

Evidence of successful interventions and policies to achieve a demographic transition in sub-Saharan Africa: Ethiopia, Rwanda, and Malawi

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About this report

The K4D Emerging Issues report series highlights research and emerging evidence to policymakers to help inform policies that are more resilient to the future. K4D staff researchers work with thematic experts and the UK Government's Department for International Development (DFID) to identify where new or emerging research can inform and influence policy. This specific report is part of the DFID–K4D Learning Journey on Supporting a Demographic Transition in Sub-Saharan Africa.

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Key messages

- The demographic transition can be initiated before having achieved significant economic growth. The new demographic transition champion countries — Ethiopia, Rwanda, and Malawi — all show that a transition is primarily the result of political commitment and leadership. This is combined with comprehensive population policies that put family planning at the centre by linking it to other policies (education, health, job creation, etc.) and laws (e.g. revision of abortion laws and child marriage laws).
- Female education and a gender lens in employment strategies and interventions are both relevant measures. In the champion countries, policies focusing on female employment have resulted in increased economic participation of women. Higher enrolment of female adolescents in secondary school has contributed to a rise in the age of first marriage and desire for fewer children. However, access to upgraded family planning services is required to support the increased demands.
- Interventions in family planning services should focus on narrowing the gap between the desired number of children and the actual fertility rate of women and couples. In sub-Saharan Africa, both women and men have consistently reported that their ideal family size is smaller than the national total fertility rate. Such interventions must be put in a wider context and should be categorised as ‘direct’ and ‘indirect’: separating the interventions targeting family planning service delivery and demand (e.g. family planning clinics, education in sexual reproductive health and rights, and tackling child and forced marriage) from the enabling environment (political, sociocultural and economic).
- Ethiopia, Rwanda, and Malawi show strong and continued top-level government support and commitment in terms of population and family planning programmes. Support is delivered through a comprehensive approach linking family planning with health, education, and job creation. Decentralisation has increased access to services by bringing the infrastructure closer to the people in rural areas and urban slums.
- Task shifting and working across sectors is a key strategy for reducing unmet need for family planning. The countries addressed different providers (Non-governmental organisations [NGOs] and private sector) to supply contraception (e.g. via social marketing and social franchising). Strong logistics for contraceptive security has greatly reduced stock-outs.
- Building coalitions of support with civil society, community and faith leaders, and inviting them to participate in advisory committees along with experts is key. In particular, engagement with faith leaders has proven to be beneficial.
- In the three countries, high-level advocacy, diplomacy, and support via community programmes by international donors have proved to be effective. Support to create more local ownership of programmes is necessary for sustainability and to improve an integrated approach suited for the specific needs in the country.
- The success of family planning programmes has not been uniform. It depends on several factors, including well-designed and implemented programmes, the availability of quality services and a wide range of methods, flexibility and responsiveness in adapting to local conditions, adequate monitoring and information systems combined with funding sources e.g. from multilateral, bilateral, and NGOs. This all affects the priorities and sequencing of interventions, which are very localised.

Executive summary

This literature review is part of the DFID–K4D Learning Journey on Supporting a Demographic Transition in Sub-Saharan Africa. The review's focus is on the available evidence that can explain the success of new champion countries in sub-Saharan Africa on spurring the demographic transition. This literature review concludes that:

- **Intersectoral approaches** (e.g. integrating family planning programmes with education, health, and economic programmes) and approaches that are embedded and strengthened through legislation (e.g. revision of abortion laws, and child marriage laws) are particularly important to support the demographic transition in sub-Saharan Africa.
- **The demographic transition can be initiated before achieving economic growth.** The transition is primarily the result of political commitment and leadership, combined with comprehensive population policies that put family planning at the centre by linking it to other policies and laws.

Although most African countries are in the phase of a demographic transition, only some have measured a significant decline in fertility rates. Research is clear that the onset of the fertility decline is not only late in sub-Saharan Africa compared with other developing regions, but that the pace in which this happens is slower than expected. Evidence shows that **the desire for children has been, and remains, much more pronounced in sub-Saharan Africa than elsewhere.** Although the desire for more children is higher in sub-Saharan Africa, both women and men have consistently reported that their ideal family size is smaller than the national total fertility rate. **Often couples have more children than they want, which shows the need for upgraded family planning services.**

Ethiopia, Rwanda, and Malawi are used as case studies because these countries' rate of transition has accelerated more than in other parts of Africa recently. **This report will appraise the extent to which the objectives of their population and family planning policies have been realised.** Data is taken from national/country-level and international sources (the United Nations World Population Policies Database, the World Bank's World Development Indicators, and the Population Council), policy documents, research findings, as well as development plan and programme reports.

The champion countries in sub-Saharan African countries show that their achievements to lower fertility rates were underpinned by **significant political commitment and policy changes.** Political commitment went beyond the health sector, and **family planning was explicitly recognised as a key contributing factor to national priorities of gender, youth, women's empowerment, rural development, and improved education.** For example:

- **A focus on gender in employment strategies and interventions,** such as the revision of the Family Law in Ethiopia in the year 2000, eradicated the legal obstacles to women's employment outside the home. In Rwanda, following peace and reconstruction efforts after the 1994 genocide, many policies were put in place to help keep women in work (e.g. three months of paid maternity leave, making it much easier for them to stay in the labour market once they have started a family). Both countries have shown that after this legal change, more women entered the workforce.
- Research also found clear evidence that **stalls in the fertility transition in several sub-Saharan African countries can in part be explained by earlier stalls in the education**

improvement of females that entered the prime childbearing ages around that time (Kebede et al., 2019). Because access to education has improved recently for young women, there could be a renewed acceleration of fertility decline when these women move into childbearing ages. However, for any impact family planning services should be available and accessible for young women.

- **Sub-Saharan African countries are seeing a rise in the age of first marriage, which is linked to the higher enrolment of female adolescents in secondary school** and thus relates to achieving a demographic transition (Hertrich, 2017).

Fortunately, there has been a broader shift in sub-Saharan Africa recently. Political engagement has increased, often related to **the idea of reaping the economic benefits from a demographic dividend, when population growth slows following an accelerated demographic transition**. Donors are becoming more involved in the subject while the young population of sub-Saharan Africa increasingly recognises that their demand for sexual reproductive health information and distribution of contraceptives is not met by the current supply.

Previously, advocates and campaigners needed to look for case studies outside the continent. Now the new champion countries Ethiopia, Rwanda, and Malawi show that **a wide range of direct (e.g. family planning services) and indirect (e.g. job creation and women's empowerment) interventions can deliver upgraded services to the population through improved, transparent and integrated policies and programmes, resulting in a significant voluntary fertility decline that is closer to the desired family size of women and couples**.

There are various drivers that have an impact on the demographic transition, such as income, education, health and urbanisation levels, which help explain differences in demographic trends between countries in sub-Saharan Africa. This literature review will occasionally touch on these drivers, but **the objective of this review is to explain which interventions that support a demographic transition have proven to be working in the champion countries, particularly regarding voluntary fertility declines**.

Although family planning services in many countries in the sub-region are provided for free or subsidised in public sector clinics, (young) women often face several key barriers to access. Amongst others, these include:

- **A lack of information on the benefits of family planning and healthy birth spacing, a lack of access to services, and a lack of method choice**. Unmet need also stems from women who have tried but stopped a modern method, largely because of side effects.¹ Furthermore, there are often long waiting times at public facilities, high transport costs to facilities, and fears of contraceptive-related side effects.
- **Specific barriers related to culture and family traditions faced by women and couples, particularly adolescents**. However, sexually active unmarried adolescents in Africa record higher use of modern methods than married women, partly because their motive to avoid pregnancy is likely to be more intense and because condoms, the main method for them, are easy to obtain (see for example Tsui et al., 2017).

¹ In East Africa nearly half of women's unmet need for family planning services can be linked to women who stopped a modern method largely because of side effects.

Improving access to quality family planning services in sub-Saharan Africa is important to support women and couples achieve their desired family size and avert unintended pregnancies and unwanted births. Access to quality and voluntary family planning services can help address this. Interventions that aim to improve family planning systems in sub-Saharan Africa are not only aiming to reduce fertility, they are also aiming to **embrace longer-term perspectives on improved women's health, educational attainment, and socioeconomic status, with the potential to spur economic development in the region.**

The key findings of this literature review have been framed around three questions.

How to define and design quality interventions?

- **Interventions that aim explicitly to support a demographic transition can be categorised as 'direct' and 'indirect'**, which often means separating the interventions targeting family planning service delivery (direct) from the enabling environment (indirect). This literature review goes further, separating direct interventions into those that focus on improving 'supply' of services and those that focus on 'demand' for services. The indirect interventions are separated by those with a focus on improving the political enabling environment, and those with a focus on the sociocultural and economic enabling environment.
- **In the three champion countries, a broad range of different interventions that support greater empowerment and reducing fertility rates have been integrated within a national population programme and an economic development strategy**, which serves as a vehicle to achieve the goals and objectives of any policy. Multiple government departments are involved and committed to shared goals and common visions. Therefore, it can be concluded that for Ethiopia, Rwanda, and Malawi the policies and interventions were deliberate in their aims to reduce fertility rates through voluntary means; the observed decline in fertility was not accidental. To succeed, coordination and leadership skills are essential, including on the sub-national levels.
- Although the policy aims have evolved, there is clear continuity in family planning service delivery in all three countries over a long period. Since the 1990s it has been recognised that programmes should focus on empowerment (e.g. the choice of how many and when to have children, rights, and responsibilities), and health benefits (Bongaarts et al., 2012; Cleland et al., 2014: 42). **Policies that improve objective conditions for women — i.e. raising their income (such as promoting policies that favour female participation in the labour force) — are important voluntary and sustainable ways to achieve the reductions in fertility** necessary to slow population growth (Pritchett, 1994: 2; Leburu et al., 2009: vii). However, participation may follow rather than precede fertility decline. More recently, there is a shift towards more explicit policy aims of improving access and use of contraception (World Population Review, 2019).
- A mix of direct interventions (e.g. family planning clinics, education in sexual reproductive health and rights, and tackling child and forced marriage) brought together in **a comprehensive family planning policy, in addition to providing guidelines on how to implement and monitor progress has been essential** to the success in Ethiopia, Rwanda, and Malawi.
- Indirect interventions (e.g. social, cultural and economic) are equally important. **Interventions that aim to change sociocultural norms, in particular gender norms, create the enabling environment** in which demand for modern contraceptive methods can

gradually increase. The same can be said about interventions that aim for economic development, in particular job creation in productive sectors and social protection, to secure better-quality and paid employment. Gender parity is relevant, giving women better and equal opportunities in the labour market, and the same level of wage and protection.

- For any interventions, it is important to have excellent design, implementation, monitoring, and finance mechanisms at work. One important feature in the three champion countries is that they started to **ensure gender parity in the design phase**, as research shows that involving males in programmes (demand and supply) is the most successful, although messages have to be targeted using different methods (see for example Tilahun et al., 2015).
- Based on the literature, proportionality and sequencing of both direct and indirect interventions that support a reduction in fertility rates cannot be defined completely. The experience of Indonesia in the 1960s, Bangladesh in the 1980s, and Ethiopia in the 2000s shows that **there is no threshold of socioeconomic development that must be reached before contraception can flourish and fertility decline**. It is futile to anticipate any linear sequence. It should also be recognised that any sequence has to take account of policies/programmes that already exist (state and civil society). The literature, however, is clear that:
 - Demand-side and supply-side interventions in family planning services should both be prioritised in sub-Saharan Africa and could establish a demand-supply dynamic that is needed to improve quality family planning services over time.
 - Short- and longer-term priority interventions need to be combined and implemented with clear and measurable indicators to follow progress with aggregated data by specific groups and regions.
 - Indirect interventions can only be effective in their role to reduce fertility when a well-functioning family planning system is already in place, to increase trust levels and avoid a surge in unmet needs for modern contraceptive methods.

What interventions realise a demographic transition?

