

REPRODUCTIVE HEALTH IN SUB-SAHARAN AFRICA

by James Gribble and Joan Haffey

Sub-Saharan Africa has experienced an impressive 5 percent annual economic growth since the late 1990s, outpacing the world average.¹ But other aspects of the region's development are lagging. The region is behind on many of the Millennium Development Goals (MDGs), a set of goals agreed upon by world leaders at a UN summit in 2000 to reduce poverty, improve health, and foster economic development.² Sub-Saharan Africa is especially deficient in areas of reproductive health crucial for meeting MDGs for child and maternal health. This brief examines successes and failures in reproductive health in sub-Saharan Africa, focusing on variations in family planning use and family size, maternal mortality, and HIV/AIDS in major sub-Saharan regions.

Family Planning Use and Family Size

Family planning has steadily decreased as an international priority in recent years, despite its documented impact on both maternal and child health and overall development.³ In addition to reducing fertility (births per woman), family planning use has a direct, positive impact on reducing maternal deaths and preventing mother-to-child transmission

of HIV. However, to achieve these health benefits, women and couples must have access to a wide range of contraceptive methods at all stages of their reproductive lives to allow them to have the number of children they want, when they want them.

In sub-Saharan Africa, 23 percent of married women are using family planning—18 percent with a modern method and 5 percent with a traditional method, shown as the two bottom segments of each bar in Figure 1. However, an even larger percentage of women—25 percent—report having an “unmet need,” meaning that they would prefer to stop having children or delay their next birth, but are not using any method of family planning.

Within sub-Saharan Africa, use of family planning and unmet need vary greatly. In Southern Africa, where the contraceptive use rate is 58 percent, almost exclusively of modern methods, unmet need for family planning is a relatively low 16 percent. In Western Africa, in contrast, only 8 percent of women use modern family planning, 5 percent use traditional methods, and the unmet need is 23 percent. Of course, these averages mask the variation within geographic areas: In Western Africa, for example, more than 14 percent of women in Ghana use a modern method, compared with less than 5 percent of women in Sierra Leone. In Eastern Africa, unmet need is high in Uganda, at 41 percent, and in Madagascar, it is 23 percent.

One direct result of the relatively low contraceptive use and the high levels of unmet need is that family sizes remain large. Today, the average sub-Saharan African woman has 5.4 children in her lifetime—down only slightly from 6.1 children in the early 1990s.⁴ Middle Africa has the largest average, at 6.1 children. In Western and Eastern Africa, women have on average 5.7 and 5.5 children, respectively. In contrast, Southern Africa's fertility is much lower at 2.8 children per woman, due in part to the high use of modern contraception.

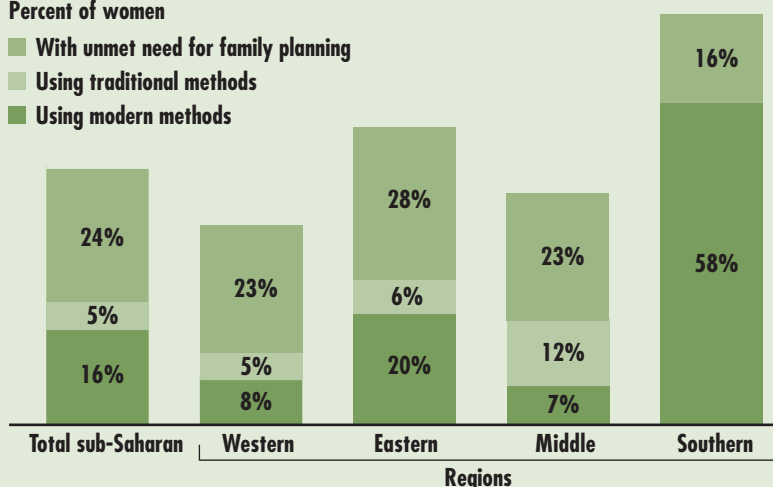
Use of family planning is often influenced by such characteristics as education, place of residence, and wealth. Survey data consistently show that within a given country, wealthier women are more likely to use modern family planning methods than poorer women. In sub-Saharan Africa as

