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WORLD REVIEW OF FAMILY PLANNING PROGRAMMES

SUBSAHARAN AFRICA

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Other Anglophones Countries

Ghana* was the first Sub-Saharan country to adopt a policy aimed at reducing the population growth rate. The National Family Planning Programme was established in 1970, following a report on "Population Planning for National Progress and Prosperity: Ghana Population Policy". The long-term goal of the Programme is to bring the growth rate from around 3.9 percent (1970) to around 1.75 percent (2000).

During the first nine months of 1975, there were 24,779 new acceptors: the loop was selected by 7.4 percent of new acceptors; the pill by 56.9 percent; and other methods by 35.7 percent. If we extrapolate to the whole year, the 33,038 new acceptors would represent a small decrease over the 1974 figure of 34,034. The three main agencies offering family planning within the Ghana National Family Planning Programme (GNFPP) are: the Ministry of Health, the Planned Parenthood Association of Ghana and the Christian Council. The expansion of commercial distribution was a major concern during 1975 and it was possible to invite the large wholesalers to be distributors. This will permit non-prescription contraceptives to be distributed beyond the 600 Ghana National Trading Company retail outlets, which had hitherto been the Programmes's sole agent in the field. Special emphasis continues to be given to information and motivation. Advertisements in newspapers and on billboards were used to promote the sale of foam and condoms. At the beginning of the year, the GNFPP carried out a Motivation and Assurance Campaign to allay acceptors' fears associated with a number of the methods of contraception advocated by the Programme. A National

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* The information on the recent activities in Ghana were kindly sent by Dr. A.A. Armar, Executive Director, National Family Planning Programme.

Family Planning Week was celebrated and was the occasion of special information activities through radio and TV. In his opening speech, the Commissioner for Economic Planning who is responsible for the GNFPP, pointed out that the thrust of the Bucharest Conference was that: "Family Planning Programmes should take into account the complex interrelationships between population resources, the environment and development. This is a vindication of a national stand on the family planning issue; for we have consistently maintained that our national family planning effort should be seen as an inseparable part of our total socio-economic development effort geared towards improving the quality of life of all our people. The first principal element of the Population Policy we adopted bears testimony to this, namely that a national population policy and programme are to be developed as organic parts of social and economic planning and development". From this, one can see that the Ghanaians felt completely in accord with the ideas expressed at the World Population Conference held in Bucharest, in 1974.

A recent study (1) on knowledge, attitudes and practices of family planning confirmed the importance of the influence of education and of urban-rural residence on the use of contraceptives. It also showed that family limitation is still generally frowned upon: 71 percent of rural women while 50 percent of urban women disapproved of the idea of family limitation. Less than 20 percent of respondents knew of at least one of the family planning methods: 30 percent in urban areas versus 15 percent in rural areas.

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(1) Armar A.A. and David A.S. (1975) "Population within the Context of National Development: Ghana's approach examined in the light of the World Population Plan of Action" paper presented to the World Population Society Meeting, Washington D.C., November 1975.

Another important research project (1) showed that traditional modes of communication are suitable and apparently more effective for communicating new ideas among rural and illiterate populations in Ghana. The general pattern appears to indicate that urban respondents tend to rank modern mass media items high whereas rural respondents tend to rank traditional media items high with respect to their influence on their attitude change in connection with family planning.

In the 1970-1974 development plan, the government of Botswana announced the intention to provide services to the population. The government decided that family planning services should be integrated into maternal and child health services within the health care programme. In 1974, about 55 health centers were offering family planning services and 4,168 new a acceptors were recorded (pill: 93%, IUD: 4%, Depo-Provera: 1.9%). However, the expansion of services was severely limited by the paucity of basic health facilities, particularly in the remote areas of the country, and by the shortage of trained manpower. Therefore, a new program was designed in 1975 to expand health facilities with the assistance of the UNFPA. Under the program, the number of health facilities will be increased from the existing 75 to 180 by 1978. MCH/FP services, including family planning, will be improved when already existing, or established through new centers. With regard to family planning services, the target is to recruit 6,400 new acceptors yearly and to reach an acceptancy rate of 4.3% by the end of 1977. It is estimated that this would bring down the birth rate in

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(1) Bame K.N. (1975) "Some Traditional and Modern Media for Communicating Family Planning in Ghana", Paper presented for the Inter-disciplinary Population Studies Seminar organized by the Population Dynamics Programme, Legon, December 5th - 6th, 1975.

