

## Family Planning Trends in Sub-Saharan Africa: Progress, Prospects, and Lessons Learned

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Sub-Saharan Africa has the highest average fertility rate in the world. In 2009 the total fertility rate (TFR), or the average number of births per woman, was 5.1—more than twice that in South Asia (2.8) or Latin America and the Caribbean (2.2) (World Bank 2009). The average contraceptive prevalence rate (22 percent) is less than half that of South Asia (53 percent) and less than a third that of East Asia (77 percent) (World Bank 2009). Population in the region continues to grow at a faster rate (2.3 percent) than in other regions, including both Asia and Latin America (1.1 percent each) (UN DESA 2008).

These dismal indicators at the aggregate level conceal ongoing and imminent fertility transitions that are taking place at the country level. Contrary to the popular perception, there is evidence of progress in fertility decline in many countries across Africa (Cohen 1998). Emerging research shows that fertility transition has already begun in Sub-Saharan Africa and that some countries are undergoing dynamic and unprecedented changes in fertility patterns.

Acceptance of family planning in the region has traditionally been low and cultural resistance to family planning high (Caldwell and Caldwell 1987). Nevertheless, over the past two decades, contraceptive use increased in several countries. Its impact, along with that of changes in other determinants of fertility, is leading the onset of fertility decline in the region.

This chapter examines contraceptive use and fertility trends in Sub-Saharan African countries between 1986 and 2009. It is based on an analysis of household survey

data from Demographic and Health Surveys in 45 countries (all countries with more than one survey during the reference period were included). Data from the World Bank's *World Development Indicators* and the United Nations were also used for additional analyses. The chapter discusses the impact of micro and macro level factors, that have contributed to changes in the dynamics of contraceptive use and fertility decline. It highlights national policies, institutional frameworks, and service delivery strategies in selected countries in which the greatest progress has been made.

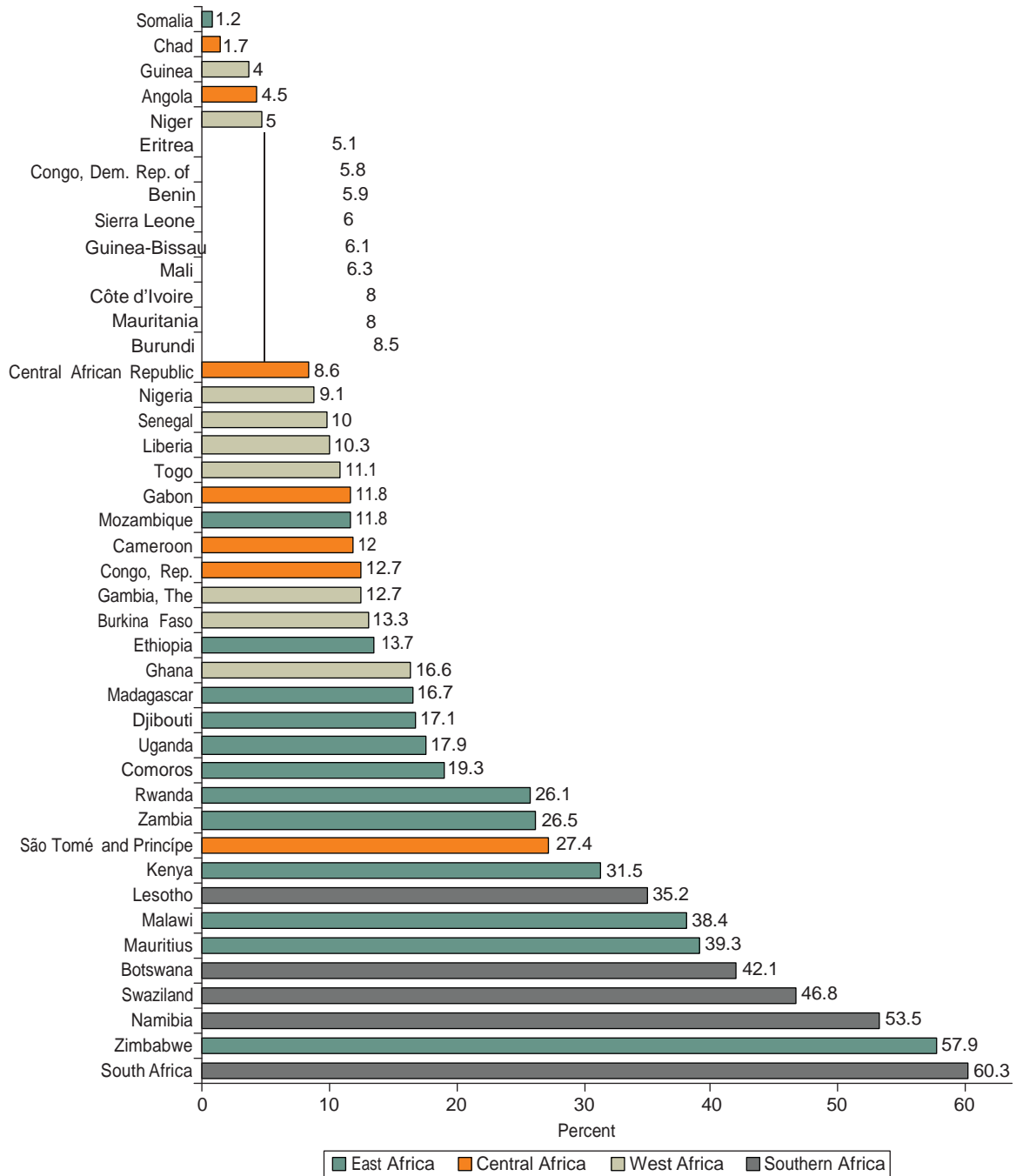
### TRENDS IN CONTRACEPTIVE USE

Contraceptive use indicators—including the contraceptive prevalence rate (CPR), method mix, and unmet need—are showing encouraging progress in some countries of the region. Such changes are often precursors of fertility decline.

#### Changes in the contraceptive prevalence rate

The modern contraceptive prevalence rate—the proportion of women of reproductive age who are using a modern contraceptive method—varies widely across the region. Among women of reproductive age, CPRs for modern methods ranged from 1.2 percent in Somalia to 60.3 percent in South Africa (figure 25.1). Geographic variations in family planning use were apparent in the findings, with countries in Southern Africa reporting the highest levels of contraceptive

Figure 25.1 Modern Contraceptive Prevalence Rates in Sub-Saharan Africa, by Country



Source: United Nations Population Division 2009.

use, followed by countries in East Africa. With a few exceptions, West and Central African countries report very low rates of family planning use. Some of the lowest contraceptive prevalence rates in the world exist in these two subregions of Africa.

Levels of fertility were high throughout Sub-Saharan Africa during the 1970s. Some indication of fertility transition began to emerge in the 1980s in some parts of Africa. Evidence was accumulating that fertility was falling or expected to fall and contraceptive prevalence was high in

Southern Africa, at least in comparison with the levels for Africa as a whole in the 1970s (Lucas 1992). Parts of East Africa were also showing signs of change. Surveys carried out in the mid-1980s reported pockets of high contraceptive prevalence in Botswana, Kenya, and Zimbabwe and an increasing desire among more than one-third of women in these countries to stop childbearing—a proportion that was above the 10 percent average for the region (Way, Cross, and Kumar 1987).

More recent data corroborate the onset of fertility decline in parts of the region. Wide variation in contraceptive prevalence persists across countries, suggesting that country-level contexts and policies may underlie these differentials.

Although overall progress is only modest, the experience of a few countries in increasing contraceptive prevalence stands out. An analysis of fertility trends in 23 countries of Sub-Saharan Africa from 1980 to 1995 showed evidence of fertility decline in two-thirds of the countries, with a particularly rapid decline in Kenya and Zimbabwe (Kirk and Pillet 1998).

Trend data on modern CPR over the past 20 years show that some countries have made remarkable progress (figure 25.2). Countries such as Namibia and Zimbabwe started out with high levels of contraceptive prevalence in the 1990s and saw their rates climb steeply over the next two decades. Other countries, such as Malawi, Madagascar, and Mozambique, began with relatively lower CPRs in the early 1990s, but these rates sharply increased in the following years. Progress was apparent not only in Southern Africa but also in countries in East Africa, where increases in Zambia, Uganda, and Tanzania were particularly noteworthy.

