention programmes.

Recent evidence shows that people with HIV infection can safely use more types of contraceptive methods than was previously thought. For example, most women with HIV infection can use intrauterine devices and take hormonal contraceptives while on antiretroviral therapy.¹⁴

- **Preventing mother-to-child transmission (PMTCT) of HIV.** Preventing unintended pregnancy among HIV-positive women is both a way to meet this vulnerable population's reproductive health needs and an effective approach to prevent mother-to-child transmission of the infection. HIV-infected women who wish to avoid pregnancy must have ready access to family planning. However, a review of PMTCT programs found that implementers have not placed a priority on family planning, thus missing an important opportunity to respond to HIV-infected women's needs.¹⁵

- **HIV/AIDS testing and counselling services.** All testing and counselling services should respond to the family planning needs of individuals, whether they are HIV-positive or -negative. Similarly, family planning services can play a vital role in combating HIV/AIDS by offering voluntary testing and counselling to women, men, and couples and in some settings, providing antiretroviral therapy.

Work is under way to integrate family planning and HIV/AIDS services in most African countries, but advocates must vigilantly promote this integration.¹⁶



Family planning and economic development

While the relationship between fertility and economic development is complex and often reciprocal, research in developing countries has shown that reducing fertility can yield economic benefits at both the household and national levels. For example, a “demographic bonus” occurs when the family size falls rapidly and there are relatively more people of working age and fewer dependent children. Some Asian countries have successfully taken advantage of their demographic bonus. In these countries, having fewer young dependents to cater to allowed the governments to invest in health, extend education, and train people for modern jobs. A healthier, better educated and skilled workforce benefited the economies of these countries and made them more competitive globally.¹⁷ A small family can generate household benefits in terms of improved women’s and children’s health, greater total assets, and greater involvement of women in activities outside the home.¹⁸

Family planning and women’s status

Access to family planning is an essential prerequisite for improving the status of women. Without the ability to space and limit births, women would be vulnerable to poor reproductive health, and their capacity to become fully empowered would be difficult if not impossible. In a large study of women in Zimbabwe, which has the second highest rate of contraceptive use in sub-Saharan Africa, women who started using family planning at a younger age were more likely to be working outside the home. Ninety-two percent of women in the study

said that family planning influences women’s success.¹⁹ Conversely, a study in Ghana found that high fertility reinforced traditional gender roles, because girls often withdrew from school to help care for younger siblings.²⁰

Family planning and the Millennium Development Goals

Family planning is essential in achieving three of the United Nations’ Millennium Development Goals: reducing child mortality, improving maternal health, and promoting gender equality. Family planning also supports achievement of the goals of eradicating extreme poverty and hunger, achieving universal primary education, combating HIV/AIDS, and ensuring environmental sustainability, since population growth exacerbates pollution and threatens fragile ecosystems.

Critical areas for action

Understanding the reasons why the need for family planning is unmet provides guidance on what must be done to help women choose the number and timing of their pregnancies. The critical areas that need focus include:

- Reproductive health outreach and education, including information on the health, social, and economic benefits of family planning;
- Education on contraceptive methods and their safety and common side effects;
- Provision of high-quality, convenient and affordable services that have on hand an adequate range of methods;
- Counselling that responds to the various needs of women, men, couples and adolescents.

Freedom to determine the number and spacing of one’s children has been recognised for many years as a basic human right. No matter where one lives or how poor one might be, women, men and couples are entitled to accessible and affordable family planning services and information to help them exercise this right. Policy-makers, community leaders, the media, nongovernmental organizations, health providers, and others have important roles to play in ensuring adequate resources and commitment are given to family planning.

Appendix: Key population and health indicators in Africa

	Population mid-2006 (millions)	Rate of natural increase (percent)	Projected population (millions)		Infant mortality rate	Total fertility rate	Population age <15 (percent)	Percent of married women 15–49 using contraception	
			Mid-2025	Mid-2050				All methods	Modern methods
AFRICA	1,030	2.4	1,412	2,084	76	4.7	41	29	23
SUB-SAHARAN AFRICA	865	2.5	1,207	1,831	81	5.2	43	23	17
NORTHERN AFRICA	209	1.9	262	329	42	3.0	33	49	44
Algeria	36.0	1.8	43.6	50.4	28	2.3	28	61	52
Egypt	80.4	2.1	103.6	137.7	28	3.0	33	60	58
Libya	6.5	1.9	8.1	9.8	18	2.7	30	42	20
Morocco	31.9	1.5	36.6	41.2	31	2.4	29	63	55
Sudan	43.2	2.2	56.7	75.9	81	4.5	41	8	6
Tunisia	10.5	1.1	12.1	13.2	18	2.1	24	60	52
Western Sahara	0.5	2.5	0.7	1.2	63	4.5	40	-	-
WESTERN AFRICA	309	2.6	435	682	81	5.5	43	14	10
Benin	9.8	3.0	13.6	22.1	89	5.6	45	17	6
Burkina Faso	16.2	3.4	25.4	47.4	81	6.0	46	17	13
Cape Verde	0.5	2.0	0.7	0.8	25	2.9	35	61	57
Côte d'Ivoire	22.0	2.4	30.8	47.2	97	4.9	40	13	8
Gambia	1.8	2.7	2.5	3.8	81	5.3	43	10	9
Ghana	24.0	2.2	31.8	44.6	50	4.0	39	24	17
Guinea	10.8	3.0	15.9	25.1	91	5.7	43	9	6
Guinea-Bissau	1.6	2.4	2.3	3.6	121	5.8	43	10	6
Liberia	4.1	3.3	6.1	10.0	95	5.9	44	11	10
Mali	15.2	3.1	22.3	35.6	116	6.6	48	8	6
Mauritania	3.4	2.3	4.4	6.1	73	4.5	40	9	8
Niger	15.9	3.5	27.4	58.2	108	7.4	49	11	5
Nigeria	158.3	2.4	217.4	326.4	75	5.7	43	15	10
Senegal	12.5	2.8	17.4	25.4	58	4.9	44	12	10
Sierra Leone	5.8	2.4	8.1	12.4	89	5.1	43	8	7
Togo	6.8	2.5	9.3	13.2	81	4.8	41	17	11
EASTERN AFRICA	326	2.7	465	709	72	5.3	44	28	23
Burundi	8.5	2.1	11.6	16.8	98	5.4	41	9	8
Comoros	0.7	2.6	0.9	1.2	53	4.1	38	26	19
Djibouti	0.9	1.8	1.1	1.5	67	4.0	37	18	17