1978 from an anticipated 42.4‰ to 39.6‰. The MCH/FP Division within the Ministry of Health will be strenghtened and the existing Interministerial Committee for Family Planning will form the core of the proposed National Family Planning Coordinating Committee which will (1) advise the Minister of Health on population activities and (2) review the impact of the family planning program. Important MCH/FP training efforts with the assistance of USAID, will continue within the Ministry of Health. At the end of that special training project (1978), it is estimated that 500 nurses will have completed in-service training, while approximately 350 student nurses will have been trained using the integrated basic nursing curriculum.

The National Family Planning Programme (NFPP) of South Africa got fully under way during 1974, when the government took charge of almost all the clinics operated by the private association. The NFPP is handled by a Division within the Department of Health and is specifically oriented towards preventive medicine and health care. The programme is concentrated in urban areas of higher population density, but efforts are being made towards expanding the operations to rural areas. The Health Minister has given permission to registered nurses working within the NFPP to distribute pills as well as other contraceptives to persons requesting birth control means. However, the local Family Planning Association asked the government in 1975 to allow all workers in the health field to distribute oral contraceptives, in order to increase their availability throughout the country.

The government of Zambia in 1974 took a favorable attitude towards family planning within its facilities, when the Ministry of Health sent instructions to all medical officers in Government service to the effect that the MCH service should provide advice on family planning to all persons wishing information and service. In 1975, the following number of health institution introduced family planning in their post-partum clinics: 72 government clinics, 3 mission hospitals, 14 mine clinics, 5 railway clinics (1). The Family Planning and Welfare Association of Zambia provides these institutions with contraceptives. At this time, it is rather difficult to know the exact situation of family planning services offered in these institutions. For the clinics that can be checked by its fieldworkers, the Association reported more than 5,000 new acceptors during 1974, a doubling over the previous year. Abortions, liberalized in 1972, are performed in the three central hospitals. At the University Teaching Hospital, over a 14 months period (January 74 - February 75), 142 pregnancies were terminated, while 32 other requests were rejected (2). Women in the age-group 20-25 years made 44.8 percent of the requests; 58.6 percent of all women were married, while 76.4 percent had two children or less. A number of seminars were held in 1975: in August, a seminar organized by the Ministry of Health and the Pathfinder Fund on Family Planning within Maternal and Child Health Services; in September, an International Labour Organization seminar on Humanism and Workers Family Welfare Progress; in October, an international seminar on Population and Environment organized by the Federation of Medical Students

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(1) From a letter sent by Dr. Chisale Mhango.

(2) E.S. Grech and C.G. Mhango, Termination of Pregnancy at the University Teaching Hospital, paper read at the MCH Seminar, Lusaka, August 1975.

of Africa.

In Nigeria*, the year 1975 saw the drafting of the Third Five Year Development Plan, the inauguration of the Population Council of Nigeria, and the announcement by the Commissioner of Health that a decree legalising abortion would soon be made. These developments flowed from the second Development Plan, 1970 - 1974, that included a "qualitative population policy" suggesting the establishment of a "Population Council" and the integration of fertility services in MCH.

In the health sector of the five year plan, the projected establishment of basic health services is a major breakthrough. These basic health services embrace family health and acute adult care. Family health would be provided for an estimated 40% of the population. Family health is defined as integrated promotive, preventive and curative maternal and child health including advice and services for childspacing. Funding for the federal and state programs in family health are still under discussion. Although under the constitution health is a concurrent matter between the states and the federation, it is likely that in the coming years the federal government will take more direct responsibility in the planning and implementation of family health.

