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Ethical Approaches to Family Planning in Africa

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In a world tense with confrontation between North and South on so many issues, it is important that family planning aid offered to Sub-Saharan Africa appear to be a rope to help people — not the "noose" it has seemed in the past.

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Africa is the geographical flashpoint for ethical issues about family planning programs. Until recently in Sub-Saharan Africa, advocacy of family planning by non-Africans was unacceptable and by Africans politically inadvisable.

This has changed in the 1980s. The health rationale for family planning is backed by strong evidence, especially in Africa, where infant and maternal mortality and morbidity rates are high. Population growth in many African countries impedes development, which — however impressive — cannot keep up with needs.

Earlier attempts to offer family planning aid were often politically inept and endangered the needed partnership between donor and developing countries. Theoretical arguments and abstract demographic projections are less persuasive than carefully designed programs geared to the health and well-being of communities that help plan them.

Increased cooperation between donor and developing countries — in transferring technical and financial resources so countries can set up their own sustainable and culturally sensitive programs — has helped resolve some of the ethical difficulties that beset family planning programs.

This concise and eloquent report summarizes many of the practical, ethical, and cultural considerations in making family planning aid acceptable.

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F. T. Sai* and K. Newman**

Introduction: Whose priority?

Africa has historically provided the geographical flashpoint of ethical issues relating to family planning programmes. Twentieth-century events in Sub-Saharan Africa have combined at times to produce a climate which made advocacy of family planning by non-Africans unacceptable and by Africans politically inadvisable. Much of this has changed in the last five to seven years. This paper describes the context of the family planning debate in Africa, and assesses the extent to which family planning may be seen as an ethically justifiable priority in general development. It discusses controversies about service delivery systems and family planning methods, as well as the ethical issues raised by research and development with regard to new methods of fertility regulation, and by abortion. Finally, it examines some encouraging trends in the provision of family planning services in Africa, noting that the political, social and economic complexities of the region intensify the importance of debating and securing ethical approaches to family planning practices in Africa.

Africa, South of the Sahara: Development Indicators

Africa, south of the Sahara, consists of 45 sovereign states (Fig. 1). Some are small island states, like Sao Tome and Principe, and the Seychelles, with populations of 86,000 and 66,000 respectively; some are large, sparsely populated countries, like Sudan (2.5 million km^2, population c.19 million) or large and populous, like Nigeria (924,000 km^2, population over 100 m.). The region is the world's least developed: it contains 23 of the 35 least developed countries. It has an estimated 470 million inhabitants (1986) and the world's fastest growing population. The average annual growth rate is about 3%, with a range of 1.6 to 4.1, as found in Mauritius and Kenya respectively. Africa is also the poorest region: per capita income averaged only $482 in 1982—or $384 if Nigeria is excluded (Fig. 2).

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Fig. 1

Source: Goliber, T. J. (1985): p. 2.

Life expectancy at birth in Sub-Saharan African countries, about 40 years in 1960, was estimated to be only 49 years in the mid 1980s. This low figure is largely due to high infant and child mortality.

In many African countries, deaths of children under age five years account for more than half the total of annual deaths, compared with 1 to 3% in developed countries. Maternal mortality rates are also high: 200 to 600 deaths per 100,000 live births (perhaps an underestimate) — 100 to 500 times the rate in developed countries. In some poor rural areas of Africa, by the time women complete their families 50% of the cohort is dead.

The distribution of the population in the region presents complex issues. About 80% of the population is rural; Africa is the least urbanized continent. In some parts, settlements are so sparse that governments find

Fig. 2 **Development indicators: Africa compared with all developing countries**

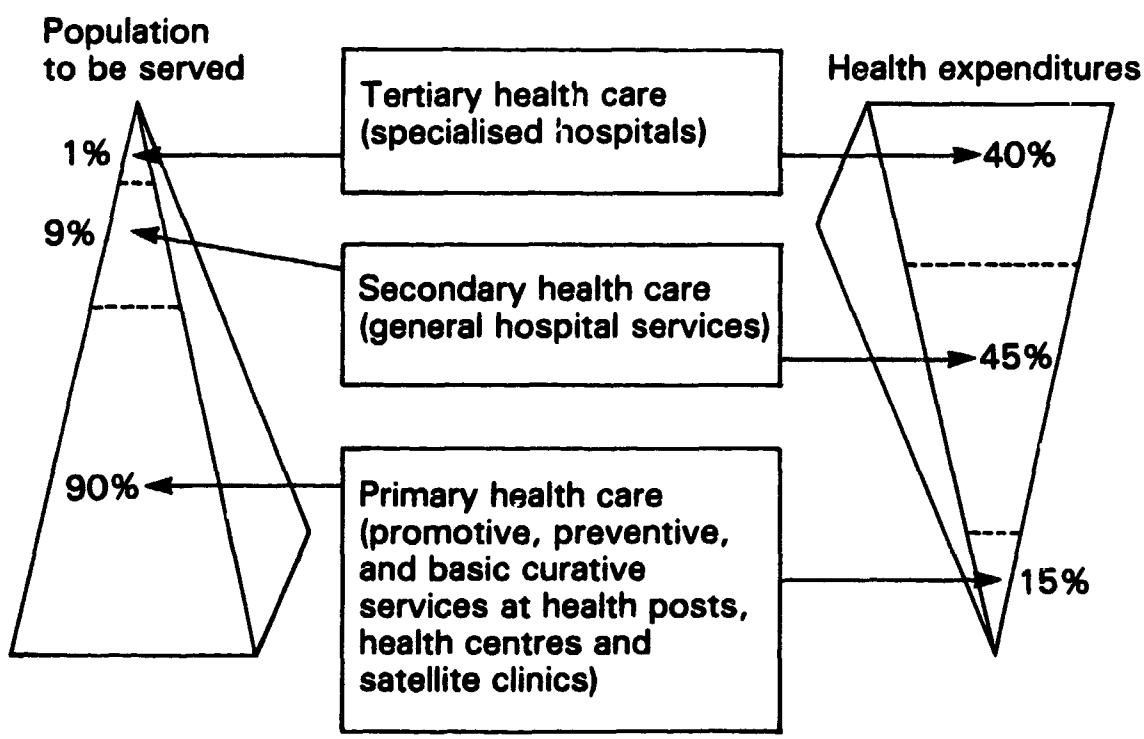
Country group	*Per capita income 1982 (dollars)*	*Adult literacy 1980 (percent)*	*Life expectancy 1982 (years)*	*Primary-school enrollment ratio, female[a] 1981 (percent)*
Sub-Saharan Africa				
Low-income	249	38	49	57
Middle-income	777	35	50	70
All low-income countries	280	52	59	81
All middle-income countries	1,520	65	60	95