Figure 1

TOTAL DEMAND FOR FAMILY PLANNING IN SUB-SAHARAN REGIONS, 2008

Percent of women

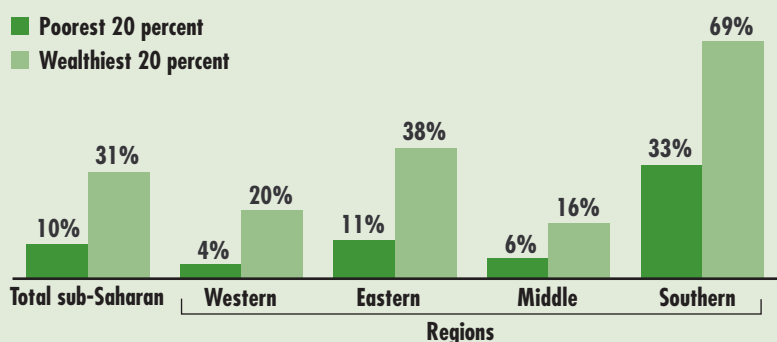
- With unmet need for family planning
- Using traditional methods
- Using modern methods



SOURCE: Population Reference Bureau and African Population and Health Research Center, 2008 Africa Population Data Sheet.

Figure 2

FAMILY PLANNING USE AMONG THE WEALTHIEST AND POOREST WOMEN IN SUB-SAHARAN REGIONS, 2008



SOURCE: D. Clifton, T. Kaneda, and L. Ashford, *Family Planning Worldwide 2008 Data Sheet*.

a whole, three times as many wealthy women use modern contraception as do poor women (see Figure 2). But just 31 percent of the wealthiest sub-Saharan women use family planning, below the rates of the poorest women in other world regions. Fifty-three percent of the poorest women in South America use family planning, as do 39 percent of the poorest in Asia excluding China.⁵

Within Africa, Middle and Western Africa have the lowest rates in all wealth groups. Less than 10 percent of the poorest women in these two regions use contraception; only about 20 percent of the wealthiest women do—lower than the rate among the poorest women in Southern Africa. Wealthy women in Southern Africa have

the highest rates of contraceptive use in sub-Saharan Africa: 69 percent. The low prevalence in Western and Middle Africa—regardless of wealth group—suggests their programs need to provide information and services to all women and couples in an effort to increase contraceptive use (see Box 1). In Eastern and Southern Africa, where prevalence is higher, efforts should focus on reaching the poor with appropriate information and high-quality services.

Maternal Mortality

In 2005, 536,000 women worldwide died from largely preventable and treatable pregnancy- and childbirth-related causes. More than half of these maternal deaths took place in sub-Saharan Africa. Sub-Saharan women have a 1 in 22 lifetime risk of maternal death, compared to a risk of 1 in 7,300 for women in developed regions.⁶

Sub-Saharan Africa's maternal mortality ratio of 900 (maternal deaths per 100,000 live births) is the highest among world regions included in the World Health Organization's recently published 2005 estimates. Within Africa, Middle Africa has the highest average ratio at 1,150, followed by Western Africa at 1,050. Women in Southern Africa have a maternal mortality ratio of 410, the lowest in sub-Saharan Africa; however, this is still high by world standards.⁷

The MDGs call for a three-quarter reduction in maternal mortality ratios between 1990 and 2015. Most African countries are unlikely to meet this

Box 1

PROMISING ADVANCES IN FAMILY PLANNING: MALAWI AND RWANDA

Although the use of modern contraceptives is slowly increasing in sub-Saharan Africa, the growing popularity of hormonal injections is having an especially notable effect on prevalence throughout the region. The experiences of Malawi and Rwanda illustrate how different strategies to better meet women's reproductive health needs can contribute to advances in family planning use.

Between 1992 and 2008, contraceptive use in Malawi rose remarkably, from 7 percent to 39 percent of married women. This increase is largely due to a surge in the use of injectable contraceptives from 1.5 percent in 1992 to 29 percent in 2008.¹ The Malawi program embraced the concept of training lower-level health workers to significantly improve access to family planning while maintaining quality standards. While physicians provide female sterilization, registered nurses and enrolled nurse-midwives provide injectables and intrauterine devices, among other methods. Community-based distributors also supply injectables and other temporary methods, effectively bringing a broad array of contraceptives closer to consumers.²

Rwanda has also experienced rapid growth in the use of modern family planning. The use of modern methods increased from 4 percent to 27 percent between 2000 and 2008.³ Injectables have also been an important part of the increase. Rwanda's accomplishment is due to a combination of factors,

including commitment to family planning by political leaders; adequate supplies and improvements to its logistics system; and coordination between donors and government agencies. Rwanda also introduced performance-based financing, which motivates facilities and providers to meet goals established in contracts with the government. This type of arrangement, coupled with the investment made in training providers to offer a full range of methods, is having a remarkable effect on reducing unmet need for family planning and increasing use.