The Population Council of Nigeria was formally inaugurated in May and its membership announced. The Council identified several issues to be examined in depth, including the need to expand family planning programme in the country

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* Information kindly provided by Dr. Cecile de Sweemer, Program Advisor in Health and Family Planning, the Ford Foundation, Lagos.

(education, motivation and services). The Census of 1973 has been invalidated and a national vital statistics system is being discussed. Both are likely to become major concerns of the Population Council of Nigeria in 1976.

Although the government of Liberia had been generally favorable to the idea of family planning (President's statements in 1973 and 1974), family planning services within government facilities have made little progress. Most family planning services are offered by private clinics. The Family Planning Association of Liberia alone had nine clinics in operation in 1975, which provided nutritional pre-natal and post-natal care for mothers and their families, together with contraceptive services. On the request of the Medical College, the Association gave a one month orientation course in family planning activities to fourteen second-year medical students. Although the government has accepted the integration of family planning within the Lofa Country Pilot Health Project and the Toure Health Center, the FPA remains the major unit in the country engaged in family planning activities.

The government of Lesotho has taken a positive attitude towards the establishment of family planning services in the context of maternal and child welfare. This was stated by the President in 1974 at the inauguration of the National Population Symposium. Although no family planning program has been established, the government allows the Lesotho Family Planning Association to operate 14 clinics (1,459 new acceptors in the first half of 1975) and it has encouraged the LFPA to ask hospitals for permission to

use their premises and integrate family planning into MCH services, with the proviso that advice on infertility must be included.

The government of Ethiopia has no family planning program, but it allows family planning activities in public and private health centers. The attitude of the present government is becoming more open: in late 1974, the Family Guidance Association was registered and recognized by the government. The Association was also permitted to have an information and education program, which was restricted in the past. The Association has three clinics and distributes contraceptives to more than 100 establishments. In 1974, the 74 clinics that provided information reported 7,112 new acceptors, well over the 1973 figure of 4,000 for 40 reporting clinics. In 1975, an important training program for doctors and paramedicals was instituted by the Association with the cooperation of the Medical School and the assistance of Family Planning International Assistance. This program is designed to train 75 health personnel (doctors and nurse-midwives) per annum (until 1977).

The government of the Gambia has been interested in population problems for several years, but it has never taken any action towards the integration of family planning services within the health services. Nevertheless, it has permitted private groups to operate clinics and is not opposed to family planning services rendered by some medical officers in the hospitals. The following statement, made in April 1975, by the Minister of Health at the inuaguration of the new headquarters of the Family Planning Association,

expresses well the basis of the government hesitation:

"Clearly, the appalling waste of young lives involved cannot be allowed to continue and efforts to combat it can be seen in the emphasis being given to Maternal and Child Health Services and nutritional standards of the young.

Apart from the human aspects, the lowering of the death rate, and more specifically infant mortality, is a "sine qua non" of any population policy.

It is quite unlikely that any population could be persuaded to reduce its birth rate when the chances of survival for children remain low. It is therefore not surprising that emphasis has shifted from mere family limitation to an integrated approach in which maternal and child health have taken an equally central position, even in cases where the aim is mainly to reduce the growth of population. This integrated approach is one that we must all welcome, both in its humanitarianism and realism. Family planning has ceased to be throught of purely in terms of limiting population... If living standards are to rise quickly, then factors which can be seen to inhibit economic growth must be removed or at least have their impact reduced. There is also the need to increase family welfare by insisting on healthy mothers and children. This may involve the limitation of families within numbers that can be maintained at a sufficiently high level of subsistence". (1)

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(1) The Minister speech is reproduced in the Annual Report (1975) of the Gambia Family Planning Association, p. 17.