- **Ethiopia, Rwanda, and Malawi show strong top-level government support in terms of population and family planning programmes.** For example, the number of children per women in Ethiopia fell from 7 to 4.5, mainly because the government has focused on the **three core areas of health, education, and job creation** by integrated family planning policies in all these areas (Kaps et al., 2018). Decentralisation has also increased access to services for rural populations by bringing the infrastructure closer to the people (for Rwanda see Schwandt et al., 2018).
- **Successful interventions depend on long-term government commitment and political will.** For example, government motivation allowed Rwanda to make impressive gains in contraceptive use; however, contraceptive use is not the goal, but rather a means to “empower the people” (Schwandt et al., 2018), giving a sense of “optimism” (USAID, 2012a). Investment in women and girls — especially adolescents — allowed them to disproportionately benefit from such programmes (Pritchett, 1994; Leburu et al., 2009). The government was heavily involved with achieving gender parity in education in Rwanda.
- **Policies addressing broader determinants of fertility such as delaying marriage** (through law or behaviour change) and improving abortion safety and revising abortion laws are also recommended to achieve voluntary fertility decline closer to the desired family size for women and couples.

- **Task shifting and working across sectors is a key strategy for reducing unmet need for family planning.** The countries addressed different providers (NGOs and private sector organisations) to supply contraception (e.g. via social marketing and social franchising).
- **The countries also trained community health workers to deliver basic services and provide modern contraceptive methods to the people.** This is only possible when family planning programmes are integrated within a wider health system strategy. For example, Ethiopia is unique in training a new cadre of government health workers, the Health Extension Workers (HEWs), to staff rural health posts. Furthermore, integrating family planning in health services increases the outreach to people in postpartum care, immunisation services, and HIV/AIDS services.
- **Strong logistics for contraceptive security has greatly reduced stock-outs in Ethiopia and Rwanda.** However, in Malawi, value chain management is less strong which has resulted in stock-outs mainly in rural areas, which could also explain the country's higher unmet demand for family planning services.
- **Youth-specific family planning services are necessary to overcome special barriers that adolescents face to access contraception.** The three countries have a strong focus on improving the family planning services for adolescents (girls and boys), consulting them for improvements in service delivery, and establishing youth-led campaigns via mass media and interpersonal communication. For example, the Smart Start programme has identified the wedding "seasons" as key months for promoting adolescent contraception in Ethiopia (Appleford et al., 2019).
- **Building coalitions of support with civil society, community and faith leaders is key. One way to do this is by inviting them to participate in advisory committees along with experts.** In particular, engagement with faith leaders has proven to be challenging, but examples from the champion countries show that it is possible, particularly in Ethiopia and Rwanda. For example, in Rwanda faith leaders signed a common declaration of support for family planning and HIV prevention policies. In Rwanda health centres run by Catholic NGOs, often have a state clinic close-by to ensure supply of all methods. Malawi does not have the capacity to do this and is struggling with the integration of family planning services within health centres run by Catholic organisations.
- **Communication is important to reach out and engage with the people, in particular for changing social norms, behaviour, and demand for modern contraceptive methods.** Mass media is often used in the form of radio, television and more recently digital platforms. Studies show that they are most effective when combined with other intervention components, such as social marketing or interpersonal communication interventions. Community dialogues are a traditional and important tool for interpersonal communication, however, new tools are increasingly used through mobile phone use (e.g. SMS services).
- **Family planning programmes need to be linked with interventions in education, health care, and better-quality job creation for both men and women,** although gender parity is an important objective in education and employment interventions. The more that women are empowered through better education (quality learning should be the main objective, not only enrolment), health, paid work, and access to finance and social protection schemes, the higher the chances that they will use modern contraceptives to space births and desire smaller families. However, this is only possible when family planning service delivery is reliable in all regions of the country.
- **For a better understanding of what impact interventions have on specific groups (e.g. rural girls) interventions must be monitored and evaluated through manageable**

information systems. Better quality data and analysis should be a focus for governments and donors. Demographic health surveys (DHSs) are the main sources of information used for family planning data, e.g. contraceptive prevalence rate (CPR). Rwanda also uses the National Educational Statistical Information System to collect and analyse data by gender.

- **The family planning system in the three countries is hugely dependent on donors. International donors can also support the coordination in health system reform, in which family planning is embedded. High-level advocacy, diplomacy, and support via community programmes have all proved to be effective.** Support to create more local ownership of programmes is also necessary for sustainability and to establish an integrated approach suited for the specific needs in the country. One way to do this is through the increased local mobilisation of resources, which need support for public financial management reforms.

What are the lessons learned from interventions?

- **The encouraging experiences of Ethiopia, Rwanda, and Malawi challenge the widely held assumption that a decline in fertility must be preceded by sweeping economic and educational advancement,** and offers other useful policy and programmatic lessons for other low-income countries, especially in sub-Saharan Africa (Grant & Bhardwaj, 2016: 5).
- The success of family planning programmes has not been uniform (DaVanzo & Adamson, 1998). **Success depends on design and implementation, flexibility, and responsiveness in adapting to local conditions. A mix of political will, generous donor support, non-governmental and public-private partnerships, and the government's establishment of a network of HEWs have all proven to be important.**
- **Interventions need a strong gender lens and need adolescent-friendly services integrated within broader health and family planning programmes.** It is far more difficult for governments to reach out to adolescents in general, and some specific groups in more remote areas or city slums. For example, men could be organised into different sub-groups: singles, married, military, urban, rural; then targeted with different messages and media (Republic of Rwanda Ministry of Health, 2006). To reach different community members, dialogues with religious leaders and community meetings are necessary (Muhoza, 2014).
- **Tradition and culture are important success factors as they respond differently to contraception adoption and then also to contraceptive use.** However, differences in contraceptive uptake may be due to regions running stronger and more efficient programmes than others, creating a difference in access, costs and acceptability of contraceptive services (Muhoza, 2014: 10-11).
- **Due to the complex nature of fertility behaviour, risks include poor programme delivery or operational issues,** hence the importance of technical working groups (de Silva and Tenreyro, 2017).
- **There are gaps in the literature regarding proportionality and sequencing of interventions.** The literature points to a number of effective approaches, notably: empowerment of girls; community approaches to change social norms and attitudes; and alternative opportunities (particularly increasing education and income generation). Legislative approaches (e.g. maternity pay and abortion law revision) also appear to be effective. However, different methods from different countries need to be selected and implemented together in order to bring about sustained change.

Introduction

Although in many developing countries a further decline in infant mortality and fertility rates is expected, population growth projections over the coming decades point to higher population growth in Sub-Saharan Africa and South Asia. Both regions will continue to have the highest concentration of young people in the years to come, and the average age gap between these regions and the rest of the world is expected to increase as most other regions' fertility rates stabilise at a low level (FAO, 2017). Sub-Saharan Africa's population is projected to grow from 840 million people in 2010 to nearly 1.4 billion in 2030 (UN, 2017). According to the 2019 revision of the United Nations World Population Prospects,² the population of sub-Saharan Africa was just over 1 billion in 2018. **With the current population growth rate of 2.3%, the UN predicts a population between 2 and 2.5 billion by 2050 for the region.**

These numbers somewhat hide the fact that **most sub-Saharan African countries are actually in the process of a demographic transition towards lower fertility rates.** Some countries show a more advanced decline, mostly in Eastern Africa (e.g. Kenya, Rwanda, Ethiopia and Malawi), while others, mainly in the Sahel region and central regions of Africa (e.g. Niger, Chad and the Democratic Republic of Congo) have started the transition later and at a much slower pace. In terms of the prospects for fertility decline in sub-Saharan Africa, the overall stance was an expectation that "most of sub-Saharan Africa was on the cusp of a rapid and pervasive revolution in reproductive behaviour, resembling what had occurred in Asia and Latin America in the preceding four decades" (Casterline, 2017). However, with some exceptions, **evidence shows that this has not been the case so far, as desire for children has always been, and remains, much more pronounced in sub-Saharan Africa than elsewhere.**³

These demographic trends are relevant for a better understanding of (and to diagnose) future development pathways. **There is a relation between the demographic transition and economic transformation of countries.** Although still contested, better economic prospects could result in higher incomes for households, which could generate higher tax revenues to invest in public services (e.g. health and education), to trigger fertility decline. However, the literature shows clearly that the relation between higher incomes (economic growth) and the demographic transition is far more complex than this and unfolds differently per country (Schultz, 2015). Furthermore, there is wide speculation of a demographic dividend (falls in the dependency ratio, resulting from fertility decline impacting on economic growth) for countries that manage to decrease fertility rates significantly over time (Groth & May, 2017; Karra et al., 2017; Bloom et al., 2017).⁴ Recently, it seems that the prospect of a demographic dividend has influenced policymakers in sub-Saharan Africa to act on population policies that openly aim for fertility rate decline (May, 2017).

² Overall total population – *World Population Prospects: The 2019 Revision* retrieved from population.un.org

³ Data from Demographic and Health Surveys (DHS): <https://dhsprogram.com/data/>

⁴ The literature mentions two demographic dividends due to lower fertility rates. The first dividend is the product of a decline in fertility that reduces the growth rate of the population of children. The more rapid the decline in fertility, the larger the dividend, because fewer children leads to a rise in household investments in education and health of children as increased savings provide the resources to allow parents and societies to make such investments. The second dividend is reaped when these children enter the labour force as more productive workers.

Drummond et al. (2014) estimate that a 1% increase in the working-age population increases real GDP growth per capita by 0.5%. **However, the demographic dividend remains negligible if fertility rates decline only modestly or if the labour market is unable to absorb the new workers in productive activities.** In Africa, 10-12 million young people enter the labour market each year, but only 3.1 million new formal jobs are being created (AfDB, 2016). The relevance of the demographic transition in sub-Saharan Africa does not only relate to economic growth, incomes and jobs, but also to issues of urbanisation, food security, environmental protection and climate change, and in that regard to the future stability of the region.

This literature review aims to focus on and **understand the processes, policies and investments that supported sustainable demographic transitions in the champion countries** of the region and learn from them in the sub-Saharan African context. The research question is:

What is the evidence from countries that have achieved significant fertility rate declines in sub-Saharan Africa on their direct interventions (e.g. family planning, girls education, tackling harmful social norms such as early, child, forced marriage, etc.) and indirect interventions (e.g. cultural and economic interventions) that can explain their success in a demographic transition?

It seems from the literature that there is a momentum building for policies and interventions in the continent that go beyond the emphasis on the reproductive health dimensions of family planning; **programmes' priorities have focused more recently on satisfying the unmet need for contraception and voluntary birth limitation by providing a mix of methods and services to meet diverse demands.** The debate about the economic prospects of fertility decline has helped rekindle national policymakers' and donors' interest in voluntary fertility reduction and family planning programmes (Cochrane & Merrick, 2015 May, 2017).

This report has three parts. The first part frames the research question by looking at the specifics of the demographic transition in sub-Saharan Africa. Then it defines the different interventions used to support a demographic transition. Part two focuses on the evidence of how champion countries, such as Ethiopia, Rwanda, and Malawi, have achieved the transition from the perspective of government and donor interventions. Finally, in part three, this report highlights lessons learned from the champion countries for other countries in sub-Saharan Africa.

The methodology for this literature review is based on the process of snowballing; sourcing references using reference lists from identified sources. The report combines evidence from academic articles and papers, with evidence published in grey literature. Academic evidence has been sourced through using academic databases and Google Scholar, and grey literature has been sourced through Google and opensource databases, such as the World Bank and the United Nations.