Note: Averages are weighted by 1982 population.
a. Number of females enrolled in primary school as a percentage of all females of primary-school age.

Source: The World Bank (1984). World Development Report 1984: Ref—p. 162.

it very difficult to provide basic services. At the same time, cities are growing rapidly, the major cities at a yearly rate of 5–7%, and some, including Lagos, Ibadan, Kinshasa and Accra, even faster. The rush of immigrants to towns over-extends fragile urban services for water, sanitation, electricity and communications. In many countries, internal policy-making may be complicated by external political or economic pressures to adopt certain policies or to deploy resources according to certain priorities. Where this happens, social welfare budgets, such as those for health, are often especially vulnerable, increasing the number of competing priorities for already meagre health-care resources. This problem is worse in countries where governments endorse primary health care but do not fund it, and policymakers are pressured to overspend on urban hospitals, which serve relatively few of the people, leaving very little for primary health care for the vast majority (Fig. 3). In many ways this conflict of health-care priorities parallels the ethical debate about family planning in Africa; it too is affected by competing priorities, and internal and external pressures, and has a moral dimension, with the health and welfare of individuals and families at stake.

Fig. 3. **The health care dilemma in Ghana**



85% of health expenditure goes to hospitals for 10% of the people. 15% goes to primary care for 90% of the people.

Source: Morley, D. and Lovel, H. (1986): p. 148.

Family Planning: A Justifiable Priority?

The priority accorded to family planning in Africa has always varied. During the 1960s and early 1970s, it was argued that family planning was a veiled attempt by white races to eliminate or keep down the numbers of non-white races: 'the genocide theory'. This controversy has abated, somewhat, as national governments have themselves begun to design and provide family planning services. Nevertheless, a number of factors still bear on the ethics of family planning in the region, and show the need of a sensitive approach. In the late 1960s and early 1970s, population programmes were advocated in some international aid quarters as a panacea for the ills of many developing countries. This disproportionate advocacy over other development goals led African intellectuals and policymakers to decry what they saw as assistance to cut down numbers rather than to generate equitable development. A subsequent shift towards more integrated development assistance has partly redressed this position.

Africa is in many ways a special case. Its countries' boundaries were drawn on political rather than national grounds. Apart from their racial and international tensions, countries have their national priorities among agricultural, health-care and other development goals. It is difficult therefore to discuss an 'African' context for family planning priorities. Yet is sometimes argued that population density figures prove that population is not an issue in Africa. It is often portrayed as an underpopulated region with a vast amount of untapped land. Average population density is low—less than one-fifth of Asia's. However, according to the Food and Agriculture Organization, some countries cannot produce enough food to sustain their populations. Of course, some, such as the Zaire and the Central African Republic, have extensive areas of underused land, and account for almost one-third of the region's land but only one-fifth of its population. However, for political and social reasons, migration from overpopulated to underpopulated countries in Africa is becoming impractical as a means of accommodating population growth. Bringing new land into production may be too costly for some economies. Pressures to use land for cash crops may worsen the situation in some countries. In any event, the argument that Africa is sparsely populated and does not need family planning is simplistic. Food self-sufficiency is not the African's only social aspiration.

Another argument used against family planning is that people are the ultimate resource, that every mouth to feed comes with a pair of hands to work, and that some countries with high population densities, such as Hong Kong, 'prove' that family planning programmes are not necessary. They prove nothing of the kind: education, health and employment needs of a rapidly growing population are difficult to meet. In the 1980s, the rationales of providing family planning programmes have been reassessed. The health rationale of family planning, together with the promotion of the human right to family planning, have become central to the consensus that family planning has a part in development

programmes. The health rationale of family planning is not widely contested. Many African countries have endorsed the concept of primary health care (PHC), which includes as an essential element 'maternal and child health care, including family planning'. In countries with high maternal and infant mortality and morbidity rates, family planning, by providing the means for postponing childbearing until after adolescence, helping to space births at two to three year intervals and preventing pregnancy in women after the age of 35, can greatly improve maternal and child health. The health-rationale case for preventing high-risk pregnancies — those which are summed up in the slogan 'too early, too close, too many, too late' — is proven. It has done much to give family planning international acceptability. The international consensus about the issues of family planning was highlighted in 1984, at the International Conference on Population (ICP) held in Mexico, when 150 governments sent representatives to discuss issues related to population and development, and to review progress since the World Population Plan of Action (WPPA) had been agreed in Bucharest, Romania in 1974. The principles and objectives of the WPPA were reaffirmed. Article 14(f) stating:

> 'All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities towards the community.'

was endorsed and expanded with the following:

> 'Governments should, as a matter of urgency, make universally available information, education and the means to assist couples and individuals to achieve their desired number of children. Family planning information, education and means should include all medically approved and appropriate methods of family planning, including natural family planning, to ensure a voluntary and free choice in accordance with changing individual and cultural values. Particular attention should be given to those segments of the population which are most vulnerable and difficult to reach.' (ICP Rec. 25)

It seemed that ten years after Bucharest the hostility towards family planning programmes had abated, and that family planning had become widely accepted internationally.

