Conference on Repositioning Family Planning in West Africa: Rapporteur-General's Report

Akunu Dake

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CONFERENCE ON REPOSITIONING FAMILY PLANNING IN WEST AFRICA

LA PALM ROYAL BEACH HOTEL, ACCRA
FEBRUARY 15 – 18, 2005

CO-SPONSORS:
USAID, WHO/AFRO, Advance Africa, AWARE-RH, and the POLICY Project, in collaboration with the GHANA MINISTRY OF HEALTH, UNFPA, IPPF, and other collaborators

RAPPORTEUR-GENERAL'S REPORT

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INTRODUCTION

A 4 – Day Regional Conference on Repositioning Family Planning in West Africa Conference was held from February 15 – 18 in Accra, Ghana to address the question of the declining international focus on family planning and recognition of its impact on health and development. It was also geared towards reviving the interest of donors and governments in the domain and the rising unmet need for family planning.

The main **conference agenda** was to provide a forum for key stakeholders in the West Africa sub-region to focus on repositioning family planning as a means of combating the impact of unmet need.

Its **goal** was to set the grounds for the increase in commitment to repositioning of family planning as a strategic objective of a country's health and development goals.

The detailed **Conference objectives** as outlined were as follows:

- Provide comprehensive data on the expressed need for family planning in the West Africa sub-region.
- Identify key factors underlying the gap between expressed need for family planning and use of family planning.
- Discuss the health and development consequences of this gap
- Explore solutions for addressing the gap.
- Demonstrate how advocacy can be used to implement solutions.
- Develop strategies that participants will undertake after the conference to advance repositioning family planning efforts in their respective countries.

The **Participants** of the Conference were made up essentially of multisectoral country teams and their partners. The participating country teams were from Benin, Burkina Faso, Chad, Cote d'Ivoire, Ghana, Guinea, Guinea-Bissau, Madagascar, Mali, Niger, Nigeria, Rwanda, Senegal, Sierra Leone and Togo. The conference registered about 255 delegates from thirteen West African countries as well as two countries outside of the West African sub-region.

The **Co-sponsors** were USAID, WHO/AFRO, Advance Africa, AWARE-RH, and the POLICY Project, in collaboration with the Ghana Ministry of Health, UNFPA, and IPPF.

Deliberations of the Conference took place in Plenary and Breakout Group thematic sessions as well as at the Country Team meetings. A number of presentations were made at the Plenary and Breakout Group sessions.

1. OPENING CEREMONY

In his opening remarks as Chairman of the Opening Ceremony, Professor Agyeman Badu Akosa**,** the Director General of the Ghana Health Service warmly welcomed participants to the Conference and to Ghana.

He noted that the central issue of the conference in reinvigorating interest and repositioning Family Planning (FP) in West Africa was a serious one particularly since an estimated twelve million unintended pregnancies occurred in the West Africa region alone in the six years following the International Conference on Population and Development (ICPD) in 1994. The human toll of this unintended fertility is reflected in unacceptably high maternal mortality figures, unnecessary ill health and disability among women and girls, high infant mortality and economic hardships to families, communities and nations.

He indicated that the resultant high population growth rates further undermine national development objectives in the region and this is especially painful and unacceptable because many of these could have been avoided by the use of FP - a well known and cost effective intervention.

Even though these statistics are worst in sub Saharan Africa, the West Africa sub region records the least use of modern contraception and has high maternal and infant mortality figures.

He again noted the information from the Demographic and Health Surveys (DHS) which suggests an increasing trend in contraceptive prevalence. Since 1988, use of modern contraception among married women has increased from 5% (in 1988) to 19% in (2003) while total fertility rates have decreased from 6.4 to 4.4 (remaining 4.4 from 1988) in Ghana. About one third of women who would want to space their next birth or end childbearing (limiters) do not use any modern method of contraception in the country. This has not changed between 1998 and 2003. While Ghana's contraceptive prevalence appears to be the highest in West Africa (excluding Cape Verde), the country is not resting but takes the issue of persistently high unmet need of 34% seriously.

He informed the Conference that the Ghana Health Service and its partners have put together a position paper outlining its "Road Map" He hoped that the conference will be a place for cross fertilization of ideas for countries to come up with strategies that outline concrete actions to be carried out successfully.

He recognized the point that health and for that matter reproductive health and FP is the responsibility of all individuals, sectors and levels and especially the community level. As is obvious, the health sector cannot do it alone and therefore needs to harness the strengths and comparative advantage of all stakeholders – private sectors, NGOs, education, finance, information and communication, traditional rulers, civil society

organizations women and men's groups, religious bodies, sociologist, anthropologists, youth and many others.

In the remarks from Dr. Doyin Oluwole, DRH of WHO/AFRO and delivered by Dr. George Melville, WHO/Ghana, it was noted that, FP is an essential component of primary Health Care and Safe Motherhood and that to date, Sub Saharan Africa has low contraceptive prevalence rates (CPR), high fertility rates, the highest maternal mortality ratio, and high unmet needs for FP. With only 10% of the world's women living in Sub-Saharan Africa, he confirmed Professor Akosa's observation that they account for 12 million unwanted or unplanned pregnancies annually and 40% of all pregnancy-related deaths worldwide.

He observed that, the statistics indicate that Sub-Saharan Africa has the highest maternal mortality and morbidity in the world with a third of all deaths of women of reproductive age being the result of a complication of pregnancy and/or childbirth. Teenage pregnancy accounts for a significant share of these maternal deaths, whilst complications of abortion, often related to unintended pregnancy, are also one of the main causes for high maternal mortality. Sub Saharan Africa is confronted by the high levels of HIV infection in the world, particularly among the youth.

He advocated for the reduction in unwanted and unplanned pregnancies as this will significantly reduce maternal deaths. Numerous studies have demonstrated that, longer birth intervals reduce maternal and child mortality and improve nutrition of both mothers and their babies. FP also has the additional value of helping to reduce the high level of HIV infection.

As a matter of consequence, WHO/AFRO in collaboration with other partners have developed a 10-year framework for repositioning FP in Reproductive Health (RH) services in the Africa Region. This, in his view, is a key step towards attaining the international goal to improve access to quality RH services as stipulated in the International Conference on Population and Development (ICPD) programme of action, Beijing Platform of Action, and Millennium Development Goals (MDGs).

He stressed that, the critical interventions in the next 10 years, will focus on advocacy, improving access to quality FP services and modern commodities, strengthening human and institutional capacity, addressing FP needs of vulnerable populations, operations research and monitoring and evaluation. He also observed that FP is a good entry point for the integration of RH services and prevention control of HIV/AIDS/STIs.

He bemoaned the situations where very little attention is given to FP programmes by governments, policy makers and donors.

He outlined the challenges confronting FP and this includes: poorly functioning health systems; lack of access to modern FP commodities; instability and crisis situation prevailing in many countries; cultural beliefs and religious barriers; lack of male involvement; and inefficient programme management and coordination.

The picture, as revealed, is that many African countries are plagued by problems related to poverty, economic failure, and war, widespread political instability, armed conflicts, and the pandemic of HIV/AIDS have reduced the ability of the African woman to cope with the daily challenges.

He contended that, many opportunities however exist to improve FP services, namely: global and regional partnerships for national RH programmes. These include the many voluntary counseling and testing services for HIV/AIDS, services at workplaces to enhance access by men and women, and community-based services.

In repositioning FP, he advocated the necessity for countries to review their RH policies and national development plans to include FP, build partnerships, coordinate stakeholders, mobilize and allocate appropriate resources, ensure quality services, and adequate and appropriately skilled personnel to manage FP services and commodities. He stated that, WHO and partners will provide adequate technical support and guidelines to countries for implementation of the Repositioning FP Framework.

He agreed that FP is one of the most effective strategies to contribute to the achievement of the MDGs as related to maternal and newborn health in Africa. It is one of the strategic approaches to reduce maternal and child mortality and morbidity, as well as improving the health and well being of women, men, and youth.

Finally, he expressed the hope that, FP will become a top priority issue in the development agenda of the respective countries and affirmed the readiness of the Regional Office, together with partners in supporting countries in the efforts to improve repositioning FP for the health of families who are the nucleus of the society.

In his statement, Dr. Kabba Joiner, Director General of the West African Health Organization (WAHO) noted that good reproductive health services, which also include strong FP programmes, are important in the health agenda for the region. The countries struggle to cope with the health and economic consequences of high population growth rates—estimated at an average of 5 percent annually—the impact of which is more pronounced in urban areas. He also acknowledged the negative consequences of poor quality and lack of access to RH and FP services.

Countries cannot therefore keep pace with the huge increases needed for social services--schools, clinics, trained professionals, infrastructure, etcetera and helping families and women to prevent unintended pregnancies and births reduces the need for household and government expenditures on such services. This contributes to improved livelihoods for women and healthier families who can earn more and save more—both primary goals of Poverty Eradication plans.