Part I. Framing and defining subjects and interventions

1. Framing the demographic transition in sub-Saharan Africa

Demographic transition model

Demographers use the Demographic Transition Model to explain the stages of population growth a country goes through, based on historical population trends of birth rate (annual births per 1,000 people) and death rate (annual deaths per 1,000 people).⁵ **Historically countries started at stage one in which both birth rates and death rates are high, resulting in fairly low population growth, but with major swings with events such as wars or pandemics.** No countries are in this stage anymore, because of the introduction of modern medicine that has lowered death rates, especially among children, even in the poorest countries.⁶ **Today, many of the least developed countries are in stage two in which death rates gradually decline while birth rates remain high, resulting in rapid population growth.**

It is in stage three where birth rates start to decrease gradually along with a further decline in the death rates, as families choose to have fewer children. This is where the fertility transition kicks in. Fertility transition, also known as fertility decline or fertility revolution, refers to one part of the demographic transition and is defined as a shift from high to low levels of fertility (number of children per woman), combined with the shift from a natural fertility regime to fertility controlled by the use of contraceptives and abortion, usually combined with the reducing mortality rates, improved economic conditions and education levels (Easterlin & Crimmins, 1985). **In stage three population growth continues but at a lower rate. Most developing countries are currently somewhere in this stage.** It is in stage four that the population stabilises again with low death rates and fertility rates around two children per woman. Some countries could even enter stage five of a declining population if the fertility rates fall below the replacement level of two children per woman and the elderly population is greater than the youthful population.

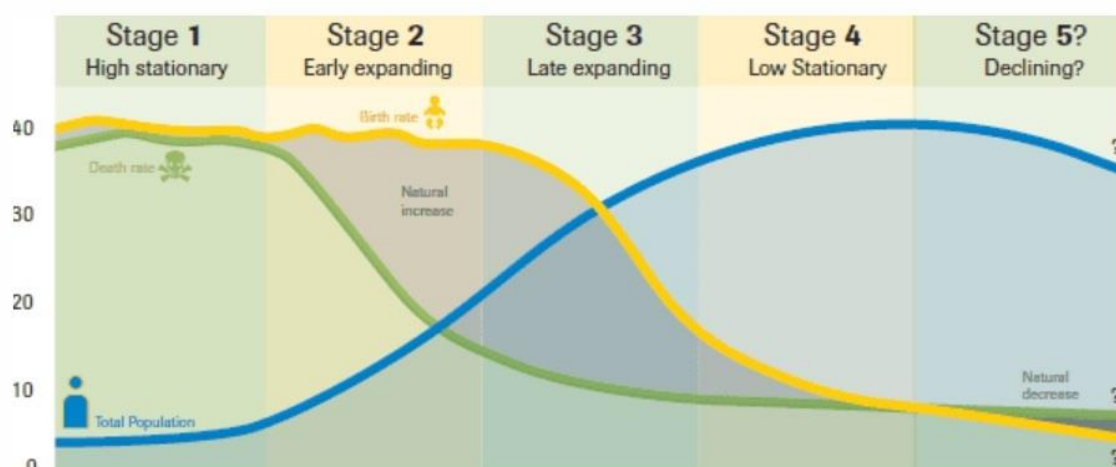
The model is often used to explain population dynamics and support countries through the specific stages of the demographic transition. However, **the model does not include the impact of other demographic variables such as migration. Importantly, neither the model can predict how long a country will be in each stage.**

This report focuses mainly on the interventions that aim to achieve a demographic transition in the context of sub-Saharan Africa modelled around family planning services as most countries are currently in stage two and three (initial stages of the fertility transition), resulting in high population growth and a youthful population (see Figure 1).

⁵ See for example https://papp.iussp.org/sessions/papp101_s01/PAPP101_s01_090_010.html

⁶ See information on each stage in the demographic transition model <https://populationeducation.org/what-demographic-transition-model/>

Figure 1: Stages of the Demographic Transition Model



Source: Grover (2014, October 13).⁷

Fertility dynamics in sub-Saharan Africa

Bongaarts and Casterline (2013) and Shapiro and Hinde (2017) show that **fertility decline in sub-Saharan African countries has not only started later but also has been comparatively slow relative to countries in Asia and Latin America**. The current average fertility rate for all sub-Saharan African countries is around 5 births per woman (Gerland et al., 2017) and 30% of women use modern methods of contraception (Cleland & Potter, 2019).

The data as presented by Shapiro and Hinde (2017) show that peak quinquennial decline in the total fertility rate (TFR) in sub-Saharan Africa is about 0.3, compared to peak declines in earlier years almost twice as large (and for a sustained time) in Latin America, and even more substantial declines (albeit of shorter duration) in Asia and Northern Africa. The slower pace of fertility decline in sub-Saharan Africa can also be measured through the time it took for the region to lower the TFR by 10% compared with the year it had reached peak fertility. **It took sub-Saharan Africa 20 years following peak fertility before the TFR for the region had declined by 10%, while the interval was only 10 years for both Asia and Latin America, and 15 years for Northern Africa** (Shapiro & Hinde, 2017). After 35 years of fertility decline (on-set of fertility transition), sub-Saharan Africa's TFR was at 75% of its peak value. In the three other regions, after 35 years of fertility decline, the TFR ranged between 44% and 50% of its peak value (Shapiro & Hinde, 2017).

Yet there is "considerable variation among countries in sub-Saharan Africa: in the duration and magnitude of fertility decline, whether stalls in fertility decline have occurred, shifts in the timing of births, and even the economic and population subgroups that have led declines in family size," as cited from Gerland et al. (2017: 21).

- **Sub-regions of sub-Saharan Africa:** The data as presented by Gerland et al. (2017) show that in Southern Africa fertility rates declined already since the 1950s and have become the

⁷ From "What is the Demographic Transition Model?", blog, by PopEd, 2014, October 13. (<https://populationeducation.org/what-demographic-transition-model/>). © 2020 Population Connection. Printed courtesy of Population Connection, www.populationeducation.org.

region with by far the lowest TFR. Both Western and Eastern African regions started approximately at the same time at the start of the 1980s the process of declining TFR. However, the pace of decline is much faster in Eastern Africa than in Western Africa. The Central African region was the latest to start the transition in the 1990s and although the pace of decline is higher than in Western Africa, the region has still the highest TFR for the region (Gerland et al., 2017).

- **Country specifics:** Population data shows that the sub-regional fertility levels mask diverse levels among countries and the timing of the transition. Gerland et al. (2017), for example, mention that in Eastern Africa it was Réunion that started the transition already in the early 1950s while Somalia started in the late 1990s. In Western Africa, Cabo Verde started the transition in the early 1960s while Niger started in the late 1990s. Peak TFR is also different, with Kenya and Rwanda having had the highest with over eight birth per woman, while other countries like Equatorial Guinea and Gabon started with a peak TFR below six. Gerland et al. (2017) show for the 2010-2015 period that:
 - In **Western Africa**, total fertility ranged from 2.4 in Cabo Verde to 7.6 in Niger. Also, Mali has a fertility level of more than six births per woman. Burkina Faso, Côte d'Ivoire, Gambia, Guinea, Nigeria, and Senegal all have TFR between five and six. The other seven (e.g. Ghana, Benin, Sierra Leone) measure between four and five births per woman.
 - In **Eastern Africa**, Ethiopia, Kenya and Rwanda have the lowest TFR between four and five births per woman (not including Mauritius and the other small island states that have less than 3 TFR), while Somalia and Burundi measure above six births per woman. The other countries (e.g. Tanzania, Uganda, Malawi) have TFR between five and six.
 - In **Central Africa**, the largest countries Angola, Chad, and DR Congo have fertility levels of six or more births per woman. All other countries (e.g. Cameroon, Gabon, Congo) have fertility rates between four and five.
 - In **Southern Africa**, the gap is narrow, with 2.4 births per woman in South Africa and 3.6 in Namibia. Also, Botswana has a fertility rate below three births per woman.

In Angola, Gambia, and Uganda, a 10% decline from the maximum fertility level took 40 years; and in Lesotho, Mozambique, Niger, and Tanzania, it took 30 to 35 years. Overall declines from the country-specific maximum fertility level to the level in 2010–2015 were very slow in Angola, Congo, Gambia, Mali, Mozambique, Niger, Nigeria, Uganda, and Tanzania, where average fertility declines were 0.2 children per woman or less: **a pace at which it would take at least 25 years to realise a decline of one birth per woman** (Gerland et al., 2017). Only some countries in sub-Saharan Africa experienced an acceleration of fertility decline with a pace like Latin America and Asia (a decline of one birth per woman in five years), however, mostly for a very short period and only during the early-transition phase for Eastern African countries Djibouti, Mauritius, Mayotte, Réunion, Rwanda, Seychelles, and Zimbabwe (Gerland et al., 2017).

- **Differences within countries:** The next step is to understand how fertility varies within countries amongst regions and groups. In the literature three ways are mentioned to measure this (Eloundou-Enyegue et al., 2017):
 - **Differentials** (static and partial measure) refer to the difference in group-specific averages; for instance, how the average fertility rate of urban women differs from that of rural women.

- **Inequality** (static and full measure) integrates information about both group rates and group size: a group's contribution to inequality thus depends on how far it deviates from the average but also how large it is.
- **Divergence** (dynamic measure) is the historical dimension of inequality, whether or not it rises over time.

Research shows that indeed for sub-Saharan Africa, **fertility inequality is relatively high compared with other continents, which can be primarily explained by the early stage in the fertility transition of most countries in the region**, which is characterised by higher fertility inequality (Eloundou-Enyegue et al., 2017). Data shows that fertility inequality rises sharply at the very start of the transition, but over time there is a deceleration of inequality. Fertility inequality grows mostly because more educated women increasingly separated themselves from the rest of the population (Eloundou-Enyegue et al., 2017; Kebede et al., 2019). Even in countries that have experienced fertility decline stalls over time, continue to experience rising fertility inequality. To cite Eloundou-Enyegue et al., (2017: 75): “[T]he stalls are not a collective experience; rather, the vanguard groups pursue their decline even as the rest of the national population stalls. This momentum in the process of divergence has important implications for demographic dividends and the extent to which these dividends are shared.”

Access to free family planning services is next to education also an important explanation for differentials, inequality and divergence. Particularly in initial stages access to free family planning services is not equal to all, for example with remote rural areas often neglected or underserved (Finlay et al., 2018). Hence, the poorest groups in African society mostly regulate fertility still via breastfeeding (Finlay et al., 2018).

Putting the fertility decline into perspective

What the above section has shown is that fertility levels in sub-Saharan Africa generally started to decline later and at a slower pace than in other developing regions. For some African countries TFR has even stalled in mid-transition, “a pattern that has rarely been observed elsewhere” (Bongaarts, 2017a: 39). This raises the question, why is sub-Saharan Africa different? The Demographic Transition Model as mentioned above suggests that socioeconomic indicators could be important to explain the course of the demographic transition. **The obvious explanation is that lack of sufficient socioeconomic development in many sub-Saharan African countries can explain the late and slow pace of the demographic transition in the region.** Bongaarts (2017a) shows this with four socioeconomic indicators (GDP per capita, education, life expectancy, and urbanisation). For example, **the slow pace of the transition after the onset is in line with a slow pace of increasing levels for each of the socioeconomic indicators in sub-Saharan Africa compared to non-African Least Developed Countries (LDCs).**

Kebede et al. (2019) conclude the same by analysing female education. They found that **stalls in the fertility transition in several sub-Saharan African countries can in part be explained by earlier stalls in the education improvement of females that entered the prime childbearing ages around that time.** Because education has picked up for young women recently, Kebede et al. (2019) are optimistic for a renewed acceleration of the fertility decline when these women move into the main childbearing ages. Overall, **sub-Saharan African countries see a rise in the age of first marriage, which in particular relates to higher enrolment of female adolescents in secondary school. Furthermore, this rise in the age of first marriage is**

strongly correlated with declining TFR in sub-Saharan Africa (Hertrich, 2017). This shows the importance of intersectoral policy interventions.

Interestingly, research results not only refer to a late onset of the fertility transition (sub-Saharan African countries compared to non-African LDCs), but also that this happened with lower socioeconomic levels as expected. This is explained with reference to older research (Bongaarts & Watkins, 1996) that concluded that **the role of diffusion of ideas and social influence at the individual, country, and global level is another (and maybe more important) factor to explain the transition in different regions and countries**. This diffusion is often largely independent of social and economic changes; the literature shows that particularly the diffusion of ideas about birth control from non-African countries to Africa appears to have resulted in an earlier African onset of the fertility transition than would have been the case without diffusion (Bongaarts & Watkins, 1996; Cleland & Potter, 2019; Bongaarts, 2017a).