CPRs between the first and the most recent Demographic and Health Survey during the study period were compared to examine the rate of change over time. The findings reveal that some countries experienced dramatic increases in contraceptive prevalence within relatively short periods of time. The increases in CPR in Namibia, Tanzania, Zambia, and Zimbabwe were particularly rapid. Mozambique experienced the steepest increase in modern CPR within the shortest time frame in the region: between 1997 and 2003 its CPR increased more than four-fold, from 5.6 to 25.5 percent. Although other countries reported larger increases, changes there occurred over longer time periods. Data show that between the first and the most recent Demographic and Health Survey, all countries reported increases in CPR. Malawi, Mozambique, Namibia, Zambia, and Zimbabwe made the greatest progress.

Analysis comparing African countries with countries in other regions shows that the rate of percentage change in CPRs in Malawi, Mozambique, Namibia, and Zambia was far greater than in many South Asian, East Asian, and Latin American countries. Although fertility transition began late in Africa, the increase in CPR occurred from a very low base, thus there was scope for a greater magnitude of change relative to countries in other regions that had already attained high levels of coverage (figure 25.3).

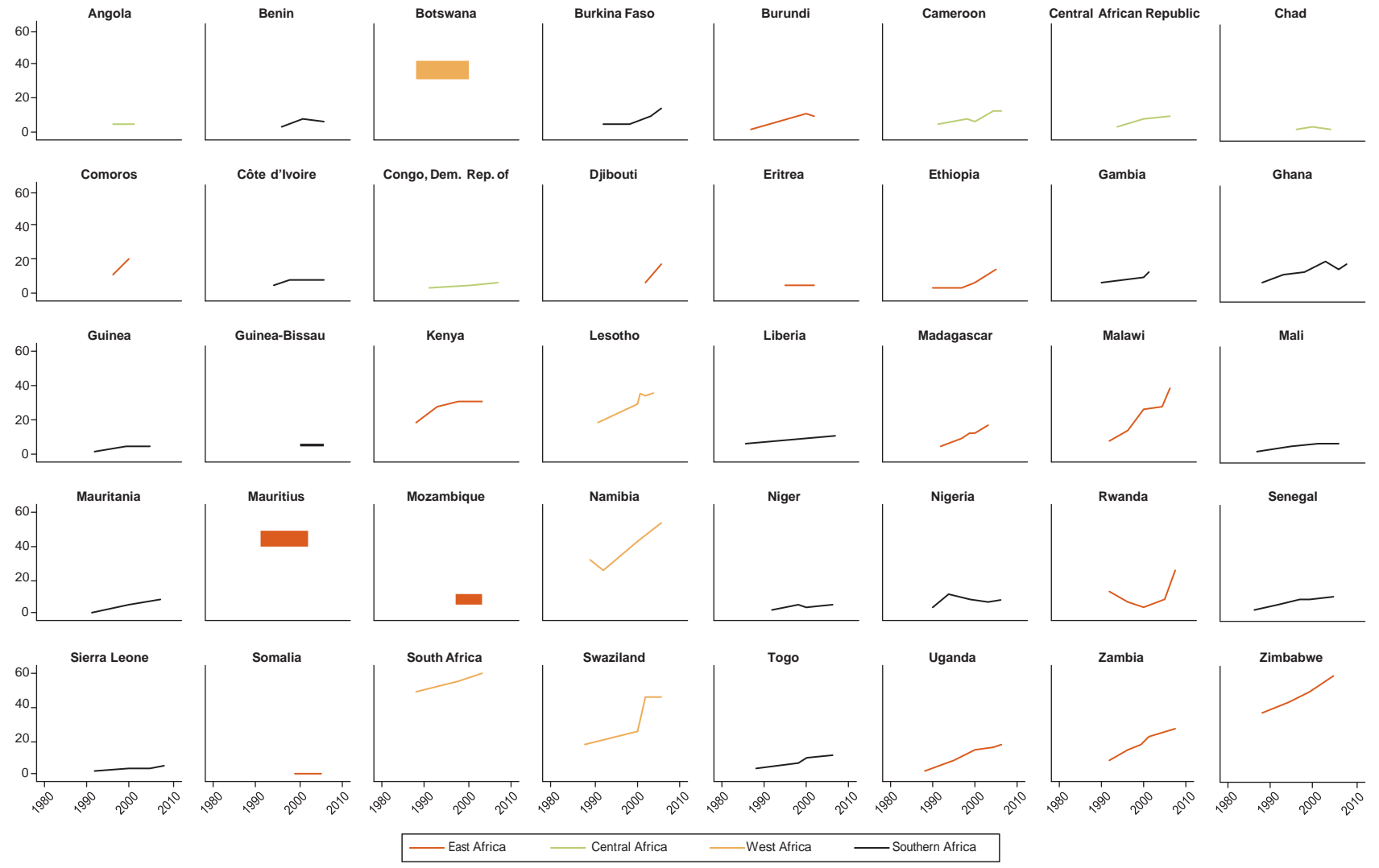
### Changes in the choice of contraceptive method

An indicator of progress in family planning adoption is the change in the type of contraceptive methods used by family planning acceptors. The use of traditional methods tends to be higher in settings where acceptance of family planning is low and use of family planning programs is weak. Traditional methods have a high failure rate compared with modern methods and are therefore not considered an effective mode of contraception.

Trends in contraceptive choice show that in many countries of the region, use of traditional methods has declined and use of modern methods increased (figure 25.4). The use of modern methods has increased most markedly in countries that had the greatest increases in CPR (Madagascar, Malawi, Namibia, Zambia, and Zimbabwe). Use of traditional methods in these countries has either remained stagnant or has decreased. Ghana, Kenya, Tanzania, and Uganda showed increases in use of modern methods while maintaining use of traditional methods. In West African countries such as Benin, Burkina Faso, Cameroon, Senegal, and Togo, traditional method use declined and relatively modest gains in modern method use were observed.

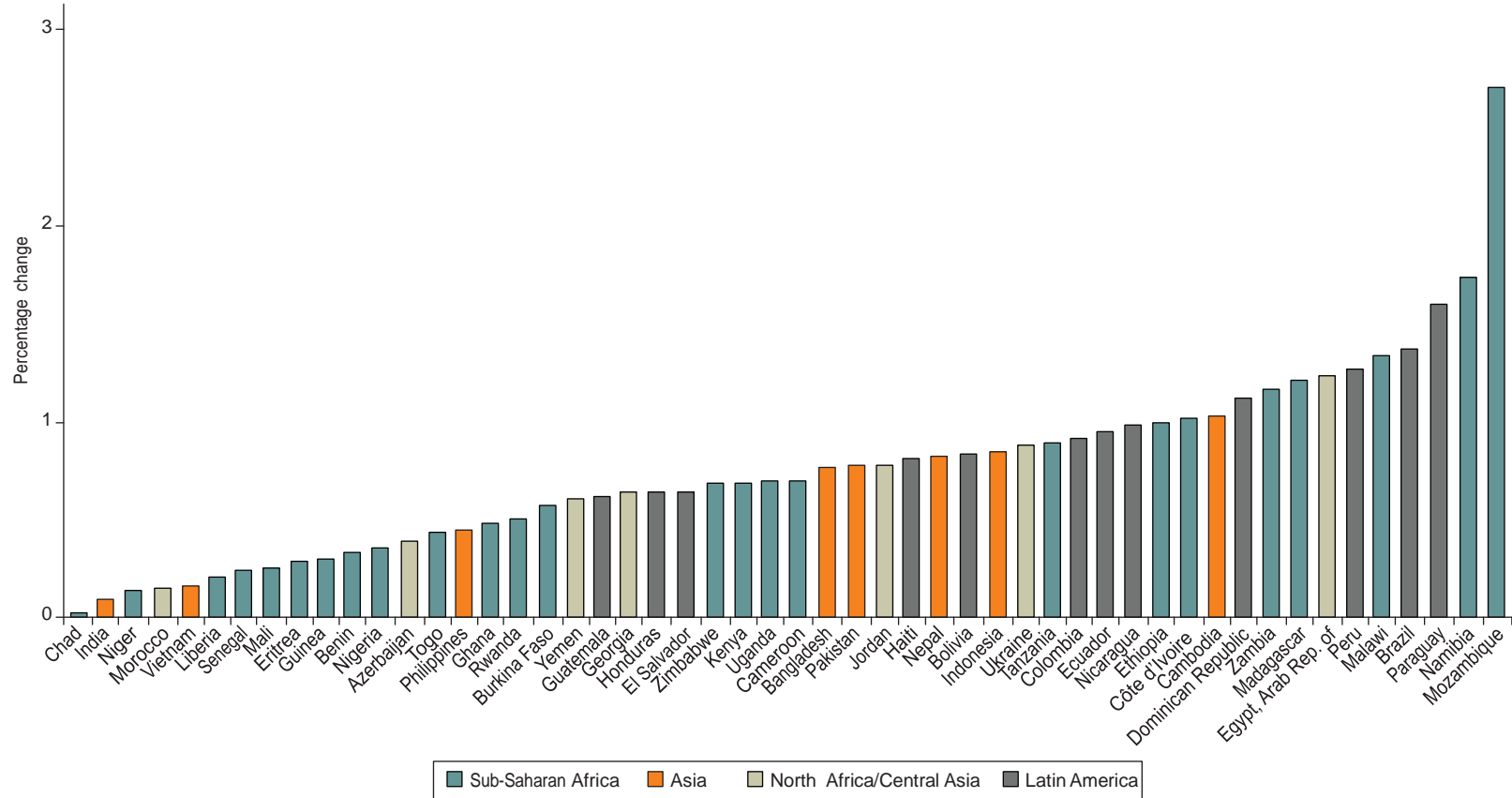
Family planning programs that have been successful in Africa have promoted birth spacing. Marriage patterns in Africa differ from those in Asia, possibly accounting for a cultural preference for spacing methods. Various studies in the region document African cultural preferences for spacing rather than limiting births (Cohen 1998). In contrast to Asian family planning programs, which have emphasized permanent contraceptive methods, such as sterilization and abortion, programs in Africa rely on temporary methods, such as pills, injectables, and implants (Caldwell and Caldwell 1988). It has been suggested that successful program strategies in Africa must promote methods that are temporary, can be used covertly by women, and do not have to be stored at home (Caldwell and Caldwell 2002).