References

¹ Malawi National Statistics Office and Macro International, *Malawi Demographic and Health Survey 2004* (2005), accessed online at www.measuredhs.org, on Sept. 16, 2008.

² Julie Soto, Roy Jacobstein, and Deliwe Malema, *Repositioning Family Planning—Malawi Case Study: Choice, Not Chance* (New York: The ACQUIRE Project/EngenderHealth, 2005).

³ Julie Soto, "Family Planning in Rwanda: How a Taboo Topic Became Priority Number One," *IntraHealth International* (2008), accessed online at www.intrahealth.org/, on July 24, 2008.

goal. The average ratio for sub-Saharan Africa was an estimated 920 in 1990, and only dropped to 900 by 2005.⁸ To make real progress, most countries will need to greatly accelerate progress in preventing unplanned and high-risk pregnancies and ensuring access to high-quality antenatal and delivery care.

HIV/AIDS

Sub-Saharan Africa continues to suffer disproportionately from the global HIV/AIDS epidemic. HIV prevalence is highest in Southern Africa, which otherwise leads other sub-Saharan regions in many health indicators. Current estimates suggest that the epidemic has stabilized—often at very high levels—in much of sub-Saharan Africa, where an estimated 22 million people are living with HIV/AIDS. This accounts for 67 percent of all people living with HIV worldwide.⁹ More than half of the sub-Saharan Africans with HIV live in four countries: South Africa (5.5 million), Nigeria (2.9 million), Zimbabwe (1.7 million), and Tanzania (1.4 million).

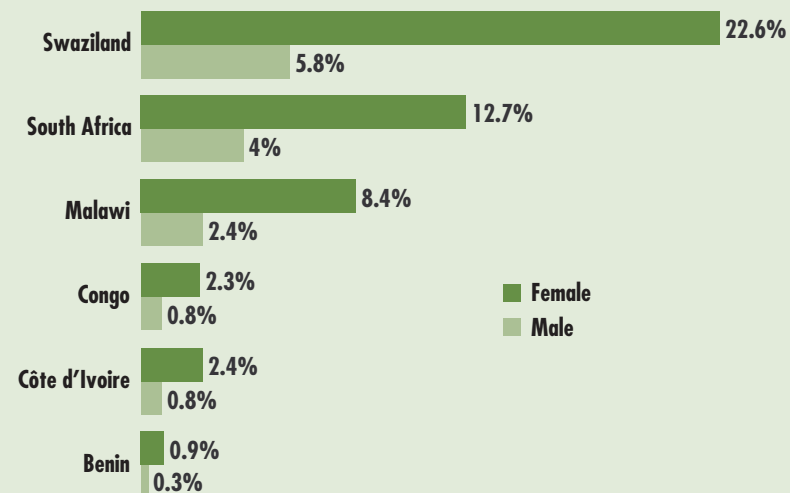
As with other health indicators, HIV prevalence varies greatly by region. In Southern Africa, for example, 19 percent of adults ages 15 to 49 are estimated to be HIV positive. In contrast, adult prevalence is estimated at 6 percent in Eastern Africa, and 3 percent in Western and Middle Africa.¹⁰

Young people, particularly young women, are especially vulnerable to HIV/AIDS (see Figure 3). Young women have higher infection rates than men due to physiological vulnerability, the exchange of sex for gifts or money between young women and older men, and women's low status in society (see Box 2). In Swaziland, almost four times as many young women are HIV positive as young men. Prevalence is three times higher among young women than young men in South Africa, Côte d'Ivoire, and Malawi.¹¹

The MDGs challenge the world to halt and reverse the spread of the HIV/AIDS epidemic by 2015. Since 2000, the percentage of people living with HIV in sub-Saharan Africa has leveled off. However, the total number of people living with HIV has steadily increased because new infections occur each year, HIV treatments extend life, and because new infections still outnumber AIDS deaths.¹² The disproportionate burden of HIV/AIDS on women—especially young women—highlights the need for services that address both HIV prevention as well as reproductive health services for women living with HIV.

