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REPOSITIONING FAMILY PLANNING IN REPRODUCTIVE HEALTH SERVICES: FRAMEWORK FOR ACCELERATED ACTION, 2005–2014

Report of the Regional Director

EXECUTIVE SUMMARY

1. Family planning, identified as an essential component of primary health care in the Alma-Alta Declaration and of reproductive health at the International Conference on Population and Development, plays a major role in reducing maternal and newborn morbidity and mortality. It contributes towards the achievement of the millennium development goals (MDGs) and the targets of the Health-for-All Policy.

2. The implementation of family planning services in Africa is challenged by poverty, poor access to family planning services and commodities, conflict situations, inadequate coordination of programmes and dwindling donor funding. Traditional beliefs favouring high fertility, religious barriers and lack of male involvement have weakened family planning interventions. Family planning has received little attention at individual, social and policy levels due to other competing priorities. These factors have resulted in low contraceptive prevalence rates among sexually active women, high total fertility rates and high unmet needs for family planning.

3. This framework aims to provide guidance on how to revitalize the family planning component of national reproductive health programmes in order to ensure a comprehensive approach to improving maternal and child health in the context of the MDGs.

4. In the next ten years, the main interventions will include advocacy for making family planning an agenda for all sectors and improving access to services at all levels. Other interventions include strengthening national capacity for sustainable programmes, strengthening community participation, addressing family planning needs of vulnerable populations and operational research.

5. Effective repositioning of family planning through improved integration into reproductive health services at all operational levels will require policy decisions from Member States as well as concerted efforts from governments, the World Health Organization and partners.

6. The Regional Committee is requested to review and adopt this ten-year framework for accelerated action.

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INTRODUCTION

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1. In sub-Saharan Africa, the contraceptive prevalence rate (CPR) is very low, estimated at 13%[1] for married women, the total fertility rate (TFR) is 5.5 children per woman and the risk of maternal death is 1:16; these facts compare unfavourably with developed countries where the CPR is high, the TFR has declined to 1.6 and maternal death risk is 1:2 800.[2] The millennium development goals (MDGs) call for three-quarters reduction in maternal mortality and two-thirds reduction in child mortality between 1990 and 2015. Effective family planning (FP) services are critical for the attainment of these goals.

2. Since the mid-1980s, most countries have developed national programmes for reproductive health, including family planning. Despite this, available data indicate high unmet family planning needs. Over 120 million women in sub-Saharan Africa still have unmet needs for family planning, and 350 million lack access to a full range of contraceptive methods.[3] The majority of these are the poor and adolescent populations who are at high risk of unwanted pregnancy, HIV/STIs and other reproductive ill-health. Tackling these unmet needs and addressing the related high disease burden poses major challenges to the African Region.

3. Family planning was identified in the Alma-Ata Declaration (1978) as an essential component of primary health care (PHC) within the context of the Health-for-All Policy. In 1997, the WHO Regional Committee for Africa adopted *Reproductive Health: A Strategy for the African Region* (AFR/RC47/8) which endorsed the vital role of family planning in attaining optimal reproductive health status and general well-being. In 2003, the Regional Committee adopted *Women's Health: A Strategy for the African Region* (AFR/RC53/11) which identifies family planning as an intervention for improving the quality of life of women. Ministers of health noted that early, repeated and frequent pregnancies negatively affect the nutritional status of women and contribute to physical exhaustion, susceptibility to infections and early ageing. They emphasized the need to address family planning and particularly birth-spacing in order to improve quality of life of African women.

4. Effective implementation of family planning services and reproductive health programmes in sub-Saharan Africa presents a formidable challenge which is now compounded by the HIV/AIDS pandemic. The need to respond to the worsening HIV/AIDS situation provides an opportunity to increase financial, human and managerial resources for reproductive health programmes, including family planning.

5. In this context, the WHO Regional Office for Africa has developed this framework to guide programme managers in strengthening and developing focused family planning services and in mobilizing resources to ensure sustainability.

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[1] UNFPA, State of the world population 2002, New York, United Nations Population Fund, 2002.
[2] WHO, UNICEF and UNFPA, Maternal mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA, Geneva, World Health Organization (http://www.reliefweb.int, 20 October 2003, accessed 18 June 2004).
[3] UN, 2001 World population prospects: The 2000 revision, New York, United Nations Population Division, 2001.