Figure 25.2 Trends in Modern Contraceptive Prevalence Rates in Selected Countries in Sub-Saharan Africa



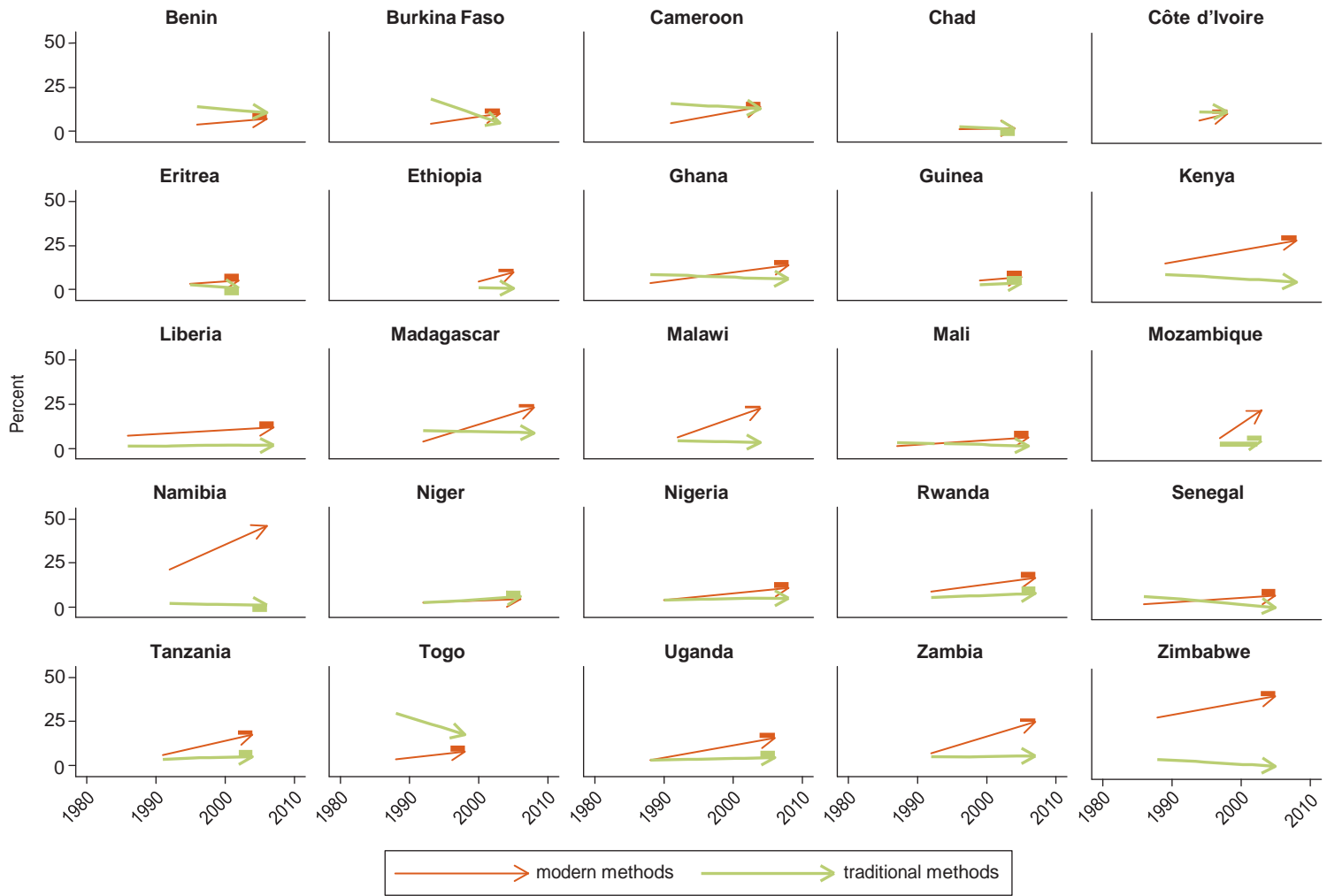
Source: Demographic and Health Surveys, various years.

Figure 25.3 Annual Rate of Change in Modern Contraceptive Use in Selected Countries between First and Last Rounds of Demographic and Health Surveys



Source: Demographic and Health Surveys, various years.

Figure 25.4 Trends in Modern and Traditional Contraceptive Prevalence Rates in Selected Countries in Sub-Saharan Africa



Source: Demographic and Health Surveys, various years.

The use of family planning methods depends not just on users' preferences but also on health system characteristics. Strong family planning programs rely on effective family planning service delivery strategies, such as those that offer methods tailored to the needs of users, provide family planning counseling and medical expertise for administering methods, and follow up on users' response to the method. Countries in the region with frail health systems are faced with the challenge of improving contraceptive method choice within existing constraints. There is growing evidence that new methods such as injectables are being readily accepted by women in the region; these methods accounted for 62 percent of modern contraceptive users in Malawi and 66 percent in Ethiopia (National Statistical Office Malawi and ORC Macro 2005; Central Statistical Agency and ORC Macro 2006).

### Changes in unmet need and satisfied demand

Unmet need measures the gap between demand for family planning and use of contraception. Expressed as the percentage of sexually active women who do not want additional children but are not using any family planning method, this measure is often considered a precursor of fertility decline, because it indicates that demand for family planning services exists but is not being met.

Changes in unmet need can be influenced by a variety of factors related to fertility preferences or family planning acceptance, which may or may not be related to the effectiveness of family planning programs. Nevertheless, when examined in relation to contraceptive prevalence, these changes provide an estimate of the gap between demand and utilization of family planning.

Trends in modern CPR and unmet need indicate that in countries such as Kenya, Madagascar, Malawi, and Zambia, decline in unmet need has corresponded with an increase in family planning (figure 25.5) suggesting a convergence of demand and supply of family planning. In contrast, in other countries, such as Eritrea, Ghana, Mali, and Senegal, the gap has remained wide and consistent.

Satisfied demand for contraception is defined as the percentage of sexually active women who do not want additional children and are practicing family planning. Increases in satisfied demand corresponded with a decrease in the unmet need for family planning in certain countries in the region. The percentage change in satisfied demand increased most in countries such as Madagascar, Mozambique, Tanzania, and Zambia where contraception prevalence rates are increasing (figure 25.6).