He described the indices in West Africa as very poor and alarming with maternal mortality averages 1,100 per 100,000 live births, and infant mortality averages 99 per 1,000 live births. A contributing factor is the low level of RH and available FP services

with modern CPR in the single digits in many countries. Unmet need for FP is high, on average, 25 percent for the sub region.

He asserted that the world has the resources and the technical knowledge to change this situation and the point is to act now.

Changing this picture will require attention to a range of concerns in terms of the demand for and provision of quality, affordable FP services, and working with the traditional, political, and religious leaders to create a supportive environment for spaced births and planned families.

He drew attention to one fundamental programme effort of WAHO working with partners to ensure that RH commodities are available and widely accessible to those who need them. There is clear evidence of severe lack of commodities in the region and this clearly is an unmet need.

He also mentioned the decisions of Health Ministers of the region in several fora. For example the October 2004 Fifth Assembly of Health Ministers of WAHO, recommended that:

- Where it does not already exist, Member States should introduce a budgetary line for RH in their national budgets
- WAHO should begin creating a mechanism for more effective procurement systems by Member States, through a subregional information exchange and clearinghouse about prices and supplies to support country procurements.
- WAHO should convene a meeting of donors in the subregion to mobilize resources for reproductive health commodity security, including the development and implementation of a subregional strategy for commodity security

He informed the meeting that steps are being taken to operationalize these recommendations.

Through these activities, WAHO hopes to use the comparative advantages of our partner organizations to strengthen planning and coordination for strategic allocation of resources. They also hope to see an increase and sustain assistance to ECOWAS Member States for RH commodities.

He gave the assurance that WAHO is well positioned and ready to build on this and other initiatives to move the Repositioning FP agenda forward. We are uniquely positioned to influence health policies and coordinate sustainable integrated responses to major health concerns amongst ECOWAS Member States.

Mary Carlin Yates the Ambassador of the United States to Ghana observed that, the conference goal of repositioning FP means that FP is not just a health issue, but one that impacts a country's overall development. Like HIV/AIDS and poverty, unmet FP needs are an urgent national and global problem.

She therefore asserted that, there should not be a competition between FP and critical health programmes, such as nutrition and immunization, and every development sector—not just the health sector—should be considering the demographic consequences of unwanted births.

The Ambassador also agreed with the earlier presentations that FP is at crossroads in the West Africa region. Both donor and government attention to FP has declined and funding has, in many cases, stagnated or declined.

She acknowledged that despite these trends, some countries, such as Ghana, have succeeded in extending FP services to its citizens. The profile in the region, and even in Ghana - one of the best performing countries in the region - is however unfortunately consistent: low rates of contraceptive use, high fertility, and high unmet need for voluntary FP services.

She reiterated the depressing statistics of nearly 12 million unintended pregnancies occurring in West Africa between 1994 -2000. The desired fertility in the region is considerably lower than actual fertility, which remains high at 5 - 7 children per women in most countries. At the individual level, the devastating impact of unwanted fertility is widely documented. There are high rates of maternal and child mortality and morbidity. Early childbearing and large numbers of girls dropping out of school are commonplace and families are unable to feed and raise children spaced too closely.

She noted that, the U.S. Government through the USAID and other multi - and bilateral agencies, such as UNFPA and WHO - have been increasingly calling for a "repositioning of family planning". This means acknowledging FP as critical tool to help countries achieve their national aspirations.

She argued that In Ghana, the total fertility rate has come down to 4.4 today from 6.3 in 1980—a rate at which many countries remain today. While there is still a large unmet FP need to be addressed, if the people of Ghana had not opted for better spaced, smaller families, Ghana's population would be higher today, and the country would be diverting many resources to keeping pace with increased needs of a faster growing population.

She prayed that the conference will not only raise awareness of the importance of FP but that participants will walk away not as passive participants but as public advocates for the need to increase RH services in their countries and throughout the sub region.

In his official opening address as Guest of Honour, Major (Rtd) Courage Quashigah, Minister of Health of Ghana expressed the belief that Ghana was selected as the venue for this conference in recognition of the Government's political support for FP and perhaps for what he described as "our modest achievement" on FP indicators in the sub-region.

He acknowledged that other countries in Eastern and Southern Africa have made greater strides in contraceptive prevalence but there also exist major gaps and deficiencies such as the persistently high unmet need and the challenges stemming out of rumours, myths and misconceptions, making the fear of side effects the major reason for non-use of modern methods of FP in Ghana.

He posed a number of issues related to:

- The real purpose of FP
- Population explosion, the effects of education in reducing family size
- FP and poverty reduction
- FP and increased life expectancy
- Is FP the best single measure of economic and social progress?
- If FP cuts population to size will the rich be prepared to share their wealth with the poor?
- Will FP reduce hunger? Then how come there are still some 800 million hungry people in the world today?
- If the statistics are accurate, then in last few years, the use of modern methods of contraception has increased to 19% and total fertility rate has reduced to 4.4 children per woman
- Have we considered our illiterate women in the remotest villages whose deliveries are not even recorded?
- Have we taken our cultural values into consideration in the application of the modern methods of contraception?

He observed that FP programmes have enjoyed tremendous donor support in the past, however with declining resources and many competing priorities, FP services have started feeling the effects of resource constraints and consequently, threats to commodity security.

He made reference the WHO Africa Region ten-year “framework for accelerated action for repositioning family planning in Reproductive Health Services” as a means to reinvigorate interest and commitment to the domain.

He hastened to add that Africans are so quick to accept anything that is handed down by the developed world without thorough analysis and noted that if Africa wants to reposition FP then it must embark on it vigorously.

The Minister informed the Conference that FP in Ghana is a major programme strategy in the Population Policy of 1969, which was revised in 1994 and being implemented as an integral part of maternal and child health services. It has also been identified as a priority intervention in the Medium Term Health Strategy and the National RH Policy and Standard documents and protocols also cover FP.

Contraceptive security has been taken very seriously starting with a national conference in May 2002, the setting up of an Interagency Co-ordinating Committee on

Contraceptive Security and the development and adoption of a National Contraceptive Security Strategy covering the period 2004 to 2010.

He conceded that the strategy will require adequate funding from both Government and the development partners and the government has taken the lead in contributing $280,000 annually since 2003 towards the procurement of contraceptives. It has also used health funds from the World Bank to bridge the gap for procurement of contraceptives in the event of dwindling donor support.

For example, in 2004 the contraceptive financing requirements excluding the commercial sector was $6.4 million. This requirement was met through the use of $1.5m of World Bank funds and $280,000 from Government budget.

There is also the tremendous reliance on development partners such as USAID and DFID for funding and the UNFPA continues to assist with the procurement arrangements for some of the contraceptive commodities.

He was of the view that if FP is to be "repositioned," then it will require the same kind of attention that the global community is giving to HIV/AIDS, poverty eradication and debt relief. The idea is not to compete with other efforts but to seek opportunities to integrate activities and get a synergy of efforts.

There is also the need for the integration of FP into non-health interventions so as to achieve national and international development goals and objectives.

To this end, he stressed that the success and benefits of FP are not limited to the health sector alone but to all sectors of the economy. There is therefore the need for greater advocacy which will lead to action and ownership at all levels.

It was his hope that with the many successful programmes in other countries, the conference will provide the forum for the serious exchange of ideas which will lead in the end to strategies and concrete actions, which will be followed through and owned by our individual countries.

2. KEYNOTE PAPER ON REPOSITIONING FAMILY PLANNING IN WEST AFRICA

Dr. Fred T. Sai, Presidential Adviser for Population, Family Planning, Reproductive Health and HIV/AIDS in Ghana presented the Keynote paper of the Conference on "Repositioning Family Planning in West Africa."

He traced the history of FP programmes in Africa from the 1960s, from the small-scale clinical activities in Liberia and Ghana, through the development of a national FP and population policy in Ghana in the late 1960s and the promotional work undertaken by Pathfinder, IPPF and other non-governmental organizations (NGOs) through which family planning message was spread all around Africa and many countries. This led to

the formation of FP organizations, as NGOs to educate the population and provide services.

As a result of the international population conferences: Bucharest (1974), Mexico City (1984), and especially that of Cairo (1994) and the UNFPA Publication: “An Agenda for People,” governments were made to accept FP as a legitimate development concern. In 1974 it was accepted as the right of “couples and individuals.”