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			Mid-2025	Mid-2050				All methods	Modern methods
Eritrea	5.2	2.9	7.4	10.8	54	4.7	42	8	5
Ethiopia	85.0	2.7	119.8	173.8	77	5.4	44	15	14
Kenya	40.0	2.7	51.3	65.2	52	4.6	42	46	39
Madagascar	20.1	2.7	28.6	42.7	48	4.8	43	40	29
Malawi	15.4	2.9	22.9	37.4	80	6.0	46	41	38
Mauritius	1.3	0.5	1.4	1.4	13	1.5	22	76	42
Mayotte	0.2	3.6	0.3	0.5	-	4.5	44	-	-
Mozambique	23.4	2.3	31.2	44.1	90	5.1	44	17	12
Reunion	0.8	1.3	1.0	1.1	8	2.4	26	67	64
Rwanda	10.4	2.9	15.8	28.3	102	5.4	42	36	27
Seychelles	0.1	1.0	0.1	0.1	11	2.3	22	-	-
Somalia	9.4	3.0	13.9	23.5	111	6.5	45	15	1
Tanzania	45.0	3.0	67.4	109.5	58	5.6	45	26	20
Uganda	33.8	3.4	53.4	91.3	76	6.5	49	24	18
Zambia	13.3	2.5	20.3	37.6	70	6.2	46	41	33
Zimbabwe	12.6	1.3	16.8	22.2	60	3.7	42	60	58
MIDDLE AFRICA	129	2.7	188	296	111	5.9	46	19	7
Angola	19.0	2.5	27.4	42.3	118	5.8	45	6	5
Cameroon	20.0	2.3	26.5	36.7	87	4.7	41	26	13
Central Africa Republic	4.3	2.2	6.6	10.3	106	4.8	41	19	9
Chad	11.5	2.9	16.9	27.8	130	6.2	46	3	2
Congo	3.9	2.5	5.5	8.2	79	5.0	42	44	13
Congo, Dem. Rep. Of	67.8	2.9	101.4	166.2	114	6.4	48	21	6
Equatorial Guinea	0.7	2.3	1.0	1.4	103	5.5	42	-	-
Gabon	1.5	1.9	2.0	2.8	55	3.6	39	33	12
Sao Tome and Principe	0.2	2.9	0.2	0.3	45	4.9	44	38	34
SOUTHERN AFRICA	57	1.0	63	68	48	2.5	32	59	58
Botswana	1.8	1.9	2.2	3.0	48	3.2	33	44	42
Lesotho	1.9	0.9	2.0	1.9	91	3.3	34	47	46
Namibia	2.2	1.9	2.8	3.6	35	3.4	38	55	53
South Africa	49.9	0.9	54.4	57.4	46	2.4	31	60	60
Swaziland	1.2	1.5	1.5	1.7	74	3.7	40	51	48

Source: 2010 World Population Data Sheet, Washington, DC, Population Reference Bureau.

Definitions

Rate of natural increase (RNI): The birth rate minus the death rate. This is the annual rate of population growth without accounting for migration. RNI is expressed as a percentage.

Projected population 2025 and 2050: Projected populations are based upon reasonable assumptions on the future course of fertility, mortality, and migration. Projections are based on official country projections, series issued by the UN or the US Census Bureau, or PRB projections.

Infant mortality rate (IMR): The annual number of deaths of infants under age 1 per 1,000 live births.

Total fertility rate (TFR): The average number of children a woman would have assuming that current age-specific birth rates remain constant throughout her childbearing years (usually considered to be ages 15 to 49).

Contraceptive use: The percentage of currently married or “in-union” women of reproductive age who are using any form of contraception. “Modern” methods include methods supported or provided by medical clinics such as the pill, intrauterine devices, condoms, and sterilisation.

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