Family Planning in Sudan

Training Course in Sexual and Reproductive Health Research 2014 WHO

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Background

The Penal Code of 1 August 1925 (section 262-267) governed Abortion in Sudan until 1983. Under this code Abortion was prohibited unless it is to save the life of the pregnant woman. A person performing abortion with the woman consent was subject to imprisonment for a period not exceeding 3 years or payment of a fine if the aborts reached the stage of "quickening". In 1983 the code was changed to meet the legislation designed to meet the Islamic law, although the performance of abortion is still prohibited, but the punishment was changed to payment of blood money. Persons performing abortions are subject to payment of compensation as well as imprisonment.

Abortion law was once more changed in 1991; with the major change was expansion of the circumstances under which the performance of an abortion was legal in the following: (a) the miscarriage is for the sake of the mother’s life. (b) The pregnancy was the result of rape less than 90 days ago. (c) It is proved that the fetus has died in the mother's womb. 1991 new legislations did not apply to non-Muslim population.

Family planning services was introduced in Sudan since Independence in 1956, The Government of the Sudan provides direct access to modern methods of family planning. In 1975 the Ministry of Health established the maternal and child health and the family planning project. The Fertility Control Association was created in 1976. Both provide family planning all over the country by their 389 service points, with 11 permanent clinics and 4 mobile units [1].

Contraceptive Methods

Generally, in developing countries as in Sudan millions of women in the reproductive age do not use proper contraceptive methods, they prefer to limit their birth; this usually reflects their failure to prevent and avoid unwanted pregnancies.

Sudan is a country of great need of frontline sexual and reproductive health (SRH) services; this was shown by statistics. Advocacy, and undertaking information, education and communication (IEC). It works with 62 associated operations, 60 private physicians, and over 90 agencies. With 158 communities - based distributors/community - based services (CBD/CBSs) provides the essential on ground support, this will meet with nearly 64% of the country’s current demand for contraceptive pills.

The census of 2011 of Sudan Family Planning Association (SFPA) delivery as follows:

-240,000 condoms
-576,000 sexual and reproductive health services.
-134,000 HIV-related services [2-4].

Unmet Need for Contraception and Children Spacing

Largely populated countries probably have high fertility rates. High fertility rates are associated with inadequate spacing between births. 99% of maternal deaths occurred in developing countries, the WHO estimated that 13% are due to unsafe abortions. 50 million of women report to induced abortion each year worldwide. Other causes of high maternal mortality deaths are, complications of pregnancy, and complications of childbirth. In Sudan maternal and infant mortality rates are among the highest in the region, 600 per 100,000 live birth, and 70% per 1,000 live births, for maternal and infant mortality rates respectively.
Countries with high fertility rates, has low contraceptive use. Unintended pregnancies have significant consequences especially in adolescents, low income, and minority groups. Oral contraceptives and condoms are the base for majority of family planning in Sudan in recent years, however earlier programs relayed on methods such as (IUD) that are less prominent now. Over time newer methods were used, ingestible, and implants also find their way for use by some. The main trend has been changed to permanent methods; sterilization although simpler has now more demand.

Before 1999, the total fertility was 6.2 births per woman. This figure decreased to 4.9 in 2002.

The proportion of women using modern methods of contraception in North Sudan increased slightly from 4% in 1977-1978 to around 6% in 1989 and 7% in 1992-1993 [5].

In 1978 a fertility survey was carried in the capital Khartoum, it showed that there was widespread knowledge of family planning in the city, the level of ever-use of birth control is significant. Pills are used universally in birth control users; IUD, Rhythm, and withdrawal are relatively popular. It was observed that there is great consistency between reports given by husbands and their wives indicating that the use is for birth spacing rather than a smaller number of children however the purpose of using birth control is yet to be explained [6].

Unmet need for family planning is defined by WHO, as the percentage of all fecund women who are married or lived in union, presumed to be sexually active but are not using any method of contraception. Either does not want to have more children, want to postpone their next birth, or they do not know when to have another child [7].

The Sudan household survey in 2010 showed that, 9% of women 45-49 years used a contraceptive method. The unmet need for contraception is 29%, with the total fertility of 5.6 children per woman. The maternal mortality rate in the same study was 600 per 100,000 live births. This will readily reflect the concept of unmet family planning leading to the high maternal mortality rate in the country [8].

In one study at the Eastern part of the Sudan, Abdulazem A. Ali and Amira Akud found a high maternal mortality rate 713 per 100,000 live births, if use of contraception (44%), they commented that in spite of the enormous effort for family planning done by both the Government and the Sudan Family Planning Association, there is no improvement in the use of contraception, the availability and/or accessibility still vary between urban and rural areas [9].

As there are scarce studies about the contraception use in the whole country, the separation of South Sudan from Sudan, I think more studies are needed to elaborate the problem and guide decision makers to start an effect programs guided by WHO guide lines and carried with the help of Sudan Family Planning teams.

Conclusion

In Sudan particularly in rural areas, other problems exist opposing family plans and contraception use, female genital mutilation, tribal believes of large families, and some wrongly translated religious believes also contribute to the low implementation of effective use of various contraceptive method.

The most commonly used contraceptive is oral contraception, followed by IUD in Cities and urban areas. Although there is very few studies for the rural areas but the mostly used method is breast feeding, as the majority will breast feed up to 2 years of age, this practice has dual effect as it is useful for spacing between children, it also prevent some common infectious diseases(pneumonias, gastroenteritis and others). This practice could be used effectively if utilized in an effective way by drawing an effective plan in the media and/or through (SFPA) Emergency contraception was of limited use, as well as withdrawal and other lines of contraception.

Acknowledgement

None.

Conflict of interest

No conflict of interest.

References

2. International Planned Parenthood Federation (IPPF), Sudan.