The Human Right to Family Planning

In a document published by the International Planned Parenthood Federation (IPPF) in 1983, 'The Human Right to Family Planning', an

independent working group set out a number of aspects of this right. One was that, without ready access to information, education, and services for fertility regulation, talk of the enjoyment of such a right has no meaning. Full access includes full and voluntary choice of method, rights of access by young people, and financial access to fertility regulation services. Each of these has caused ethical controversy, and yet the absence of any of them significantly limits free access to information and services. The promotion of family planning as a basic human right, as well as an important health measure, has increased appreciably its acceptability in Africa during the last decade.

Right of access to family planning services follows from a basic right to make decisions about reproductive behaviour. This has always been controversial in some African countries, especially former French colonies such as Burkina Faso, Chad, Gabon, Mauritania and Niger, all of which still have a provision from a 1920 French law banning advertising and distribution of contraceptives. (It is not always enforced, however.) Ethical and political aspects of the right to make decisions about reproductive behaviour not only touch upon reciprocal responsibilities of governments and citizens, but also strike at the core of what constitutes contraceptive action — namely the separation of sexual behaviour from reproduction. Sometimes people do not accept that sex and procreation can be separated, and they therefore oppose all artificial methods of fertility regulation, allowing only periodic abstinence. Others feel that, because contraception frees sexual activity from the risk of pregnancy and its consequent 'moral sanction', it will lead to moral laxity and greater promiscuity. Certain cultural beliefs may give rise to misgivings — for example, certain communities believe in the direct reincarnation of ancestors, and might feel that to limit family size could prevent the rebirth of a dynamic former elder. The right to make decisions about reproductive behaviour may also be denied to certain groups — the young, the poor, if they must pay for services, and even the unmarried. In some African communities only males can make reproductive decisions — husbands or older male siblings; also, some service facilities may, in effect, exclude potential users of contraceptives, such as men, where services are offered mainly in maternal and child health centres. Finally, governments with pro-natalist policies, including those of Guinea and Ivory Coast, where fertility rates are considered too low, and of Sudan, where incentives to have large families have been proposed, may seek to restrict the right to family planning, either by legally restricting the availability of services, or by means of social and fiscal incentives for couples to have large families.

Population Programmes

After consideration of the ethical aspects of family planning, claims that family planning is a justifiable priority for African development must

distinguish between population programmes and family planning programmes. In some countries, fertility regulation programmes form part of national population policies. Before the 1974 World Population Conference, the only Sub-Saharan African nations with official policies of reducing population growth as an aid to development were Kenya, Ghana and Mauritius. Since then, and especially since the late 1970s, government views have changed. By mid-1986, at last 13 countries had indicated that they considered their fertility rates too high and supported government or private family planning programmes to reduce fertility: Botswana, Burundi, Gambia, Ghana, Kenya, Lesotho, Nigeria, Rwanda, Senegal, South Africa, Uganda, Zambia and Zimbabwe; and five had set explicit goals.

The Second African Population Conference, at Arusha, Tanzania, in 1984, noted that high levels of fertility and mortality were causing great concern about the region's ability to maintain standards of living it had attained since independence. The Conference adopted the Kilimanjaro Programme of Action on Population, which called on member states to ensure that all couples or individuals seeking family planning services have access to them freely or at subsidized prices.

By mid-1986, about 26 Sub-Saharan countries were providing some government family planning services, usually integrated with maternal and child health services. About 20 countries in the region had private services provided by national family planning association (FPAs) affiliated with IPPF; many of these received some government funding. The rationale of family planning services in all but the 13 countries with population policies is not explicitly to reduce fertility, but to improve the health of mothers and children. Where the rationale of family planning programmes is demographic, it is often a matter of controversy whether any government has the right to influence the reproductive behaviour of individuals or couples, or such action infringes human liberty. It can be argued that, where governments have provided certain essential services, they have a right to expect some kind of reciprocal responsible behaviour of the citizens, with regard to the spacing of their children and the size of families. Clearly, all population policies need to command the broad support of the people. Otherwise, the chances of successfully reducing population rates are diminished, and the credibility of the policy is severely undermined. In Africa, with so many still not enjoying the fruits of development, the ethical dimensions of such 'social contracts' between government and people are more complex than elsewhere.

Also, it is critical that anti-natalist policies be seen to apply to whole populations, and be evenly implemented, without discriminating against anyone. Policies can justifiably become discredited when multiracial countries apply policies which appear designed to modify the balance of ethnic groups to the advantage of one or another, as a means of political control. In such circumstances, minority or subordinate ethnic groups may view any effort by government to promote population programmes or fertility limitation projects as designed to keep them in permanent subjugation. In some African countries, whose populations comprise a

number of ethnic groups, the ethical aspects of this issue are especially relevant.

The Status of Women: Planned Parenthood and Women's Development

The status of women is of great concern to Africa. It has been said that various social roles, cultural practices and the biological tasks imposed by fertility have combined to keep the condition of the average rural African woman close to that of a beast of burden. In some countries, fewer than 20% of the schoolchildren are girls, and they are even fewer in secondary and tertiary education. Traditionally, women have been responsible for most of the family food-crop production and have therefore played a major role in agriculture, but in many communities women do not own land and cannot obtain credit. Extension services have done very little for or with women. Whenever cash crop production has been seriously introduced, or modern technology is put to the service of agriculture, the tendency is to ignore the role of women or keep them away from the land.