### TRENDS IN TOTAL FERTILITY RATES

Another set of analyses examined trends in total fertility rates, or the average number of children per woman. In most countries the TFR declined over time; in some countries it remained stagnant (figure 25.7). The steepest declines in average fertility were observed in Ghana, Kenya, Liberia, Namibia, and Zimbabwe. Other countries, such as Madagascar, Senegal, and Togo, also showed promising declines. The TFR increased or remained constant in a few countries, including Mozambique, Niger, and Nigeria.

Despite increases in contraceptive prevalence in many countries, fertility decline has been slow. As there tends to be a time lag between changes in contraceptive use behavior and a corresponding decline in average fertility, it is likely that subsequent rounds of surveys will show greater fertility declines in countries in which CPRs have risen. Fertility decline also tends to be correlated with demographic and socioeconomic factors, such as the level of urbanization, women's education, women's labor force participation, and economic growth. Studies in Africa have shown that differentials in fertility trends across countries are associated with women's education, child survival (Kirk and Pillet 1998), and exposure to modern roles and behaviors linked with growing urbanization (Garenne and Joseph 2002).

Trends in actual and wanted TFR were examined in each of the countries for which data were available. Actual TFR exceeded wanted TFR in all countries (figure 25.8), indicating that women were not able to regulate their fertility preferences. In countries such as Uganda, that have high unmet need, the gap between the actual and wanted TFR widened, suggesting a growing demand for small family size and the failure of family planning programs to meet the latent demand for services. Countries, such as Kenya and Zimbabwe, that have had strong family planning programs and have improved contraceptive prevalence showed a narrowing of the gap between desired and actual fertility.

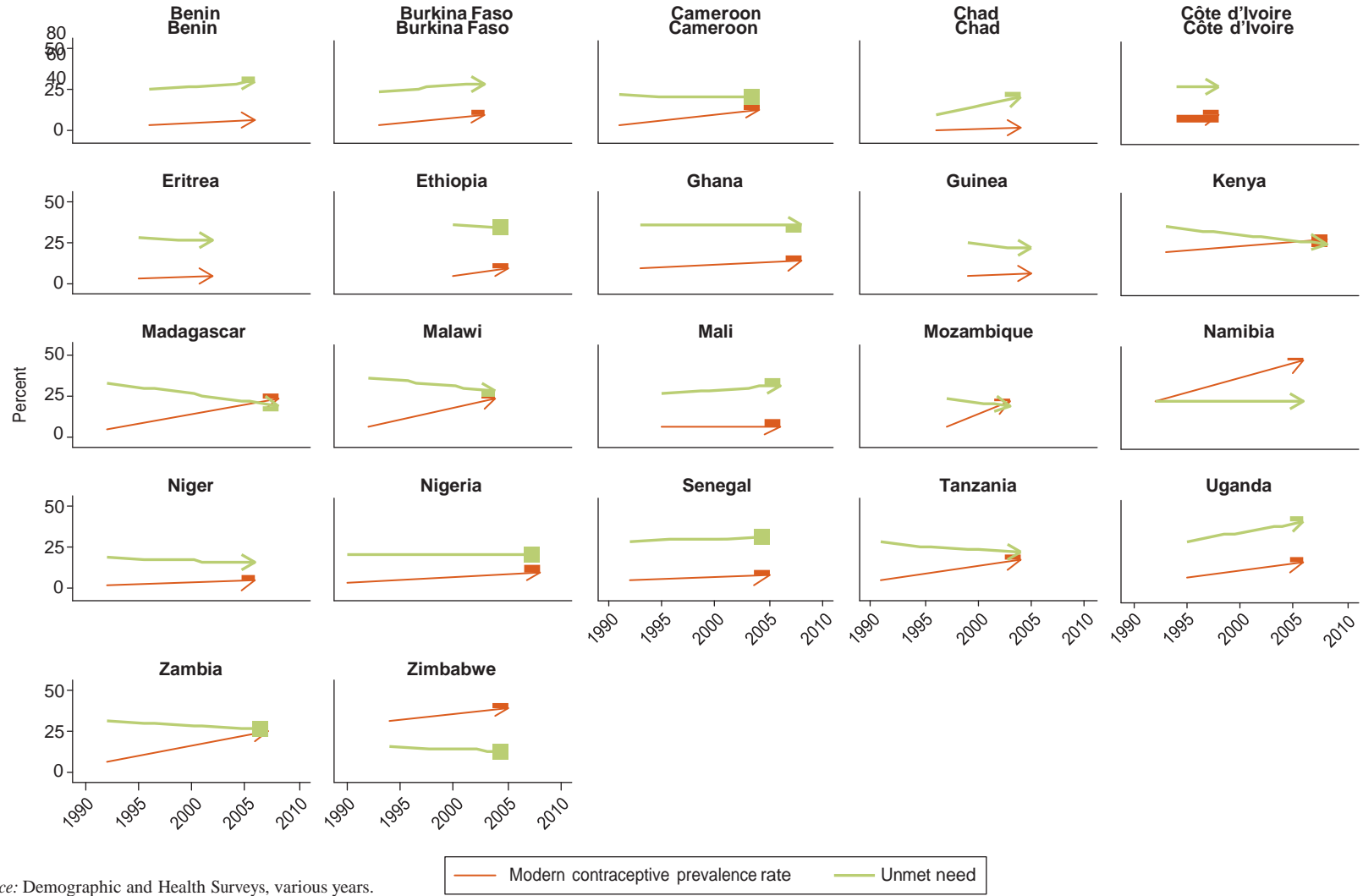
Some countries that made progress in the 1990s started to falter at the beginning of the 2000s. Stagnation on contraceptive prevalence and total fertility rate, was evident (see figures 25.2, 25.7). Uganda, Tanzania, Malawi, Kenya, and Ghana underwent large increases in contraceptive prevalence in the 1990s but stagnated after 2000. Stagnation in satisfied demand was evident in Kenya, Malawi, Tanzania, and Zambia. Total fertility rates also stagnated in the 2000s, especially in Cameroon, Ghana, Kenya, and Zimbabwe. In some countries, such as Rwanda, Tanzania and Uganda, the gap between actual and wanted fertility widened after 2000, a



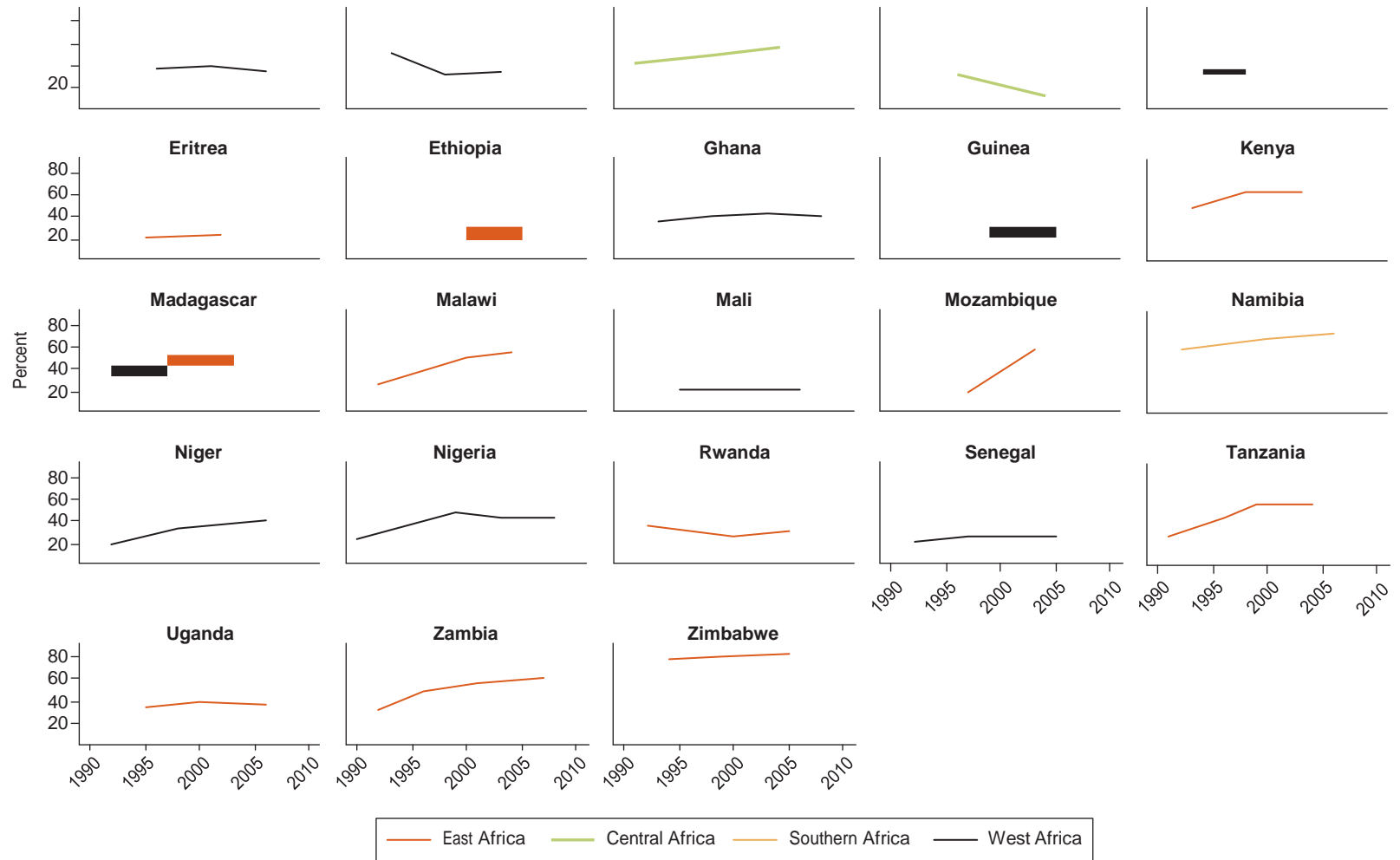
*Source:* Demographic and Health Surveys, various years.



