

Despite the positive change in official attitudes towards population issues, African governments still face enormous challenges in making high quality family planning and other reproductive health services widely available. Health systems across the region are improving, but still do not adequately cover large segments of the population. Knowledge of contraceptive methods and the range of methods available has grown considerably over the past decade, but programs often place unnecessary barriers to contraceptive use. Finally, in spite of the enthusiasm for implementing the broader reproductive health approach advocated by the ICPD, there is still a great need to improve links between family planning and other reproductive health services.

Expanding Access to Family Planning Services

As governments increasingly provide support for family planning services in most countries in the region, African men and women are better able to obtain contraceptive services. Between 1982 and 1994 availability of contraception increased faster in sub-Saharan Africa than in other developing regions. Kenya, Zimbabwe and countries in southern Africa have made solid progress towards improving access to family planning.

Still, overall shortcomings in health systems – particularly in rural areas – are preventing more rapid increases in contraceptive use. The public sector, while an important source of contraceptive services in most countries, is struggling to make more efficient use of its limited resources. Meanwhile, private groups – both for-profit and nonprofit – have yet to reach their full potential to complement government efforts.

As a result, serious gaps in coverage remain. Demand for family planning continues to outpace services,

and millions of couples who want to delay or avoid another pregnancy are not using family planning. The average African couple still had poorer access to family planning in 1994 than couples in other developing regions had a dozen years earlier. Fewer than two of the five most common family planning methods are widely and easily available. Most rural women must travel an hour or more to obtain contraceptive services; in Zambia, half of all women must travel two hours to reach a source of family planning.

Health Services in Africa

In general, family planning programs are stronger in countries where an increased emphasis on primary and preventive care has broadened access to health services.

Countries with relatively effective family planning programs, such as Botswana and Zimbabwe, showed a commitment early on to the expansion of public sector primary health care; both countries provide virtually universal access to health services.

However, progress on health care coverage varies considerably across the region. Despite impressive gains since independence, health services – both public and private sector – still reach only slightly more than half of Africa's population. In many countries, health care coverage is still appallingly low, especially in rural areas. In Mozambique, where the population is two-thirds rural, just 15 percent of the rural population is within an hour of a health facility; in Sierra Leone, the figure is 11 percent.

Qualified health workers are in short supply in many African countries compared to other regions. The ratio of doctors to population is lower than 1 to 10,000 in Africa; the world average is 1 to 800. Nurses are somewhat more abundant, but Africa still has only about one-third as many nurses per capita as the rest of the world.

Demand for family planning continues to outpace services.

practicing modern family planning obtain services from the public sector – a proportion significantly higher than in most other areas of the world. In fact, the more successful programs in the region tend to have a very high degree of public sector involvement. In Zimbabwe, for example, the government supplies 85 percent of family planning clients.

Almost all governments in Africa provide family planning within existing maternal and child health services. A notable exception is Zimbabwe, which also provides contraceptive services through specialized family planning clinics and outreach activities. Given the severe budget constraints most African governments face, integration of family planning and health services appears to be an efficient use of scarce resources. Creating a large, parallel infrastructure to provide family planning services, as in some Asian countries such as Pakistan, is simply not an option for most African countries.

Many of the current efforts to strengthen contraceptive services are focused on rural areas, where weak health infrastructure is a major barrier to contraceptive use. For example, Ghana, like many African countries, has historically neglected investment in primary health care and rural outreach in favor of large hospitals and curative services. Family planning clinics in urban areas are relatively well-equipped and adequately staffed; in contrast, rural areas have insufficient staff and infrastructure and outreach programs are lacking. In Mankranso, a rural district of Ghana with a population of 118,000 for example, the government operates one health center and employs just one doctor and five nurse-auxiliaries to provide a full range of preventive and curative services. To improve coverage in areas such as Mankranso, the government of Ghana has set up district-level health management teams to plan and implement health services, including family planning and reproductive

health services. Compared to Ghana, in many other countries, especially in French-speaking Africa, coverage is much worse.

In African cities, where public sector health services are concentrated, access to family planning services is generally better than in rural areas. Urban government hospitals and health centers often place family planning clinics side-by-side with busy antenatal and well-baby outpatient services. Nevertheless, high rates of urbanization across Africa may be contributing to a steady deterioration in the availability and quality of family planning services in cities – especially in those peri-urban areas housing new migrants.

Because of deficiencies in coverage in rural and peri-urban areas, and the poor range and quality of services frequently offered in those facilities that do exist, many clients for both health and family planning services prefer using larger, better-equipped urban clinics, even if it means longer travel time and higher cost. Consequently, family planning services in many large urban hospitals are heavily used, resulting in long waiting times. In Kenya, where demand is growing rapidly, district hospital family planning clinics commonly serve 200 clients a day. At the same time, facilities in rural and peri-urban areas are often underused. Studies in Nigeria, Tanzania and Zimbabwe have found that a quarter of facilities serve over 80 percent of all family planning clients.

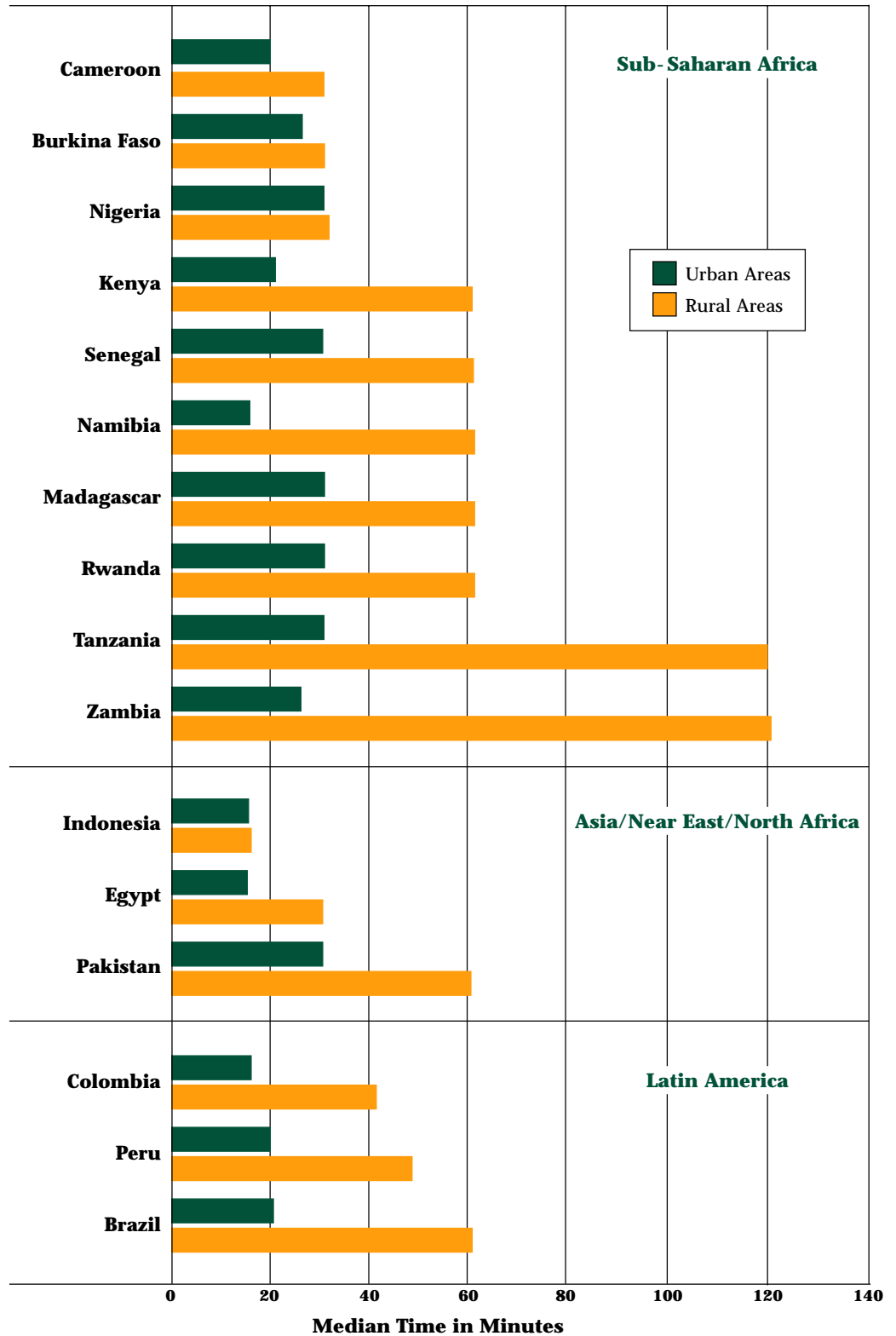
Support Systems for Public Sector Programs

One of the greatest challenges governments face is improving the systems that support the delivery of family planning and reproductive health services in government health facilities. Most public sector family planning services require enhancements in management and supervision, staff training, and the supply of contraceptives, essential drugs, and medical supplies.

Studies in Nigeria, Tanzania and Zimbabwe have found that a quarter of facilities serve over 80 percent of all family planning clients.