SITUATION ANALYSIS

6. In the six years following the 1994 International Conference on Population and Development (ICPD), the world's 1.3 billion women of childbearing age experienced more than 1.2 billion pregnancies of which more than 25% were unintended. These unwanted pregnancies resulted in the deaths of nearly 700 000 women. The majority (over 400 000) died as a result of complications of unsafe abortions.[4]

7. Sub-Saharan Africa, which is home to only 10% of the world's women, contributes annually, 12 million unwanted or unplanned pregnancies[5] and 40% of all the pregnancy-related deaths worldwide.[6] Women under 20 years of age account for 70% of abortion complications as a result of unwanted and unplanned pregnancies.[7]

8. Reducing unwanted pregnancies significantly lowers the number of maternal deaths. Studies on maternal and child mortality have shown that longer birth intervals reduce maternal mortality and improve nutrition. An under-five is twice as likely to survive and be better nourished if the previous birth was two years to five years.[8]

9. In the 1980s and 1990s, family planning services were mainly implemented as vertical, donor-driven projects and not as part of a national comprehensive reproductive health programme. Governments rarely had ownership. With declining donor support and many competing priorities, FP services have not received adequate government budget allocations. Consequently, irregular supply of modern contraceptives has threatened commodity security, i.e. secure supply and choice of quality contraceptives to meet every person's need at the right time and in the right place.

10. Inadequate coordination of family planning partners has encouraged proliferation of small-scale projects. Consequently, the expected impact on maternal and child health and survival has not been realized.

11. Quality of health care is inadequate in most countries. The health system remains weak and cannot respond to health needs due to inadequately skilled health providers; lack of equipment, medicines and supplies; and an inefficient referral system. There is a high attrition rate among skilled personnel, including midwives, and lack of both institutional and human capacity to manage family planning service delivery, including contraceptive logistics. Studies show that inadequate health care contributes to contraception discontinuation rates.

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[4] Daulaire N et al., Promises to keep: The toll of unintended pregnancies on women's lives in the developing world, Washington, DC, Global Health Council, 2002.
[5] AGI, Sharing responsibility: Women, society and abortion worldwide, New York, Alan Guttmacher Institute, 1999, p. 51.
[6] Lim AT, Satia J, Reproductive health issue in sub-Saharan Africa, *Innovations*, 6:1–25, 1998.
[7] WHO, Unsafe abortion: Global and regional estimates of incidence of mortality, third ed., Geneva, World Health Organization, WHO/RHT/MSM/97.16, 1997.
[8] Setty-Venugopal V, Upadhyay UD, Birth spacing: Three to five saves lives, Baltimore, Johns Hopkins Bloomberg School of Public Health, 2002.

12. Over the years, the loss of emphasis on traditional and cultural values, including traditional family planning methods, has encouraged early, frequent and numerous pregnancies.

13. In spite of major gaps in the delivery and quality of services, some countries have developed comprehensive reproductive health policies and programmes. This has facilitated the provision of integrated RH services, including family planning. Family planning has also been an entry point for integration of RH services and the prevention and control of HIV/AIDS/STIs.

14. Many countries have adapted WHO family planning approaches, generic guidelines and training modules to develop or strengthen programmes. The WHO Strategic Approach[9] has enabled at least 11 countries in the African Region to improve the quality of family planning services. Consequently, some countries have attained a contraceptive prevalence rate above 50% for married women.

CHALLENGES

15. Health systems pose a challenge to family planning programmes. Access to FP commodities has remained poor. Sale and distribution of contraceptives have mostly been restricted to medical practitioners in health facilities. Although commodities are often available from private for-profit suppliers, they are not affordable to the majority of clients. Lack of user-friendly services for sexually active and married adolescents has been a constraint in access to services. Civil wars and conflicts in the African Region have resulted in many displaced persons living in camps where social services are minimal, destroyed or non-existent. Often, there are no functioning health institutions or systems of governance and no access to family planning services.

16. Cultural beliefs and religious barriers influence family planning programmes. Men are often neglected in FP interventions although they represent about 50% of the global population.[10] Their roles as community leaders, policy-makers, technical experts, clinicians and husbands are critical in decision-making for access to reproductive health services and family planning commodities. Religious barriers and cultural beliefs in Africa often favour high fertility, create misconceptions that prevent men and women from using specific methods or prevent providers from suggesting certain methods as options.

17. Inadequate coordination of many health programmes at country level results in duplication, inefficient utilization of resources and missed opportunities. There are no linkages between procurement and distribution procedures for family planning commodities and those for HIV/AIDS and STI programmes, for example, condoms.

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[9] WHO, Making decisions about contraceptive introduction: A guide for conducting assessments to broaden contraceptive choice and improve quality of care, Geneva, World Health Organization, WHO/RHR/02.11, 2002.
[10] Planned Parenthood Association of Sierra Leone, Male involvement in sexual and reproductive health and family planning, Innovations, 6: 83–96, 1998.