In addition, **research shows that the adoption of voluntary family planning programmes (politically and culturally) could be slower and less pervasive in sub-Saharan Africa than in other regions of the developing world**. Bongaarts (2017a, 2017b) shows that at a given level of development Africa's fertility is always higher, contraceptive use is lower, and desired family size is higher than in non-African LDCs. The reasons for the relatively high preferences lie in 'traditional pronatalist social, economic, and cultural practices' and reluctance of policy-makers in many sub-Saharan African countries to invest in family planning and explain the benefits of smaller families (Bongaarts, 2017a: 55).

The data shows that **women in sub-Saharan African countries have a preference for fewer children, but the preference is still high in comparison with non-African countries, which could explain the slower pace of the transition**. However, some countries have seen a rapid reduction of the desired number of children (e.g. Rwanda, Kenya, Malawi), even in Central and Western Africa (with the exception of some countries in the Sahel region) there is a change in the desired number of children (Casterline & Agyei-Mensah, 2017). To cite Casterline and Agyei-Mensah (2017: 106): "High fertility desires are undoubtedly an obstacle to fertility decline in the region, but it does not follow that reducing these desires alone will have much impact on fertility."

Their research shows that **'meaningful fertility decline' is only the result when the desire for fewer children (demand-side) is accompanied by effective implementation of these desires through access to contraception services (supply-side) and sociocultural and economic changes (enabling environment)**. High demand for children and ineffective implementation of preferences to terminate childbearing (i.e. unmet need for effective contraception among women who do not want a child soon or want no more children) are both factors that sustain high fertility in Africa. Hence, "reduced demand for children and more effective fertility control should not be regarded as competing alternatives, rather they are inter-dependent and reinforcing drivers of fertility decline" (Casterline & Agyei-Mensah, 2017: 108).

A study by Singh et al. (2017) indeed confirms that meeting the existing need for effective contraception in sub-Saharan African countries by shifting toward a more effective mix of family planning services (e.g. contraception) would have a 'notable impact' on fertility. This could result in between 35 and 40 fewer births per 1,000 women. Therefore, **to effectively promote effective contraceptive use, policies and programmes must address both the demand and supply side** (Singh et al., 2017).

However, **under the current trends, the fertility decline in sub-Saharan African countries has been too slow to force a change in age structure in the population that triggers significant socioeconomic progress or a demographic dividend.** Cleland and Machiyama (2017: 284), therefore, conclude that for the next 35 years with continued growth in numbers of births this has significant implications for:

“pressure on health and education services; the need to feed a population that will double in size; the danger that rapid urbanization will outstrip efforts to improve living conditions; the challenges of employment and productivity for an adult population that will be 2.5 times larger in 2050 than today; and the prospect of mass migration within the region due to Malthusian factors or chronic failure of some countries. None of these implications represents insuperable barriers to progress but, considered together, they underscore the magnitude of the task ahead”.

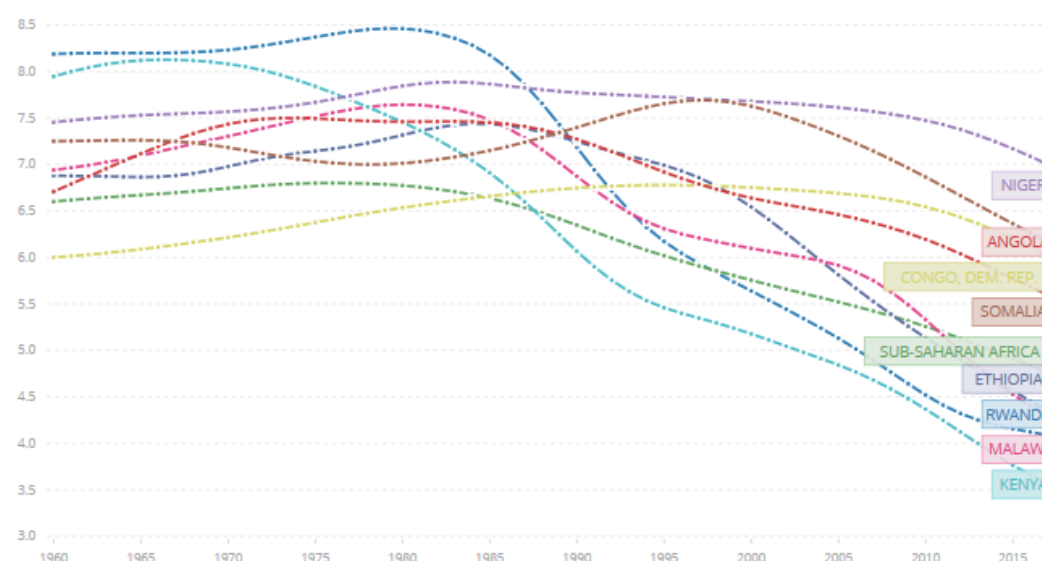
Why policy matters

The sections above clearly showed that, in general, a significant decline in fertility goes hand in hand with strong government policies, programmes and voluntary incentives. This was mostly the case in Asian countries, although not always linked with strong demand, with the exception of China and Vietnam, which used forms of non-voluntary family planning policies (Cleland & Potter, 2019). There is also evidence of the relationship between strong government commitments resulting in fertility reductions in specific periods for countries in Latin America (e.g. Mexico) and North Africa (e.g. Tunisia and Egypt). However, NGOs also played a role in Latin America in places where governments were reluctant to provide sexual reproductive health and abortion services (Cleland & Potter, 2019). **It is mostly in sub-Saharan Africa where widespread demand and strong government actions are both lacking** (Cleland & Potter, 2019; May, 2017). However, this is a generalisation, as some countries show strong government commitments resulting in higher demands for family planning services. Historically these were South Africa and Kenya. More recently Ethiopia, Malawi, Rwanda and Zambia are often mentioned as champions (Cleland & Potter, 2019; May, 2017).

Interestingly, the new champions are not the countries with the highest GDP per capita, but some of the poorest countries in sub-Saharan Africa. In these countries fertility rates have declined, and the use of modern contraceptive methods among women have risen, while gains in life expectancy and health have been achieved (see Figure 2, 3 and 4). The lesson from these countries is that “determined government initiatives can bring about rapid reproductive change as part of a wider agenda of health improvements, educational expansion and economic vibrancy” (Cleland & Potter, 2019). In other words, it is clear from the research that when incentives to use and supply modern contraceptive methods are weak, it contributes to slow transitions in much of the continent. By contrast, **in the few countries where governments have made this a priority, rapid uptake of contraception and fertility decline has followed.**

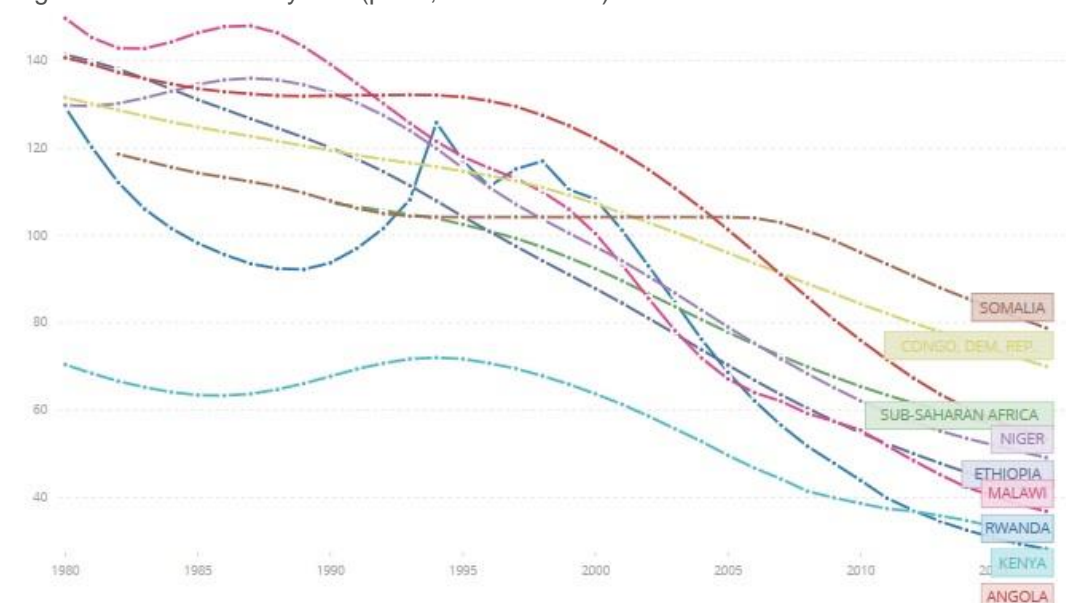
As the evidence shows, **success will depend above all on political will and sound governance to increase reproductive health and rights services in combination with women’s empowerment and aligning population policy with other socioeconomic policies and interventions.** Therefore, this report focuses on the champion countries to better understand what policies, programmes and incentives they have used, mainly for Ethiopia, Rwanda and Malawi, but also for other sub-Saharan African countries.

Figure 2. Fertility rates (births per woman) for selected countries in sub-Saharan Africa



Source: Authors' own.⁸

Figure 3: Infant mortality rate (per 1,000 live births) for selected countries in sub-Saharan Africa

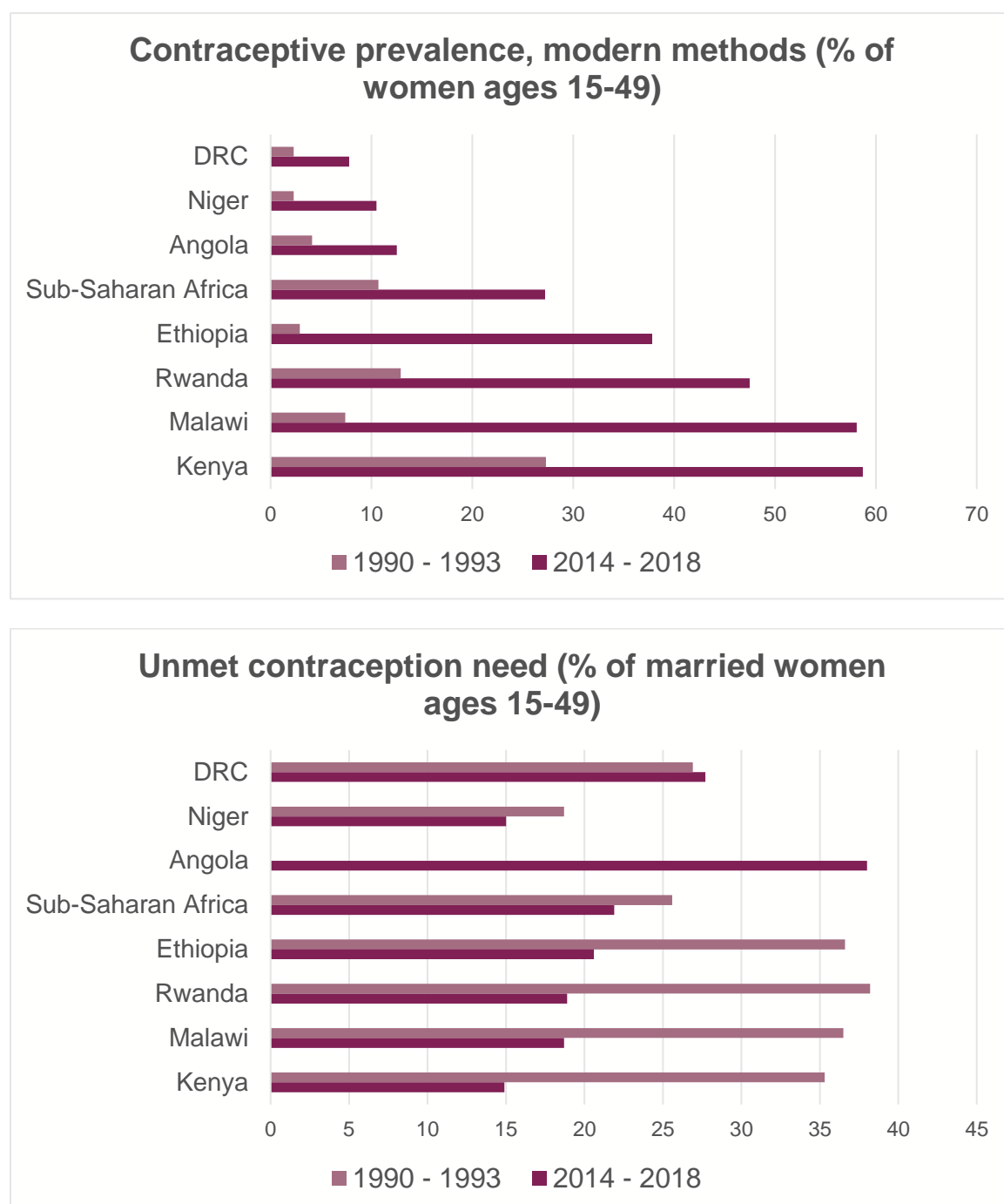


Source: Authors' own.⁹

⁸ Based on data from the World Bank: Dataset: Fertility rates (birth per woman). Data set source: (1) United Nations Population Division. World Population Prospects: 2019 Revision. (2) Census reports and other statistical publications from national statistical offices, (3) Eurostat: Demographic Statistics, (4) United Nations Statistical Division. Population and Vital Statistics Report (various years), (5) U.S. Census Bureau: International Database, and (6) Secretariat of the Pacific Community: Statistics and Demography Programme. Retrieved from <https://data.worldbank.org/>. Accessed February 2020. CC BY 4.0 license.