The usual African fertility pattern requires that childbearing be started as soon as it is biologically possible and stopped only at the menopause. The total fertility rate is therefore very high, ranging from about 4–8 (mostly between 6–8). Thus the African woman spends 16–20 years of her adult life in childbearing (interval between first live birth and last one) compared with 3–5 for many developed countries. She has therefore little time for other pursuits.

If women are to improve their status they must first control their fertility. However, in certain countries and cultures, men have the right to make the decisions about fertility, and they can deny women access to family planning services for various reasons. In some places, wives may not use fertility regulation services without their husbands' consent, and quite commonly they may not opt to be sterilized without it. Since female education is directly related to women's control over their fertility, their use of contraception increases with their access to education. Not only can more and better education for women reduce family size, but also it can reduce infant mortality, as educated women learn about nutrition, hygiene and basic child care. Family planning can help women space pregnancies at least two years apart, so that they can recover from one pregnancy before they start another, and give their babies the best chance of survival. Smaller family size greatly improves women's capacity to realize their potential and participate in national development. Programmes for promoting women's development encounter few ethical difficulties. Yet, despite those undertaken during the United Nations Decade for Women, there is little evidence of rapid change in the role and status of women in Africa. Some projects for combining the provision of information and education about family planning with other activities directed at women's development, such as paid work or business, or the teaching of other skills, have been successful. But these 'Planned Parenthood and Women's Development'

(PPWD) projects are, for the most part, small-scale. A far more sustained approach is needed if women are to participate fully in the social, economic and cultural future of Africa.

Infertility

Facts and figures on population growth rates in Africa mask the fact that, for many couples, talk of family planning is a cruel joke. Infertility is a serious problem in some parts of Africa. Surveys have found that an average of 12% of women who had passed their childbearing years in 18 Sub-Saharan countries were childless, compared with 2 to 3% in other developing countries. Childlessness — 'primary infertility' — was greatest in Central African Republic (17%), Cameroon (17%), Zaire (21%), Congo (21%) and Gabon (32%). In parts of Zaire, up to 65% of women aged 45–49 were childless. Of course, very high maternal mortality rates may influence these figures. Childlessness in younger age groups is less common (presumably owing to improved medical care) but still high. In addition, many women have 'secondary' infertility — inability to conceive or give birth again following an earlier birth. It affects 14–39% of women aged 15–50 in different regions of Cameroon.

Though women are usually held responsible for childlessness, they account for only about 40% of infertility cases. Men account for another 40%, and both partners for the remaining 20%. The consequences of infertility are particularly severe for women, who may be ostracized, abandoned or divorced if they do not produce children.

The principal causes of infertility in Africa are the spread of sexually transmitted diseases, poor obstetric care, and unskilled abortion practices. Infertility faces decision-makers with ethically difficult choices in the need to decide whether to give priority to preventing infertility or to treating it. Better obstetric practices are needed everywhere. The spread of sexually transmitted diseases can be reduced by preventive programmes designed to inform and educate people about the causes of infertility, and they can be prevented by limiting the number of sexual partners, and the use of barrier methods of contraception, especially condoms. Such programmes are of particular significance in many African countries where infection with the human immuno-deficiency virus (HIV) is spreading rapidly, as its control depends on the same measures. Treatment of infertility is costly, difficult and uncertain in outcome, and there are few specialist centres for diagnosis and treatment in Sub-Saharan Africa. Depending on the cause, only one-quarter to one-half of couples treated may subsequently have a live birth. This indicates that meagre health resources should be reserved for prevention rather than treatment, but this does little to relieve the misery of infertile couples. The concept of planned parenthood has always embodied concern for individuals and couples who cannot have children when they desire them; programmes should provide sympathetic counselling for infertile couples, and make every effort to help them come to terms with infertility.

Family Planning Service Delivery

Family planning as part of primary health care services

All countries have adopted primary health care as the best strategy for attaining 'Health for all by the year 2000', and 'maternal and child health care, including family planning' is an integral part of many primary health care programmes. Nevertheless, ethical concerns arise when family planning programmes are vigorously promoted while other basic health needs of communities remain neglected. Recent international conferences, such as the conference on 'Better Health for Women and Children through Family Planning', in Nairobi in 1987, have emphasized that family planning workers must remain sensitive to other health care needs, and that primary health care programmes that exclude family planning are incomplete. In some areas, fertility regulation services are offered alongside maternal and child health or other primary care services, and this can improve their acceptabilty where basic health conditions are poor.

Service Delivery Issues

The delivery of family planning services is associated with many ethical difficulties, some due to the disparity between health care circumstances of developed countries and the infrastructure, the financial and human resources, and the needs of some developing countries.

Incentives and disincentives

Incentives and disincentives raise extremely complex ethical problems. They are not major features of African programmes, but it is useful to assess their possible effects on service delivery. They may have a place in family planning programmes, but they should never have discriminatory or coercive effects. By their nature, incentives and disincentives are aimed primarily at the poor, since it is mainly the poor who will be susceptible to them; it may be reasonable to reimburse costs of transport, for example, or to compensate workers for lost work-time, since this may help the poor use services which are within easy reach of the less poor. It is important to consider the context in which incentives or disincentives operate, to be in a position to judge their possible impact. In general, however, they can never take the place of education and information about contraceptives — indeed they increase rather than reduce the need of comprehensive counselling services.