Francophone countries

Among these countries, only two have as yet adopted a policy favorable to the development of family planning: Mali and Zaire. It should be mentioned that the policy of these two countries with respect to family planning has no demographic objective: it is defined mainly in terms of improving maternal and child health. In Mali, from the beginning of the activities in May 1972 up to November 1974, there were more than 2,600 female acceptors. Ninety per cent of them chose the IUD as their first method, and the rest chose the pill. Family planning services are now offered at six locations in Bamako, representing almost all the facilities in the capital area that are susceptible to having such services. In 1973, the program planned to have family planning consultations in each of the five regional capitals. Some of the consultations outside Bamako have already been implamented and in 1975 there were some training activities related to this expansion. Four persons went to the three-month family planning course in Rennes (France). A Seminar sponsored by the Malian National Women's Organization and the Ministry of Health was held in February 1976. Delegates came from four other Francophone countries: Mauritania, Togo, Popular Republic of Benin (Dahomey), Cameroun, Congo.

In Zaire* the President defined the general policy towards family planning, in 1972. Some recent actions seem to indicate that new development will occur in the near future. Indeed, the members of the National Council of "Desirable Births" created in 1973 were nominated in November 1975. The

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* The information on activities in Zaire were kindly provided by Fr. J. Boute, Université Nationale du Zaire, and by Dr. R. Brown, Bulape Community Health Project.

Council has also been incorporated into the new National Council for Health and Welfare (NCHW) formed in 1974. In a statement on general health policy released shortly after its founding, the NCHW emphasized preventive care and health centers whose responsibilities would included MCH and family planning. In the same statement, the NCHW charged the National Council of Desirable Births with preparing a policy of "desirable births" and a program to promote that policy. Family planning services are offered mainly at Kinshasa in the large hospitals and in some health centers. Services are also offered at some locations outside the capital, but very little information is available. A new project was initiated in 1975 in a rural area, near Kanaga: the Bulape Community Health Project and Family Planning Program. In the first year of operations, there were 411 acceptors, of which 49% adopted the IUD, and 25%, the pill; 56% of the women were thirty years of age or more, and 60% had 5 children or more. In October 1975, medical institutions which participated at a Medical Seminar organized by the Catholic Bureau for Medical Activities showed a marked interest in collaborating with the national family planning program.

Although the government of the Malagasy Republic has not yet formulated a family planning policy, it welcomes the activities of the local Family Planning Association. In 1974, the seven clinics of the Association provided contraceptives to 2,344 new acceptors. Although it did not prove possible in 1975 to expand the activities as much as planned, the eighth clinic was established in the southern part of the country. The government sent two physicians and four nurse midwives to the training course at Rennes, France, in 1975.

In Togo, the new Family Welfare Association was inaugurated in March 1975 at a national seminar on Family Welfare and Development. The major role of the Association will be in the information and education field, as medical and clinical activities are to be provided by the government services. Family planning services are already offered in Lomé the capital in an MCH center. In the coming months, it is planned to have family planning consultations in two other centers in Lomé and in two centers outside the capital (1). In Cameroun, for the first time, family planning services were offered at the University Training Center, in Yaoundé.

In Rwanda, concerns are expressed by some circles within the government over problems ofhigh density and high growth rates (see for example, the Preliminary Draft of the Five-Year Plan, Department of Social Affairs, Health and Population Commission, n.d.). There is a reluctance to considering purely demographic solutions to these problems. There are few possibilities for international or internal migrations, a solution that was often proposed in the past,and the government is still opposed to family planning activities. However, the creation in 1974 of an Advisory Scientific Council for Socio-Demographic Problems indicated the beginning of a change. The Council has met three times since then and has strongly recommended the adoption of a family planning program. Indeed, it has recommended a series of social and economic measures to cope with population problems: agrarian reform, industrial development, economic association with neighbouring countries, the sensibilization of the population to population problems, the establishment

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(1) C. de Medeiros, Le planning familial au Togo, paper presented at the Interafrican Seminar on Family Planning, Bamako, February 16-21, 1975.

of family planning services, and the raising of the legal age of marriage. Reservations were expressed towards the possibilities of using migration as a means of alleviating population pressure. These resolutions were adopted by the Council in November 1974 and submitted to the government, but no official reaction has been received as yet. Two persons attended the training courses in family health and welfare in Rennes in 1974, and seven other persons did so in 1975. A seminar on Population Dynamics Employment and Social Welfare organized by the government with the collaboration of the ILO is planned for 1976.