⁹ Based on data from the World Bank: Dataset: Mortality rate, infant (per 1,000 live births). Data set source: Estimates developed by the UN Inter-agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA Population Division) at childmortality.org. Retrieved from <https://data.worldbank.org/>. Accessed February 2020. CC BY 4.0 license.

Figure 4: Contraception use and unmet need in selected sub-Saharan African countries



Source: Authors' own.¹⁰

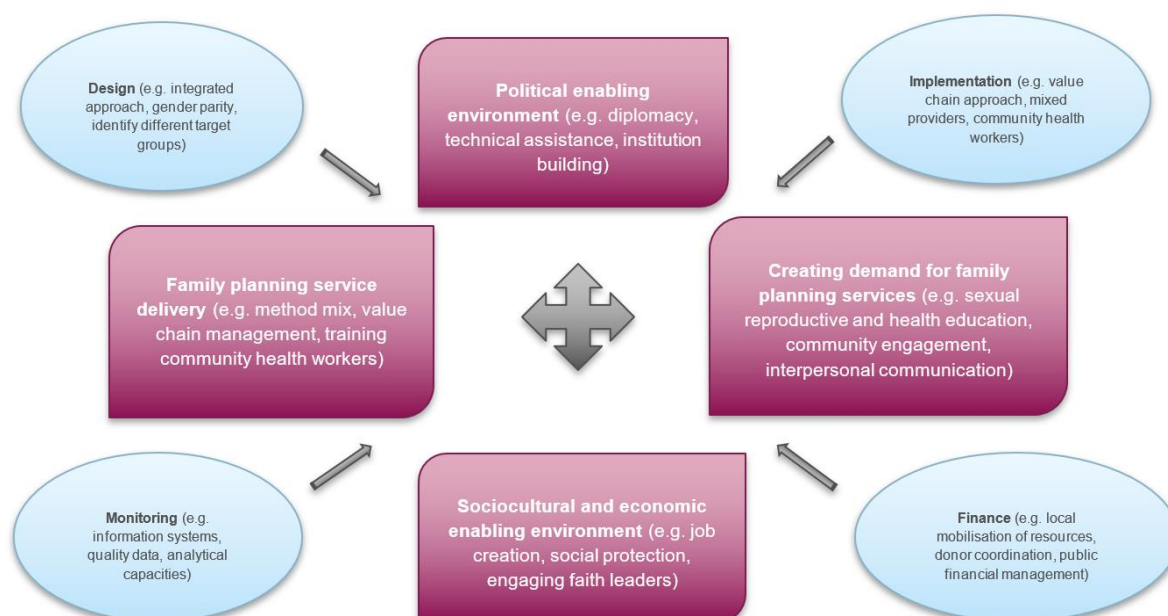
¹⁰ For some countries, no data is available between 1990-1993. The earliest data from Ethiopia is from 2000, Sub-Saharan Africa 2000, DRC 2007 and no earlier data is available for Angola. Based on data from the World Bank: Far left figure: Dataset name: Contraceptive prevalence, modern methods (% of women ages 15-49). Data source: Household surveys, including Demographic and Health Surveys and Multiple Indicator Cluster Surveys. Largely compiled by United Nations Population Division. Far right figure: Dataset name: Contraceptive prevalence, modern methods (% of women ages 15-49). Data set source: Household surveys, including Demographic and Health Surveys and Multiple Indicator Cluster Surveys. Largely compiled by United Nations Population Division. Retrieved from <https://data.worldbank.org/>. Accessed February 2020. CC BY 4.0 license.

2. Defining interventions

Interventions to support a demographic transition come in many forms. This literature review focuses mainly on interventions that support a decline in fertility. Such interventions can be categorised into direct and indirect interventions. Direct interventions are the ones that target fertility outcomes, such as family planning services or sexual and reproductive health education, while indirect interventions are aiming at broader development outcomes (e.g. gender parity in education, healthier people, and better-paid job creation), which have high correlations with fertility rate declines. In the literature, direct interventions are often related to the supply of and demand for family-planning services. Indirect interventions are often associated with the improvement of the enabling environment in which supply and demand can increase.

Furthermore, as this literature review will show, intersectoral approaches (e.g. integrating family planning programmes with education, health, and economic programmes) and approaches that are embedded and strengthened through legislation (e.g. revision of abortion laws and child marriage laws) are particularly important. A better understanding of proportionality and sequencing of specific sets of interventions are particularly important for governments and donors. However, there is no consensus as it depends very much on local circumstances. The interplay between direct and indirect interventions, and between supply-side and demand-side interventions, is often the difference between successful and less successful interventions regarding fertility outcomes. As this review will show in more detail, interventions that support social, economic and cultural norms changes are important for creating an enabling environment in which women are empowered and in which the acceptance of modern contraceptive methods can surge; both positively related with strong fertility decline. However, the other side of the coin is when this acceptance and increased demand for modern contraceptive methods is not met with reliable services, such as out of stock methods, low capacity and motivated health workers, and no differentiation between target group approaches.

Figure 5. Conceptual framework of interventions in support of a demographic transition



Source: Authors' own.

As Figure 5 shows, a combination of different approaches (targeting a political enabling environment, sociocultural and economic enabling environment, family planning service delivery, and demand for modern contraceptive methods) is necessary, although the proportionality of the intervention mix can be different between countries due to country-specific circumstances.

Finally, as for all interventions, the figure also shows that it is not only the interplay between the different interventions that are important in the support of fertility decline but also the quality of the intervention, as specified in the design, implementation, monitoring, and finance components.

Part II. Key interventions for achieving a demographic transition: what do we know

3. Strong government involvement

Top-level commitment and leadership

Sub-Saharan African leaders and policymakers have traditionally deprioritised population and family planning issues for several reasons.

- Their views on fertility have been affected by **traditional cultures and social norms**. As May (2017: 311/312) explains, “African leaders’ attitudes are framed by their relationship with their people and their ethnic groups as well as local social institutions”.
- Many African leaders have **perceived large populations to be socially, economically, and politically advantageous** (Khandan & Pritchett, 2017) and often emphasise the low population density in Africa (May, 2017).
- African policymakers often refer to **economic growth as the main pathway for declining fertility, not family planning** and underestimate the implications of population growth for economic development (May, 2017).

Even African leaders who are convinced of the validity of the rationale to curb high fertility levels might decide not to intervene because they do not want to antagonise their constituencies and create unwanted political problems due to sociocultural and religious sensitivity. In such situations, they can rarely muster the political will and courage to counter entrenched views. However, **there are signals that African leaders and policymakers are showing changing attitudes and show more commitment and leadership on the topic of reducing fertility** due to the prospect of the demographic dividend, widely advocated by the African Union (May, 2017).

Although some scholars use the example of Latin America for a more bottom-up approach where authorities were reluctant to facilitate family planning, it is significant to mention that **all champion countries in sub-Saharan African countries (long-term champions such as Botswana and Kenya, and more recent champions such as Ethiopia, Malawi and Rwanda) show that their achievements to lower fertility rates were underpinned by significant political commitment and policy changes**. In these countries, political commitment went beyond the health sector, and family planning was explicitly recognised as a key contributing factor to national priorities of gender, youth, women’s empowerment, rural development, and improved education (USAID, 2013a).

Many Ethiopian leaders, including the Prime Minister and Minister of Finance, were concerned with the rate of population growth. Prime Minister Meles Zenawi was looking for a way to improve the country in the wake of a number of challenges including the war with Eritrea, prolonged drought, and food shortages in specific regions (USAID, 2012a: 11). He appointed Dr Tedros, a dynamic leader, to the post of Minister of Health in October of 2005, which led to many positive changes, including a major **expansion of the Health Extension Programme**, and focused on increasing the quality of the family planning programme through training, logistics, and management, resulting in the creation of **HEWs**. In Ethiopia, the government has also been keen to put into place the necessary **human capital development policies** to facilitate the capturing of the first demographic dividend (Admassie et al., 2015: 3, 16–18).

In the case of densely populated Rwanda, leadership was also important as the country's leaders started to change their attitudes towards family planning programmes at the start of the 2000s. President Paul Kagame declared family planning a national priority. Rwanda's leadership has invested in its network of CHWs, running communication campaigns to drive demand and behaviour change, and providing training on long-acting and permanent contraceptive methods.

“Everything starts at the higher level...his Excellency, our president of this country. He is really committed to family planning” - Family planning programme expert - interviewed by Schwandt et al. (2018).

The importance of **government leadership and focus** was also stressed in the success of Rwanda's family planning programme (Schwandt et al., 2018). All positive aspects of the programme are based upon the strong foundation the government has built and developed. Recent research shows that all partners, public and private, stressed the **importance of government ownership and guidance** of the entire programme for consistency and sustainability (Sharan et al., 2011; Schwandt et al., 2018).

“One of the successes in Rwanda is...the political people are engaged in the system. The political weight is a success because they will accept innovation, they will accept whatever we want to implement, they will be flexible” - Family planning programme expert - interviewed by Schwandt et al. (2018).

Government leadership and commitments have also contributed to the adoption of policies to reduce fertility rates in Malawi. The government prioritised family planning as a way to achieve a better quality of life for its people after committing during the Family Planning London Summit (FP2020) in July 2012 to achieve a modern contraceptive prevalence rate (mCPR) of 60% by 2020 from 33% for married and sexually active women, with a focus on reaching the 15–24 age group (Government of Malawi, 2015; 2019). The Population Unit within the Ministry of Finance and Development Planning provided necessary **technical input and collaborated with planning units to ensure the integration of population variables into development plans**. Additionally, the Population Unit advocated population issues to create awareness among various government decisionmakers and sectors of development (Ministry of Finance and Development Planning, 2012). With a comprehensive reproductive health programme in place in 2016, coordination and implementation of family planning became a priority within the Ministry of Health, while overall population policy is coordinated within the Ministry of Finance and Development Planning.

Linking family planning with policies and laws

USAID (2013a) shows the importance of laws, regulations, codes, and policies as they affect most directly the operations of health systems, including family programme services, linking policy with quality health service delivery, health workforce, health information systems, use of methods and technologies, financing and governance.¹¹ Often, barriers to accessing high-quality health services have their roots in non-existent, inadequate, or conflicting policies, which is the same for family planning services (Cross et al., 2001). Specific evidence from family planning

¹¹ Ranging from “those governing import duties and budget allocations, tenders, and purchases of contraceptives at ministerial levels to those influencing how health personnel at the primary care level spend their time and the quality of treatment clients receive at the facility level” (USAID, 2013a: 1).

programmes show that the most **“lagging” programmes lacked strong, widespread support for family planning policies**, and none adopted family planning policies with broad popular consensus (Robinson & Ross, 2007). The majority of the lagging countries had weak leadership, and the family planning programmes in these countries worked outside the Ministry of Health network; as a result, they had little access to facilities, personnel, or research and evaluation resources (Robinson & Ross, 2007).