Figure 25.6 Satisfied Demand for Contraception in Selected Countries in Sub-Saharan Africa  
 Figure 25.5 Unmet Contraceptive Need and Modern Contraceptive Prevalence Rate in Selected Countries in Sub-Saharan Africa

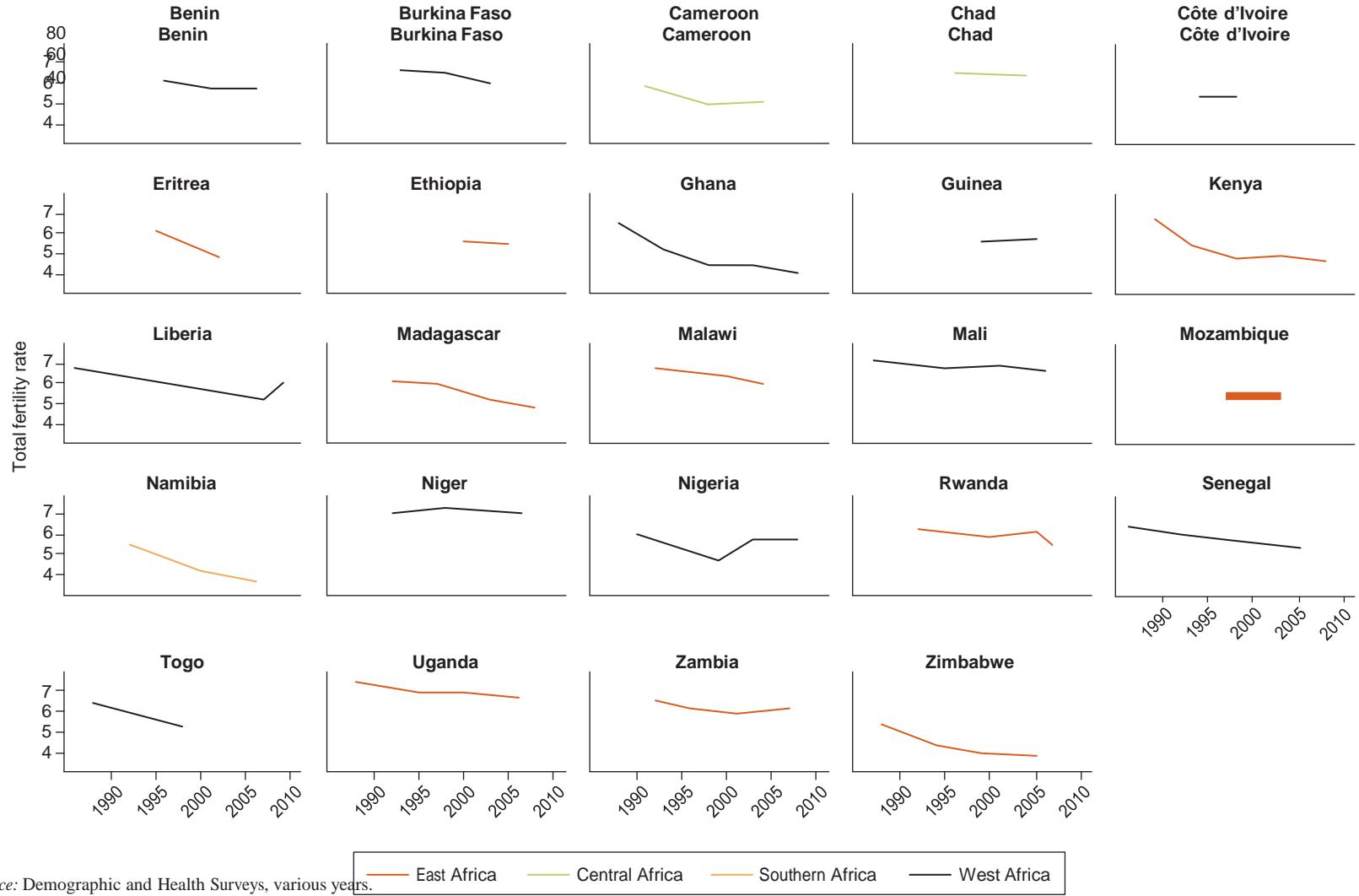


Source: Demographic and Health Surveys, various years.