FIGURE 14
Travel Time to Family Planning Services
for Married Women Using Modern Contraceptives

Median Time in Minutes



SOURCE: Sian L. Curtis and Katherine Neitzel. *Contraceptive Knowledge, Use, and Sources*. Demographic and Health Surveys Comparative Studies, no. 19. Calverton, MD: Macro International, Inc., 1996.

Management and Supervision

The quality of leadership of health and population programs in Africa has improved immensely in the past two decades. Countries have accumulated experience in designing and running programs, and African governments have made efforts to expand and professionalize the cadre of public health managers.

A critical mass of qualified family planning and reproductive health professionals is gathering strength in West Africa, although it has yet to reach levels already achieved in eastern and southern Africa. All over the continent, Africans now occupy technical assistance positions for major international agencies working in reproductive health and population – in contrast to the past, when expatriates almost exclusively held these posts.

Still, as is the case with the public sector in general, there is a shortage of professionals qualified to design, manage and evaluate health and family planning services. This shortage has been exacerbated as international donors have cut back funding for long-term training of health professionals. Furthermore, AIDS has decimated the ranks of young, educated health sector managers in several countries, including Malawi and Zimbabwe.

Management shortcomings diminish the capacity of programs to effectively absorb additional funding, a serious concern in countries where rapid expansion of services is needed. Frequent turnover in top management positions and the continuing exodus of highly-qualified staff in search of better paying work and greater opportunity for professional advancement outside the region undermine program continuity. Low salaries and lack of opportunities for advancement affect staff motivation and contribute to personnel shortages.

Program supervision is another area that needs strengthening virtually everywhere in Africa. Funds for super-

vision are often minimal, resulting in infrequent visits. For example, a 1995 study in Kenya found that, in the six months prior to the study, 43 percent of Ministry of Health clinics had received no supervisory visit; a 1994 study in Senegal found an even lower frequency of supervision. The quality of supervision is also of great concern. Lacking the resources and skills to help workers resolve service delivery problems, supervisors often focus on administrative and data collection tasks.

Training

The quality of national training programs varies greatly. Countries such as Ghana, Mali and Zimbabwe now design and conduct training successfully without external assistance. Yet, despite significant investments, many African countries still lack sufficient, trained health workers with the skills to provide quality family planning and other reproductive health services. In particular where governments have only recently introduced family planning services, training workers has proved to be a difficult and costly task.

Moreover, most countries face a shortage of skilled trainers and a lack of appropriate materials and curricula. The rote learning tradition, particularly strong in French-speaking countries, is a formidable obstacle to introducing competency-based training approaches that emphasize practice and mastery of essential skills that trainees will use on the job. In addition, training often ignores management and supervisory skills. Finally, trainee follow-up and evaluation rarely occur according to plan because of budget and time constraints.

Governments and donors are responding to the need to lower costs and increase training efficiency through two fundamental shifts in approach. The first is a move towards on-site training of staff as a team in the clinics where they work. Training

Despite significant investments, many African countries still lack sufficient, trained health workers.

Marked improvements in contraceptive supply systems over the last 10 years are part of the reason for the rapid increase in availability of family planning services.

in regional or national training centers tends to be expensive, is rarely sustainable without significant donor financing, and disrupts services by taking clinic staff out of the field for extended periods. Moreover, it generally does not replicate the conditions in which most health personnel work on a daily basis. While training staff in the clinics where they work may be more cost-effective, it also requires better and more frequent supervision and follow-up.

The second change in approach is a greater focus on improving the family planning skills health workers learn during their initial or preservice training. This method has the advantage of training larger groups of workers at lower cost, helping to institutionalize services on a broad basis and creating a critical mass of trained personnel. After a steady growth in interest since the early 1980s, most African medical, midwifery and nursing schools now include instruction on family planning. Currently, many schools aim to develop comprehensive curricula covering both family

planning and related reproductive health skills.

Contraceptive Supply

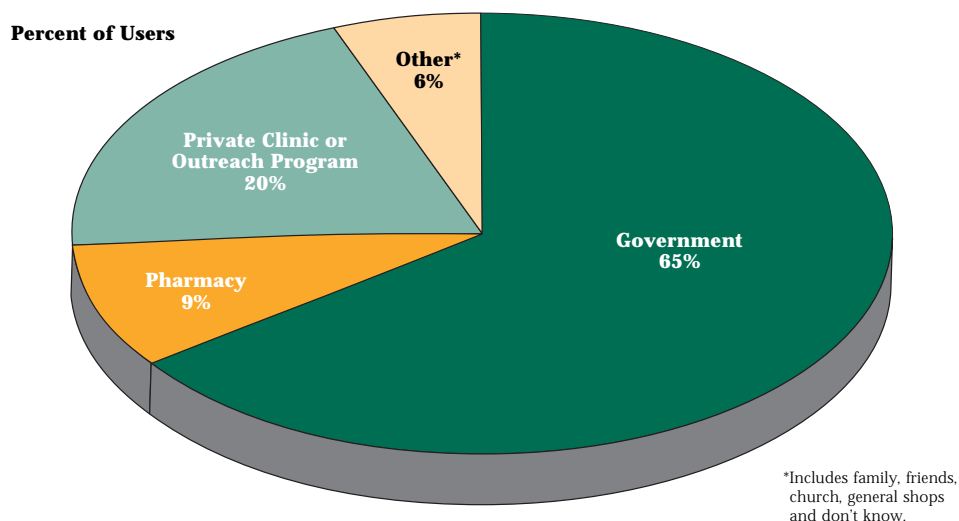
An adequate and regular supply of contraceptives for both clinics and outreach workers is a crucial but often overlooked component of program effectiveness. There are probably few problems that are more likely to discourage a new family planning user than traveling some distance to a clinic and not being able to find the contraceptive method of his or her choice.

Marked improvements in contraceptive supply systems over the last 10 years are part of the reason for the rapid increase in availability of family planning services. In Kenya, a sustained technical assistance effort supported by U.S. funds has significantly raised the consistency with which contraceptive supplies are available; similar progress has been made in Tanzania, also with U.S. support.

Still, most contraceptive supply systems continue to need upgrading

FIGURE 15

Source of Modern Contraceptive Methods Sub-Saharan Africa



SOURCES: Sian L. Curtis and Katherine Neitzel. *Contraceptive Knowledge, Use, and Sources*. Demographic and Health Surveys Comparative Studies, no. 19. Calverton, MD: Macro International, Inc., 1996; PRB. *1997 World Population Data Sheet*; various Demographic and Health Surveys.

and are ill-equipped to meet the rising demand for contraception in many countries. In varying degrees, all contraceptive distribution systems in Africa suffer from some common problems, many related to wider inadequacies in the procurement and management of essential drugs. Reliable information on numbers and patterns of contraceptive users are often unavailable, clinic staff typically have no background in supply management, and policymakers rarely understand the importance of a well-functioning contraceptive distribution system. Lacking good information, planning is usually weak and procurement often inefficient and wasteful.

As a result, the supply problems that afflict family planning programs worldwide are particularly severe in Africa. Clinics around the region are frequently without adequate stocks of contraceptive methods. Shortages are particularly acute for IUDs, injectables and progestin-only oral contraceptives; it is not uncommon for half or more of clinics to be out of one or more methods on a given day.

Access to Family Planning Through the Private Sector

There are promising opportunities for expanding the role of the private sector in provision of family planning and reproductive health services in Africa. The Cairo conference gave private efforts a boost in the region by recognizing the potential contribution of NGOs, including women's groups. Furthermore, governments increasingly recognize that, with declining resources and deteriorating health systems, private sector partners can help share the responsibility of providing health services. Finally, the rapid expansion of African social marketing programs is an encouraging sign that consumers are willing to purchase subsidized contraceptives through existing commercial networks.

Compared to some other regions, however, the private sector

in Africa currently plays a relatively small role in provision of family planning services. On average, non-governmental organizations and private for-profit clinics serve roughly 1 in 5 contraceptive users, somewhat below the developing country average of almost 30 percent. Commercial pharmacies supply about 1 in 10 contraceptive users – about the same as in other developing countries.

The Contribution of NGOs

The pioneering efforts of private, nonprofit groups in Africa laid the groundwork for transforming public attitudes and government policy in favor of family planning. African NGOs, particularly national family planning associations, have also been in the forefront in testing and implementing new approaches such as community-based distribution of contraceptives, adolescent services and male involvement in family planning. Currently, many of these organizations are breaking new ground in incorporating related reproductive health services into existing family planning programs.

A second important private source of family planning services – especially in English-speaking countries such as Kenya, Nigeria and Zambia – are clinics run by Protestant churches. The Christian Health Association of Kenya, a coalition of over 200 of these clinics, provides almost 10 percent of contraceptive services in the country. (Church institutions, including the Catholic Church, provide 40 percent of all health services in Kenya).

Increased external assistance will most likely be necessary if private voluntary groups are to significantly expand their current limited role in providing family planning services. Some of the more well-established national family planning associations are poised to substantially expand their efforts. However, overall, NGOs account for only between 5 and 10 percent of all health care spending in

The pioneering efforts of private, nonprofit groups laid the groundwork for transforming public attitudes and government policy.