Within the range of policies that could be useful to reduce fertility, family planning policy is often examined separately and most often has the strongest direct relationship with change in fertility (Tosun & Yang, 2018: 3). Family planning policies and programmes (as part of a broader health systems approach) aim to reduce unintended births and unmet needs for contraceptives, and has therefore been the main policy instrument to moderate rapid population growth and affect demographic change for the past half-century (Cleland et al., 2014: 8). USAID (2013a) argues why it is important that policymakers provide clear policy, laws, and guidelines for family planning:

- **Laws and policies can protect individual reproductive rights, and they represent political commitment to develop systems that support these rights.** Laws and policies can codify and articulate the commitment of countries to respect, protect, and fulfil reproductive rights (Hardee et al., 2013; Rodriguez et al., 2013 – as cited in USAID, 2013a). Laws and policies can also set standards for family planning financing and for the regulation of contraceptive quality and private-sector providers of family planning services.
- **Policy plays a critical role in scaling up and sustaining health interventions.** Scaling up evidence-based innovations requires integrating new practices into health programs and services, including addressing the policy dimensions of scaling up. Without attention to the policies that underlie health systems and services, the scale-up of promising pilot projects is not likely to succeed.
- **Clear, up-to-date clinical guidelines maximise safe access to services.** Evidence-based clinical guidelines promote the effectiveness, safety, and overall quality of care for the delivery of reproductive health services. Global experts regularly review and update international recommendations based on current evidence. National guidelines should be reviewed routinely to ensure that they reflect international standards.
- **Comprehensive national guidelines clarify standards for the provision of contraceptives by non-traditional service providers.** A review of family planning clinical practice guidelines in 13 countries in sub-Saharan Africa found that national guidelines were generally inconsistent with current evidence (Wilson et al., 2011 – as cited in USAID, 2013a). Many of the guidelines restricted the provision of contraceptives by lower-level providers or provided little or no guidance about which methods could be provided through the private sector, such as pharmacists and drug shop keepers.

Sub-Saharan African **champion countries all show clear legal and regulatory framework, defined goals and indicators, and commitment to deliver better quality family planning programmes.** In Ethiopia, research in the 1990s showed that the country had differences in both the availability of family planning services and in the use of contraceptives in different regions and ethnic groups (Shemeikka, 2006: 28). Therefore, the family planning programme focused on **ensuring contraceptive security and provision of long lasting and permanent contraception.** The family planning programme has received direct government support since

1976.¹² However, policy became more of a focus in 1993. In 2005, the government of Ethiopia started with a community-based health programme, Health Extension Program (HEP), that was fully integrated within the health system and consisted of the provision of family planning services and information (Admassie et al. 2015: 5).

In Rwanda, the government formulated the National Family Planning Policy (2006–2010) and required all ministries to develop action plans for addressing population issues in their respective sectors towards a multi-sectoral approach to improving the quality of and access to family planning. The updated National Family Planning Policy and its' five-year strategy (2011-2016) set out to **increase access to a wider range of long-term family planning methods, including vasectomy** (Zulu et al., 2012: 29; Lantos, 2019). The government also took concrete steps to improve the implementation of the family planning programme. The ability to choose between several contraceptive methods further increased the CPR, since the needs of users could be met more easily (Solo, 2008). Other measures included making contraceptive services free of charge, offering incentives to family planning service providers, and improving the coordination of family planning activities between the numerous governmental agencies and private organisations. Between 2005 and 2014/5 the percentage of married women using a modern method of contraception rose from 10 to 48%, and fertility fell from six births per woman to a little over four.

More recently in 2017, with two-thirds of the population under the age of 25, Rwanda revised its commitment from 2012 to measure successful demand creation for family planning, and **increase total demand for contraception for married women** from 72% to 82% by 2020. The message for the population is “**produce children you are able to raise**” (Nsabimana, 2019).

In Malawi, the 2013 Gender Equality Act guarantees access to reproductive healthcare and bars discrimination in providing services based on marital status. This law aims to promote gender equality, specifically, equal integration, influence, empowerment, dignity, and opportunities for men and women in all areas of society (Rosen et al., 2017). It also prohibits and provides redress for sex discrimination, harmful practices, and sexual harassment. Finally, it provides for public awareness on the promotion of gender equality and related matters (Rosen et al., 2017).

In Malawi, the government embraced family planning in the Malawi Family Planning Costed Implementation Plan (FP-CIP) 2016–2020 with detailed plans to achieve Malawi's vision and goals to improve the health and well-being of the country's population, with the clear aim to achieve the goals of the London Family Planning Conference in 2012. **FP-CIP ensures that the government has one, unified country strategy for family planning that is followed by different departments.** The FP-CIP articulates Malawi's consensus-driven priorities for family planning. All stakeholders must align their family planning programming to the strategy detailed in the document (Government of Malawi, 2015; 2019). In addition, the Ministry of Health must hold development and implementing partners accountable for their planned activities and must realign funding to the country's needs identified as priorities. All other sectoral ministries should work in tandem with the Ministry of Health to implement the FP-CIP and coordinate efforts, and the FP-CIP should be consulted in the development of broader policies and strategies (Government of Malawi, 2015; 2019).

The FP-CIP includes all necessary activities, with defined targets appropriately sequenced to deliver the outcomes needed to reach the country's publicly committed family planning

¹² United Nations World Population Policies database: https://esa.un.org/PopPolicy/about_database.aspx

goals by 2020. This includes monitoring costs and outcomes, a clear budget with a strategy to increase funding, and a framework for inclusive participation of several stakeholders. **Family Planning programmes are embedded within broader policies and laws, such as the National Sexual and Reproductive Health and Rights Policy and the Health Sector Strategic Plan** (Rosen et al., 2017).

Comprehensive population policies with defined goals

A comprehensive national population programme also serves as a vehicle to achieve demographic goals and objectives (Hailemariam, 2016: 29). This means **integrating family planning into a population approach** that also includes actions to reduce mortality (in particular for infants) rates, increase human capacities and economic development.

In Ethiopia, the Government declared its first-ever explicit, comprehensive, and multi-sectoral population policy in 1993 (Hailemariam, 2016: 19). The launch of the National Population Policy Ethiopia (NPPE) was a landmark measure to advance the process of economic and social transformation in the country. The goal of the policy was to harmonise the rate of population growth and the capacity of the country for the development and rational utilisation of its natural resources (TGE, 1993).

Ethiopia articulated in its population policy and Health Sector Development Programme (HSDP IV) several targets to be achieved by 2015. Total fertility was to be reduced by nearly 50%, from 7.7 children per woman to 4.0. The CPR, which stood at 4.8% in 1990, was to be increased to 66% (Alemayehu et al., 2016). The reproductive health interventions in the NPPE were **all inclusive**:

“Interventions to improve the reproductive health of women, men and adolescents are key elements of ICPD-PA¹³ and the National Population Policy of Ethiopia” - Mekonnen Manyazewal, Vice Minister- Ministry of Economic Development and Cooperation (1999).

In Rwanda, family planning has received direct government support since 1976.¹⁴ The population policy that started after 1981 under donors' pressure to tackle the high rate of population growth (family planning was not among the priorities of the Habyarimana regime before 1994), with the creation of the National Office of Population (ONAPO), faded into the background in the second half of the 1990s. Building-up the new society and restoring peace and reconciliation became a more important policy focus than population growth reduction. Only some years afterwards could the government reformulate population and public health policies (Rutayisire et al., 2014).

In 2007, Rwanda became the first African government to **attempt to set a limit on the size of families**. President Paul Kagame hoped to cut the birth rate by half - the average number of

¹³ 1994 International Conference on Population and Development. The *ICPD Programme of Action* was remarkable in its recognition that reproductive health and rights, as well as women's empowerment and gender equality, are cornerstones of population and development programmes. Specifically, the Programme of Action called for all people to have access to comprehensive reproductive health care, including voluntary FP, safe pregnancy and childbirth services, and the prevention and treatment of sexually transmitted infections.

¹⁴ United Nations World Population Policies database: https://esa.un.org/PopPolicy/about_database.aspx

children per couple at the time was six. However, this policy was delayed as it was seen to be too much of a heavily politicised issue:¹⁵

“I had the opportunity of conducting an assessment in Rwanda regarding the rising birth rates. Focus groups discussions among many Rwandans showed that genocide played a role in their decisions to have children. Some women said that ‘having children was a way of finding meaning to their lives,’ a reason to go on. While I fully support that women should limit the size of their children, I believe that this must come from a truly independent decision, based on understanding the benefits of having less children, peace, reconciliation and development. The scars of the Rwandan genocide for both the perpetrators and the victims is too soon for the government to come up with a policy such as this one” - Belkis Wolde Giorgis, NGO worker, Addis Ababa (2007).¹⁶

Malawi has a National Population Policy since 1994. More recently the population policy is better integrated with family planning goals. **In Malawi, the family planning 2020 goals and vision (Ministry of Health key responsibility) are supported by the National Population Policy and the Growth and Development Strategy (both part of the Ministry of Finance and Development Planning) that recognise that future population size and structure will have a big impact on the likelihood of achieving these goals** (Government of Malawi, 2019). In the National Population Policy, there is a focus on the drivers (e.g. education, health, jobs) of demographic transition while improving the supply of reproductive health and rights services through the family planning programmes.

Decentralise decision making

Although all the evidence in sub-Saharan Africa shows that commitment in central government is key for achieving the demographic transition, this does not mean that all decision should be made at the central level. Decentralisation transfers power from the central government to local authorities. In terms of family planning, decentralisation has **increased access to services for rural populations** by bringing the infrastructure closer to the people (Schwandt et al., 2018). It stimulates more participatory decision-making structures, services that suit the particular needs of specific population groups, and improved value chain management.

In Ethiopia, responsibilities such as setting policies, as well as mobilising and managing resources have been partially devolved to regional and district levels. Citizen advocates for reproductive health commodity security influenced the reallocation of regional funds to address contraceptive stock-outs. A flexible and robust **supply chain** and an **enabling environment for contraceptive security** have been instrumental in ensuring the availability of a quality mix of contraceptives to meet the growing demand.¹⁷

Territorial decentralisation of family planning programmes was also crucial in Rwanda: a family planning programme can only be efficient if it provides access to counselling and services for all

¹⁵ Approximately 800,000 Tutsis and moderate Hutus were killed in the 100-day genocide. The Hutu majority will be most affected by this policy; opportunists will use it as further evidence of Kagame's Rwandan Patriotic Front (RPF) systematic erosion of their community.

¹⁶ For more information, see: <http://news.bbc.co.uk/1/hi/world/africa/6358381.stm>

¹⁷ See DELIVER Project: https://deliver.jsi.com/wp-content/uploads/2017/01/FinaCounRepo_ET.pdf

women and couples through national coverage. This has been particularly important in Rwanda, where 70% of the population live in rural areas (Lantos, 2019). Decentralising the healthcare system also allowed the programme to incorporate the needs of different communities in the decision-making process (Solo, 2008; Lantos, 2019).

In collaboration with development partners, the Ministry of Health has invested in **innovative interventions within an increasingly decentralised** health care delivery system. The international scientific and medical community recognises that excellent improvements have been achieved in Rwanda in infant and child survival, maternal health, and HIV, tuberculosis, and malaria outcomes.¹⁸

In Malawi decentralisation is mainly evident in the coordination that increasingly takes place at the district level. The role of family planning coordinators in the district has been strengthened and investment in the capacity of district health management must result in better monitoring and supervision of family planning programmes. The Family Planning Technical Working Group as a body for coordinating partners and managing work at the central level has been duplicated at the district level (Government of Malawi, 2015), however, no information is available how this has impacted on family planning service provision.