OPPORTUNITIES

18. Existing national reproductive health policies and programmes supported by global and regional level partnerships provide an enabling environment for implementing family planning activities. In addition, training materials and reference documents on the benefits of birth-spacing and contraceptive methods are available for capacity building. The ongoing health sector reforms, including sector-wide approaches, in many countries allow for integration of FP into national development plans as a component of reproductive health programmes using a multisectoral approach.

19. Maximum benefit should be made of the renewed interest of international development partners and donors in family planning as a means of improving maternal and child health and survival as well as achieving the millennium development goals.

20. Voluntary counselling and testing (VCT) services for HIV/AIDS can be entry points for family planning as FP and VCT services are complementary. Family planning provides opportunity for strengthening VCT which offers opportunities for FP by emphasizing the dual protection role of condoms in prevention of both pregnancy and HIV infection.

21. The WHO Maternal and Newborn Health Programme, which aims at strengthening health systems for improved services to mothers and their newborns, provides a major entry point for scaling up family planning services especially at antenatal and postnatal clinics.

22. The workplace is ideal for providing both men and women with family planning services, but this entry point has not been fully exploited.

23. The promotion of exclusive breastfeeding as a child survival strategy provides an entry point for traditional family planning and birth-spacing methods.

OBJECTIVES

24. The aim of this framework is to provide guidance to Member States on how to revitalize the family planning component of national reproductive health programmes in order to ensure a comprehensive approach to improving maternal and child health in the context of the MDGs.

25. Specific objectives for Member States are to:

(a) Advocate at all levels of population for quality family planning services

(b) Build capacity for improved family planning services

(c) Improve access to and use of quality family planning services at all levels

(d) Mobilize resources for family planning services.

GUIDING PRINCIPLES

26. The accelerated implementation of effective and efficient family planning services within reproductive health in countries will be guided by the following principles:

(a) *Availability, accessibility and affordability* of quality family planning services: based on national priorities, and responsive to specific needs, even in settings which lack resources;

(b) *Gender equity:* improving access to quality services and enhancing responsibility at all levels; involving all relevant population groups in the planning and implementation of family planning interventions; and providing male and female contraceptive methods;

(c) *Stewardship:* ensuring national ownership and responsibility for the security of commodities in spite of the changing epidemic and economic environment;

(d) *Sustainability:* ensuring optimal allocation of resources and strengthening managerial capacity as prerequisites for commodity security;

(e) *Multisectoral approaches:* strengthening the linkages between health and other sectors, and taking advantage of the comparative strengths of stakeholders in the provision of family planning services so as to make use of all available entry points and opportunities to address unmet needs;

(f) *Partnerships:* ensuring coordination and collaboration at all levels within and outside the health sector to avoid duplication and maximize resources;

(g) *Male involvement:* empowering boys, youth and men within homes, communities, workplaces and recreation centres through information on reproductive health matters.

IMPLEMENTATION AGENDA

27. *Advocacy* based on evidence of the cost-effectiveness of family planning and its benefits to maternal and child health and national development should be promoted at individual, family, community and policy levels. Ministries of health should use appropriate tools to advocate with government and relevant ministries to prepare messages that address the needs of the people, including assurance of their future fertility. Education of the girl-child is crucial for development and poverty alleviation, both of which are important for health service utilization, including family planning and birth spacing. Family planning should be included in the national reproductive health policy. It should be discussed in the context of the United Nations Development Assistance Framework (UNDAF), poverty reduction strategy papers (PRSPs), Commission on Macroeconomics and Health investment plans and sector-wide approaches (SWAps); and addressed in resource collaborations with the World Bank, the New Partnership for Africa's Development (NEPAD) and other development partners. Specific allocation should be made for FP commodities by both government and partners. Innovative ways

for financial resource mobilization and disbursement, especially at operational levels, should be explored and implemented.

28. *Improving access* to quality family planning services and various regularly available modern contraceptive methods requires expanding delivery points to antenatal and postnatal clinics, voluntary counselling and testing centres, vaccination points, child welfare clinics, pharmacies, laboratories, markets, workplaces and other community-based outlets. Subcontracting services to the private sector and social marketing strategies should be explored. Effective contraceptive logistics and security systems for procurement, local manufacture, storage and distribution are important. Regional partnerships for condom manufacture and procurement of contraceptives at the best price can be explored under the umbrella of NEPAD. Skilled managers, reliable infrastructure and effective monitoring mechanisms are the keys to access.

29. *Strengthening capacity* for improved family planning services requires institutional capacity building, including maintenance, rehabilitation of infrastructure and equipment as well as pre- and in-service training of providers. This means updating the curriculum to integrate reproductive health, including family planning, HIV/AIDS and STIs. Each country will require appropriate retention and motivating mechanisms, especially for community-based distributors.