Professional associations of doctors, nurses and midwives have been important catalysts for improving public health policy.

most African countries. Most NGO family planning programs – especially in French-speaking West Africa – remain small and urban-based, and their management capacity is limited.

The relationship between government and family planning NGOs varies considerably from country to country. In Ghana, Kenya and Senegal there is a healthy partnership between the public and private sectors. In countries such as Ethiopia, however, governments still place important legal and administrative barriers to the work of NGOs. These barriers reflect the discomfort some governments have with the role of NGOs as advocates for the poor and, in some cases, as competitors for scarce international aid.

Private For-Profit Health Providers

The private, commercial sector is smaller in Africa than in other developing regions, but has the potential to expand its role both as an advocate for family planning and related reproductive health services and as a direct provider of such services. Professional associations of doctors, nurses and midwives have in many parts of the region been important catalysts for improving public health policy. Furthermore, across Africa, private health practitioners are getting more involved in provision of contraceptive services. In Ghana, for example, many midwives maintain private practices and include family planning among their services. In 1996, 500 midwives – mostly in rural Ghana – served 20,000 new family planning clients. Similar efforts to encourage private midwives to provide family planning services are underway in Nigeria and elsewhere in Africa.

Programs to promote employer-based family planning services have had some success in Africa. With modest amounts of technical assistance, many such programs have become almost wholly sustainable with private resources. In Zimbabwe, where the employer-based approach has been

particularly intensive, roughly 70 large companies directly provide some type of family planning service through existing company health clinics. A number of large employers in Kenya provide similar services.

Efforts to include reimbursement for contraceptive services in private insurance plans have also proven successful in Zimbabwe and Madagascar. In Zimbabwe virtually all plans – covering seven percent of the population – pay for family planning; in Madagascar, 12 of 22 national employee insurance plans, covering 390 businesses and 12,000 workers, have added contraceptive services and STD prevention activities.

The Role of Social Marketing of Contraceptives

The importance of social marketing programs, which promote and sell subsidized contraceptives through commercial networks, increased dramatically in Africa during the 1990s. Between 1991 and 1995, the number of countries using the social marketing approach grew from 8 to 22. Initially, the U.S. foreign aid program was the sole supporter of social marketing efforts in Africa, but by 1995 other donors were financing a third of existing African programs.

African social marketing programs differ from those in Asia and Latin America in that most began with AIDS prevention rather than family planning as their primary goal. As a result, most programs have focused on condom distribution. Condom sales quadrupled between 1991 and 1995 to 166 million annually – one-quarter of worldwide social marketing totals. Yearly sales of 55 million condoms in Nigeria and 20 million in Ethiopia place those programs among the 10 largest contraceptive social marketing programs in the world.

The emphasis on AIDS prevention has increased support for social marketing programs by African governments. For example, concern over high

AIDS prevalence in neighboring countries persuaded the government of Chad to approve a condom social marketing program in 1996, despite earlier misgivings. Resistance from religious conservatives has been less than expected, and condom sales in 1997 reached three million, in a country of just seven million people.

In some countries where social marketing programs have made good progress with AIDS prevention campaigns, efforts are now underway to expand the focus to include family planning. For example, the formerly condom-only project in Côte d'Ivoire has launched a brand of oral contraceptives and is marketing a new brand of condoms to married couples.

However, major barriers remain to broadening the scope and coverage of social marketing programs. Promoting condoms for family planning *and* prevention of sexually transmitted diseases requires distinct sales messages, packaging and distribution channels,

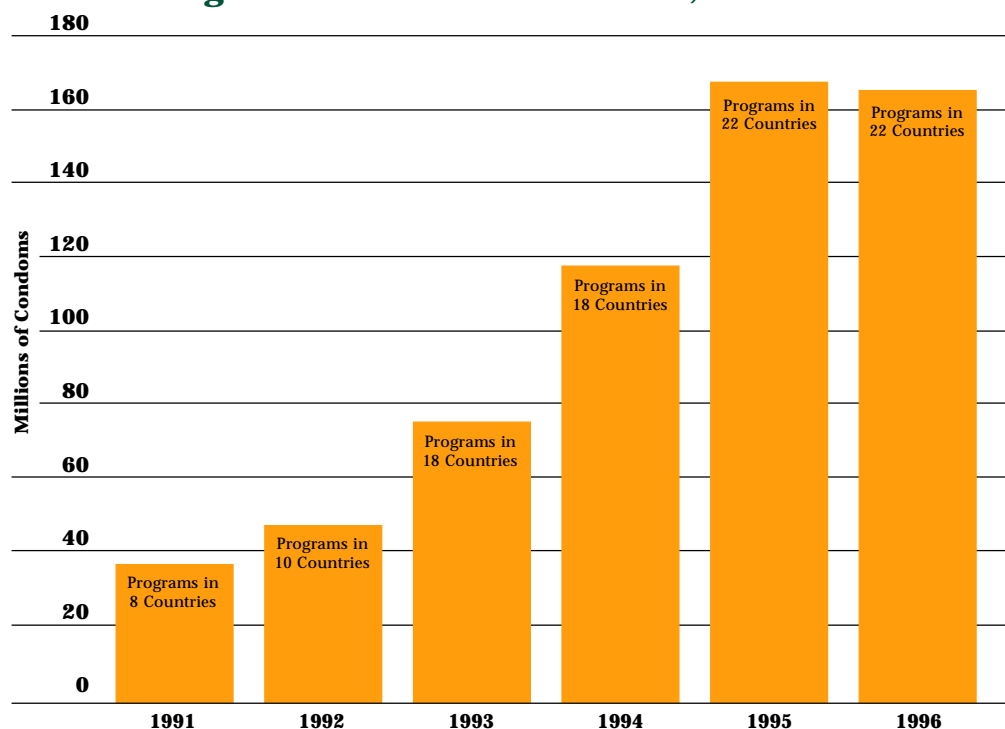
yet markets in most countries are not big enough to support separate brands cost-effectively. Donors have often earmarked funds specifically for AIDS prevention, and have lacked the flexibility to expand social marketing programs to include contraceptives other than condoms. Coordination is often difficult between separate national AIDS control and family planning programs. Except for some of the more developed countries of the region, such as South Africa, commercial networks outside cities are weak, limiting distribution efforts in rural areas.

In addition to the emphasis on STD prevention, strong legal and regulatory barriers have hampered the introduction of other contraceptives – particularly oral pills and injectables – into social marketing efforts. Conservative medical groups generally oppose over the counter sales of oral contraceptives and have prevented the launch of an oral pill in Zambia. Pharmacy owners often block sales

Where social marketing has made good progress with AIDS prevention, efforts are underway to include family planning.

FIGURE 16

Sales of Condoms Through Social Marketing Programs in Sub-Saharan Africa, 1991-1996



SOURCE: DKT International. *Contraceptive Social Marketing Statistics*. Washington, DC: DKT, 1991-1996.

The environment for community-based family planning has improved dramatically since the 1980s.

of social marketing products outside of formal commercial channels, thus cutting off distribution channels through the far more numerous chemist shops and retail outlets. Many countries – including those with relatively strong family planning programs, such as Zambia, Kenya and Malawi – restrict television and radio advertisements for contraceptives.

The Importance of Outreach Programs

Many years of experience in Africa and elsewhere show that community outreach programs can effectively

extend family planning education and services beyond the clinic while ensuring client safety. Especially in rural areas where family planning is new, trained volunteers or paid workers from the community can help bridge the cultural divide that usually exists between the client and the clinic-based health worker.

The environment for community-based family planning in Africa has improved dramatically since the 1980s; virtually all countries now have some type of outreach program. Yet, in contrast to Asia, most are small-scale, private efforts; there are still few large-scale government ventures.

Out of the Clinic, Into the Community Kenya's Community-Based Family Planning Programs

Community-based family planning programs in Kenya are many and varied, and have made a significant contribution to the success of national family planning efforts. Each program focuses on bringing appropriate family planning counseling and supplies out of the clinic and into the community, although programs differ in size, field worker selection, compensation and supervision, range of methods and services, and ties to clinical services.

A recent review of selected programs shows that field workers can be extremely effective in serving their local communities. In the areas they cover, outreach workers supply 40 percent of all women who use oral contraceptives, condoms or spermicides – the principal methods that field workers distribute. Yet, national surveys have tended to understate the effectiveness of the community-based approach. For example, the 1993 Kenya Demographic and Health Survey reports that outreach workers supply just 2.5 percent of users of modern contraception. The low figure reflects in part the limited geographical range of the field workers; only between one-fifth and one-half of Kenyan women live in communities served by outreach workers. In addition, many clients have family planning needs which the field workers cannot directly meet given the limited range of methods they provide.

Field workers do, however, play a significant role in referring clients for clinical contraceptive methods. Rural outreach workers in the various programs refer on average between 3 and 35 clients annually for methods such as injectables, IUDs and female sterilization. Because of gaps in reporting, these numbers most likely substantially underestimate the true volume of referrals.