He noted that the conferences seemed to have opened up the issue of FP engendering the confidence that African political leaders needed to discuss the subject openly and in most cases, to encourage the development of policies and plans for the incorporation of FP into mainly health programmes. But he was quick to add that the achievements did not match the rhetoric in terms of results. One factor stands out about all: there has never been widespread public recognition among the countries’ leaders and the donor community that a very high proportion of women and men in sub-saharan Africa clearly want better spaced, limited family size, and that their unmet need must be systematically targeted for attention as the highest priority for achieving national development goals. He mentioned that the CPR for married women is considered one of the best indicators of FP practice by a community. In West Africa today Ghana has the highest level of modern contraceptive use, 19-20%. No other country has a prevalence rate in the double digits.

He observed that the generally low level of development—with Africa last in every major indicator including, high levels of poverty, low levels of quality education and very low access to even poor quality health services—partly account for the low usage of contraceptives. This is worsened by the slowness or even refusal of the political and other leaders to accept FP as a legitimate development need.

Further, local financial support is inadequate or erratic and, where financial support is good, programmes tend to be monovalent or vertical. Lack of skilled manpower is often a major constraint to programmes. Some leaders, who should know better, at times consider and project FP as a foreign imposition or as something not needed by African families.

It is however true that, FP as birth spacing has proved, is a powerful tool for reducing infant and young child mortality. He contended that FP, as birth spacing, has been practiced by African traditional societies for a long time. Some customary methods, such as geographic separation, and prolonged lactation are still common practice; as are the use of some herbs. Polygyny is also widely accepted.

Addressing the issue of unmet need, Professor Sai indicated that ideal family size studies have demonstrated that individuals and couples really need FP and would use methods if supplies are accessible and methods of provision acceptable to clients. The presence of such high levels of unmet need are a powerful indictment that FP programmes are either non existent or are not responding to their rights as recommended in international consensus.

He referred to the “unmet need for FP” as narrowly defined in DHS surveys to try to assess the number of potential clients. It is defined as the percentage of women of reproductive age who claim they do not want any more children, or that they want to wait a certain number of years before having the next child and who are however not using any contraception to support their wish.

He observed that often the unmet need is related to availability, accessibility or quality of services. They may also be due to true or mythical beliefs about safety and efficacy of the methods. If the definition were expanded to include women using traditional methods because they had no access to modern methods, and women in amenorrhea who want to space or limit, the size of unmet need would substantially increase.

He underscored recent DHSs in West Africa which have demonstrated the existence of high levels of unmet need. For Ghana, Senegal and Togo it is over 30%. In six other countries, Benin, Burkina Faso, Cameroon, Cote d’Ivoire, Guinea and Mali the reported unmet need is 20-30%. In Niger and Nigeria the need is 17% and 16% respectively. In Chad, only 10% are reported to have an unmet need. Even for ten percent, in a situation where the CPR is in single digits it must be accepted that FP is not reaching a sizable proportion with felt need.

He also observed that “wanted” fertility, which is calculated on the basis of whether the last birth was wanted, is different from “ideal family size,” which is a separate question. According to some DHS findings, a majority of Sub Saharan African countries – many of them with the lowest total fertility rates (TFRs) in the region – actually have desired family sizes larger than the TFRs.

In Ghana this ideal has come down from 6.1 in 1979/80 to 5.3-5.5 in 1988 to 4.7-4.4 in 1993 and has since been hovering between 4.4 and 4.1

On the consequence of unmet need, Professor Sai suggested that individual and family levels are the most obvious result of unmet need for FP, represented by a high rate of unwanted, unplanned, or unintended pregnancies. Many of these must have ended in unsafe abortion, and contributed to maternal mortality. Africa has the highest maternal mortality ratios in the world. Such ratios reflect a measure of unwanted pregnancy.

The contribution of teen births and births by “unmarried women” to the national birth rate is also a reasonable indicator of absent or poor FP access. These are both very high in West Africa. Although the teen birth rates have been coming down in Ghana, the 2003 GDHS found that 14% of adolescents have begun childbearing.

Also, the human toll and deaths; physical ill-health, deaths and disabilities of the mothers, higher death rates of infants and the thwarting of future social and economic development could all be the result of unmet need for fertility management.

Further, unintended pregnancies help to fuel West Africa's high rates of population growth. At rates of over 2.5% per annum such growth undermines and frustrates the attainment of national development objectives.

He revealed that recent research from Population Action International (PAI) has also demonstrated the important link between demographic realities, national security, and local conflicts. Those countries with a large proportion of children and young adults tend to have more conflicts and be less secure.

He argued that, whilst equitable development, especially quality education and some income security, particularly for women, does help generate a high demand for fertility management, it must not be forgotten that there is already an existing need for better spaced and limited family size and this demand must be met by a good FP service. Secondly there is enough evidence that meeting an unmet need for FP by reducing unintended fertility could help, even in very poor circumstances, to make good contributions to development programmes.

In making a case for FP, he opined that it should be given a much higher priority rating in development thinking than it is receiving right now. For FP has proved to be one of the most important and cost effective development interventions.

Better FP means lower levels of unplanned pregnancy and unsafe abortion and therefore of lowered maternal mortality.

Better spacing of births translates to better infant and young child mortality and illness statistics. There are studies showing that infants spaced at two or more years apart survive better than those with closer spacing.

It contributes to health in many other ways and some of the technologies have health benefits which may be considered as bonuses. The decrease in levels of anaemia in pill users is one such.

It is a major contributor to women's status improvement by making it possible to plan their lives and pursue their own development aspirations with confidence.

The demographic changes brought about by reducing unwanted fertility through FP programmes could have good socio economic benefits. The decrease in social expenditures and freeing of national funds for other investment is obvious.

Above everything else, FP has now been accepted as a "right of couples and individuals".

He expressed the concern that FP has lost ground and in some countries quite steeply. Even the donor communities appeared, until recently, to be fatigued and lowering their contributions to the programme.

Identifying the reasons for the waning interest and support for FP, Professor Sai noted that it was not such a problem in the more advanced countries where it is accepted as a normal part of health and other social services.

Secondly the programmes have been relatively successful in the Asian countries and the expectation is that others would follow.

Thirdly, FP has been considered neutral.

The HIV/AIDS pandemic, whose dimensions could not be anticipated created an overwhelming human and developmental appeal. It took centre stage in development thinking in health generally and reproductive health in particular. Some of the funds which could have gone to FP went to HIV/AIDS.

The Summit Declaration of 2000 and the MDGs did not make any specific reference to RH goals meant a rejection or at best a minimization of the importance of the Programme of Action agreed to in Cairo.

He suggested that the development field is so tied to the MDGs right now that, a way must be found to get the most appropriate RH targets (including access to and use of contraceptives, reductions in unintended, unwanted, ill timed pregnancies) included within the MDGs.

One way of helping the process is for those concerned to reposition FP and show the world its importance and promise for helping with the other goals. The UN system, as a whole, and the donor community, must help to right this wrong. The group of 77 bears a major responsibility and there is the need to work hard to change the group's vacillating stand on RH.

He noted that, UK Prime Minister launched the Commission for Africa, expected to help push Africa to the top of the international development agenda. There is also the sensitivity already shown by DFID to sexual and reproductive health. It was his contention that, through the UK, Africa could have a major opening to make RH a major international development priority and thereby help increase the funding for repositioning FP.

In repositioning FP programmes, he advocated for the rededication in trying to understand the programming, socio-cultural and leadership gaps behind the failure in addressing unmet need.

He made a number of suggestions in this regard:

1. Political leadership. The highest possible leaders have to identify consistently with the related policies and programmes make FP a priority budget item just as has been done to HIV/AIDS and poverty eradication.
2. Comprehensive policies should be developed and translated into action.

3. The policies and programmes should be wholly owned and completely internalized by the populations involved.
4. By being holistic the policies and programmes will pay attention to both demand creation and supply issues as well as to other development needs.
5. Technological issues like method mix are very important.
6. The exclusion of methods for ideological; or political reasons should not be accepted; and methods such as emergency contraception must be made available over the counter.
7. Post abortion care must be part of all FP programmes and to the extent permitted by national legislation safe abortion services must be provided
8. Easy and comfortable access is important. This includes geographic, social, cultural and financial accessibility.
9. Evidence-based advocacy is very important and the use of satisfied clients as witnesses and advocates should be pursued.
10. Appropriate communication methods and strategies would be important for sustainable change. These should include all possible avenues, including traditional communication methods.
11. Special efforts are needed to involve males in practical ways.
12. Attention to youth and their realistic involvement at all levels of the programmes, including separate youth programmes is needed.
13. Adequate and reliable flow of financial resources.
14. Availability of trained and reliable manpower at all levels.
15. Cultivation of strategic partnerships between programme and NGOs.
16. A system for monitoring and evaluation that provides a feed back into programme planning and implementation.