Community-based distribution

Access to contraceptive methods can be greatly reduced if certain substances, particularly steroidal contraceptives, are available on prescription only. In many countries doctor:patient ratios can be as low as 1:100,000. Community-based distribution systems can make family planning available to many who would otherwise have no access to contraception. Where legitimate check-lists can be issued to ensure that

women with contraindications do not receive steroidal contraceptives, a woman may prefer to receive contraceptive services from a known and trusted individual in her own community. People sometimes question the ethics of community-based distribution services on the grounds that they perpetuate a 'double standard' of service: sophisticated medical attention for users of contraceptives in developed countries, while those in developing countries can have no such services. These issues must be assessed in the light of standards in countries where most people could have no health care, including fertility regulation, if it were to be obtainable only from doctors. Many rural areas have no doctors. Nevertheless, such programmes, to be medically and ethically acceptable, must be part of a system with adequate referral and back-up facilities: the community-based-distribution worker is a recognized link in a service delivery chain which includes medical care.

Whose Services? Designing Programmes for Special Sub-groups of the Community

Maternal and child health care (MCH) services

MCH services are a successful and popular way of providing family planning services to women. They are especially useful for mothers of young children, as certain child health care services, such as immunization, may be available at the same place; and each service may generate greater use of other services. One drawback, however, is that, family planning services, for the most part, exclude men. At present, when many countries are trying to increase male involvement in family planning, as well as the use of condoms to prevent the spread of HIV infection, it is important to match the MCH programmes for women with innovative programmes for men.

Services for men

Special education services are needed to prepare African men for the roles and responsibilities of parenthood, and to teach them about the fertility-related needs of women and their own roles in contraception. The ethical issues of traditional positions need to be confronted. Men may be reached in the work-place, in bars or on the farms.

Services for youths

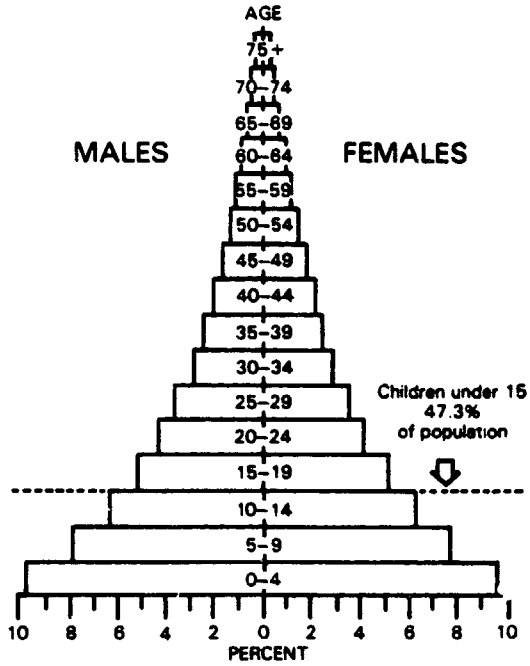
The age-group 15–24 years will have increased from 90.2 million in 1980 to 170.1 million by 2000, a slightly faster rate of growth than that of the general population. Adolescent and younger women form a significant and increasing proportion of females in the reproductive age-group (15–49 years). In 1980, 41% of all potential mothers were aged 15–24, and UN projections indicate an increase to 43% by 2000. At least 40% of potential mothers are under 25.

The youthful nature of the African population is important for many reasons. One is that a relatively large proportion of national resources

goes towards meeting the immediate needs of the young; education, for example, often commands 25 to 35% of recurrent government expenditure.

Demographically, the large proportion of young people gives a strong built-in momentum to future population growth. Children less than 15 years old account for more than 45% of Africa's population, compared with 37% in Asia and 40% in Latin America (Fig. 4).

Fig. 4 **Zambia; Population Age Distribution, 1985**



Source: United Nations (U.N.). Population Division, *Demographic Indicators by Countries as Assessed in 1982*, medium variant, New York, December 14, 1963, computer printout.

Source: Goliber, T. J. (1985): p. 12.

Demographic considerations apart, the grave health consequences of adolescent pregnancy are sufficient reasons for young people to have access to fertility regulation services. The medical and social risks of pregnancy are greater for adolescents than for adult women. Rates of prematurity, low-birth-weight babies, maternal and infant mortality, anaemia, and pre-eclampsia are dramatically higher for adolescent mothers.

People often contend that it is unethical to provide contraceptive services for adolescents, on the grounds that it encourages promiscuity, or at least greater, as well as earlier, sexual activity. The available

evidence suggests, however, that sexual experimentation usually precedes by several months a request for contraception. Nevertheless, opposition to family planning services for adolescents is consistently strong, although often it comes from those who are most appalled by the inevitable result of withholding contraception from sexually active adolescents — namely, unwanted pregnancy. The conflict between this position, the relatively early age at marriage of the illiterate African, and the modern adolescent's need of prolonged education and training is not being confronted. The principle that teenagers who are old enough to become pregnant are old enough to receive advice and assistance to avoid becoming pregnant — such advice may at times be to say 'no' and mean 'no' — seems rational. To deny family planning services to adolescents who request them is not only the denial of a right: it can be seen also as irresponsible behaviour which can have grave social and medical consequences.

Some of the graver medical consequences of unwanted pregnancy are due to illegal abortion. The limited information on abortion among young African women suggests that it is a growing problem, particularly in cities. It is performed clandestinely, often by untrained persons, and under poor hygienic conditions. Complications from septic abortions are one of the principal causes of death among females aged 15–19. One way to reduce the social, medical, educational, economic and emotional costs of unwanted pregnancy in adolescents can be to supply them with contraceptives when they need them and educate them about family planning and its health benefits, and about sexually transmitted diseases and abortion.

Ensuring that Family Planning Services are Available

Approaches to delivering family planning services vary widely, according to whether couples live in cities, towns, villages or remote and inaccessible areas. Services for different groups, e.g. adolescents, need to be available at different times, possibly after school hours. In cities and towns, they are most often available in clinics. The more remote areas may have community-based distribution systems. Projects in Ghana and Kenya have shown that commercial outlets may be used for some methods. Ethical propriety in this content often requires the balancing of advantage and disadvantage of different delivery systems in the light of funds and staff, and of the risks and benefits of making or not making services available. The major characteristics of the main service delivery strategies are outlined in Fig. 5.