4. Develop an effective service delivery system

Provide a range of available and affordable contraceptive methods

A mix of modern contraceptive methods that provide short-acting, long-acting or permanent methods including injectables, implants, pill, condoms, and sterilisation amongst others is important to **meet the different demands of the population** (e.g. adolescents vs adults; married vs unmarried; men vs women). Therefore, early phases of family planning programmes in most developing countries typically sought to provide **a range of contraception methods** - some combination of oral contraceptives, intrauterine devices (IUDs), condoms, sterilisation, and abortion - and information on their use (de Silva & Tenreyro, 2017: 8). The range of the mix should not only be **available** but also **affordable**, particularly for the poorest part of the population.

Therefore, it is important to introduce a **manageable value chain approach** to secure availability at all times (USAID, 2012b). In the champion countries, therefore, a key component of a comprehensive strategy is contraceptive security, which is achieved when every person is able to choose, obtain, and use high-quality contraceptives and other reproductive health supplies whenever needed. If the value chain approach is not well managed (governed) supply shortages and lack of a wide choice of methods can prevent couples from using contraceptives effectively.

Evidence shows that availability improves with **mobile outreach services** that supplement static clinics. It is important that these mobile outreach services provide a good mix of methods and have high-skilled and motivated staff. These services particularly important for sub-Saharan Africa to reach regions that are underserved by static health clinics, but also to reach the poorest

¹⁸ Contributing to this are Rwanda's community health insurance scheme known as "mutuelles de santé," infrastructural developments, and FP-related outcomes such as improved modern FP uptake. The number of trained medical personnel has steadily risen, and their motivation and retention within the health care system has been addressed through unique interventions, such as performance-based financing (Republic of Rwanda Ministry of Health, 2012: iii).

communities to bring services closer to them. As Hayes et al. (2013) show **mobile outreach service clients in sub-Saharan Africa are more likely to be new to family planning** (41%). Some studies as cited in USAID (2014) show the impact of such services:

- Between 2004 and 2010, **Malawi** experienced a 14 percentage point increase in modern contraceptive prevalence among married women—from 28% to 42% (NSO [Malawi] and ICF Macro, 2011 – as cited in USAID, 2014). A case study of Malawi's experience concluded that the mobile outreach service delivery program played a key role in achieving this success (USAID/Africa Bureau et al., 2012 – as cited in USAID, 2014).
- Introduction of mobile services within existing clinic-based services in a post-conflict setting in **Northern Uganda** led to increased use of modern contraception, from 7% in 2007 to 23% in 2010, including increased use of long-acting reversible contraceptives (LARCs) and PMs, from 1% to 10% (Casey, 2013 – as cited in USAID, 2014).
- **Tanzania** experienced a slight but steady increase in modern contraceptive use between 2004/05 and 2010—from 20% to 27% (NBS [Tanzania] and ICF Macro, 2011 – as cited in USAID, 2014). According to interviews with key officials, mobile outreach contributed to this increase, although the magnitude of the effect is unknown (Wickstrom et al., 2013 – as cited in USAID, 2014).

In Ethiopia, the utilisation rate of LARCs is still low and dominated by short-term contraceptive methods. In 2004, the Ethiopia Contraceptive Logistics System (ECLS) managed by the government with technical support from USAID DELIVER, a parallel logistics system, was developed to improve the contraceptive supply chain. This was as a result of the 2001 contraceptive inventory and logistics system survey, funded by USAID and UNFPA, which showed stock outs ranging from 30-60% despite adequate supplies in the system.

The updated National Family Planning Policy in Rwanda and its' five-year strategy (2011-2016) set out to **increase access to a wider range of long-term family planning methods, including vasectomy** (Zulu et al., 2012: 29; Lantos, 2019). The ability to choose between several contraceptive methods further increased the CPR since the needs of users could be met more easily (Solo, 2008). Between 2005 and 2014/5 the percent of married women using a modern method of contraception rose from 10 to 48%, and fertility fell from six births per woman to a little over four.

Malawi has set some clear goals in the FP-CIP to increase the mix of methods by 2020, in particular, to increase the use of condoms, implants and injectables (the last in particular for unmarried women). The method mix changes take into account the recommendations of the Ministry of Health and stakeholder groups **to shift use, wherever feasible, from less effective to more effective methods, while maintaining the widest possible range of method choices**. Importantly, it has a focus on reaching underserved populations (e.g. youth, rural population, and the urban poor) and creating demand and improving access for LARCs (i.e. scale-up training). However, as research shows, gaps in and discontinuation of use of the injectable may play a role in the discrepancy between high use of mCPR and higher fertility rate than expected in rural Malawi (Dasgupta et al., 2015). Dasgupta et al. (2015) conclude that interventions to help women in rural areas adhere to injectable use and promoting long-acting methods should be strengthened.

Integrate family planning into health services

In the champion countries, **family planning has been fully integrated within health services and part of health strategies and policies**. Evidence shows that when family planning services are provided during the **postpartum period** it is very effective to avoid unmet needs. If women are provided comprehensive counselling and are proactively offered contraception from a range of choices as part of childbirth care, between 20% and 50% of women will leave the facility with a method (USAID, 2017a). In Rwanda, the postpartum family planning counselling is used as an opportunity to plan for returning to a facility for postnatal care and immunisation and for obtaining a method at that time. Data from one quarter in 2017 from 10 districts showed that 24% of women adopted a method pre-discharge and an additional 67% left with a plan of when to start (USAID, 2017a). The review by Cleland et al. (2015) might give a more realistic evaluation.

Also, **immunisation services** tend to reach high coverage and provide a possible platform for linking or integrating family planning services. A modelling exercise using data from five countries in sub-Saharan Africa demonstrated that reaching postpartum women through immunisation contacts could decrease the overall unmet need for family planning by 3.8 to 8.9 percentage points (Gavin et al., 2011 – unpublished report as cited in USAID, 2013b). In Mali, dedicated providers who were only responsible for providing family planning services discussed a range of contraceptive methods with clients waiting for immunisations, including both short- and long-acting methods (PSI, 2012). Women were then offered contraceptive methods, including an IUD or implant, at a subsidised price on the same day at the same clinic. A programme assessment showed that 24.6% of women who received information during immunisation visits chose to have an IUD or implant inserted that day. The intervention also successfully reached younger women; 48% of implant acceptors were under the age of 25 between 2010 and 2011 (PSI, 2012).

As part of the FP2020 commitment, the Government of Rwanda updated its commitment at the 2017 family planning Summit in London, UK, long-lasting contraceptive methods, including permanent ones, will be introduced, as well as high quality integrated family planning services in every hospital and health centre (FP2020/GoR, 2017). Using the same comprehensive approach, the Rwanda Zambia HIV Research Group¹⁹ is now establishing LARC provision as the standard of care in family planning programmes and integrating family planning services with couple-focused HIV testing programmes (Wall et al., 2018).

A unique feature in Ethiopia has been the creation of a new cadre of government health workers, to staff rural health posts. The aim was for reliance on these health providers to offer family planning services within the community (Grant & Bhardwaj, 2016: 5).

Malawi's family planning policies in the FP-CIP have defined high quality postpartum and immunisation family planning services as high impact areas. It aims at developing and rolling out a family planning integration protocol (antenatal care, postnatal care, postpartum care, immunisation and routine childhood vaccination). Furthermore, the Health Sector Strategic Plan guides the efforts of the Ministry of Health and it highly acknowledges the need to increase family planning use and address unmet need for contraception (Rosen et al., 2017).

¹⁹ The Rwanda Zambia HIV Research Group, established in Kigali in 1986, has successfully supported the government to establish **couples' voluntary counselling and testing (CVCT)** as a national standard of care in all government antenatal clinics through research, outreach, policy, and advocacy efforts.

Using community-based or outreach workers

There is proven evidence of the advantages of using participatory approaches with strong community-level involvement (Bongaarts et al., 2012: 76) in particular through CHWs.

Integrating CHWs into the health system is an important success factor. CHWs are important when there are shortages of health workers, reduce the cost of service provision, and address social barriers within communities (USAID, 2015a). In Madagascar, individuals who had direct communication with CHWs were 10 times more likely to use modern contraceptives than individuals who did not have contact with CHWs (Stoebe et al., 2003). In Ghana, in communities where CHWs operated in conjunction with community volunteers, the TFR was reduced by one birth after three years compared with communities with the typical health care system (Phillips et al., 2006).

In Ethiopia family planning services are available at various locations. The community-based health programme, HEP, includes family planning services and information, and is fully integrated within the Ethiopian health system (Admassie et al. 2015: 5). In 2009, Ethiopia became the first African country to train HEWs (mainly female lower-level health providers) to insert contraceptive implants (Grant & Bhardwaj, 2016: 5). Today, it involves more than 35,000 female HEWs, who were recruited from local communities and chosen with the active participation of community members. HEWs have been deployed throughout Ethiopia, first among agrarian populations in rural areas and later in pastoral and urban communities. HEWs were responsible for delivering clearly defined health packages, family planning information and services at the community level, through visits to individual households (Teller & Hailemariam, 2011: 291). Data analysis shows that HEP might have helped to increase all-method contraceptive coverage in Ethiopia to 42% in 2015 (Population Reference Bureau, 2015). However, other factors may have been influential as well, such as improvements in female education, increased population pressure in the Highlands, and sweeping ideational changes (Admassie et al. et al. 2015: 8).

A study in Ethiopia demonstrated that provision of injectable contraceptives by CHWs proved to be safe and acceptable among women, and clients of CHWs were less likely to discontinue use of contraception over three cycles than clients who acquired their injection through clinic-based services (Prata et al., 2011). This can free up HEWs to offer more long-term methods, such as implants (Halperin, 2014). Further evidence from Ethiopia demonstrates that, even where CHWs are restricted to providing a limited set of contraceptive methods, they are capable of increasing use of other methods, including long-acting reversible methods, through proper counselling and referrals to clinic-based services. An analysis of DHS data found that in areas where CHWs were operating, use of injectables, implants, and IUDs was higher than the national average even though CHWs did not provide these methods directly (Tawye et al., 2005). A review of strategies to increase IUD use concluded that community-based contraceptive counselling and referral can double the rate of IUD use among women of reproductive age (Arrowsmith et al., 2012). More recent DHSs for sub-Saharan Africa, however, shows a change with less than 1.4% of women using IUDs with the single exception of Kenya. When IUDs and implants are offered together in an intervention, women overwhelmingly choose implants.

Furthermore, in Ethiopia, CHWs began keeping a “family folder” for every family in the catchment area of a health post. The family folder used a simplified tickler system, whereby health cards were organised in wooden boxes according to the month in which follow-up services were needed for family members (USAID, 2015a). If a health card was left in the previous month’s box, it alerted the health worker that a service had not been provided, prompting the health

worker to reach out to the family to provide care. HEWs also use the boxes/health cards to plan follow-up with pregnant women, family planning clients, and children for immunisation (Chewicha & Azim, 2013).

HEP is now recognised as the single most important reform in the health sector of Ethiopia that has brought family planning services and other essential health services to the “door step of the community” (Zulu et al., 2012: 71). Community events including educational sessions in community gatherings, churches, mosques, and youth clubs have played a role in the promotion of family planning in Ethiopia (USAID, 2012a: 10).

Like Ethiopia, the Ministry of Health in Rwanda is implementing community-based provision of family planning services. Community-based provision is one of the key approaches implemented to increase the accessibility and uptake of family planning services. As a component of the National Community Health Policy and the Family Planning Policy, Community-based provision of family planning services were introduced in late 2010. The programme was implemented in phases. CHWs provide the first line of health service delivery at the village level as the government addressed limitations in geographical access to family planning at the community level by tackling the limited human resource capacity through task shifting and de-medicalisation of contraceptives (Zulu et al., 2012: 35). CHWs were trained to record and report on family planning consumption. Particular innovations have CHWs positioned at village level and the mass mobilisation using community service meetings on the last Saturday of the month, called ‘Umuganda’ in the national language, to raise awareness (Muhoza, 2014: 6). These were shown to be more effective (Muhoza et al., 2016). Due to a policy change the previous year, services provided include not only counselling, but also the provision of contraceptive methods such as cycle beads, condoms, contraceptive pills, injectables, implants, IUDs and permanents (Wesson et al., 2011; Zulu et al., 2012: 35; Halperin, 2014).