Professor Sai strongly suggested for strong advocacy for the political leaders to rededicate themselves not only to attaining the MDGs but also for fullest possible implementation of the ICPD PoA. This would mean:

- The development of comprehensive policies for reproductive and sexual health and rights programmes
- The statement of explicit sexual and reproductive and FP goals within all poverty alleviation strategy papers and programmes
- A decentralized approach to programme planning and implementation
- Such programmes should pay due attention to the special needs and roles of the youth, and make men important partners
- Implementation due attention is to be paid to legal, religious and cultural realities of different communities
- Whilst Political Heads may be the de jure Leaders for the programme, he/she should be supported by a de facto leader who may come from any of the line agencies for example in health or women affairs
- Provisions must be made for the coordination and actual integration of the HIV/AIDS programmes with the FP and RH activities
- The programmes must be well resourced financially and with well trained local personnel

- Donor funds should be resourced and utilized efficiently
- Laws and regulations which impede the expansion of programmes to difficult to reach areas and groups must be reviewed
- Over-medicalization of FP must be avoided
- Programmes of research must be made part of all programmes and should include both social science and bio-medical issues
- A well thought out monitoring and evaluation scheme must be developed and operated

Concluding, he noted that, it is time quality FP information and services are made available and easily accessible to the millions of the citizenry with an expressed unmet need for FP.

3. PLENARY SESSION ONE: "WHAT WE NEED TO KNOW ABOUT FAMILY PLANNING IN WEST AFRICA"

The panelists for the session were:

Dr. Richard Turkson, former Director Ghana National Population Council: ***Evolution of FP: 1964-2004***

Dr. Justin Tossou, The Futures Group, Benin: ***Patterns of Use***

Dr. Kadidiatou Maikibi, The Futures Group, Niger: ***The "Preference" Gap: Evidence of what women and men want***

Dr. Timothee Gandaho, Executive Director, Partners in Population & Development: ***<u>Who</u> is "in need"?: Secondary analysis of DHS***

See presentations for details on data presented.

A. Dr. Richard Turkson, former Director Ghana National Population Council: ***Evolution of FP: 1964-2004***

The main issues of his presentation include the following:

In the Pre 1960s modern FP was non-existent in West Africa
In Francophone West Africa there was the French Anti-Contraception Law of 1920

The period 1960-1970s saw:
- Changes beginning to emerge
- Some countries had official government policies
- In others, there was the perception of the problem of under population

The period 1980-1990s witnessed:
- Reverses in economic gains of the 1970s

- High rates of population growth – Credibility of FP enhanced

The 1990s witnessed a period of rising expectations:

- FP seen as integral part of socio-economic development and a contributor to quality health
- Preparatory regional meetings produced the DAKAR-NGOR Declaration – Re-affirmation of Arusha Declaration
  The historic ICPD, Cairo 1994 - 20 year Programme of Action
- World-wide recognition of FP as a basic human right

Ten years on:

- Evidence available indicates awareness has been created
- This has led to significant changes in official positions and attitudes toward FP
- Even as major challenges remain since FP/RH is central to development and in meeting the MDGs

Some of the challenges posed at present include the need to:

- Strengthen FP programmes and expand coverage in rural areas-improve access to basic health services as well
- Do community outreach
- Expansion implies improved logistics and commodity supply – resource mobilization
- Comprehensive review of laws, policies, administrative regulations and socio-cultural practices relating to SRH
- Build stronger partnerships and collaboration

He concluded by indicating that:

- ICPD Programme of Action needs to be continuously explained, promoted and defended
- There is the need for greater advocacy to keep the relevant issues on the front burner
- Continue to involve males, expand scope and coverage of such programmes
- Continue and conclude research into method mix, e.g. male methods
- Continue resource mobilization as it is still critical to our success

B. Dr. Justin Tossou, The Futures Group, Benin:
Patterns of Use

The main issues in his presentation include the following:

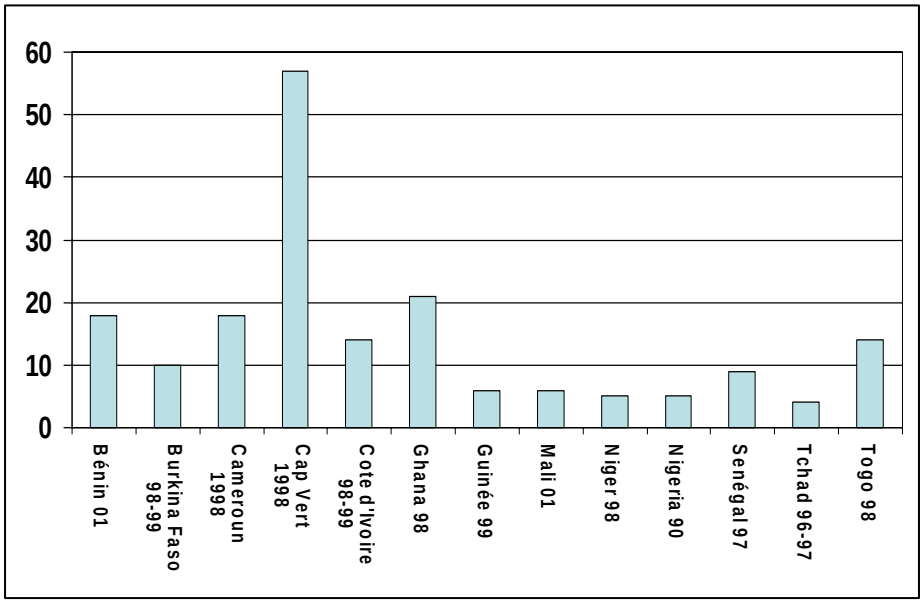
FP seems to be one of the cardinal ingredients in the battle for survival as the cost is minimal and it saves lives and contributes to a significant reduction in poverty and deprivation.

Contraceptives are used most commonly by married women between 15 and 49 years in the developing world.

The use of contraceptives is low between ages 15 – 19, hitting its peak between 30 – 39, and then declines again.

Parity increases with the number of children that are alive.

Contraceptive Prevalence among Married Women ages 15-49: AWARE Countries



Education is closely related to the use of contraceptives.

Generally speaking, the trend is more urban than rural.

Knowledge of sources of supply varies greatly in West African countries.

In certain countries, there is a large gap between knowledge of a method and the place where it is obtained. It is the case in Burkina, Niger and Senegal.

The methods used vary greatly according to the country. The use is dependent on several factors such as:

- the range of methods available
- the level of sensitization
- the cost
- geographical accessibility
- social factors

The modern methods now frequently used in West Africa are pills, injectables, implants, IUD, and male condoms.

The traditional methods include periodic abstinence, withdrawal, lactational amenorrhoea, and prolonged abstinence.

Results have shown that the rate of fertility has started to decline in all West African countries except Mali and Niger. The decline is too low as compared to other regions of the world. This trend is due to some direct factors. The most important factors in our region are the low rate of contraceptive use and the age of marriage.

The outcomes include:

- Indirect factors
- A strong demand for large families
- Low level of economy
- Persistently high levels of infant and teenage mortality
- Refusal of some past governments to implement FP programs
- Internal conflicts in certain countries

C. Dr. Kadidiatou Maikibi, The Futures Group, Niger:
The "Preference" Gap: Evidence of what women and men want

Key issues presented include:
Existing interest in FP include: Breast feeding, desire to space births, desire to use modern methods of contraception, unwanted pregnancies, abortion, fertility

There is high desire among men and women to space births and high intention to use contraception, but yet there are high levels of unintended pregnancy and abortion. There is a gap between desired fertility and actual fertility across the region.

Unmet need is defined by women who desire to space or limit births and whether or not they have the means to meet that desire.

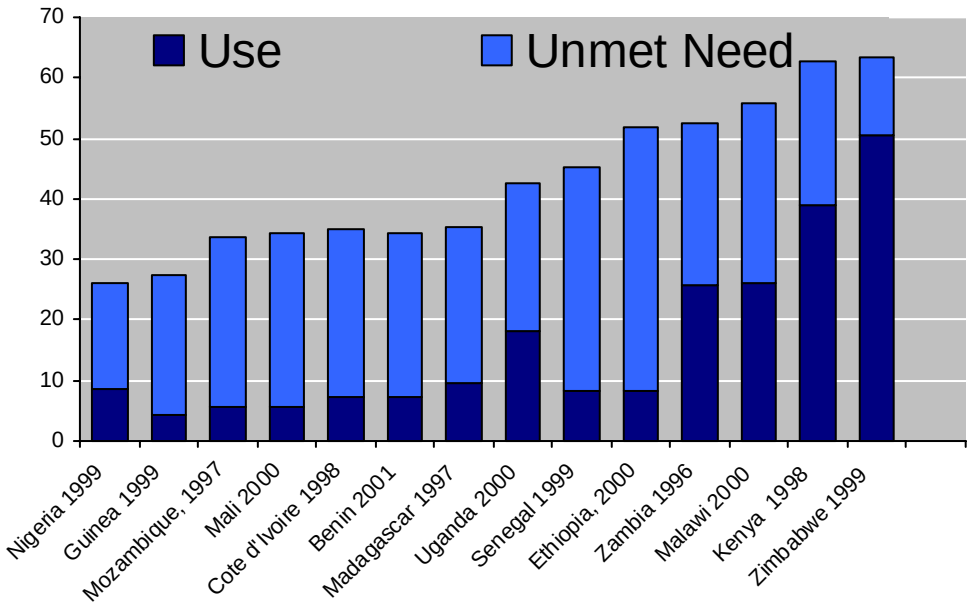
"Unmet need" results from fertile women who are sexually active and do not use any method of contraception and yet want to space births at least two years or would like to limit births.