Family Planning Methods: Which?

With regard to methods, freedom of choice is the paramount ethical consideration. To enable people to make a free and informed choice of method, they must be told the advantages and disadavantages of the different methods, and fully counselled about, *inter alia*, side-effects and

Fig. 5. ***Characteristics of principal approaches to providing family planning services.***

DESCRIPTION	ADVANTAGES	DISADVANTAGES
I. COMMUNITY-BASED Local volunteers, usually village women, are recruited to educate their neighbors. The volunteers are also responsible for distributing the family planning methods to users. In their training, the volunteers learn the basic concepts of family planning, how each method must be used, what the contraindications and adverse effects are for each method, and how to maintain simple data collections systems. A physician, midwife, or family planning nurse supervises the volunteer's activities to manage any problems that may occur.	Users can obtain methods more cheaply. More convenient for patients, who need not travel long distances. Supplies are distributed by someone the patient knows and trusts. Post-partum mothers can be identified and visited. Follow-up is easier. User motivation is maintained at high level through continuous interaction with volunteer.	Initial program costs per user are high. Full maternal and child healthfamily planning services are not offered. No immedicate access to clinical staff for management of problems. Some health professionals resist volunteers offering services. User may lack confidentially. User may lack confidence in nonmedical worker.
II. COMMERCIAL DISTRIBUTION Commercial distribution was begun with the knowledge that remote areas having no access to medical care somehow seem to have other types of consumer items available in retail outlets. If other supplies can reach these very remote areas, then so can family planning supplies. Most countries limit commercial distribution of oral contraceptives to pharmacies. Barrier methods, however, are sold in nearly every place: groceries, markets, and streets by hawkers.	Can reach very remote areas not reached by other programs. Users need not travel long distances. Distributors are motivated by profit from sales. Availability of methods is well publicized. User does not need to wait in lines to receive methods. User has privacy. Costs to the government can be low. Usually resupply to distribution points is reliable.	Patients must go to clinic for management of problems. It can be costly to start a program. Full services are not offered. Promotion and advertising of contraceptives may be subject to criticisms. Public health officials do not have control over resupply system.

DESCRIPTION	ADVANTAGES	DISADVANTAGES
III. CLINIC-BASED SERVICES		
Clinic-based service is a reasonable approach in areas where health workers are available and users do not live far from the clinic. With some physician supervision, trained nurses and midwives examine women, prescribe the appropriate family planning methods, and manage problems.	Patients are seen at each visit by health care professionals. Problems can be spotted and treated at visit. A switch in contraceptive method can be quickly done at the clinic. Start-up costs low if Maternal Child Health services (MCH) already available. More complete services are offered.	Patients are primarily limited to those living close by. Followup depends upon user's returning to clinic. The nurse or midwife may not be familiar to the patient. Patients are expected to come on their own initiative. Patients may have to wait in long lines. The doctor or nurse may be a male, which would not be acceptable to women in some cultures.

Source: Centers for Disease Control (1983): p. 283.

complications, and how to deal with them. The need for a *full* choice of methods is important, since there is no — and may never be — one ideal contraceptive to suit all couples throughout their reproductive lives. The 'cafeteria approach', offering the widest possible range of methods, appears to be the most acceptable arrangement, leaving the final choice to the contraceptive user, in consultation, as necessary, with a health adviser. Informed choice is as important as informed consent. To limit the number of methods available is to restrict access to family planning for couples whom the available options may not suit. The need of *voluntary* choice is also of ethical importance — without it the entire concept of family planning would risk being seriously undermined and falling into disrepute.

Provider attitudes

The attitude of the health worker is crucial for the provision of ethically acceptable family planning programmes. The experience of a health project in Zaire illustrates the importance of provider characteristics with reference to the patterns of acceptability of intrauterine devices (IUDs). IUDs were new to the community and early acceptors were reluctant to try them. After encouragement by members of the health team, several of whom accepted IUDs themselves, a number of women accepted them. Subsequently two local women suffered excessive bleeding, after which there were almost no new acceptors. Service providers decided to be especially encouraging and supportive of women

during their first few weeks of IUD use, and the acceptance of IUDs rose. Subsequently, direction of the clinic services was taken over by a trained midwife, who, because of personal dislike of IUDs, removed more devices than she inserted, and the number of acceptors dwindled. After her departure, the number of IUD acceptors rose again, as the supportive counselling of the other team members increased. In many parts of Africa there are service staff who are not well informed about contraceptives and who pass on their prejudices and ignorance to clients. It should be part of staff training to show that this is unethical.

The attitude of service staff is only one of the determinants of the acceptability of contraceptive methods. Different methods vary in the ethical problems they raise.

Oral contraceptives: It has been suggested that, if drug regulatory systems had been as demanding 20 years ago as they are today, oral contraceptives might never have been made widely available. Some 60 million women throughout the world now rely on them. An ethical difficulty arises when studies carried out in developed countries yield findings which may or may not be relevant for developing countries. A recent example would be the studies carried out in the United Kingdom suggested a link between long-term use of oral contraceptives and an increased risk of cervical cancer. Is it ethical to give African women oral contraceptives if they have no access to cervical cytology services? However, this question has, in turn, raised doubts about the extent to which epidemiological data from developed countries may be valid for developing countries. One must try to balance the paucity of epidemiological data from developing countries against the differences in lifestyle, nutritional status, and other variables between women of developed and those of developing countries, and take into account the wide differential in the risks of pregnancy and childbirth in different parts of the world, which radically affects the risk/benefit ratio of contraceptives.