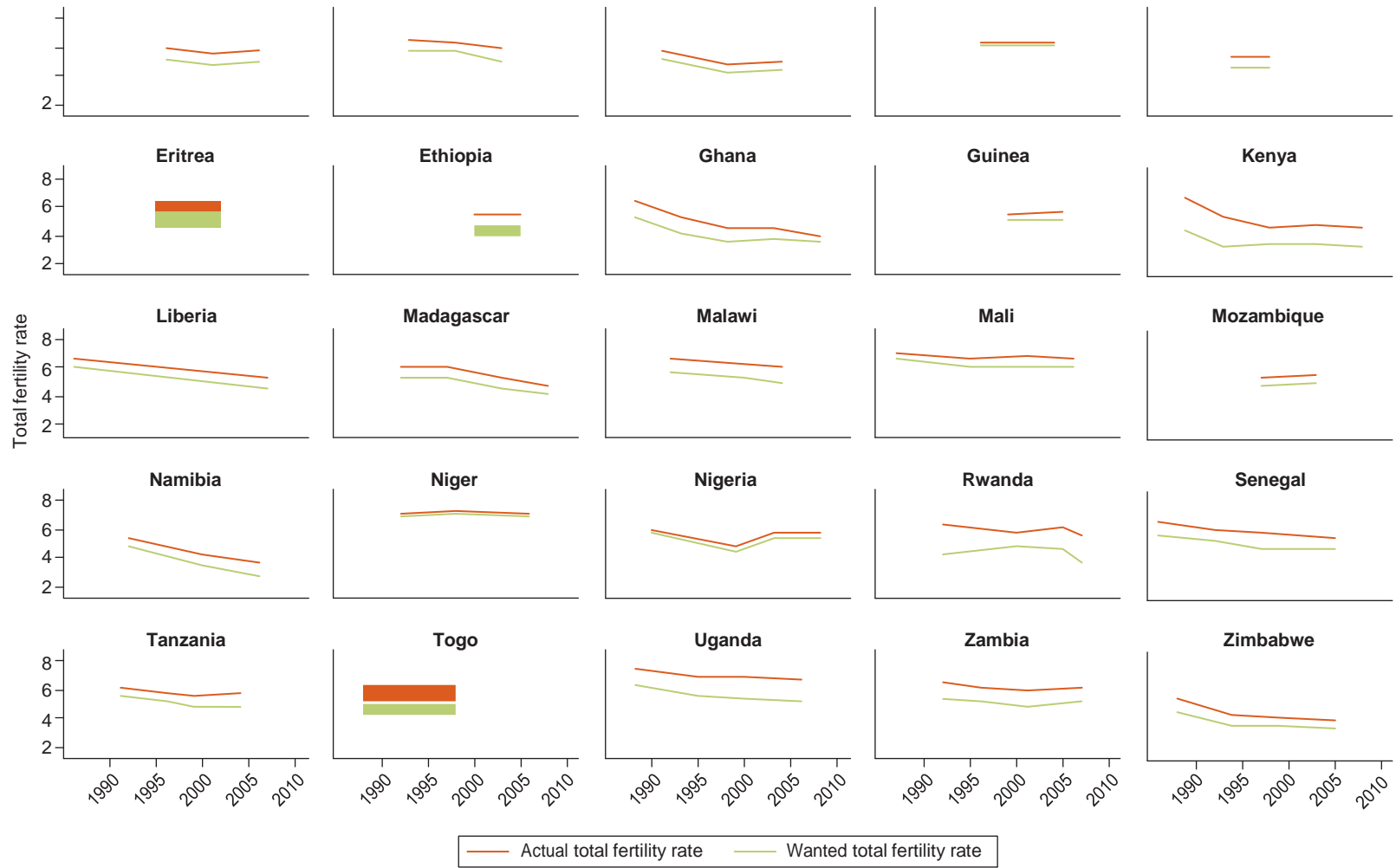


Source: Demographic and Health Surveys, various years.

Figure 25.6 Satisfied Demand for Contraception in Selected Countries in Sub-Saharan Africa  
 Figure 25.7 Total Fertility Rates in Selected Countries in Sub-Saharan Africa



Source: Demographic and Health Surveys, various years.



Source: Demographic and Health Surveys, various years.



probable consequence of the weakening of the family planning program or a shift in desired family size (figure 23.8).

Although conclusive evidence on the reasons for the stagnation remains elusive, some explanations include changes in the international policy arena and contextual changes at the country level. A key policy factor is purported to be the reduced priority of reproductive health and family planning after its exclusion from the Millennium Development Goals as well as competition for resources from diseases such as tuberculosis, malaria, and HIV (Gillespie 2004). Country-level studies (for example, in Kenya) attribute the faltering of the fertility decline to dwindling donor support for family planning and a greater emphasis on HIV/AIDS and other sexually transmitted diseases (Blacker and others 2005). A regional study on the stagnation of fertility decline in Eastern Africa concludes that changes in socioeconomic variables, the family planning program environment, and reproductive behavior models are associated with the decline in contraceptive use and increases in unmet need, preferences for larger families, and adolescent fertility (Ezeh, Mberu, and Emina 2009).

The HIV/AIDS epidemic has also impacted fertility levels in Sub-Saharan Africa. The region has the highest prevalence of HIV/AIDS and the largest number of people living with HIV/AIDS in the world. Stagnation in fertility decline over the past 10 years has been related to the increase in HIV prevalence. In Zimbabwe, for example, estimated total fertility was 8.5 percent lower than it would have been in the absence of HIV, and HIV-associated changes in fertility behavior accounted for one-quarter of the drop in fertility since the 1980s (Terceira, Simon, and Gregson 2003). In South Africa, where the prevalence of HIV is among the highest in the region, the spread of HIV is expected to accelerate fertility decline (Moultrie and Timaeus 2003).

## **DETERMINANTS OF FERTILITY DECLINE**

Fertility patterns tend to be influenced by proximate and socioeconomic determinants of fertility. Findings indicate that changes on both fronts are taking place in Africa.

The proximate determinants of fertility are the biological and behavioral factors through which socioeconomic and environmental variables operate to influence the rate of childbearing in a population (Bongaarts 1987). These determinants have been classified into two broad categories: fertility-enhancing trends (shortening of breast-feeding periods and postpartum abstinence, decline in pathological

sterility) and fertility-reducing trends (rise in age at first union, higher prevalence and effectiveness of contracep-

Figure 25.8 Actual and Wanted Total Fertility Rates in Selected Countries in Sub-Saharan Africa

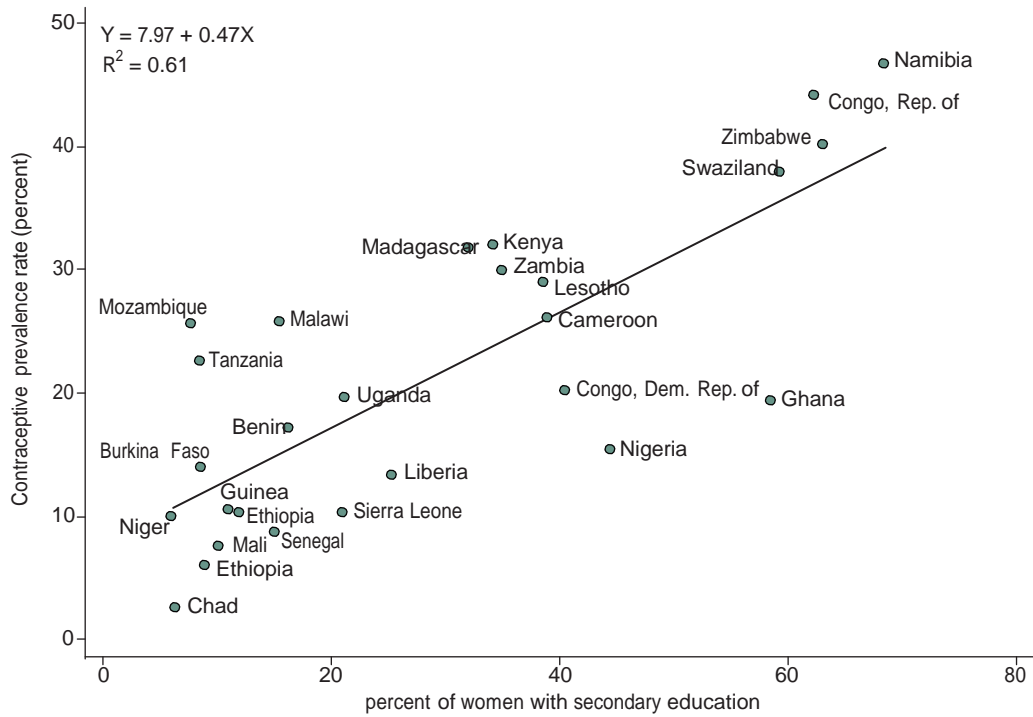
tion) (Bongaarts, Frank, and Lesthaeghe 1984). In countries in which fertility reduction is most pronounced, there is evidence that fertility-reducing variables such as age of marriage have risen (Cohen 1998). However, comparison of the proximate determinants of fertility in countries in which the fertility transition is more advanced and those in which it is delayed indicates that contraceptive use is by far the most important factor accounting for intercountry differences (Kirk and Pillet 1998).

Increases in induced abortion—suspected to be a major method of contraception in urban areas of Africa—are associated with recent declines in fertility (Garenne and Joseph 2002). Abortion is the most likely explanation for the drop in fertility, from 6.9 in 1980 to 5.5 in 2010, in Western Africa, where contraceptive use remains very low (Cleland, Ndugwa, and Zulu 2011). An estimated 14 million unintended pregnancies occur in Sub-Saharan Africa every year (Hubacher, Mavranouzouli, and McGinn 2008). Consequently, the demand for medical abortion is expected to be very high. Because abortion remains illegal in all but a few countries in the region, women have to seek unsafe abortions from illegal practitioners. It is estimated that more than 4 million unsafe abortions are performed in Africa every year (Brookman-Amissah and Moyo 2004). Abortion is a major risk factor underlying the high levels of maternal mortality in Africa.

The main socioeconomic determinants of fertility include socioeconomic status, women's education, and urban residence. The negative association between women's education and fertility level observed in other settings is apparent in Africa as well (figure 25.9). Analysis of the relationship between economic growth and fertility indicates that increases in GDP are associated with higher rates of contraceptive prevalence (figure 25.10). The direction and pathways of causality between fertility and economic growth remain debatable. In general, socioeconomic change is believed to modify the incentives to have children, diffuse new ideas about childbearing through society, and provide women with better access to contraceptive methods (Bryant 2007). Emerging economic growth prospects in the region indicate potential for future fertility decline.