Other categories of unmet need include:
Fertile women who are sexually active, use traditional methods (which are unreliable) and lack access to modern methods.

Women who use a method of contraception but are likely to abandon it at any time for various reasons – either by choice or for problems of inadequacy.

Women in post partum amennorhoea whose previous pregnancy was a desired one and wants to wait for a two-year period before a new pregnancy.

If these women are included, the unmet need in Sub-Saharan Africa increases from 26% to 43%.



The consequences of unmet need include pregnancies that are not spaced, high risk pregnancies (abortions, deaths, morbidity, after effects) and increased rate of rapid population growth.

The benefits of meeting the needs include:

- Improvement in health of mothers and children
- Impact on very high risks pregnancies that lead to death
- Impact on morbidity
- Impact on suffering
  - At the individual level
  - At the family and local government levels
  - At national level
- Development efforts are sustained and national objectives as well as MDGs are achieved
- Reproductive health rights are also met

D. Dr. Timothee Gandaho, Executive Director, Partners in Population & Development:
Who is "in need"?: Secondary analysis of DHS

Main issues presented include:

Data was presented –
Unmet need is high across the region in both urban and rural areas. Unmet need to *space* births is high toward the beginning of the reproductive cycle (15-29 years) and unmet need to *limit* births is high toward the end of the reproductive cycle (40-49 years). Most women with unmet need intend to use contraception in the future. Discussion of

family planning with one's partner influences future intention to use. Concerns over side effects and health are a major contributor to non-use among women with unmet need.

Concluded by indicating that:

- strong evidence exists that there is a high level of unmet need for FP in West Africa
- Considerable information exists about the characteristics, intentions, and preferences of women with an unmet need for FP services
- These characteristics differ from country to country
- Many obstacles related to unmet need can be removed with appropriate policies, strategies and programmes using the available information on unmet need.

QUESTION AND ANSWER SESSION
MAIN ISSUES

The key issues discussed were:

- It is women with unmet need who try to initiate the discussion on FP. The question is whether they have the courage to discuss it with their partners. When both partners are involved, it facilitates decision- making.

- Abortion is high with serious consequences and there will be the need for emergency contraceptives.

4. PLENARY SESSION TWO: "WHY THE GAP BETWEEN *EXPRESSED NEED* AND *USE* OF FAMILY PLANNING?"

The panelists for the session were:

Dr. Oluwole Akande, Chair, Reproductive Health Task Force **- *The program gap: need versus coverage, access, quality***

Dr. Christine Naré, Sociologist/Gender Specialist **- *The social-cultural gap: FP knowledge, attitudes, practice***

M. Moustapha Ka**,** former Vice President, Senegal National Assembly **- *The leadership gap: commitment, legal-policy framework, resource allocation***

See presentations for details on data presented.

A. Dr. Oluwole Akande, Chair, Reproductive Health Task Force:
The program gap: need versus coverage, access, quality

Key issues in the presentation dealt with:

CPR is low and TFR is high in West Africa

Programme factors contributing to unmet need for FP in West Africa

Shortfalls in funding for commodities and its consequences

Inequity in access to FP services between the poor and the rich

Negative effects of vertical FP programmes

Limited range of contraceptive choices

Poor geographical and/or financial access

Poor quality of services

Provider bias

Limited community involvement and poor coverage of rural areas

The presentation concluded with the following suggestions:

- To ensure satisfactory progress in FP in West Africa, strategic and targeted action is needed
- There is a need for Programme managers to prioritize programmatic issues that jeopardize programs' success; and take strategic action to attain maximum results
- Government, donors and NGOs should eliminate user fees (or charge minimal fees) and scale up models that support the access of the poorest to FP services
- Programmes should focus on integrating HIV/AIDS services into RH/FP and FP into HIV/AIDS programmes

Governments should strive to align their programs with their MDG plans and ensure that by 2015 all primary health care and FP facilities are able to provide, directly or through referral, the widest achievable range of health care such as:

- Safe and effective family planning and contraceptive methods
- Essential obstetric care
- Prevention and management of reproductive tract infections, including sexually transmitted diseases
- Barrier methods, such as male and female condoms and microbicides to prevent infection and unwanted pregnancies

B. Dr. Christine Naré, Sociologist/Gender Specialist:
The social-cultural gap: FP knowledge, attitude, practice

Key issues in her presentation include the observation that:

- Women and men are aware of modern methods of contraception but do not make use of them
- Women desire to space or limit their births but do not use the modern methods of contraception available

This situation has to be understood within the social and cultural context of reproduction in Africa and the impact of this background on FP needs

Social and cultural background of reproduction in Africa tends to promote the existence of large families.

Socio-cultural context relating to unmet need includes:

- Economic factors – costs and hidden costs (time constraints) for women and belief in rumours pertaining to the methods, especially fear of future barrenness
- Religious factors - non-natural FP is forbidden by the church and Islamic religion is more tolerant and favours the use of methods of contraception within the ambit of marriage (exceptions in certain Islamic groupings)
- Social norms in terms of sexuality
- Social norms - negative image about women who use contraceptives as these are not in keeping with the primary role of the woman: to give birth
- Post partum abstinence on the part of the woman -traditional mechanism for the regulation of births, taboos around breast feeding (incompatibility in having sexual relations while breastfeeding), etc.
- For most women, the use of a modern method of contraception is first and all a social act which implies the approval or the support of the partner and other influential members of the family (mothers in law)
- For women in the rural communities or those who are not economically independent, the approval or the consent of the partner (spouse) is unavoidable

The implications for programming were noted as follows:

- Adopt a participatory approach for the implementation of FP programs, solicit the support of the community, the husband and the leaders as a product of all FP programs
- Give high priority to social mobilization of the leaders and members of the community especially regarding teenage FP issues
- Men should be specifically targeted
- Focus the interventions on women and teenagers who have unmet need
- Focus the interventions on the post-natal period and suggest to them appropriate methods of contraception; develop the messages to promote the use of contraception and the resumption of sexual relations during the post-partum and breastfeeding periods
- Survey have proven that when women participate in decisions in the home, they are more likely to use contraceptives
- When women earn income and contribute financially to the management f the home, they also participate in decision making

- Possible solution: improve the status of women and young girls by integrating their economic activities in FP programs
- Surveys have proven that the belief in personal efficiency and self esteem among teenagers increase capacity to look for and use contraceptives; promote programmes that are geared towards life skills with an emphasis on self-esteem and personal efficiency

C. M. Moustapha Ka, former Vice President, Senegal National Assembly: ***The Leadership Gap: commitment, legal-policy framework, resource allocation***

Key issues made in the presentations are as follows:

Identified a number of commitments made by governments and they include:

- 1994 Cairo Programme of Action (ICPD)
- 1997 Program of Action of Ouagadougou
- 1997 Reproductive Health Strategy for the Africa Region (WHO AFR/RC47/8)
- 2003 Women's Health Strategy (WHO AFR/RC53/11)
- 2004 Repositioning Family Planning Framework (WHO AFR/RC54/11 Rev.1)
- National laws, policies and strategies

Identified those in leadership and they include a variety of persons and institutions both public and private as follows:

- At national, regional, district and local levels
- Those who set policies, control resources influence socio-cultural practices…
- In legislatures & ministries of health, plan, finance, education, gender, etc
- In civil society including NGOs, religious institutions, business and other

Noted that leaders can do a number of things to address unmet FP need in development strategies. These include:

- Strengthen policy, planning, budgeting process
- Implement public-private partnerships
- Learn lessons from efforts in other areas

QUESTION AND ANSWER SESSION
MAIN ISSUES

The main issues discussed concerned the following:

- The private sector has a critical role to play in bridging the gap between supply and demand of FP products and services. The government gives the policy direction and does the monitoring and evaluation. The private sector should be in the driving seat

- Women should not be the only users of contraceptives. It is a collective issue but what is noted is that service providers agree that women need to consult their partners. The involvement of men must be seriously considered.

- No barriers should be put in the way of women. Polygamy can lead to large families. Women also want to satisfy the needs of their husbands. There is the need to reflect on reducing family sizes.