It is crucial to find ways of solving the ethical problem posed by the tying of the use of oral contraceptives to doctors' prescriptions. Apart from the low doctor:patient ratios, which lead to discriminatory coverage of availability of oral contraceptives, the system helps to reinforce the public's belief that contraceptive drugs are dangerous. The risks of oral contraceptives are fairly well known. Methods of distribution that do not depend on doctors have been successfully tested with adequate check-lists, and where good back-up and referral systems have been established and maintained. Not to develop such systems is to deny millions of women the health benefits of family planning, and can, therefore, be said to be a serious ethical matter.

Barrier methods: Barrier methods of contraception — condoms, diaphragms, cervical caps and spermicide, but especially condoms — are enjoying a resurgence of interest, primarily because of the protection they offer against sexually transmitted diseases. Barrier methods are 'safe' in that they have fewer side-effects, but are less effective than other

methods. However, safety must be balanced against the risk of pregnancy from contraceptive failure, which is higher than for other methods; also, the prevailing risk of pregnancy for most women in Africa is higher than in some other areas. Nevertheless, it is very significant that they protect against sexually transmitted diseases, especially in countries with high prevalence of these diseases. Most barrier methods require a supply of clean water; hence if couples are to have as *full* a choice of methods as possible, other development needs must be taken into account. Family planning service providers in places short of clean water have a duty, as well as an interest, to press for projects for supplying clean water. Such collaboration can immeasurably enhance the reputation of family planning programmes and personnel by clearly demonstrating the belief that family planning cannot be promoted in isolation, when basic health and sanitary needs are not being addressed.

Male and female sterilization: Service delivery programmes must take exceptional care with sterilization services. Since sterilization is permanent, it can be abused. It has happened that sterilization operations carried out on a massive scale, not in Africa, have incited opposition which threatened to give voluntary sterilization, and fertility regulation in general, a bad name. Male and female sterilization procedures are safe (the male being by far the safer), and couples who are sure thay have completed their families may find sterilization their best option. For sterilization to be tainted, possibly deterring couples from using it, is to deny them their right to choose it. This denial is the more unfair if it is caused by factors unrelated to the procedure or to couples' contraceptive needs. Doctors who refuse to discuss this option for highly fertile African couples, even with parities of five and above, ought to examine their ethics.

Another ethical issue in regard to sterilization is insistence that a woman may not be sterilized without her husband's consent. The biological load of fertility falls so heavily on women that everything possible should be done to give them the right to private and safe contraception. In parts of Africa some husbands say that access to private contraception will encourage wives to be unfaithful. Taking away a woman's right to control her own fertility may not be the most ethical way of resolving this problem. In any case, the man can be the contraceptor, especially for sterilization, which should make him more confident about the woman's fidelity.

Ethical Aspects of Research and Development

Where and on whom to test contraceptives have become major ethical issues. Some hold the view that, no matter how beneficial a drug is, it should not be imported into any developing country if its use is not permitted in the more developed country where it originated, and that the initial human tests should not be conducted in the developing world.

However, it would not be realistic to insist that people in developing countries should have no part in the testing. There is a need of balance.

As fertility is not a disease, many communities view drugs for fertility regulation completely differently from drugs for treating diseases. A drug for preventing malaria, for example, has a margin of risk that would not be acceptable in a contraceptive, and it is ethically acceptable to test it in a malarious area. However, though fertility and maternal-death rates are much higher in developing than in developed countries, it would not be ethically acceptable to test contraceptives in the former without also testing them in more developed countries. Nevertheless, a contraceptive with special qualities suitable for certain developing countries may be ethically acceptable in those countries, but not in countries with a different risk-benefit ratio between the side-effects of a contraceptive and the risks associated with unwanted pregnancies. The circumstances of users of contraceptives should be considered during testing. The possible effects on general health, nutritional status, and other physiological conditions are all related to the local environment and may come to light only when tests are carried out in the locality. Also, contraceptives may interact with some drugs in common use in certain environments, and such a situation can be studied only in those environments.

Many countries have regulatory authorities that establish rules for testing and approving drugs. Most countries, however, have either no regulatory agency or one which lacks adequate scientific support for carrying out the tests needed to determine whether a drug should be put on the market; they must therefore rely on assessments made in industrialized countries. Since these take into account only the risk-benefit ratios pertaining to themselves, this can cause serious problems, in that researchers may fail to take into account the cultural and social circumstances of many potential users in developing countries. In the long run, institutions for contraceptive research and development must be established in developing countries so that the resulting technology will reflect local conditions. The World Health Organization, with its network of test centres in developed and developing countries, is helping to resolve some of the ethical problems of testing contraceptives. Africa needs to develop many more research centres and create regulatory agencies.

Many of the ethical difficulties raised by research and development issues are reflected in the controversy about injectable contraceptives. Injectables are highly effective. They are very popular with rural African women. There is concern about their possible side-effects, but expert groups, including the International Medical Advisory Panel of IPPF and a WHO consultative group, have recommended their continued availability as contraceptives. The ethical debate concerns the lack of 'good' data on injectables. One view is that, since there is no conclusive evidence that the products are safe, they should not be used. The opposite view is that, since there is little to suggest that they are unsafe, and since one injectable, DMPA, has been in use for nearly 20 years,

they should be used more widely so that their possible risks might be evaluated by proper case-control and long-term follow-up studies. The two positions are deadlocked, and this has considerably intensified the debate about injectables. Scientists have questioned the suitability of animal trials administering 50 times the human dose for 10 years (the regimen to which monkeys which developed endometrial tumours were subjected) for assessing possible risk to humans.