The visibility and active involvement of outreach workers have been crucial components of program success. In communities served by outreach programs, nearly 60 percent of both women and men know a field worker. Furthermore, of current contraceptive users that know a field worker, 35 percent of condom users and 57 percent of oral contraceptive users obtain their supplies from that worker.

Some of the countries in Africa where family planning programs have been most successful have invested heavily in community outreach. Kenya pioneered the community-based approach in Africa in the 1980s; it now has the most extensive outreach effort in the region, with 25 programs employing roughly 17,000 community agents, including 9,500 government workers.

Zimbabwe's 800 paid full-time community family planning workers are the cornerstone of its successful national program; community workers supply one in five users of modern contraceptive methods. Mali's government has placed male-female outreach teams in almost 600 villages, with plans to expand to an additional 1,320 villages by the end of 1998. Governments in Tanzania and Uganda are also moving rapidly ahead with community-based programs.

One obstacle to progress is the need and the time required to reaffirm in every country that nonclinical program strategies such as community-based distribution of contraceptives are viable and safe for clients. In most countries, community workers are only permitted to distribute condoms and spermicides in addition to their responsibilities for client education on family planning and referral for clinical services. Despite research showing that community workers spend more time with clients and are just as good as physicians in identifying precautions for use of oral contraceptives, African doctors and even some family planning program managers remain cautious about non-prescription distribution of hormonal contraceptives via community workers. Nevertheless, in countries such as Guinea and Mali, women who obtain a prescription and initial supplies from a clinic can obtain subsequent supplies from community workers.

Setting up and running outreach programs is also a complex undertaking. Inappropriate selection of outreach workers is a common problem and a

heavy reliance on volunteers makes it harder to motivate outreach workers. Although community workers need to be supported by trained health staff and facilities, many outreach programs lack adequate links between community workers and clinics. A lack of effective management and supervision also make it an enormous challenge to blend outreach schemes with existing government services. Moreover, programs are often designed without adequate community involvement, and do not take local cultural conditions sufficiently into account.

Improving the Quality of Family Planning Services

Improvements in the quality of family planning services are an important complement to expanded access to services. Africa has made substantial progress in raising the quality of family planning services, and the choice of contraceptives has steadily expanded. Still, long-term methods such as sterilization are largely unavailable; many programs create unwarranted obstacles to family planning use; and safety measures such as infection control remain a critical concern. Knowledge of family planning methods has greatly increased in the past decade, yet programs can do more to provide accurate and complete information to clients.

Contraceptive Choices

Africa's relatively recent adoption of population policies and programs gives its governments the unique chance to draw on almost 50 years of international experience in building population programs in other regions. An important difference in Africa is that health concerns, rather than concerns over rapid population growth, have been the primary force behind the expansion of family planning programs in the region. As a result, African programs have avoided the emphasis of

Africa has made substantial progress in raising the quality of family planning services, and the choice of contraceptives has expanded.

Oral and injectable contraceptives account for two-thirds of all modern method use.

some older Asian programs on meeting numerical goals for recruitment of family planning clients. This target orientation has been associated with lapses in voluntarism and an overreliance in some Asian countries on sterilization. In contrast, African programs have been generally free of abuses and have relied more heavily on contraceptive methods that are appropriate for couples who want to space births.

■ Oral and injectable contraceptives account for two-thirds of all modern method use in Africa. Several brands of oral contraceptives are available in most countries, but supplies are often uncertain and government programs often substitute brands without regard to client preferences. There is a high demand for proges-

tin-only pills in many countries because breastfeeding women prefer them, but programs do not consistently stock them.

■ Use of injectable contraceptives is increasing rapidly in Africa. Almost half of the recent rise in modern method use in the region can be attributed to the growing popularity of injectables. Rural women especially prefer the convenience of only having to visit a clinic once every two or three months (depending on the brand) for injectable contraceptives and like the injection because it allows them to keep their contraceptive use confidential.

■ Imported condoms – either subsidized social marketing brands or commercial products – are

New Approaches to Rural Outreach in Northern Ghana

An innovative project in Ghana is demonstrating that it is possible to increase acceptance of family planning even in conservative rural areas of Africa. The Community Health and Family Planning project was begun in 1994 and is managed by the Navrongo Health Research Center of the Ghanaian Ministry of Health. Operating in a rural district where family planning use has traditionally been extremely low, the project upgraded health clinics and trained government community health nurses (CHNs) and village volunteers to provide contraceptive services and other basic health care. Rather than waiting for clients to come to them in the clinics, CHNs now make scheduled visits on their motorcycles to every family compound in the villages they serve. Nurses persevere despite rough roads and bad weather to provide basic preventive health care, including family planning counseling and supplies of oral contraceptives, condoms, injectables and foam tablets. Each village has prepared a house for their CHN where she lives throughout the work week, and it is not unusual for a nurse to wake in the morning to find a line forming at her door for care.

Full community participation is a hallmark of the effort. Project staff have continuously involved chiefs, elders, soothsayers and others with influence over reproductive decisionmaking in developing and carrying out activities. The project also uses traditional channels of leadership, communication and participation, such as village meetings and social groups.

The investment in understanding the cultural setting and the comprehensive approach to community outreach appears to be paying off. When the project began, just 2 of 900 women in pilot villages were using modern contraceptives; after one year, 255 women became contraceptive users.

increasingly accessible in pharmacies, shops and health clinics. By international standards, availability of condoms as well as oral contraceptives is close to the developing country average. For the region as a whole, condoms still account for a relatively low share of modern method use, just 4 percent. However, condom users make up a significant proportion of family planning acceptors in Côte d'Ivoire (49%), Central African Republic (31%), Zambia (24%) and Ghana (22%).

- Studies in a number of African countries have shown relatively high levels of acceptability for the

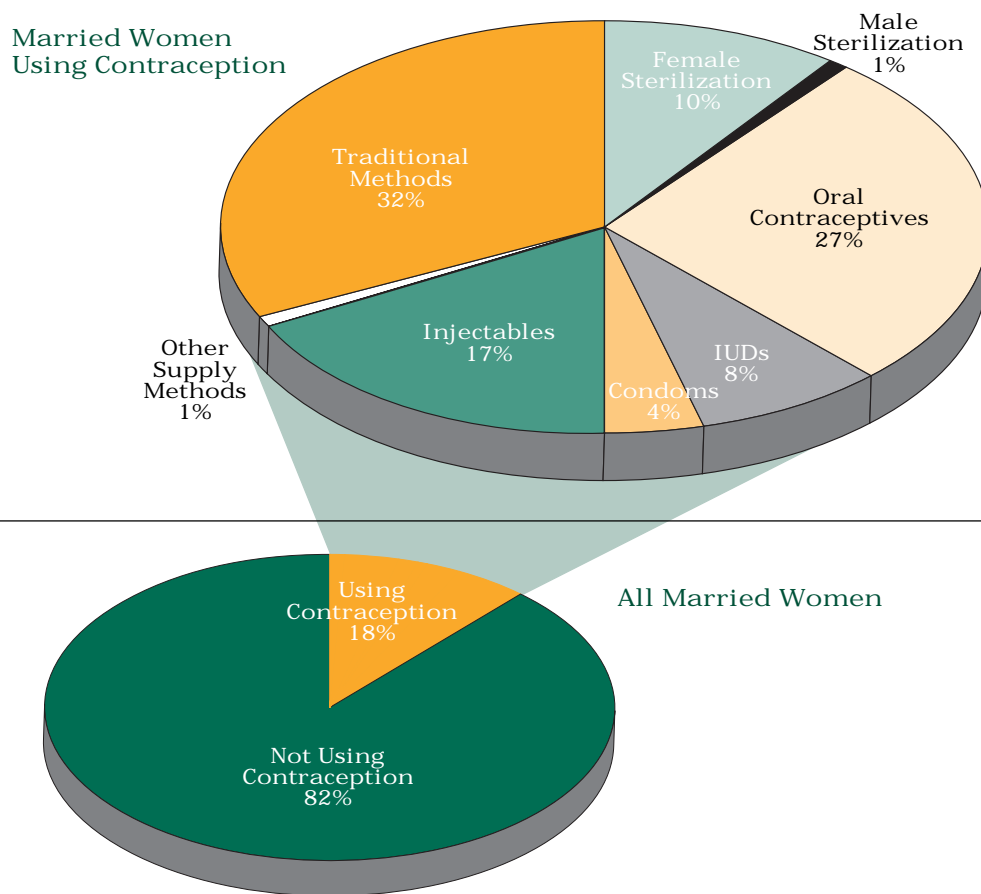
female condom, currently the only product controlled by women that protects against both STDs, including HIV/AIDS, and pregnancy. Despite the high cost of the female condom relative to the male condom, interest in the method is growing. In Zambia, for example, the government recently acquired 500,000 female condoms for distribution at government clinics and through commercial outlets as part of the contraceptive social marketing effort.

Offering a wide range of contraceptive methods is important to improving client satisfaction and is generally linked to higher family

Limited access to long-term methods of family planning remains a major constraint to expanding contraceptive choices.