- The question of polygamy being an impediment to FP should be an issue of greater reflection and discussion. Some traditional leaders say that they like FP but they are in the minority. The majority dominate in terms of opinion.

- There is the need to do a lot of programming to improve sexual and reproductive life in West Africa. There is lack of knowledge. Majority of the youth are ignorant about the processes of sexuality and what leads to pregnancy. The youth need to be empowered through relevant information

- Holistic services and programmes should also be put in place. Young people do not access FP products. The services should be tailored to the needs of the youth and should be user friendly because people are judgmental. The best thing is to improve their knowledge base.

5. REPORTS FROM BREAKOUT GROUPS

Groups met to discuss a number of subtopics under the topics of
A. Programme related barriers
B. Social cultural factors
C. Leadership gap

The main thrust of the discussions is to brainstorm and investigate how the different subtopics relate to unmet need and agree on the findings and conclusions.

Find below the two key issues identified by each sub topic working group.

TOPICS	Sub-Topics	Problems/Obstacles/Barriers
Programs	Management & Supervision	- Human resource management - Lack of coordination, collaboration, communication among stakeholders
	Access & Quality	- Inadequate skills and competencies of service providers to give comprehensive and quality FP services - Limited services for the youth and rural population
	Integration of FP	- Weak social, political and structural enabling environment to support integration - Obstacles in service delivery and utilization for integration of FP
	Procurement & logistics	- Weak distribution systems - Weak logistics management information systems

TOPICS	Sub-Topics	Problems/Obstacles/Barriers
		(LMIS/SIGL)
Sociocultural factors	Gender	**-** Low women's social status - Low access to adequate information
	Economics/ Education	- Lack of women's empowerment - education/economic - Low level of comprehensive education on FP at all levels
	Religion	- Multiplicity of religious interpretations with respect to the role of FP in the life of the faithful - Insensitivity to each other's religious needs
Leadership	Legal Policy	- Religious and cultural barriers (marital age) - Lack of/inadequate legislative framework conducive to FP
	Political commitment/ civil society	-Lack of political understanding of unmet FP needs of women, men and youth and of their link with development - Lack of framework for public-private partnership
	Financing contraceptive security	-Weak distribution systems -Weak logistics management information systems (LMIS/SIGL)

QUESTIONS AND ANSWER SESSION ON OBSTACLES TO FP USE

PROGRAMS

Key Issues

- There is the need for the synergy between FP and HIV/AIDS programmes
- Decentralization should be a priority in FP/RH programmes
- The capacity of young people need to be enhanced in the supervision and management of FP programmes
- Warehousing and transportation poses immerse problem for FP programmes at the local level. The problem relates to inadequate data to inform distribution. Where programmes are established it is easy, it is possible to deal with the problem. Donor coordination is essential even as they all have their respective objectives.

SOCIO-CULTURAL FACTORS

Key issues

- It is important that religion should help reach young people who are not necessarily religious
- Religious leaders need to interact more often in FP matters as the model in Sierra Leone demonstrates where there is an inter faith council on HIV/AIDS
- On gender, the major problem involves the social status of women
- There is the need for concrete actions which should incorporate the gender dimension. This also raises to the fore the question of social norms.

- Women need to be empowered within a rights based approach in FP programmes
- The question of early parenthood and forced marriage also needs to be addressed

LEADERSHIP
Key issues

- Programmes need to be structured for young people from varied backgrounds and for specific needs
- We have multi sectoral groups and institutional links to address the issue of the leadership role of young people in FP programmes
- Data needs to be used when discussion are being held.

6. PLENARY SESSION THREE: "WHAT ARE THE HEALTH, DEVELOPMENT AND ECONOMIC CONSEQUENCES OF THIS GAP?"

The panelists for the session were:

The Moderator for the session was Margaret Neuse of USAID

Dr. Therese Lesikel, WHO/AFRO & Dr. Alimata Diarra, WAHO ***- Saving Lives, Preserving Families***

Jean Pierre Guengant, Institut de Recherche pour le Developpement & Scot Moreland ***- Achieving the Vision: Meeting Millennium Development Goals***

See presentations for details of data presented.

A. Dr. Therese Lesikel, WHO/AFRO:
Saving Lives, Preserving Families *(Spacing Births to save lives and preserve families: An overlooked strategic opportunity)*

Key Issues raised in the presentation include:

- One of the most critical consequences of the huge gap between perceived need and use of FP in West Africa is short birth interval and its dramatic health effects for the mother and child
- Using family planning to achieve longer birth intervals saves lives
- Infants are more likely to survive if the previous birth interval is at least 3 years.
- Evidence of longer birth intervals has positive effects on both children's and mother's health
- FP for longer birth interval can reduce neonatal, infant, under-five, and maternal morbidity and mortality
- Few post–partum women want another birth within two years, yet many do not use family planning

- Large percentages of too closely spaced births occur among women ages 20-29

Avoiding short birth intervals would lower both fertility, and maternal, infant and child mortality by additional substantial amounts
West African countries' fertility would drop by half a child if no intervals were shorter than 36 months
The fertility rate would drop 8-10%, or about half a million births per year.
Made suggestions on Strategies to space Births as follows:

- Increase access to good-quality contraceptive services with full range of contraceptive methods
- Encourage community based programs that speak about needs of younger couples – and cultural norms and tradition beliefs
- Use prenatal and post natal periods as crucial times for information and counseling about birth spacing the birth of next child
- Discuss with mothers during well-baby and immunization visits the benefits of using FP for 3-5 years before the next child
- Support initiatives that strengthen women's decision-making power

B. Dr. Alimata Diarra, WAHO:
Saving Lives, Preserving Families

There is an ethical problem: unmet need is at variance with the concept of sexual and reproductive health, which presupposes that every woman should be able to enjoy her sexuality in a safe and satisfying way, and with the option of giving birth and the freedom of deciding the time and the frequency of those births.

The needs-use gap in family planning:

- Threatens the lives of thousands of women and children
- Threatens the foundations of the family
- Undermines developmental efforts in the West African sub-region

Birth spacing of less than 14 months increases the risk of maternal mortality by 2.56 times as compared to a spacing of between 27 and 32 months.

Induced abortions constitute the greatest risk.

Contraceptive prevalence and maternal mortality in West Africa – low level of contraceptives is accompanied by a high mortality rate.

The shorter the spacing of births (less than 3 years), the more children under 5 years run the risk of malnutrition and death.

On the average, children born with less than two years of spacing are two times more at risk than those born after two years or more.

Within the context of HIV/AIDS, unmet need is to prevent:

- Unwanted pregnancies among HIV-positive women
- Infection of women

Concluded by indicating that:

- There is growing evidence of the contribution of family planning to the improvement in the health and welfare of women, children, families, and communities.
- The unmet family planning needs constitute an obstacle to saving thousands of human lives and to protect large numbers of families.
- To prevent women from getting family planning services is to prevent them from controlling their fertility, from learning, getting a profession and working and participating in various developmental activities in the communities.

C. Jean Pierre Guengant, Institut de Recherche pour le Developpement & Scott Moreland, The Futures Group:
Achieving the Vision: Meeting Millennium Development Goals

Key issues related to the MDG include:

- The contribution of fulfilling unmet need for family planning
- The number of women of reproductive age is large and growing
- The number of pregnancies will on average double in the next 25 years
- A significant percentage of these pregnancies are unintended
- Many women want to space or limit births, but do not use family planning
- Meeting the unmet need for family planning will increase the percentage of women practicing family planning
- The number of women using family planning will increase when unmet need is met
- Meeting the unmet need for family planning will reduce unintended pregnancies
- …as well as reduce the number of abortions
- …and therefore reduce the number of unintended births

Reducing unmet need for FP can help countries to meet the MDGs by reducing the cost of meeting the MDGs.

Focus on 4 MDGs as follows:

- Achieve universal primary education
- Reduce child mortality
- Improve maternal health
- Ensure environmental sustainability

Calculate the savings in the costs of meeting the MDGs due to increased contraceptive use:

1. Project the population with constant FP use and with unmet need fulfilled.

2. Calculate the costs of meeting MD goals for each projection.
3. Compare the costs projections and calculate the difference.

- Fulfilling unmet need generates savings by reducing the costs of meeting primary education MDGs
- Fulfilling unmet need reduces child mortality
- Fulfilling unmet need generates savings by reducing the costs of child vaccination MDGs
- Fulfilling unmet need reduces the number of maternal deaths
- Fulfilling unmet need ensures environmental sustainability
- The costs of achieving safe water and sanitation goals are reduced by fulfilling unmet need
- Fulfilling unmet need reduces air pollution so that MD environmental goals will be easier to achieve

The benefits of reducing unmet need are much greater than the costs. The additional costs of reducing unmet need for FP are (partially) offset by MDG cost savings by 2015.

