Sub-Saharan Africa has the highest total fertility rate in the world, but some countries in the region are undergoing dynamic and unprecedented fertility transitions. Contraceptive prevalence rates, especially for modern contraceptive methods, have increased several-fold in Malawi, Namibia, Tanzania, Zambia, and Zimbabwe. The region is also witnessing changes in the proximate determinants of fertility, including increases in the age of marriage and the incidence of induced abortion. In countries in which the greatest progress has been made, some of the key ingredients of success have been a high level of political commitment, strong country-level institutions, and effective family planning service delivery strategies.

Sub-Saharan Africa has the highest average fertility rate in the world. In 2009 the average number of births per woman was 5.1—more than twice as many as in South Asia (2.8) or Latin America and the Caribbean (2.2) (World Bank 2009). The average contraceptive prevalence (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). As a result of these patterns, the region is growing at a faster rate (2.3 percent) than other regions of the developing world, 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 taking place in the region. Contrary to the popular perception of no or very limited fertility decline, there is evidence of fertility decline in countries across Africa (Cohen 1998). The shift in fertility patterns have implications for policy level planning in all sectors.

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 usage increased in some 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 the analysis of household survey data from Demographic and Health Surveys in 45 countries (all countries for which data from more than one survey during the period were available). 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, including the policy environment, and identifies family planning program inputs 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, method mix, unmet need, and satisfied demand—are showing encouraging progress in some countries of the region. Such changes are often precursors of declines in fertility.

**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 1). Countries in Southern Africa reported the highest levels of contraceptive 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.

**Figure 1. Modern Contraceptive Prevalence Rates in Sub-Saharan Africa, by Country**  
Levels of fertility were high throughout Sub-Saharan Africa during the 1970s. Some indications of the beginnings of fertility transition began to emerge in the following decade. The 1980s heralded declines in fertility in some parts of Africa. Evidence was accumulating that Southern Africa encompassed a zone in which fertility was falling or expected to fall and contraceptive prevalence was high, 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 the 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 across countries continues to persist, 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 particularly stands out. An analysis of fertility trends in 23 countries of Sub-Saharan Africa from 1980 to 1995 showed that in two-thirds of the countries there was evidence of fertility decline, 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 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.

**Figure 2. Trends in Modern Contraceptive Prevalence Rates in Selected Countries in Sub-Saharan Africa**
*Source: Demographic and Health Surveys, various years.*
Comparison of CPRs between the first and the most recent Demographic and Health Survey during the study period (1986–2008) reveal that some countries experienced dramatic increases in contraceptive prevalence within relatively short periods of time. The increases in CPR in Zimbabwe, Zambia, Tanzania, and Namibia were particularly rapid. Mozambique experienced the steepest increase in modern CPR within the shortest time frame in the region: in a five-year period, 1997–2003, its CPR increased more than fourfold, from 5.6 to 25.5 percent. Although other countries reported larger increases, changes occurred over longer time periods. Between the first and the most recent Demographic and Health Survey, all countries reported increases in CPR. Zimbabwe, Zambia, Namibia, Mozambique, and Malawi made the greatest progress.

Changes in CPRs in countries such as Zambia, Malawi, Namibia, and Mozambique were far greater than changes in countries in South Asia, East Asia, and Latin America—largely as a result of the low base from which countries in Sub-Saharan Africa started (figure 3).

**Figure 3. Annual Rate of Change in Modern Contraceptive Use in Selected Countries between First and Last Rounds of Demographic and Health Surveys**
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 family planning programs weak. Traditional methods have a high failure rate compared with modern methods and are therefore not considered an effective mode of contraception.

Trends in method choice show that in many countries of the region, use of traditional methods has declined and use of modern methods increased (figure 4). The use of modern methods has increased most markedly in countries that had the greatest increases in CPR (Zimbabwe, Zambia, Madagascar, Malawi, and Namibia). Traditional method use in these countries has either remained stagnant or has decreased. Uganda, Tanzania, Kenya, and Ghana showed increases in use of modern methods while maintaining use of traditional methods. In Senegal, Togo, Cameroon, Burkina Faso, and Benin, traditional method use declined and relatively modest gains in modern method use were observed.

Figure 4. Trends in Modern and Traditional Contraceptive Prevalence Rates in Selected Countries in Sub-Saharan Africa

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

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 method choices 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, as it indicates demand for family planning services that 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 within the context of contraceptive prevalence, they provide an estimate of the gap between demand and utilization of family planning.