FIGURE 17

Contraceptive Method Mix, Sub-Saharan Africa



NOTE: Based on the most recent available survey data. Average date, 1990.

SOURCE: UN Population Division. *Levels and Trends of Contraceptive Use as Assessed in 1994*. Population Studies Series, no. 146. New York: UN Department of International Economic and Social Affairs, 1996.

Female sterilization is the most widely used contraceptive method in the world, but levels of use in Africa remain extremely low.

planning use. In Africa, however, the limited access to long-term methods of family planning remains a major constraint to expanding contraceptive choices.

■ IUD use is low, just 8 percent in Africa compared to 13 percent for developing countries, excluding China. A growing problem is that health workers are reluctant to perform IUD insertions owing to the lack of adequate supplies such as gloves to help protect them from exposure to HIV/AIDS. Low IUD caseloads also limit training opportunities in insertion and removal. In addition, given the high prevalence of STDs in many countries and the limited diagnostic tools available, many health workers are concerned about the increased risk of pelvic infection associated with IUD use in women who may have an STD.

■ The contraceptive implant Norplant has been introduced in a number of countries in sub-Saharan Africa, but has yet to have a major impact on contraceptive use. Studies in Ghana, Kenya and Nigeria have shown that African women like the convenience of Norplant. However, removal of the method remains a problem in countries where there are still few sites for removal, underscoring the importance of follow-up care. The higher initial cost of the device relative to other long-term methods such as the IUD has also limited the quantities that donor agencies have been willing to provide.

A further obstacle to expanding method choices is that, except in a few African countries, there is little domestic capacity for producing drugs and medical devices of any kind, including hormonal contraceptives. Most countries depend on imported contraceptives and other essential drugs, and are likely to do so for the foreseeable future.

Access to Sterilization

Female sterilization is the most widely used contraceptive method in the world, but levels of use in Africa remain extremely low. Even though roughly one-quarter of married African women do not want more children, only about one percent currently rely on sterilization.

Nevertheless, evidence points to a growing interest in voluntary sterilization. Clinics in nine countries supported by AVSC International reported almost 25,000 procedures in 1994. In Kenya, where nearly 14,000 procedures now occur a year, the proportion of married women for whom sterilization is the method of choice more than doubled between 1984 and 1993, to 5.5 percent. Doctors in Ghana performed 2,300 sterilizations in 1996, a 50 percent increase over the previous year. Demand in Malawi, Tanzania and Zambia appears to be strong and growing.

Strong cultural factors, in part, continue to inhibit demand for sterilization. African women often refrain from choosing permanent contraception out of fear that they may want another child in the event of divorce and remarriage or the death of a child. Additionally, women considering sterilization often face strong opposition from husbands and extended family members.

Until recently, female sterilization services were virtually unavailable across much of Africa. The lack of services has contributed to low levels of public awareness; on average only half of African women know of female sterilization. Moreover, health workers typically fail to counsel clients on sterilization, and when they do, often exaggerate the side effects. Even in Kenya, one of the only countries in Africa with some access to female sterilization, as recently as 1995 only one-third of family planning clients were receiving information on the procedure during their visit to a clinic.

Contrasting experiences in Kenya

and the Democratic Republic of Congo confirm the interplay between service availability and attitudes towards sterilization. In parts of Kenya with large numbers of satisfied sterilization users, the general population has very positive attitudes towards sterilization. In the Democratic Republic of Congo, where few services are available, feelings about permanent contraception continue to be negative and rumors are widespread.

In practice, access to sterilization is difficult even at those sites where services are nominally offered. Public sector hospitals have chronic shortages of the expendable supplies required for surgery; clinics may schedule procedures only one day a week; doctors and facilities assigned to perform sterilizations are often diverted to other more urgent surgical needs.

Many of the same factors that limit access to female sterilization also severely restrict the use of vasectomy. Five percent of couples worldwide use vasectomy for family planning. In Africa, however, vasectomy is virtually unknown. Among men, fewer than 30 percent have heard of the procedure.

Where it is known in Africa, vasectomy often still carries great stigma, even where female sterilization is becoming increasingly accepted. Both men and women wrongly believe that vasectomy harms a man's health or sexual function. Family planning workers are uninformed about the procedure and biased against it. Furthermore, until recently, few doctors were trained in vasectomy. Pilot vasectomy services are now available in a few countries, including Ghana and Kenya, where knowledge has increased substantially. Still, the number of vasectomies performed yearly probably does not exceed 100 in any country in the region.

Safety of Clinical Procedures

Evidence from Kenya suggests that sterilization in Africa can be as safe as

in other settings; a rate of 5.5 deaths per 100,000 procedures in Kenya is slightly below the average rate of 5.9 per 100,000 found in an analysis of sterilization experience in 35 countries. Safety in Kenya has been enhanced by attention to quality and the widespread use of simpler techniques using local rather than general anesthesia. The less complicated procedure eliminates overnight hospital stays, cutting down on costs and adding to client confidentiality.

Nevertheless, proper infection control in clinical procedures remains a crucial concern for family planning programs in the region, given the high prevalence of HIV/AIDS and other infectious diseases. Health personnel need to protect both themselves and clients from disease transmission during voluntary sterilizations, IUD and Norplant insertions, administration of injectable contraceptives and pelvic examinations.

In many African clinics, however, lack of running water and inadequate staff training result in an absence of even the most basic infection control practices. One study showed that in Senegal just 14 percent of workers wash their hands before performing a pelvic examination; the proportion in six other countries ranges from 49 to 83 percent. Many facilities are also chronically short of infection control supplies and equipment, leading health workers to reuse gloves and other materials without proper disinfection.

Regulatory Barriers and Staff Biases

In many African countries, the choice and availability of contraceptives is further confined by outdated laws, regulations based on misperceptions about health risks and lacking a medical rationale, and biases among health workers. These barriers tend to be greater in French-speaking than in English-speaking Africa, partly because of the legacy of anti-family

Proper infection control in clinical procedures is a crucial concern for family planning programs.

In many African countries, the choice and availability of contraceptives is confined by outdated laws.

planning laws dating from the French colonial era.

In some former French colonies, these laws are still in effect. Although they are not strictly enforced, together with other restrictions on contraceptive availability these laws inhibit the development of family planning programs by maintaining legal ambiguities that can block access to specific contraceptive methods. In Côte d'Ivoire, for example, there is a widespread belief among family planning staff that sterilization is illegal. In fact, the lack of availability of sterilization appears to be the result of discretionary action by health authorities rather than because of a specific law.

Clinic workers across the region commonly, and unnecessarily, restrict contraceptive use based on a woman's age, number of children and marital status. Studies show that many of the health staff who create these barriers believe they are acting out of concern for the safety of their clients. However, these workers often lack adequate knowledge of the contraindications, benefits and potential side effects to the use of specific family planning methods. As a result, they often do their clients more harm than good by overemphasizing the potential dangers from contraception.

In Zimbabwe, for example, many program staff set minimum age requirements for use of contraceptives, despite guidelines dictating that family planning services be available to everyone regardless of age. Likewise, over half of health workers in Zanzibar set unwarranted age restrictions on all contraceptive methods, and many refuse to provide injectable contraceptives – the most popular method – to women with fewer than three children.

Zambia recently dropped its requirement that women obtain written permission from their husbands to receive government family planning services. Government regulations in many other African countries, however, require spousal approval for female sterilization; many field staff also apply

this restriction to other methods. For example, between 30 and 40 percent of family planning workers in Ghana require consent of the spouse before providing women with oral contraceptives, IUDs and injectables.

Contraceptive availability is further restricted by regulations that allow only physicians to provide family planning methods such as Norplant and IUDs – despite studies showing that trained nurses and midwives are just as competent in performing the procedures. Moreover, some countries impose prerequisites for contraceptive use that go far beyond internationally accepted norms for counseling and medical testing. A 1994 study in Senegal found that, to receive Norplant, most women had to wait over two months and make more than four clinic visits for various tests and counseling. Clients wanting sterilization faced similar hurdles.

As an important first step to addressing biases among health staff and unwarranted program restrictions, several African countries have developed and disseminated standardized national guidelines for providing family planning services. However, the effectiveness of these guidelines in removing unnecessary barriers thus far has been uneven. In Cameroon, the introduction of service guidelines in 1993 did not diminish biases among health workers, in part because the new rules were not specific enough in their guidance to field staff. The guidelines also failed to address the most important bias among health workers – the erroneous belief that women menstruating the day of their clinic visit are ineligible to receive oral contraceptives. In Kenya, in contrast, improved medical guidelines are thought to have played a role in large increases in referrals for female sterilization.

Client Counseling

Insufficient training, poor supervision and lack of basic client education

materials leave most family planning workers in Africa with weak counseling skills. In large, busy family planning clinics, workers often lack the time to adequately counsel each patient on contraception; they have even less time available to discuss broader reproductive health topics such as prevention of HIV/AIDS and other STDs. Furthermore, as in many regions, clinic staff traditionally have not given clients enough information to make knowledgeable choices about family planning. Under these circumstances, many clients choose inappropriate contraceptive methods.