In conclusion:

- Low level of contraceptive use results in:
  - Many unintended pregnancies
  - Many abortions
  - Many unintended births

- Eliminating unmet need will allow couples to achieve their reproductive rights by reducing:
  - Unintended pregnancies
  - Abortions
  - Unintended births

- Achieving the Millennium Development Goals will be a major challenge

- These goals will be easier and cheaper to achieve if contraceptive use increases as a result of fulfilling unmet need

QUESTION AND ANSWER SESSION
MAIN ISSUES

The main issues discussed were the following:

- There is the need for parents to talk to their children about sexuality parents should leave all the education to teachers

- West African countries have not utilized the modern methods. Maybe it is time to test the traditional methods

- USAID has done some studies and research into the traditional methods. This includes lactation and breast-feeding such as the use of six months of exclusive breast feeding

- Periodic abstinence, its calculation to be used as a standard days method can be encouraged

- The method has its downsides and needs good communication between couples

- On CPR, there is the need for the maximization of contraceptive use

- On the MDGs, governments always have priorities and are interested in committing funds for FP programmes

- Studies have shown that FP pays for itself and this translates in the cost of meeting the particular MDG

- If FP programmes are addressed, pregnancies will go down and we can achieve population control. If we project 25 years ahead, the gains will be greater

- FP not only benefits health but also education and indeed impacts and development

- The needs of the youth are not only health needs but the larger issue of livelihoods and that has to be addressed also. Livelihood needs are unmet needs and therefore leads to gaps

- FP also has benefits at the household level. Research has established that small family size creates the opportunity for much more to be spent on education, healthcare etc. and this enhances livelihoods.

- Helping the youth find livelihood jobs will entail the need for close connection between the youth and adults; getting close to a mentor adds to protection

- All contraceptives are produced in the developed countries. There is the need to engage the manufacturers to make their products cheaper and also set up industries in developing countries

7. PLENARY SESSION FOUR AND CONCURRENT SESSIONS: "WHAT ARE SOME SOLUTIONS FOR ADDRESSING THIS GAP BETWEEN NEED AND USE?"

A. Dr. Levent Cagatay, Program Associate for Family Planning, ACQUIRE Project//EngenderHealth:
Change and the Diffusion of Innovation

The presentation addressed the issues of:

- Change and why it takes so long
- Factors affecting diffusion of innovation
- Some communication lessons learned

It noted that:

- Any development intervention requires behaviour change
- Any public health intervention requires behaviour change
- Any medical or clinical intervention requires behaviour change

Further that a research paradigm is not enough to change behaviours and that we often fail to factor the principles and dynamics of change into our thinking and programming.

It also recognized that change is central to development; has predictable phases and dynamics, is empirically-based; applies to both “developed” and “developing” countries and can point the way to strategic solutions, to better interventions and programming

The slow pace of change in medical settings is the result of

- Lack of perceived need for change
- Lack of provider motivation
- Ignorance
  - of latest scientific findings
  - of risks and benefits
  - of concept of relative risk

It also discussed the factors affecting innovation diffusion as related to perceptions, characteristics of the adopters, and contextual factors such as the environment.

There is need for communication, motivation, and leadership.

In recommending what to do, it suggested the need to understand the principles, patterns, and dynamics of change. They are:

- Empirically-based
- Largely predictable
- Universal
- Helpful in pointing to better/more strategic interventions

It is important to find sound innovations, hence the emphasis on:

- “Evidence-based” medicine
- “Data-driven” programs
- “Best practices”

It is critical for the message to be kept simple, support champions, tailor effort of context and be realistic.

Finally, appreciate the fact that there is no quick fix and that there are always two persons in the room – the provider and the client.

B. Concurrent Sessions on Solutions

In finding solutions to the questions related to addressing the gap between need and use, a number of concurrent sessions were organised around the following topics:

- Programs: Management and Supervision
- Programs: Access and Quality
- Programs: Integration of Family Planning and other Health and Non-Health Sectors
- Programs: Commodity Logistics Management
- Social-Cultural Factors
- Leadership

See presentations for further information. The discussions were to inform the expected discourse at the Country Team meetings.

8. PLENARY SESSION FIVE: HOW DO WE ADVOCATE TO ACHIEVE THESE SOLUTIONS?

The topic discussed was: ***What is advocacy, and where has it worked in family planning in West Africa?***

The Presenters were:
Modibo Maiga, The Futures Group, Mali
Kate Parkes, CEDPA, Ghana

A. Modibo Maiga, The Futures Group, Mali:
The Experience of the Process of Participatory Advocacy: A case study of Mali

The presentation provided a historical background to the special law on RH as evidenced by the commitment of the Network of Malian Parliamentarians to population and development (REMAPOD). Before 1997, there was existence of several legal and

non-legal barriers to RH/FP. For example there was the 1920 law forbidding anti-birth and abortion campaigns.

The process for the formulation of the new law in Mali consisted of the:

- Amalgamation of 3 legal initiatives into a single draft law under the auspices of REMAPOD
- Meeting with key stakeholders on the content of the law taking into account Malian specifities
- Consensus among parliamentarians and introduction of the draft law at the National Assembly

The opportunities and key stakeholders existing included:

- The political will and commitment of parliamentarians in Mali and the support of the regional network of parliamentarians;
- Cooperation between the Ministries of Health, Development of Women, Civil Society and lawyers….;
- Support of partners (UNFPA, USAID, and Policy)

The RH Law was adopted by the National Assembly on June 7, 2002.

The lessons learned on essential elements included:

- Strong leadership by REMAPOD (the strength of the group)
- The support of the Regional Network (FAAPPD) to the REMAPOD
- The synergy existing between parliamentarians and civil society, the ministries, and development partners
- Demonstrated patience and understanding towards the religious leaders
- Religious leaders must be:
    - Open to share issues relating to FP among themselves
    - Open to supporting FP
- Existence of positive arguments in favour of FP among couples in the Holy Koran and the Hadiths

Major outcomes:

- Policy change among certain religious leaders
- A more active role among couples now in favour of FP
- Creation of a network of religious leaders on population issues as well as quality of life within the Islamic Council in Mali

B. Kate Parkes, CEDPA, Ghana:
Advocating to Achieve Desired Solutions

Where advocacy has worked in FP in Ghana, West Africa
Work of the FP/RH Advocacy Networks in Eastern & Central Regions

The presentation indicated the positive environment which included:

- Revised 1994 Population Policy
- ICPD
- Decentralization process
  - NPC
  - Local Government Reform
- The Participation Programme
- There is also the broadened participatory approach and the necessary favourable policy environment for advocacy.

This involves:

- Empowered of stakeholders to participate in the development process
- Built capacity of NGOs to represent needs and interest of the community
- Encouraged NGOs to network

There was also the "small beginnings" approach of RH/FP Advocacy Networks. She also presented a case study of best practice network activities in the Eastern Region of Ghana.

The impact includes:

- Training of NGOs/CBOs in advocacy for repositioning FP
- Municipal Assembly sponsored community fora on sexual and reproductive health issues relating to HIV/AIDS
- Partnership with the Ghana Health Service in its 5-year programme of action – incorporating FP in maternal and child health activities

QUESTION AND ANSWER SESSION ON SESSION ON ADVOCACY

The main issues discussed were the following:

- The priority issues in communities include maternal mortality and child survival

- Young people need to be involved in the networks

- The experience has shown that it is young people who bring relevance to the fore and are very good advocates

9. PLENARY SESSION: OVERVIEW AND PARTNER PERSPECTIVES

A. Synthesis of Countries' Follow Up Plans

The synthesis of the country follow-up plans was presented.

The common elements identified in the country discussions are:

- Opportunities – every country identified important opportunities (e.g., tools, norms, training materials, existing experiences)

- Community organizations – every country stressed importance of the opportunity of community organizations of women, teachers, religious leaders, youth

- Advocacy – there is a need for advocacy and their proposals were very well throughout

All countries indicated the systematic use of information provided to them during the conference.

They all expressed the commitment to go back and report and take actions; some country teams plan to meet.

Many of them recommend elevating FP higher up within the government structure.

There was the expressed need for co-ordination and control.

They expressed the lack of integration of FP into all RH and primary care services.

They expressed the problem of quality – including the skills of staff and supplies.

B. Partners Perspectives

1. Yves Bergevin of UNFPA indicated that the conference presented a unique opportunity for attaining the MDGs since FP is essential in achieving the desired results and for poverty reduction.

He noted that unmet need is a major challenge in West Africa and the region is poised to move the process forward. The objectives need to be clearly defined and we need to ensure that FP is fully accessible by 2015. He observed that, there is the danger of not addressing unmet need, which means that we need to do things differently.

He advocated for the necessity for a solid national coordinated action by the Ministry of Health of the different countries and the need for frequent meetings with the partners.