There is also concern about their mode of administration. The objection is that, since an injection remains contraceptively active for three months, it could be misused by being given to women without their fully informed choice or consent. It is argued, however, that the drug should not be blamed for its misuse; that counselling about possible side-effects must be comprehensive, and that these objections are not scientifically valid. Nevertheless, it is interesting that these objections, concerned with mode of administration, are the 'mirror image' of a claimed major advantage of injectables, that one injection allows a women to make a personal decision which confers contraceptive protection for three months.

Abortion

Abortion is an emotional subject and has been receiving a great deal of attention. Reverberations from the 'right-to-life' versus 'pro-choice' debate in the United States and the United Kingdom are spreading around the world. While most of the world's people live in countries where abortion is legal and easy to obtain (in populous countries like China or India, for example), many developing countries, particularly in Africa and Latin America, retain restrictive abortion laws. The ethical arguments about abortion are complex, although often presented simplistically. Often debated is a woman's 'right' to control over her body and to refuse to carry to term a pregnancy she does not want. However, not often considered is the ethics of withholding the benefits of a technology which is less hazardous than carrying a pregnancy to term. Nineteenth-century anti-abortion laws were generally designed to save women from the dangerous, and often experimental, surgical procedures of the time. However, this reason is no longer valid, and today the effect of applying anti-abortion laws is to increase rather than reduce risk to women's lives and health.

Abortions are sought and obtained, of course, whether they are legal or illegal. Wealthy women, who can afford private doctors or travel to countries where abortion is legal and safe, can get abortions almost free of risk; but poor women often pay for abortions with their health, their future fertility and possibly their lives. Such discrimination against the poor cannot be accepted as moral or ethical under any circumstances,

Fig. 6. **Legal Status of Abortion in Sub-Saharan Africa**

Country	Illegal	Medical		Eugenic (fetal)	Juridical (rape, incest, others)	Social and social-medical	Legal (grounds not specified)
		Narrow (life)	Broad (health)				
Benin		x					
Burkina	x						
Burundi	x						
Cameroon			x		x		
Central African Republic	x						
Chad		x					
Congo			x				
Côte d'Ivoire		x					
Ethiopia			x				
Ghana			x				
Guinea			x				
Kenya			x				
Liberia			x	x	x		
Madagascar		x					
Malawi		x					
Mali	x						
Mauritania	x						
Mozambique		x					
Niger	x						
Nigeria		x					
Rwanda	x						
Senegal		x					
Sierra Leone			x				
Somalia	x						
Sudan		x					
Tanzania			x				
Togo		x					
Uganda			x				
Zaire	x						
Zambia		x		x		x	
Zimbabwe			x	x	x		

Source: Tietze (1983), pp. 16–17.

Source: World Bank (1986). Population Growth and Policies in Sub-Saharan Africa: p. 47.

and yet this is what legislation that forbids abortion ultimately achieves. (The legal status of abortion in the various countries in Sub-Saharan Africa is summarized in Fig. 6.)

Conclusions

The ethical issues in family planning in Africa form a complex web of social, economic, cultural and developmental dilemmas. The health rationale for family planning is proven, and is especially pertinent in Africa, where infant and maternal mortality and morbidity rates are high. Population growth in many African countries is impeding development, in that development, however impressive, cannot catch up with increasing needs. Nevertheless, programmes for slowing population growth must be linked with development needs and priorities. Emotive attempts to draw attention to the issue, such as describing Africa's population growth as 'spiralling out of control', not only are politically inept but, worse, endanger the needed partnership between donor and developing countries. Theoretical arguments and abstract demographic projections are less likely to win hearts and minds for family planning than are carefully designed programmes, geared to health and well-being, and serving communities that have taken part in their planning and design. Apart from its use for demographic purposes, family planning is a powerful health tool and a major element of the rights of women. Its importance in this respect was portrayed vividly by an American physician, Elizabeth Connell, when she described the implications of withholding contraceptive technology from communities in desperate need:

> 'The look of horror on the face of a 12-year old girl when you confirm her fears of pregnancy; the sound of a woman's voice cursing her newborn and unwanted child as she lies on the delivery table; the absolutely helpless feeling that comes over you as you watch a woman die following criminal abortion; the hideous responsibility of informing a husband and children that their wife and mother has just died in childbirth—all these are deeply engraved in our memories, never to be forgotten. Since we have had more effective means of contraception, the recurrence of these nightmares has blessedly become less frequent.'

Dr Connell was testifying at the Nelson Hearings, in 1970, but in many African countries all the heartrending experiences she describes still occur.

Over the past 15 years, the global context of discussion on family planning in developing countries has changed. In 1974, it was the developed countries that convened the World Population Conference, in Bucharest, but in 1984 it was the developing countries that convened the International Conference on Population, in Mexico. The cooperation in

this field between donor and developing countries, in transferring technical and financial resources so that countries can set up sustainable and culturally sensitive programmes, has helped greatly in solving some of the ethical difficulties that beset family planning programmes.

In his play *A Map of the World*, David Hare, in a conference to discuss world poverty, has a delegate from a Sub-Saharan African country say to a delegate from a donor country 'You throw us a rope, but it's in the shape of a noose'. The international agreement on the value of family planning is immensely valuable. It has taken time to 'depoliticize' family planning sufficiently for large numbers of couples around the world to have access to fertility regulation services. Dialogue on ethical issues in family planning is crucial if this process is to continue, especially to African countries, with so many couples who want no more children but are ignorant of or have no access to family planning. In a world tense with confrontation between North and South on so many issues — nuclear arms and energy, food, trade, to name only a few — it is especially important that family planning aid is not offered or perceived as being offered 'in the shape of a noose', but in the spirit of true partnership, one component of agreed development programmes and priorities.

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