Many family planning workers in Africa do not educate clients sufficiently about correct use of their chosen contraceptive method, what side effects to expect and how to manage side effects should they occur. A study of family planning services in 10 African countries found that although two-thirds of clients on average receive information on how to use the method they chose, clinic staff consistently tell

less than half of new family planning users about potential side effects. The percentage receiving information on how to manage possible side effects is even lower – ranging between 1 percent in Côte d'Ivoire and 42 percent in Burkina Faso.

When clients do experience side effects from contraceptive use, field staff typically fail to adequately address client concerns – a shortcoming that is a major factor in the decision by many clients to discontinue family planning use. In studies in Ghana, Nigeria and Tanzania, workers discussed the possibility of switching to another method with fewer than a third of clients experiencing problems with their contraceptive method.

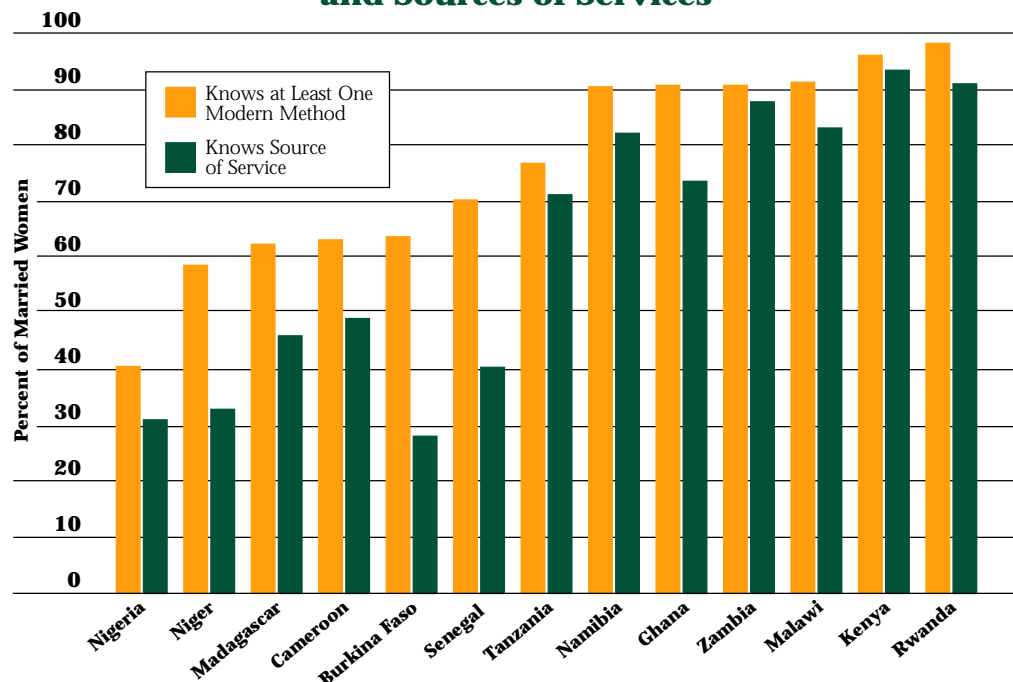
Challenges to Effective Mass Communication

Public awareness of contraceptive methods in Africa has increased dramatically in recent years as a result of the expansion of family planning

Public awareness of contraceptive methods in Africa has increased dramatically in recent years.

FIGURE 18

Knowledge of Contraceptive Methods and Sources of Services



SOURCE: Sian L. Curtis and Katherine Neitzel. *Contraceptive Knowledge, Use, and Sources*. Demographic and Health Surveys Comparative Studies, no. 19. Calverton, MD: Macro International, Inc., 1996.

Many public information efforts fail to give potential family planning clients specific information about where to obtain contraceptive services.

programs and public education efforts. On average, 77 percent of married women in Africa now know of at least one modern contraceptive method. Still, levels of knowledge in most African countries remain below the average for other developing country regions, and public awareness varies substantially from country to country.

In Zimbabwe and Kenya, sustained public information campaigns through mass media and community outreach have helped achieve almost universal knowledge of modern contraception. In contrast, where family planning programs are weak or nonexistent, knowledge of contraceptive methods is generally low. However, some African countries have made extraordinarily rapid advances. In Mali, the proportion of women knowing at least one modern contraceptive method rose from under 30 percent in 1987 to 65 percent by 1995.

A region-wide shortcoming is that many public information efforts fail to give potential family planning clients specific information about how contraceptive methods work, which methods are most appropriate for them and, most importantly, where to obtain contraceptive services. Indeed, almost everywhere in Africa, substantially fewer women know the source for a contraceptive method than know of the method. A good example is Burkina Faso, where 63 percent of women know of at least one modern method of family planning, yet only 28 percent know where to obtain contraceptive services. The national program in Ghana is attempting to increase knowledge of family planning sources by developing a communication strategy that will bridge the gap between knowledge and use.

To succeed, public education programs in Africa must overcome a number of difficult obstacles. Both governments and donor agencies tend to undervalue the long-term impact of health communication, relative to the pressing need for health and family

planning services. Professional opportunities for health educators in Africa are extremely limited, and Africa still lacks enough health staff who understand health education and can design and implement high quality, effective educational programs and materials. Weak communication infrastructure and lack of local technical expertise complicate program design and implementation. Moreover, lack of coordination among international donors, governments and family planning NGOs often results in fragmented and ineffective public education efforts.

Most family planning mass media campaigns use radio, the most cost-effective channel for reaching large numbers of people, especially in rural areas of Africa. Still, exposure to radio and other mass media is low in Africa compared to other developing regions. Radio costs are rising as stations increasingly charge market rates to air health education messages. Also, in many countries, the government tightly controls mass media outlets, and often restricts the broadcast of potentially controversial messages on population and family planning.

The relatively underdeveloped state of the mass media in Africa has stimulated development of other, less hi-tech approaches for disseminating health and population messages, and produced some of the world's most creative family planning communication efforts. One such program in Kenya integrates family planning and reproductive health messages into traditional forms of entertainment such as street theater, dancing, singing and puppet shows.

Beyond Family Planning: Broadening Population Programs

The ICPD *Programme of Action* emphasizes the goal of universal access to basic reproductive health services. In addition to family planning, essential elements of the reproductive health

care package agreed to at the 1994 conference include pre- and postnatal care and safe delivery; prevention and management of complications of unsafe abortion; prevention of HIV/AIDS; and prevention and management of sexually transmitted diseases. The *Programme of Action* also recognizes the importance of extending family planning and reproductive health services to previously underserved groups such as men and adolescents, and of eliminating harmful practices against women, including female genital mutilation.

The intersection of all these issues makes the Cairo agenda especially relevant to Africa, where, as in other regions, governments face the challenge of implementing a significantly broader scope of health services. Important questions remain unanswered regarding which services to provide, in what combination and at what level of the health system. Financing the expanded package of reproductive health services is an important issue for Africa, where health care resources are extremely limited. Additionally, governments in many African countries have only recently incorporated family planning services into health systems. With family planning services new and government commitment to these services still fragile, there is concern that adding other reproductive health services could undermine progress to date in expanding access to family planning.

Linking Family Planning and Related Reproductive Health Services

There is still only limited information on efforts to link family planning with related reproductive health services. The preliminary experience suggests that some degree of integration can enhance the effectiveness of the various components of reproductive health services. In many instances, such integration has been implemented without

undermining family planning efforts; in some cases, it has actually bolstered use of contraceptive services.

- Countries such as Uganda and Zimbabwe already have integrated family planning and reproductive health services in training curricula for health workers. Workers now learn screening and management of reproductive tract infections as part of an integrated curriculum, a skill that allows them to better meet client needs and ensure safer IUD insertion.
- Many contraceptive supply systems in Africa were initiated separately from public sector systems for the distribution of essential drugs. To some degree, the better-functioning family planning programs owe their success to a single-minded focus on the efficient supply of contraceptive methods. Now, however, governments are taking a fresh look at supply systems dedicated to contraceptive distribution alone, and are beginning to explore integrated models that may be more cost-effective in the long run. In Kenya and Eritrea, systems originally set up to manage contraceptive supply are now being used to manage supplies of essential drugs as well, to the benefit of both family planning and STD prevention efforts.
- A number of African countries, including Tanzania, Uganda and Zambia, are combining mass media messages on family planning and reproductive health and at the same time working to improve the counseling skills of health workers in both family planning and STD prevention. Moreover, there is growing interest on the part of African health education programs to incorporate messages on double protection – using condoms for disease prevention together with a more effective contraceptive method such as hormonal

Financing the expanded package of reproductive health services is a difficult issue for Africa because health care resources are limited.

At existing family planning clinics, there is too little integration of family planning with other reproductive health services.

contraception or sterilization for preventing pregnancy.

Despite these positive developments, the synergy between family planning and other reproductive health services has yet to be fully developed. At existing family planning clinics, there is often too little integration of family planning with other related reproductive health services, such as counseling for HIV/AIDS and

STD prevention. Moreover, the quality and scope of these other services are highly variable. Smaller facilities do not offer the range of reproductive health services seen at larger hospitals. However, in hospital settings, family planning is also more likely to be physically separate from other reproductive health services.