30. *Strengthening community participation* by involving key community and religious leaders and men in family planning education and communication strategies will improve demand for services. Cultural and religious misconceptions should be addressed through promotion of the benefits of FP to the individuals and communities. Community resource persons, including traditional birth attendants, can render service such as information dissemination, advocacy on methods and supply of selected commodities. Providing male contraceptive methods and strengthening men's decision-making role in contraception are crucial. Increased condom use by men should be reinforced. Information in youth programmes, family life education, peer counselling and clinics can empower boys, youth and men in reproductive health matters. Men's involvement in HIV/AIDS programmes provides opportunities for involving them in discussions on the benefits of family planning. Male involvement and participation in family planning is crucial, taking into consideration their central role in decision-making in families.

31. *Addressing the family planning needs of vulnerable populations* requires that countries promote humanitarian initiatives for reaching out to young people, displaced persons, refugees and others. Family planning commodities should be included in the essential medicines list for war and conflict situations.

32. *Operational research* on service barriers, commodity security and other implementation issues is an important part of the family planning agenda. Other research areas are sustainable financing, male involvement and traditional family planning methods. Research data should be used to guide interventions and improve services.

MONITORING AND EVALUATION

33. The goal of the International Conference on Population and Development (ICPD) is to assist couples and individuals to achieve their reproductive goals and provide the opportunity for exercising the right to have children by choice. The global target is universal access to a full range of safe and effective family planning methods as part of comprehensive reproductive health care. By 2005, 60% of PHC facilities should offer the widest possible range of safe and effective family planning methods; this target should be expanded to 80% by 2010 and 100% by 2015.

34. Countries should be supported to monitor progress of implementation using agreed indicators. Countries should set specific targets, taking into account current total fertility rates, contraceptive prevalence rates, population growth rates and number of unwanted pregnancies. National health information systems and demographic health surveys are possible data sources for monitoring progress.

35. More attention should be focused on contraceptive logistics by strengthening record-keeping at all levels and ensuring commodity supply at delivery points. Self-assessment by family planning service providers using client-oriented, provider-efficient methods will improve the quality of service delivery at operational level.

36. Community level data are crucial for effective monitoring of impact. The performance of community-based distributors shall be monitored by the community as well as the formal health system. This is essential for quality control, availability of and accessibility to FP commodities.

ROLES AND RESPONSIBILITIES

37. Policy on family size and birth spacing is required for impact. In their leadership and stewardship role, countries should review their reproductive health policies to create an enabling environment to promote an integrated and comprehensive RH programme in which family planning is a crucial component. Ministries of health should play a leadership role in using the potential benefits of a multisectoral approach at all levels of service delivery. Clarification of roles of the various sectors based on comparative advantages at different levels will improve coordination and ensure synergy.

38. Governments are also responsible for partnership building, coordination of stakeholders, resource mobilization, quality assurance, and monitoring and evaluation. Key stakeholders at country level include the private sector; NGOs; bilateral agencies; professional associations; women's, men's and youth groups; faith-based organizations; community-based networks; individuals and families. The family planning agenda should be included in national and subnational development plans as well as collaborative plans with the World Bank, NEPAD and regional economic blocs.

39. Local production of condoms coupled with quality assurance should be explored and encouraged. Special family planning logisticians should work at improving the

management of commodities. Where possible, there should be a national family planning coordinator within a reproductive health unit of the ministry of health. Where not possible, existing staff of the reproductive health unit should have specific responsibility for family planning.

40. WHO and partners will collect evidence on client satisfaction, cost, cost-effectiveness and socio-economic benefits of family planning. Countries will be supported to adapt and implement available guidelines and tools for capacity building. Activities will be undertaken for advocacy and resource mobilization in the context of improved maternal and newborn health. Support for capacity building on logistics and other vital areas will improve service delivery.

CONCLUSION

41. Family planning is one of the four pillars of safe motherhood. Access to affordable, high-quality family planning services is one of the most important interventions to reduce maternal morbidity and mortality, reduce poverty and promote sustainable development.

42. Family planning services, including contraceptive methods and logistics, counselling and funding, must be repositioned within reproductive health programmes in Member States if the African Region is to significantly reduce maternal mortality.

43. Considering the central role men play in decision-making in families, and the impact of these decisions on the health of women and children, men’s involvement and participation in family planning are crucial and should be ensured.

44. Birth spacing of more than two years promotes the health and survival of the woman and her child, a major target of the millennium development goals and the Health-for-All Policy. “More than two years birth interval saves lives” is a clear message for repositioning family planning.

45. The WHO Regional Committee for Africa is hereby invited to review and adopt this ten-year framework.