The largest percentage decreases in unmet need were observed in Tanzania, Mozambique, Malawi, Madagascar, and Kenya (figure 5). (Directional trends in unmet need were based on the net change between data obtained from the first and the last survey available in the specified time period.) In most countries in the region, unmet need declined or remained stable. Net increases in unmet need were noted in a few countries, particularly Chad and Uganda, indicating rising demand for family planning that is not being met in these countries. Trends in modern CPR and unmet need indicate that in countries such as Zambia, Madagascar, Malawi, and Kenya decline in unmet need has corresponded with an increase in family planning. In other countries, such as Senegal, Mali, Ghana, and Eritrea the gap has remained wide and consistent.

Figure 5. Unmet Contraceptive Need and Modern Contraceptive Prevalence Rate in Selected Countries in Sub-Saharan Africa

Source: Demographic and Health Surveys, various years.
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 Zambia, Tanzania, Mozambique, and Madagascar (figure 6).

**Figure 6. Satisfied Demand for Contraception in Selected Countries in Sub-Saharan Africa**

*Source: Demographic and Health Surveys, various years.*
Another set of analyses examined trends in total fertility rates (TFR), or the average number of children per woman. In most countries the TFR declined over time; in some countries it remained stagnant (figure 7). The steepest declines in average fertility were observed in Zimbabwe, Namibia, Liberia, Kenya, and Ghana. Other countries, such as Togo, Senegal, and Madagascar, also showed promising declines. The TFR increased or remained constant in a few countries, including Niger, Nigeria, and Mozambique.

Figure 7. Total Fertility Rates in Selected Countries in Sub-Saharan Africa
Source: Demographic and Health Surveys, various years.
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 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. This change may be related to changes in the demand for family size and the failure of family planning programs to meet the latent demand for services. Countries, such as Zimbabwe, that have had strong family planning programs and have improved contraceptive prevalence showed a narrowing of the gap between desired and actual fertility.

Figure 8. Actual and Wanted Total Fertility Rates in Selected Countries in Sub-Saharan Africa
Some countries that made progress in the 1990s started to falter at the beginning of the decade. Stagnation on almost all indicators of fertility, including contraceptive prevalence, satisfied demand, unmet need, and total fertility rates, was evident (see figures 2, 7, 8). 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 Zambia, Tanzania, Malawi and Kenya. Unmet need trends also followed the familiar pattern of decline in the 1990s, followed by stagnation in the 2000s. Total fertility rates also stagnated at the turn of the present decade, especially in Zambia, Kenya, Ghana, and Cameroon. In some countries, such as Uganda and Rwanda, the gap between actual and wanted fertility widened after 2000, a probable consequence of the weakening of the family planning program or a shift in desired family size.

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 reduced 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. There is evidence 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 breastfeeding and postpartum abstinence, decline in pathological sterility) and fertility-reducing trends (rise in age at first union, higher prevalence and effectiveness of contraception) (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). It has been estimated that there are about 14 million unintended pregnancies in Sub-Saharan Africa every year (Hubacher, Mavranzouli, 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 9). Analysis of the relationship between economic growth and fertility indicates that countries with higher CPR also
have higher GDP levels (figure 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).

**Figure 9. Relationship between Women’s Secondary Education and Contraceptive Prevalence Rates in Sub-Saharan Africa**
*Source: Demographic and Health Surveys, 2000–08*

![Figure 9](image)

\[ Y = 7.97 + 0.47X \]
\[ R = 0.61 \]

**Figure 10. Relationship between Annual Percentage Change in GDP and Contraceptive Prevalence Rate, 1990–2009**
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 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 survival may be a necessary condition for fertility decline in Africa (Caldwell, Orubuloye, and Caldwell 1992).

**Figure 11. Relationship between Contraceptive Prevalence Rates and Infant Mortality Rates in Sub-Saharan Africa**

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 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 and others 1998) (box 2). Emerging evidence from Rwanda suggests that major strides in improving family planning uptake can be made if political commitment exists (box 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).

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

Many countries in Africa 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 utilized 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 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 and modest economic growth, 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. However, political commitment is not enough: 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 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 affect 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 are key factors underlying fertility decline in Africa (Guengant and May 2002). Health, education, and socioeconomic factors can also be harnessed to accelerate fertility reduction. 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 program commitments can easily reverse the gains that have been made in the past.

Family planning remains an unfinished agenda in the region, as 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 Africa in the coming decades.
Box 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*, the aim of which was 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 (NGOs). Community-based distribution and social marketing of contraceptives have been effective in increasing coverage.

The combined program efforts of public and private agencies facilitated Kenya's transformation from one 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 (IEC) 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).
Box 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, business community, mass media, NGOs, 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 that 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 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).
Box 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 (ONAPPO) 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 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 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 the fact that several 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.
References