A further barrier to integration is that AIDS and STD prevention programs typically are administered

The Challenge of Integration: Experience from Kenya

A recent effort in Kenya illustrates some of the challenges programs face in integrating STD prevention with maternal and child health and family planning (MCH/FP) services.

Before 1990, women in Nakuru, a city of 220,000 located 160 kilometers northwest of Nairobi, had few options when seeking diagnosis or treatment for sexually transmitted diseases. STD services were available only in the curative wings of the five clinics operated by the Nakuru city council and the health ministry hospital. Information and counseling on HIV/AIDS and other STDs were virtually nonexistent.

As a result of growing concern over the spread of HIV/AIDS, in 1990 health officials designed an approach to better identify and treat women at risk of infection. HIV/AIDS and STD services were introduced at the outpatient MCH/FP clinics which for many women serve as their only contact with the health system. At the same time, the hospital in Nakuru established a special clinic for STD treatment.

Training and adequate drug supplies have been the cornerstones of the integration effort. Staff at the outpatient clinics learn to counsel women and assess their risk of infection. They also receive training in simple techniques to screen and treat clients for common STDs and in notifying partners of clients suspected of having an STD to prevent reinfection. The project also aims to keep clinics well-stocked with drugs for treatment of common STDs.

In practice, the approach has faced some difficulties. While the city council clinics have adequate supplies of the essential drugs needed to treat common STDs, the provincial hospital and the STD clinic often have shortages. Furthermore, because of Kenyan regulations prohibiting nonphysicians from prescribing antibiotics, nurses at the city council clinics still must refer STD clients to a doctor for treatment. Most clinics also lack sufficient quantities of brochures, posters and pamphlets for client education on STDs and HIV/AIDS.

Counseling efforts also face a number of obstacles. Few women receiving MCH/FP services know that STD services are also available within the same clinic. Client knowledge of STD symptoms or modes of transmission of HIV/AIDS is often poor. Moreover, clinic staff are successful in notifying partners for just one-third of clients with syphilis and just 10 percent of women diagnosed with symptoms of other STDs.

The experience in Nakuru is typical of the challenges facing programs across Africa. The seriousness of the AIDS epidemic will require health officials to intensify efforts to seek effective models of STD prevention and treatment.

and funded separately from other health services, often leading to disagreement among program officials over strategy and priorities. For example, in Ghana the government is attempting to introduce STD prevention and treatment at clinics providing family planning and maternal and child health services; however, poor communication between the two programs has held up these efforts.

Key Challenges

The following are key challenges programs face in more fully capitalizing on the synergies between family planning and other reproductive health services.

Preventing HIV/AIDS and Other Sexually Transmitted Diseases

In sub-Saharan Africa more than in any other region, sexually active men and women have closely related needs to protect themselves from unwanted pregnancy as well as from debilitating and often life-threatening disease. With HIV prevalence high in many countries and other sexually transmitted diseases common throughout Africa, there is a strong likelihood that many family planning clients already have or are at high risk of contracting a sexually transmitted disease. Despite some progress, health and family planning services have not adequately responded to this reality.

At the clinic level, there are still many missed opportunities to provide clients with information about sexually transmitted diseases. A study in 10 African countries revealed that health workers discuss sexually transmitted diseases with only 1 in 10 new family planning clients; HIV/AIDS was discussed with just 1 in 14 new family planning clients.

Lack of training in proper management of STDs and the reluctance of health workers to discuss sexually

transmitted diseases with clients are major reasons for this serious omission. Clinic staff often believe married women are at low risk of infection and are uncomfortable raising such a sensitive topic. Yet, studies show that many women perceive themselves to be at high risk and want to hear about STDs. By failing to adequately assess a client's risk of sexually transmitted disease, health workers miss an opportunity to both prevent new infections and to use simple and effective approaches to diagnose and treat common STDs.

Moreover, STD testing and referral services are weak and few family planning clients are even aware of the availability of such services. One cross-country study found that fewer than 40 of over 2,500 women seeking family planning services received an STD laboratory test or referral; less than 10 percent of clients were aware of STD or HIV/AIDS services available at the clinic they were visiting. These results are hardly surprising. Outside of large cities, few laboratory facilities exist for accurate diagnosis, and drugs for STD treatment are often in short supply, especially in public sector programs. Also, across most of sub-Saharan Africa, only physicians are allowed to prescribe the antibiotics that are used in STD treatment.

Additionally, in most African countries, STD/HIV screening and treatment services have almost always been focused on specialized urban clinics serving high risk groups such as commercial sex workers. Women from the general public shun these facilities because of the stigma attached to being identified as carrying an STD and because of the judgmental attitudes of many of the staff at these clinics. As a result, even those women who suspect they may have an STD are unlikely to seek treatment at specialized facilities; as in other developing regions, most women in Africa with an STD go undiagnosed and untreated.

To help increase the chances that women will seek and receive STD screening and treatment, African

At the clinic level, there are still many missed opportunities to provide clients with information about sexually transmitted diseases.

A recent study shows that local communities want outreach workers to provide information on HIV/AIDS and other STDs.

program managers are testing various strategies to incorporate STD services into existing family planning and maternal and child health programs.

- Training of health and family planning staff in management of STDs is moving forward in some countries. By 1995, 50 percent of family planning staff in Kenya and 66 percent in Botswana had received training in management of sexually transmitted and reproductive tract infections; less than a quarter, however, had received training in HIV/AIDS counseling.
- Mass media campaigns to inform the public about sexually transmitted diseases have been implemented in a number of African countries, often in conjunction with condom social marketing programs. These public education efforts have successfully raised awareness of AIDS; over 90 percent of adults surveyed know of the disease. Still, information campaigns have been uneven in their scope and effectiveness, and knowledge does not necessarily translate into behavior change.
- A recent study in Kenya showed that local communities want outreach workers to provide information and counseling on HIV/AIDS and other sexually transmitted diseases. Moreover, the study showed that communities also support education for young people and single men and women, a further sign of the seriousness of local concern over the impact of the AIDS epidemic. While many outreach programs in Africa – especially those run by NGOs – have already taken steps to incorporate AIDS and STD prevention activities alongside family planning information and services, they still face many challenges in effectively implementing this new approach.
- Research on the cost of adding STD services – a concern to governments everywhere in Africa – is also underway. A recent study in Kenya

found that the cost of providing integrated family planning and STD services is up to one-third lower than providing the two services separately, mainly because of savings in staff time and economies of scale from sharing space. Nevertheless, the laboratory and drug costs associated with most STD services are high. Clients will likely have to share some of the cost of these services, but setting prices too high may put services beyond the reach of many poor Africans.

Reducing Maternal Mortality

It has now been 10 years since the 1987 Safe Motherhood Conference in Nairobi – a landmark event in the effort to combat high maternal mortality in Africa and other regions. Yet, despite heightened awareness among policymakers of the magnitude of the problem in Africa, maternal death rates in Africa show no sign of decreasing, and may even be on the rise in some countries.

Along with expanding coverage of family planning services, the most effective strategy to reduce maternal risk is improving essential obstetric care for pregnant women. Yet, because of limited access to overall medical care, use of maternal health services is poor; resources to handle obstetric emergencies are limited and becoming scarcer in some countries. From Nigeria, for example, there is evidence that deepening poverty and increased client fees have caused a drop in the number of women using health facilities for normal delivery services, although women with complications are still being seen with the same frequency.

Ghana, Nigeria and Uganda are attempting to address the need for emergency care through improved training of clinic and hospital staff, and improved community education. In part because of the difficulty of measuring maternal deaths within a relatively small population, these

programs have not yet demonstrated a clear impact on reducing maternal risk. In Tanzania, however, one regional hospital was able to show a substantial decrease in maternal mortality at the facility after implementing a program to improve quality of care.

In practice, African governments have done little to address the problem of maternal death; those programs that exist are small in scope. Also, experts acknowledge that initially too much effort went into approaches that proved relatively ineffective in reducing the risk of maternal death, including training of traditional birth attendants and the development of screening tools to identify pregnant women at high risk of complications.

Improved maternity care includes outreach to women who deliver at home; referral as needed for management of complications; and improved transportation for women in need of emergency care. Better treatment of complications requires improvements in facilities and staff training, especially at health centers and hospitals. By contrast, the bulk of family planning and other reproductive health services such as STD prevention can be provided at smaller health centers and posts, and through outreach workers. Therefore, at the operational level, opportunities for integrating family planning services with activities to prevent maternal death are relatively few.

Improving Postabortion Care

One bright spot in the battle to reduce maternal risk is the headway being made on expanding emergency care for women suffering complications from unsafe abortion. The high number of deaths from unsafe abortion has helped spur public debate in a number of African countries, and some governments are at last taking effective action to deal with the enormous health consequences of unsafe abortion. Programs to expand access to emergency treatment of abortion

complications and postabortion family planning and reproductive health counseling and services are growing.