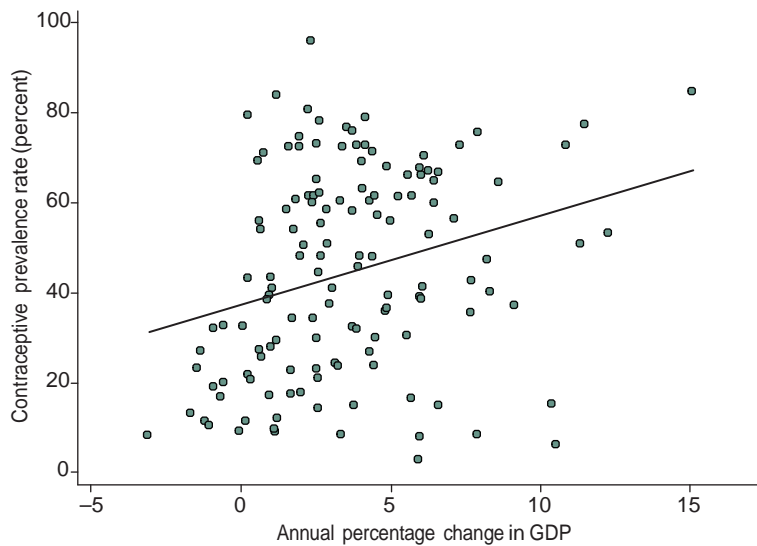
Other covariates of fertility, such as infant mortality rates, have declined in the region. A plot of the relationship between contraceptive prevalence rates and infant mortality rates indicates the negative correlation between the two variables (figure 25.11). Fertility decline in countries such as Botswana, Kenya, and Zimbabwe, which had lower levels of infant mortality than other countries in the region, provides evidence that improved rates of child

Figure 25.9 Relationship between Women's Secondary Education and Contraceptive Prevalence Rates in Sub-Saharan Africa



Source: Demographic and Health Surveys, 2000–08.

Figure 25.10 Relationship between Annual Percentage Change in GDP and Contraceptive Prevalence Rate in Sub-Saharan Africa, 1990–2009

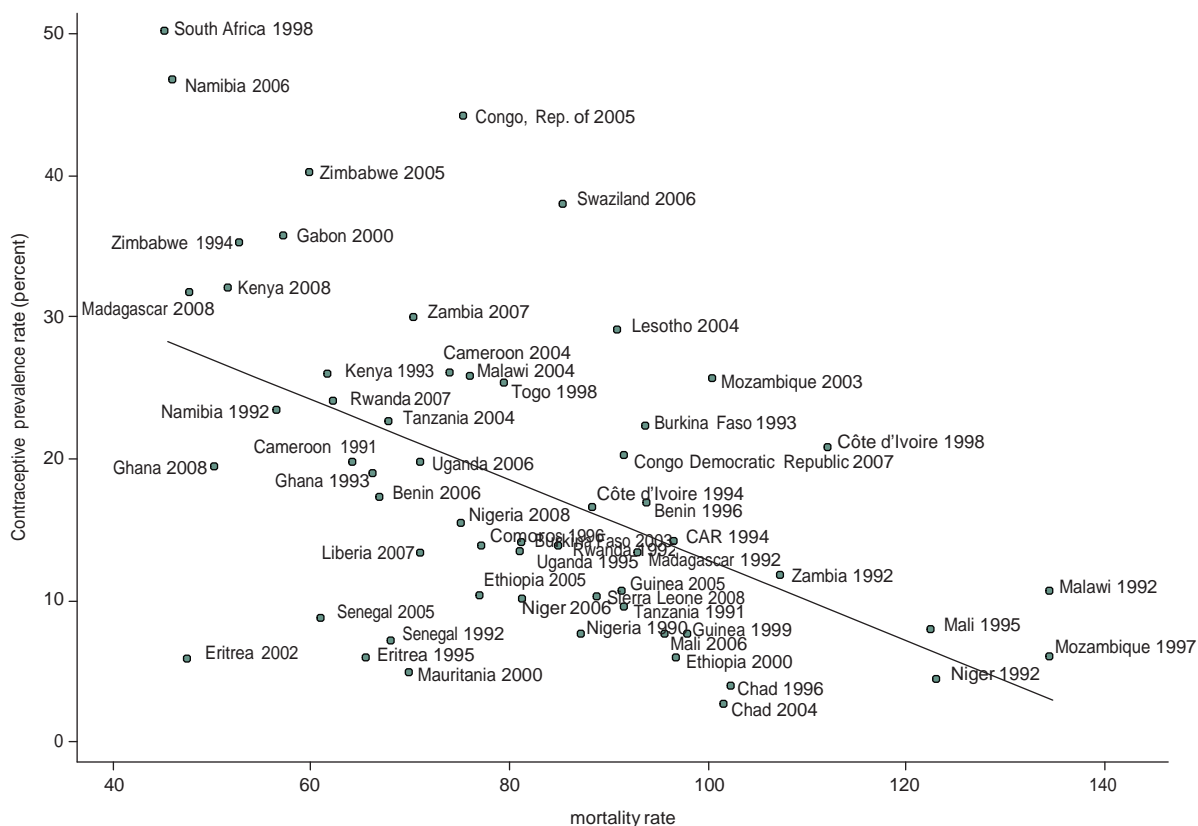


Source: World Bank 2009.





Figure 25.11 Relationship between Contraceptive Prevalence Rates and Infant Mortality Rates in Sub-Saharan Africa



Source: Demographic and Health Surveys, 1986–2009.

survival may be a necessary condition for fertility decline in Africa (Caldwell, Orubuloye, and Caldwell 1992).

### FAMILY PLANNING POLICIES AND PROGRAMS

Some studies have tried to identify reasons why certain countries in the region underwent fertility decline whereas others did not. One study compares Kenya, where total fertility fell about 40 percent between 1980 and 2000, with neighboring Uganda, where fertility declined by 10 percent. It finds that both economic development and a strong national family planning program were associated with lower fertility in Kenya (Blacker and others 2005) (box 25.1).

A comparative analysis of Zimbabwe, where the fertility rate fell more rapidly than in Zambia, reveals that a strong family planning program in Zimbabwe backed by high-level political commitment and institutional and financial stability were key ingredients of success (Lee et al. 1998) (box 25.2). Emerging evidence from Rwanda suggests that

major strides in improving family planning uptake can be made if political commitment exists (box 25.3).

Some observers have argued that high rates of fertility in the region can be linked with the lack of policy level commitment for family planning programs. During the 1960s and 1970s, African governments were reluctant to institute effective family planning programs; political support for family planning in the public sector was weak throughout the continent. Since the 1974 and 1984 World Population Conferences, however, governments in several African countries have acknowledged high levels of fertility and initiated family planning programs (Kalipeni 1995). Africa has lagged other regions on fertility decline because family planning programs were introduced relatively late in the region. Family planning programs in Africa are not as strong or as old as those in other parts of the world, but as the experience of many African countries reveals, if strong and high-quality family planning programs are developed, people will use them and fertility will decline (Mbacke 1994). Relatively better progress on

## Box 25.1 Kenya Case Study

Kenya was the first country in Sub-Saharan Africa to adopt a population policy, with the launch of a national family planning program in 1967. Initially, the promotion of the program was halfhearted and ineffective: fertility appeared to be rising rather than falling. In the 1980s, however, the government rapidly expanded the number of outlets from which contraceptives could be obtained and the number of health workers trained in family planning. By the end of the century, more than half of the country's 3,500 (governmental and nongovernmental) health facilities were offering maternal and child health and family planning services.

In 1996, the National Council for Population and Development published its *National Population Advocacy and IEC Strategy for Sustainable Development, 1996–2010*, which aimed to promote the use of modern contraceptive methods among less educated women (Blacker and others 2005). Modern methods of contraception have been available in Kenya since 1957 through the facilities of the Ministry of Health and the private sector, including nongovernmental organizations. Community-based distribution and

*Source:* Authors.

social marketing of contraceptives have been effective in increasing coverage.

The combined program efforts of public and private agencies facilitated Kenya's transformation from the country with the highest fertility level in the world in the late 1970s to one in which significant fertility decline has been achieved. The rate of contraceptive use among married women increased from 17 percent in 1984 to 39 percent in 1998, one of the highest rates in Sub-Saharan Africa (Magadi and Curtis 2003). The main driving force behind the success was the government's effort in increasing the number of family planning service delivery points and an intensified and focused information, education and communication strategy (Aloo-Obunga 2003). The leveling off in the fertility decline after 2000 may have been caused by problems in the supply of contraceptives, weaknesses in the quality of care, and changes in the contraceptive method mix (Pathfinder International 2005). Another factor may have been the HIV/AIDS program, which gradually pushed family planning off the agenda as it became a priority for funding and strategic programming considerations (Aloo-Obunga 2003; Pathfinder International 2005).

family planning indicators in Eastern Africa compared to Western Africa has been attributed to stronger family planning efforts that ensured wider availability of modern contraceptive methods (Cleland, Ndugwa, and Zulu 2011).