Conclusion

In 1975, no major change of policies and programs regarding family planning can be reported. At the regional level, the Post-Bucharest Conference at Lusaka witnessed again the influence of politics on the debate surrounding population problems and particularly population growth. There is a refusal to accord high priority to the reduction of the rate of population growth. The debate on whether governments should choose between Malthusian or developmental strategies is meaningless, since one should assume that governments are currently doing their best towards the socio-economic development of their countries. Indeed, the high priority given to the population factor, in the last ten years, within development theories and by international organizations and developed countries agencies, is subject of strong criticisms (1). Nevertheless, the attitude towards family planning is not as negative as some debates would lead us to think. For example, the Conference of Ministers held at Nairobi in February 1975 adopted a resolution requesting African governments "to give due attention to the socio-economic conditions of parents and children and to ensure that family planning becomes, subject to national sovereign rights and priorities, an integral part of development, particularly where maternal and child health services, community and rural extension activities and urban development are concerned".

At the national level, four countries (Ghana, Kenya, Botswana, Mauritius) have government policies and programs explicitly intended to decrease population growth rates. In these countries, as well as in the countries

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(1) See for example: ECA, Report of the Regional Post World Population Conference Consultation, Lusaka, Zambia, April 1975, paragraph 74: "International agencies should not concentrate their assistance on family planning".

where a national program is implemented on health grounds only (Mali, Zaire), activities are progressing but very slowly. Only in Mauritius did the birth rate has fallen due to wider acceptance of family limitations. However, even in the case of Mauritius fertility reduction began before the government established family planning services within its health facilities, while private groups have offered these services relatively long before then. Differences between Francophone and Anglophone countries are diminishing slowly as evidenced by the creation of a new family planning association (Togo) and by new concerns over population problems (Rwanda).

Several countries are not opposed to family planning but seem satisfied with a situation where family planning services are offered mainly by private groups (Liberia, Lesotho, Ethiopia, Gambia, Malagasy Republic). The delivery of family planning services within government facilities is desirable and would increase the availability of the services. Nevertheless, even if family planning services were integrated in health services, it is certain that family planning acceptance and practice will remain low for health services are still limited in most countries and attitudes towards family planning remain rather negative. Okediji has summarized the factors accounting for the ineffectiveness of family planning programmes in the developing nations in the following way: (a) the structural contradictions in the character of economic arrangements of the developing nations; (b) prevalence of high mortality rate, especially infant and child mortality rates; (c) the existence of sizeable areas of subfertility and infertility; (d) influence of cultural factors; (e) prevalence of particular myths about large population size; and (f) the blacklash effects generated by harmful side-effects of particular

contraceptive methods (1). For these reasons, the integration of family planning services within health services which is seen the most readily acceptable way of introducing family planning in Subsaharan Africa will have few demographic impact until other social changes have occurred.

Some of these changes have already begun: for example, the increasing number of urban,educated families which are the most likely users of family planning services, and the progress of education. It is possible that with modernization including urbanization which is progressing at a tremendous rate (2), and education, demand for family planning will steadily increase. The increased demand for family planning will push governments to establish services, if these have not been made available. However, one can only guess concerning the rate of adoption of family planning practice and its impact on levels of fertility.

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(1) F.O. Okediji, "The Limitations of Family Planning Programmes in the Developing Nations", Cultures et développement, Vol. VII, 3-4, 1975, p. 551-574.

(2) According to a background paper of the World Population Conference, the urban population of Subsaharan Africa will reach 200 millions (on a total population of 632 millions) in year 2000, compared to 44 millions on 265 millions in 1970 (World and Regional Prospects, paper no 15).