Manual vacuum aspiration (MVA) – a safe, simple and low-cost technique for treating incomplete abortion – has now been introduced into at least nine countries in sub-Saharan Africa, including Ethiopia, the Gambia, Ghana, Mozambique and Zambia. The new technique has lowered treatment costs and helped save the lives of many women.

The postabortion care programs in Kenya and Nigeria, both begun in 1987, are the most advanced in Africa. The Kenyatta National Hospital in Nairobi, the country's most important teaching hospital, has trained over 200 Kenyan doctors in the MVA technique, and now trains physicians from around the region. Introduction of MVA at one facility in Kenya reduced the cost of treating a woman with an incomplete abortion by 66 percent. In Nigeria, virtually all large teaching hospitals now train doctors in postabortion care; training for staff at several smaller state-run hospitals and for private practitioners is expanding.

Efforts to train nurses and other health auxiliaries in emergency postabortion care are also gaining ground. The presence of trained personnel at the nearest health facility, which often has no physician on staff, will allow women to obtain emergency services more quickly. Ghana is one of a number of countries around the region training midwives in post-abortion care; some 40 Ghanaian nurse-midwives – mostly in private practice – have received training and equipment to perform MVA. Changes in national policy support these efforts. Ghana's new national reproductive health service guidelines require that all doctors and midwives receive training in emergency postabortion care and that MVA equipment be available at all health centers and hospitals.

Family planning services are an integral part of postabortion care. Women who have undergone abortion

Programs to expand access to emergency treatment of abortion complications and postabortion family planning are growing.

High rates of unintended teen pregnancy, unsafe abortion and HIV/AIDS have contributed to a public awareness of adolescent sexual health needs.

are often in immediate need of family planning services; many are highly motivated to use contraception. However, links between family planning services and emergency postabortion care are still weak in most of Africa. Family planning services themselves are still not widely available in many countries. Even where they exist, the two services are often provided by different staff and in separate facilities. Health workers providing emergency treatment may not view contraceptive provision as their responsibility; even those clinic staff willing to provide family planning services to abortion patients often know little about which contraceptives are appropriate to provide to women who have just undergone an abortion.

A number of countries are taking steps to expand access to safe abortion. South Africa changed its abortion laws in early 1997 to allow elective abortion during the first trimester of pregnancy and for a range of reasons later in pregnancy; similar legislation is being considered in neighboring Namibia. Participants from 18 African countries at a recent symposium on removing legal barriers to sexual and reproductive health recommended that safe abortion be available in cases of rape, incest, early pregnancy and congenital malformation.

Even in countries such as Ghana and Zambia, where the law permits abortion on broad social and health grounds, access to safe abortion – especially for rural women – is still difficult. Neither the public nor health workers have a good understanding of laws regulating abortion, and the vagueness and cumbersome administrative requirements of the law leaves many doctors reluctant to provide abortion services.

Meeting Adolescent Sexual Health Needs

High rates of unintended teen pregnancy and unsafe abortion, coupled

with the heavy toll that HIV/AIDS is taking in young lives, have contributed to a growing public awareness of adolescent sexual health needs in Africa. A number of innovative initiatives are underway to meet these needs.

- In Kenya, Madagascar and Nigeria, among other countries, special clinics provide STD prevention and contraceptive information and services for young people. Elsewhere, youth centers provide contraceptive and other reproductive health services as one element of more comprehensive programs including recreation, education or job skill training.
- Community-based outreach programs using youth peer counselors often have a contraceptive distribution and clinical referral component. One program in Ghana teaches young men in rural villages traditional handicraft skills while educating them about important reproductive health issues such as prevention of sexually transmitted diseases. However, most of these activities remain small-scale, private efforts, and few have been rigorously evaluated for their effectiveness.
- Contraceptive social marketing programs in African countries such as Nigeria have had success marketing condoms to young people. By making contraceptives available in commercial outlets, social marketing programs offer youth an alternative to the potential embarrassment of a clinic visit. In the Nigerian social marketing program, a youth-oriented radio series and peer education efforts complement commercial condom distribution.
- In addition, most national family planning education campaigns in Africa now have special youth components. Radio programs geared to young people in Kenya, Nigeria

and Uganda transmit messages on sexual responsibility and information on AIDS and pregnancy prevention.

Yet, despite greater understanding of the high rates of teenage pregnancy and elevated risks of childbearing that young African mothers face, reproductive health services for adolescents remain inadequate virtually everywhere in Africa. In most countries, the provision of sexual and reproductive health information and services to unmarried young people remains highly controversial. Laws and policies severely restrict their access to reproductive health services.

The attitudes of health workers are another major obstacle to the effective provision of reproductive health services to adolescents. Field staff often refuse to provide unmarried or childless young people – especially young women – with contraceptives. As a result, many young people feel unwelcome in regular health clinics. A 1995 study in Kenya found that three-quarters of community family planning workers are unwilling to provide contraceptives to young women who have not yet given birth. By contrast, 80 percent of these workers said they would give contraceptives to young men, regardless of the number of children they have.

In varying degrees, almost every country in sub-Saharan Africa now has some sexuality education in schools, yet implementation of these programs has encountered numerous problems. Specific information on family planning methods and STD prevention is often absent from the curriculum; when it is included, it often comes in secondary school – too late for the majority of youth who have already dropped out. Moreover, teacher training and materials are generally inadequate; even when more specific information is given, it tends to be scattered throughout the curriculum, undermining the extent to which

students absorb and comprehend this information.

Despite the vital importance of sexuality education programs in promoting healthy and responsible sexual behavior, conservative religious forces often strongly oppose such programs for young people. In Kenya, for example, the Catholic church has been a major obstacle to implementing large-scale adolescent reproductive health programs. Under church pressure, the Kenyan government has all but terminated sexuality education in the schools.

Men and Reproductive Health

African men play an important role in decisions about the number and spacing of children. They also bear the prime responsibility for efforts to prevent the spread of HIV/AIDS and other sexually transmitted diseases.

Programs in a number of African countries are attempting to enhance the participation of men in family planning and reproductive health and increase male support for use of family planning by their partners. The prime example of this strategy is social marketing programs, which across Africa have successfully encouraged men to use condoms for both STD and pregnancy prevention. Several information campaigns in Africa have helped to improve men's knowledge of family planning and STDs, while also contributing to better communication between spouses.

Other small-scale efforts to provide services for men have had encouraging results. Community outreach efforts in Cameroon, Ghana, Kenya, Mali and Swaziland have provided men with information and contraceptives in their homes and at their places of work. A program in Cameroon enlisted male community leaders in rural areas; after one year, knowledge of condoms among men in the project communities rose from 52

Programs in some African countries are trying to encourage the participation of men in family planning.

The deep cultural roots of female genital mutilation have made it difficult to mount successful efforts to diminish this practice.

to 81 percent. In Ghana, an information campaign designed to encourage men to visit Ministry of Health facilities increased discussion of family planning between men and their partners, as well as use of contraceptive methods. Male-only clinics have also been tried in a few African countries, with mixed results.

In spite of these efforts, family planning and reproductive health programs in the region for the most part continue to ignore the needs of men. Most men lack good information on family planning and reproductive health; existing services are rarely geared towards meeting their needs. In the vast majority of clinics, men still feel neither welcome nor comfortable asking for family planning services.

Female Genital Mutilation

The deep cultural roots of female genital mutilation (FGM) have made it difficult to mount successful efforts to diminish this practice. The most promising approaches thus far appear to be those that combine community education on the harmful effects of FGM with activities to persuade women who perform FGM to abandon the practice. Although in most cases it is too early to know whether these efforts are successful, one program in eastern Uganda lowered the incidence of the practice by 36 percent between 1994 and 1996. Community leaders in the program area agreed to replace the traditional ceremony with symbolic gift giving, while preserving all other aspects of the rite of passage of girls to adulthood. The project combines education on FGM with delivery of family planning and other reproductive health services.

The introduction of legal prohibitions appears to have had little impact on the practice. Anecdotal evidence suggests that enactment of anti-FGM laws simply drives the practice underground. Moreover, most African governments are reluctant to take a strong stand in opposition to FGM, in part because of continuing high levels of popular support for the procedure, including among women. In Mali, for example, where 94 percent of women have undergone FGM, fully three-quarters of women continue to support the custom. Eradication efforts are meeting vocal public resistance and are increasingly becoming a volatile political issue in countries such as Sierra Leone.

An exception to government inaction has been Burkina Faso, which in 1996 became one of the first countries in Africa to ban the practice, as part of a comprehensive national eradication program. Strategies to address the health consequences of FGM include training all staff in health ministry clinics to identify and treat complications related to FGM; establishing a referral system for women suffering complications; and employing mobile surgical teams to treat complications.

However, in Burkina Faso, as in other areas where FGM is prevalent, the role of health workers in prevention efforts is unclear. While health professionals can participate in activities to raise awareness of the harmful health effects of the procedure, their influence may be limited by strong social and cultural factors. Ultimately, reductions in the practice of FGM may depend on overall improvements in the status of women within African society. Survey evidence shows that women (and men) who are more highly educated are less likely to support the continuation of FGM.