Although family planning programs in the region have been weak overall, some encouraging progress in program implementation began to emerge in the 1980s. A study of family planning program effort finds that the greatest improvement among all regions of the world between 1982 and 1989 occurred in Sub-Saharan Africa, where there was a sharp increase in family planning program effort indicators, albeit from a low base (Mauldin and Ross 1991). Policy-level support in countries in which strong commitments existed translated into successful national family planning programs.

Certain family planning program management strategies have been found to be particularly effective in the region. Countries such as Kenya and Zimbabwe had strong family planning associations that spearheaded policy changes and program implementation. A unified institutional structure responsible for program implementation was found to be effective in Zimbabwe. In Zambia the

separation of institutions responsible for policy formulation and implementation resulted in a weaker family planning program (Lee and others 1998).

A few countries have tried community-based distribution of contraceptives to extend family planning to hard-to-reach populations, particularly in rural areas. Community depots, mobile clinics, women's groups, and both paid and volunteer village health workers are some modes of service delivery used by such programs. Countries such as Ghana, Kenya, Nigeria, and Zimbabwe have implemented large community-based distribution programs at the national level. Although conclusive evidence on the effectiveness of such programs is not available, these programs provide good examples of successful bottom-up approaches that have been applied in the region (Phillips, Greene, and Jackson 1999).

### LESSONS LEARNED

Notwithstanding the high levels of aggregate fertility in Sub-Saharan Africa, some countries in the region have made significant progress on fertility decline. Ongoing

## Box 25.2 Zimbabwe Case Study

After independence, in 1980, the government of Zimbabwe reformed and expanded the family planning program with great success. The family planning program was spearheaded by the Zimbabwe National Family Planning Council, a body created in the early 1980s and backed by high-level leadership from Sally Mugabe, the president's wife, and Ester Boohene, his sister-in-law. The Zimbabwe National Family Planning Council built consensus for family planning among opinion leaders including religious groups, the business community, mass media, nongovernmental organizations, and civil servants (Lee, and others 1998).

Initially, Zimbabwe's family planning program was clinic-based. A community-based distribution system was launched in 1983 and it was considered among the most successful programs of its type in the region (Way, Cross, and Kumar 1987). Distributors were selected by the communities they served and paid government salaries and benefits. They were responsible for making household visits to deliver modern contraceptives, recruit new acceptors, follow up on dropouts, and make referrals where necessary (Phillips, Greene, and Jackson 1999). Mobile clinics covered about 29 percent of the rural population (Koblinksy 2003). Groups of men and women were recruited to motivate and educate people in communities about family planning. Other innovative approaches included the mobilization of farmers' wives to provide contraceptives to workers on their farms and the launching

*Source:* Authors.

of a large national information, education, communication campaign that promoted family planning with messages targeting men. The number of service delivery points was increased, particularly in rural areas; the number of family planning personnel more than doubled in some units; and the government made health care free to lower-income groups, thereby removing a major barrier to contraceptive use (Zinaga 1992).

The availability and quality of family planning and health services in the community was a key determinant of higher rates of adoption of modern contraceptives (Thomas and Muvandi 1994). The impact of community-based distributors was associated with increased adoption of modern methods. Mobile family planning clinics had a powerful impact on adoption, as did the presence of a general hospital in the area. These two investments in infrastructure had an above-average impact on women with little education. The program also provided a range of contraceptive methods, including Norplant, the female condom, and emergency contraception (Koblinksy 2003). Family planning was positioned as an integral part of the maternal and child health program. The primary health care strategy adopted by the government included both maternal and child health and family planning. All service delivery units were instructed to provide family planning as an integral part of their maternal and child health services (Zinaga 1992).

transformations in contraceptive use and fertility behavior signal the onset of fertility declines in more countries in the years to come. Despite tumultuous political situations several success stories in family planning policy formulation and program implementation have emerged. Lessons drawn from countries that have made progress attest to the importance of political commitment, institutional arrangements, and service delivery strategies in increasing the use of family planning methods and lowering fertility.

Many countries that were successful in reducing fertility adopted population policies and instituted family planning programs relatively early. Programs in Botswana, South Africa, and Zimbabwe have been considered particularly successful in this regard (Lucas 1992). High-level policy commitment and political ownership of the population program was a key ingredient for success. Political com-

mitment is not enough, however; the leadership must provide contraceptives and appropriate outlets for obtaining them and create an environment that is conducive to adoption of family planning (Caldwell, Orubuloye, and Caldwell 1992).

The existence of strong family planning programs is a prerequisite to reducing fertility. Family planning programs that have delivery points throughout the country; provide a range of contraceptive methods; ensure easy availability of contraceptives; adopt a reproductive health approach; and reach adolescents, men, and unmarried people are most likely to accelerate progress toward fertility decline in Africa (Caldwell and Caldwell 2002). Some specific service delivery strategies that have been found to be effective in Africa are those that promote spacing methods, give women the means to assume responsibility over contraceptive adoption, and allow women to use contraception

### Box 25.3 Rwanda Case Study

In the 1980s Rwanda had one of the highest levels of fertility in the world (8.6). The availability of family planning service was very limited, and cultural attitudes dictated the desire for a large family. As a result, contraceptive prevalence rate was extremely low, at 3–4 percent in 1988 (May, Mukamanzi, and Vekemans 1990).

The National Office of Population (ONAPO) was established in 1981 to increase demand for and improve the supply of family planning services. It made some initial progress, but its gains were lost during the genocide of 1994. After the recovery, the government introduced sweeping reforms that have resulted in dramatic progress on health and family planning indicators, with the contraceptive prevalence rate increasing several-fold, skyrocketing from 4.3 percent in 2000 to 26.1 in 2007.

The importance of providing family planning services as a rationale for national development found strong support at the top leadership level of the government. A number of innovative strategies were applied to

*Source:* Authors.

improve access and quality of health services. Some successful strategies included the introduction of a performance-based financing mechanism at various levels. Performance contracts were established between the presidency and district mayors (*Imihigo*) that included an indicator on family planning. Performance incentives were also given to health workers to improve their motivation levels and to health centers for providing quality care. Universal health insurance schemes (*mutuelles de santé*) further enhanced the coverage of health care and encouraged community involvement in health provision. Other strategies included decentralizing health services, strengthening contraceptive supply systems, training health workers for family planning provision, and establishing secondary posts as an alternate means for providing modern contraceptives to circumvent that religiously affiliated health facilities were not allowed to do so (Solo 2008). Rwanda's remarkable turnaround from its conflict-torn past to current achievements serves as a model for other countries in the region.

without their partners' knowledge (Caldwell, Orubuloye, and Caldwell 1992).

Policies that go beyond simply increasing contraceptive prevalence to address the proximate determinants of fertility can accelerate fertility decline in significant ways. Increasing the age of marriage through legislation and behavior change, encouraging natural child spacing through promotion of exclusive breastfeeding, and reducing the risk of unsafe abortion by removing legal restrictions will be key factors underlying fertility decline in Africa (Guengant and May 2002). Improvements in health, education, and socioeconomic factors can also catalyze fertility reduction in the region. For example, experiences from Botswana, Kenya, and Zimbabwe show that countries that are making improvements in child survival and women's education have the greatest potential for reducing fertility (Caldwell, Orubuloye, and Caldwell 1992).

Although fertility transition has begun in Africa, it is limited to a few countries; fertility decline across the region remains a distant goal. Even in countries in which contraceptive prevalence is increasing, huge differentials exist by socioeconomic strata, urban-rural residence, and correlates such as female education and autonomy. The stagnation in recent years provides compelling evidence that faltering

policy and resource commitments can easily reverse the gains that have been made in the past.

Family planning remains an unfinished agenda in the region, because high fertility and rapid population growth present a great threat to the achievement of the Millennium Development Goals (Cleland and others 2006). A greater thrust in this direction will be required to sustain and improve the prospects for health and development in Sub-Saharan Africa in the coming decades.

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