He made a number of recommendations to scale up actions. These include:

- The need for strong logistic and information management systems in the respective countries
- The need to cost out the plans and forecasts
- The need for multi-year donor commitments
- The need for comprehensive national plans that would enable a number of persons to be reached

The main efforts of the UNFPA will be to ensure a marked presence in all the countries and to support low cost programmes and products all the way to the clients

He pledged the UNFPA's commitment to participate in the follow-up actions at the regional and national levels. He expressed the hope that if all goes well, we should be able to meet unmet need in the next five years.

2. Wilfred Ochan of IPPF/AR expressed the disappointment that the gap is still widespread ten years after the commitments made in Cairo. Policies and commitments are weaker and FP is being edged out of the development agendas. Funding has remained static and is declining.

He indicated the need to resume the struggle essentially because unmet need is growing, and the repositioning effort is important for the growing interests of different actors.

He noted that RH is embedded in the MDGs, but they cannot be achieved without FP.

Dr. Ochan advocated for the need to seek the commitment of the U.K. Commission on Africa and to exploit the opportunity noting that the European Union is expressing interest.

In addressing the question as to what to do differently, he asked that we examine our work closely and devise ways of influencing the agenda of global forces so that we can be visible.

He also advocated for the review of national policies and the need to shift the debate of FP from its present focus to the level that responds to the economic health and family life benefits. He also recommended the need for one strong national planning programme with coordinating machinery that everybody can buy into.

He made a number of recommendations:

- Start a fund raising process and mechanism that will bring in more resources
- Provide the necessary infrastructure and enhance the human and institutional capacity as well as training of the actors
- Develop partnership and coordinated effort of actors and partners.

He informed the conference that, IPPF is already involved in partnership and it is critical that a youth component is recognized in FP/RH efforts.

Finally, he called for a greater commitment to FP.

3. Mayuki Oikawa of JICA indicated that as the "newest member" of the donor community, JICA is seeking to expand its activities in West Africa and increase its assistance in the health sector.

The focus of JICA will be in three priority areas:

a) Safe motherhood
b) Family Planning (to solve population problems and reduce poverty)
c) Reproductive Health (and contribute to HIV/AIDS and empowerment)

She acknowledged that the current budget allocation is small but there is the room for discussion. The conference has opened up the issue and will assist JICA in its planning and intervention.

4. Luise Lehmann of KFW indicated that as a German Development Bank, KFW is not necessarily a donor but supports public health. The organization has developed a social marketing approach to assist national governments to enhance their coverage in HIV/AIDS, FP, and other issues.

KFW has, since 1990, enhanced its coverage in social marketing in West Africa.

It has earmarked Eu70 million for the 2004-2009 period for HIV/AIDS, FP, and RH.

Its coverage includes product production, training of service providers, and market surveys. She stressed the need for sustainability and noted that revenues from subsidies are used to cover programme funding needs and this enhances the rational use of resources. She indicated KFW ensures that FP is seen as part and parcel of the product.

Political guidelines are critical to the work of KFW, and there is the need for a total marketing approach in repositioning FP.

5. Margaret Neuse of USAID informed participants that USAID handles only one portion of the Development Assistance Budget and that funding is currently channeled through the Millennium Challenge Account which is managed by the Millennium Challenge Corporation.

The criteria for accessing the account includes:

a) Investment in people (that is, education and health)
b) Upholding the principles of democracy and governance
c) Willingness to make decision and choices

The second major outlay is through the HIV/AIDS President's Initiative which has a number of focus countries.

She indicated that funding comes through the commission in respective countries and there is also a regional office which is in Ghana.

USAID Washington also has the Africa Bureau and the Technical Bureau which manages the FP budget.

On the allocation of funds, she intimated that, USAID has similar funding areas as other donors.

On repositioning FP, they have realized that some of the programmes are not using best practices and, therefore, there is need to scale up advocacy.

They have also been putting in resources in reproductive health commodity security and logistics.

Further, there are funding outlays for FP-HIV/AIDS integration to ensure that FP is integrated into HIV/AIDS programming and vice versa.

She noted that overall funding was high in 2001 and has been flat in the last two years.

Funding has shifted from Latin and Central America to Africa and this has gone up to $30 million allocated to the whole of Africa.

She affirmed USAID's commitment to intervention efforts at the regional and international level including being involved in different coalitions and with support to countries at risk.

C. Launching of Network on Family Planning

Fatimata Denie of Senegal introduced the initiative to launch an African organization on FP. This is based on the appreciation to reposition FP and fight against maternal and child morbidity and mortality.

She expressed the need for a steering committee is to be put together as a preparatory group to move the process forward. There is the need for an initiative committee and appealed to participants to come on board and assist in the realization of the MDGs.

QUESTION AND ANSWER SESSION

In response to the question as to how USAID was going to partner UNFPA and IPPF, Margaret Neuse indicated that, there is already collaboration with them as partners on the project. There are policy level concerns but there is collaboration at the technical level.

In his closing remarks as Chairman for the panel, Dr. Kabba Joiner of WAHO indicated that, a meeting has been scheduled in the next couple of months to move the process forward.

A RH supply commission has also been created for them to tap into, and that the repositioning FP will have other donors such as DFID and DANIDA.

He expressed the need for greater activism, and for participants to be proactive so that the donors can support their initiatives.

He concluded by reaffirming the point that RH is key to attaining the MDGs and called for their support in its realization.

10. CLOSING PLENARY

In her statement at the closing plenary, the **Honourable Minister of Health of Sierra Leone, Madam Abator Thomas,** noted that the issue of FP has come out strongly at the conference. It is now up to the individual countries to put together enhanced intervention programmes of FP. She expressed her thanks to the donors and partners for their assistance.

Felix Awantang of USAID/WARP suggested that a process has started with the conference and there is the obligation to maintain it.

He indicated that USAID/WARP operates at the regional level and invited participants to knock on their doors and contact the USAID offices in the respective countries. He expressed their commitment to work with them at the regional and bilateral levels for the next four years.

He further welcomed the initiative of WAHO and the expressed the necessity to leverage each other's support for country initiatives.

Finally, there is the need to keep hope alive in the region and slated that there are young people in the region today who face bleak futures; there are children who hawk in the streets with no future and it is therefore critical that action is taken relentlessly.

Ms. Adelaide Awulutey, a youth advocate, presented the Youth Communiqué on Advocacy to Action.

The Communique acknowledged the recognition of the conference of the youth as critical agents of repositioning family planning as evidenced in the plenary and group discussions, and most importantly, in the country follow up plans.

It raised the need to act on these plans and observed that they all had roles to play. As young people, they would want to work with the participants to implement the plans and to ensure that the FP needs of young people are met.

The Communique stressed 4 main areas that young people would require support to be effective. These are:

1. Develop and strengthen the capacity of youth for leadership
2. Strengthen capacity and coordination of existing youth related institutions, mechanisms, and structures
3. Institutionalize youth participation and leadership by providing youth a space in the decision making processes at policy, programme and civil society levels.
4. Increase access to information and services geared to meet the needs of the diverse youth population

Along the same lines, the youth have also developed country-specific draft proposals to operationalize the four specific areas. They sought the collaboration of the country teams and donor partners (immediately after the conference) to mobilize their support in refining and financing follow-up as part of the overall country efforts in repositioning FP.

Issakha Diallo of Advance Africa expressed the gratitude of the organizers to all participants, facilitators, the partners, interpreters and other services for the support in ensuring a successful conference.

In his closing address, **Honourable Moses Dani Baah, the outgoing Deputy Minister of Health of Ghana** expressed the hope that with such diverse backgrounds and nationalities, participants have been very thorough in looking at the most innovative ways of implementing the solutions to unmet need for FP in order to improve access to services and ultimately increase contraceptive prevalence.

He posed the question as to how participants will advocate to achieve these solutions and what they can expect to do in their respective countries as a follow-up to this conference.

Regarding opportunities that exist towards ensuring the implementation of these solutions, he expressed the belief that the framework developed by WHO/AFRO and which has been adopted by member countries of the African Union provides a basis for making progress.

He commended the commitment that has been shown by USAID in organizing the conference and expressed the hope that together with WHO/AFRO, UNFPA and other multi-lateral and international NGOs, they will continue to provide funding and or technical assistance to countries based on the key actions that have been outlined in the respective country follow-up plans.

Mr. Dani Baah urged delegates to continue the dialogue back in their respective countries and explore the local opportunities for resources to help in implementing the actions that have been identified.

He informed the delegates that Ghana has already started a series of consultations among key partners, and the President is committed to providing the necessary assistance towards the realization of the goals of the country strategy in repositioning.

Finally, he challenged the participants to make a special commitment toward ensuring that they have actively contributed in one way or another to scaling up FP services in their respective countries, stressing that the RH and FP needs of the people cannot wait any longer.