Figure 3

PERCENT OF YOUNG PEOPLE AGES 15-24 WITH HIV/AIDS, SELECTED AFRICAN COUNTRIES, 2007



SOURCE: UNAIDS/WHO, *Report on the Global HIV/AIDS Epidemic 2008*.

Box 2

YOUTH: A PRIORITY FOR REPRODUCTIVE HEALTH SERVICES IN SUB-SAHARAN AFRICA

There are approximately 157 million young adults ages 15 to 24 in sub-Saharan Africa; by 2015, this number is expected to increase to 198 million.¹ As growing numbers of young people enter their reproductive years, they will need significantly expanded reproductive health services.

Young people in sub-Saharan Africa have particular reproductive health vulnerabilities:

- High rates of adolescent childbearing persist, which contribute to higher illness and death among young mothers and their children. In Chad and Mozambique, for example, more than 70 percent of 19-year-olds interviewed in recent Demographic and Health Surveys had already had at least one child.² Young pregnant women are at greater risk of death from pregnancy-related causes than adult women.
- Young people ages 15 to 24 also account for an estimated 45 percent of new HIV infections worldwide, with young women disproportionately affected.³
- Sexual activity between young women and older men is a relatively common practice in many countries. In Nigeria, for example, 21 percent of sexually active young women ages 15 to 17 had at least one partner 10 years older than they were.⁴
- Female genital mutilation/cutting (FGM/C) threatens the health of 3 million girls each year in Africa. Recent surveys in Somalia and Ethiopia reported that 97 percent and 62 percent of young women, respectively, had undergone the procedure.⁵ The adverse consequences of FGM/C include complications in childbirth, tetanus, urinary incontinence, and even maternal death.

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- ² Data accessed online at www.measuredhs.com, on Sept. 22, 2008.
- ³ UNAIDS/WHO, *Report on the Global HIV/AIDS Epidemic 2008* (Geneva: UNAIDS, 2008): 42.
- ⁴ Charlotte Feldman-Jacobs and Heidi Worley, *Cross-Generational Sex: Risks and Opportunities* (Washington, DC: Population Reference Bureau, 2008).
- ⁵ Data from Demographic and Health Surveys and Multiple Indicator Cluster Surveys.

For More Information

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Also see the following data sheets, available at www.prb.org or by contacting PRB at the address above:

Donna Clifton, Toshiko Kaneda, and Lori Ashford, *Family Planning Worldwide 2008 Data Sheet*.

Charlotte Feldman-Jacobs and Donna Clifton, *Female Genital Mutilation/Cutting: Data and Trends*.

Carl Haub and Mary Mederios Kent, *2008 World Population Data Sheet*.

Population Reference Bureau and the African Population and Health Research Center, *2008 Africa Population Data Sheet*.

Looking Toward the Future

As 2015 approaches—the target date for achieving the MDGs—much work remains to be done in all areas of reproductive health, especially in reducing maternal mortality and slowing the spread of HIV/AIDS. Many countries are making advances in reaching the targets; yet throughout sub-Saharan Africa, there are still great needs and opportunities to do more. Policymakers and program managers must:

- Re-energize family planning programs to ensure a wide range of contraceptive choices for all women and couples to help address the unmet need for services. Family planning can improve the health of mothers and children, reduce the spread of HIV/AIDS, and reduce family sizes.
- Invest in maternal health so that women obtain the care they require during delivery. Reducing maternal mortality calls for government leadership, more trained health providers, and community involvement.
- Halt the spread of HIV/AIDS by addressing the range of social and economic factors that contribute to the epidemic. At the same time, continued commitment to making treatment available will mitigate the negative effects of the epidemic on families and communities.
- Implement effective policies that support youth's reproductive health needs by increasing access to reproductive health services and HIV prevention programs, abandoning female genital mutilation/cutting, and supporting efforts to reduce early marriage and childbearing.

Continued support from governments and donors can aid efforts to improve the reproductive health of women in sub-Saharan Africa. The variation across and within regions demonstrates that effective policies and high-quality programs can make a difference.

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