In Malawi, the 2008 Community-Based Injectable Contraceptive Service Guidelines encourage the scale-up of community delivery of injectables through training health surveillance assistants to provide them. Women and girls benefit from the guidelines promoting increased access to an expanded method mix and choice (Rosen et al., 2017). Moreover, the guidelines encourage the formation of youth groups to engage in dialogue on family planning and HIV. They also encourage male involvement through couples counselling, which could benefit young married women (Rosen et al., 2017).

Kenya is also a good example where an integrated design of both health systems strengthening and community engagement enabled the national family planning programme to optimise both community platforms and facility-level resources. The government supported CHWs in providing injectable contraceptives, together with the expanded implementation of the government's community health strategy that supported CHWs in providing contraceptive information and commodities to largely rural populations. The rapid increases in mCPR (primarily in injectable use) were greatest in the provinces where the government's community health strategy was most thoroughly implemented (Askew et al., 2017).

Although Ghana has also instituted a large-scale community health strategy that increases access to injectables and other contraceptive services—namely, the Community-based Health Planning and Services (CHPS) programme, a lower degree of integration within a broader health systems strengthening approach appears to have lessened its reach and impact (Askew et al., 2017)

Create tailored approaches for adolescents and youth

Teenage pregnancies are an issue in sub-Saharan Africa, as well as globally. In sub-Saharan Africa fertility rates for adolescents are particularly high. **Adolescent-friendly Contraceptive Services** that are mainstreamed within existing contraceptive services proves to be important to reach out to adolescents, tailor services to their specific needs and break the specific barriers they face (USAID, 2015b). A review of research evidence and programmatic experience on needs, barriers, and approaches to access and use of contraception by adolescents (i.e. aged between 10 and 19 years) in low- and middle-income countries concluded that all adolescents, especially unmarried ones, face a number of barriers in obtaining and using contraception (Mbizvo & Phillips, 2014).

Policies targeting adolescents need a distinction between sexually active single and cohabiting/married adolescents because their situations and needs are so different (Radovich et al., 2018; Ali & Cleland, 2018). For singles in Africa, the commonly acceptable contraception method is the use of condoms, particularly in East and Southern Africa, where it is justifiably because of the high risk of HIV. The most optimal intervention for adolescent singles remains the promotion of condoms and emergency contraception (Ali & Cleland, 2018).²⁰ Promotion of effective hormonal methods only, would not protect against HIV/sexually transmitted infections. For cohabiting/married adolescents, who are at equally high risk of HIV as single adolescents, condom use is typically unacceptable (Radovich et al., 2018; Ali & Cleland, 2018). For this group, promotion of hormonals, including LARCs, is a priority, together with voluntary counselling and testing for HIV (ECHO Trial Consortium, 2019).²¹

While adolescents will use a variety of methods (AAP, 2014; WHO, 2015), **they are often not provided with a range of methods** (USAID, 2015b). There is also often **a lack of privacy** for adolescents. In a study in Uganda, 38% of public and private providers stated that they required a consent form either from a parent, a spouse, or both for clients under 18 years of age requesting contraceptives (Nalwadda et al., 2011). Adolescent-friendly services aim to increase the age at first sex and marriage as well as providing contraceptive methods.

Ethiopia has continued working to improve the health status of adolescents and youth by increasing mCPR among married youth aged 15-24 years. However, one-fifth of the Ethiopian population constitutes of adolescents; 8 in 10 of them live in rural areas (Abajobir & Assefa, 2014). Therefore, as part of the FP 2020 commitment, the government committed to improve the health status of its youthful population. The country prepared a National Adolescent and Youth Health Strategy (2016-2020) in line with the Global Strategy for Women's, Children's and Adolescent's Health (2016-2030). There will be a coordinated effort to improve access to contraceptives through **strengthening unmarried adolescent and youth-friendly services**. Programmes such as Smart Start²² have identified the wedding "seasons"²³ as key months for

²⁰ Information on medical abortion coupled with subsidised pregnancy test kits would be valuable supplements but, in most countries, legally impossible.

²¹ ECHO Trial Consortium (2019) show that among sexually active, young, predominantly single women in South Africa, Swaziland, Zambia etc., 18% were infected with chlamydia and 5% with gonorrhea; HIV is not the only sexually transmitted infection of concern.

²² This programme, Smart Start (SS), is a service for married adolescents, as part of the HEW programme.

²³ January and April are wedding 'seasons' for Christians, there is no season for Muslims.

promoting adolescent contraception. This is because weddings are associated with demonstrating fertility (Appleford et al., 2019: 5).

*“The needs of married and unmarried adolescent girls will be met through **partnerships with non-government and private providers**, as well as expanding youth-friendly services” - Dr Tedros Adhanom Ghebreyesus, on behalf of the Government of Ethiopia at the London Summit on Family Planning, July 2012 (FP2020, 2018:3).*

In Rwanda, traditional avenues of receiving family planning care offered little privacy to unmarried adolescents who were heavily influenced by the stigma around family planning. Since unmarried adolescents and youth make up a significant share of the population, **expansion of family planning services** was necessary as this group was underserved. **Examples used include stand-alone “youth centres” as well as “youth corners” integrated into existing health facilities** (Schwandt et al., 2018).

*“Unlike the days before the adoption of the population policy when FP programmes concentrate on married women alone, the **reproductive health programme** now seeks to meet the sexual and reproductive health needs of adolescents as well”- Family planning programme expert - interviewed by Schwandt et al. (2018).*

Malawi still has high adolescent fertility rates in comparison with its overall fertility rates (Mandiwa et al., 2018) and the family planning programmes are increasingly focused now on the adolescents and youth. Teenage pregnancies are even on the rise with teenage girls amongst the group with the highest unmet needs for contraception (Self et al., 2018). The National Reproductive Health Service Delivery Guidelines and National Youth-friendly Health Services Strategy **promote a differentiated, tailored approach to providing services to adolescents**. The 2015-2020 National Youth-friendly Health Services Strategy recognises that the family planning needs of young women vary by marital status and notes **differences by early, middle, and late adolescence**, but provides no guidance on specific approaches by age group (HP+, 2017). The strategy calls for services in line with the minimum health package, with the aim of increasing acceptability and use of health services by young people (Rosen et al., 2017). Self et al. (2018) show that costs, contraception misconception, failing support by parents, and negative attitudes of health workers towards adolescents are all important barriers.

Malawi started providing family planning to youth in 2000 and created its first Youth-Friendly Health Service (YFHS) program in 2007. A study found that 68% of health centre providers had been trained in YFHS and only 63% of those trained in YFHS were trained in contraceptive counselling (Evidence to Action, 2015). These findings led to Malawi’s 2015–2020 YFHS strategy (Self et al., 2018). Self et al. (2018) and Evidence to Action (2015) research findings both show that YFHS implementation in Malawi varied by district, was implemented sporadically and relied heavily on donor support. Thus, although a YFHS policy exists in Malawi, the availability and acceptability of the services provided are largely unequal or unknown (Mandiwa et al., 2018).

Furthermore, in Malawi, the 2007 Guidelines for Community Initiatives for Reproductive Health not only outline actions to provide a standardised method of implementing community interventions for reproductive health to accelerate the reduction of maternal and neonatal mortality, but they also mention the need to include boys and girls ages 15–24 in focus group discussions for intervention design. The impact on adolescents’ access is indirect, in that the guidelines mean to improve health outcomes for all women of reproductive age. Including young

women in the intervention design process could help tailor solutions to the adolescent age group, including how to address access by married versus unmarried women (Rosen et al., 2017).

Including social marketing

Social marketing in family planning programmes makes contraceptive products accessible and affordable through **private-sector outlets**, such as pharmacies and shops, while using commercial marketing techniques to achieve specific behavioural goals. Three social marketing models are often used to simultaneously increase demand and supply: NGO-model (subsidising contraceptive methods combined with own branding and campaigns), manufacturer-model (a partnership between manufacturer and donor, with donors working on increasing overall market through campaigns, programmes and networks), and hybrid-model (a broader partnership between businesses and NGOs including managing, distribution and pricing).

According to USAID (2013c), the **NGO model** works best in a situation of “extreme poverty, weak distribution systems, poor public health systems, and low ability to pay for family planning”, the **manufacturer-model** in countries “where large segments of the population have the ability to pay for family planning and where free and subsidized products are effectively targeted to the poorest and most vulnerable population segments”, and the **hybrid model** works well in a context of “strong commercial presence and distribution but insufficient market potential for a manufacturer’s model”. However, when subsidised social marketing programmes are ineffectively targeted, they can crowd out commercial brands. Overall, USAID (2013c) mentions that effective social marketing interventions can help achieve:

- increased availability of family planning products,
- increased range of available products at a variety of prices resulting in increased client choice,
- reduced burden on the public sector by shifting clients who can pay to the private sector,
- increased family planning program sustainability,
- better targeting of donor funding, and
- increased family planning use in general and among underserved populations.

In Ethiopia, social marketing has been used for condom, pills and injectables promotion and sales. Other family planning commodities, e.g. emergency contraceptives pills, can be distributed through social marketing which complements the services that are rendered in the public, private, and NGO health institutions. Social marketing also involves pharmacies, drug stores, and rural drug vendors (FMoH, 2011: 34).

In Rwanda, Population Services International (PSI)’s Confiante social marketing programme includes condoms, oral contraceptives, cycle beads, and injectables (Rwanda Family Planning Policy Assessment Report, 2011: 11). It receives funding from KfW,²⁴ as well as USAID and the Global Fund. In 2010, PSI’s social marketing contributed approximately 1% of the market share for injectables, and around 3% for oral contraceptives (combined pills) – the latter representing a decline in recent years due to limited availability of contraceptive products in the private sector. In

²⁴ Kreditanstalt für Wiederaufbau, a German government owned development bank.

addition to product distribution, PSI also contributes significantly to behaviour change communications activities and training of private sector providers (e.g., pharmacists and nurses).

In Malawi and Rwanda, according to most recent DHSs, about 30% of condom users obtain supplies from commercial outlets. As mentioned in the Malawi National Condom Strategy, social marketing is a prominent part of the total market approach with the aim to increase the demand and supply for condoms (Ministry of Health, 2017). Overall, the FP-CIP in Malawi emphasises the use of social marketing with involvement of community-based distribution agents. The government hosted meetings with private sector providers and NGOs to agree on where gaps can be filled by social marketing (Government of Malawi, 2015). For example, PSI supports contraceptive social marketing through its Tunza Network, which also includes 28 youth-friendly service providers in the Central Region, with plans to expand to the Northern Region (Government of Malawi, 2015).

Revision of abortion law and care

Revision of often very strict abortion laws in sub-Saharan Africa should be part of a broader provision of family planning services. Legal access to abortion care increases safe methods of abortions. Imposing liberal abortion laws should go hand in hand with the provision of quality post-abortion care spread over the country. Medical abortion will also become more and more important in sub-Saharan Africa, which many regard as the most significant development in reproductive freedom, but it will diffuse widely and purchasing could remain illegal in many parts of Africa (Moseson et al., 2019). Medical abortion has the potential to reduce abortion-related mortality and morbidity (Baggaley, et al. 2010).

In 2005, Ethiopia had one of the highest rates of maternal death in the world.²⁵ It is estimated that abortion-related complications accounted for 32% of all maternal deaths at that time. The Abortion Law was revised in the country's revised Criminal Code in 2004 (FDRE, 2004). The revision of the law was argued as part of the national effort to bring down maternal mortality, and to achieve the aims of MDG5.

The revision of the abortion law came as a surprise, and points to the importance of central actors in the government. This is even though the late Prime Minister, Meles Zenawi, and the then Minister of Health, Dr Tedros Adhanom, had the reduction of maternal mortality high on their political agenda (Tadele et al., 2019). Horn (2014) notes that many of the women whose lives doctors and NGOs have saved in the past few years have been ushered through a legal loophole — and it's possible that's what the government intended all along.

The revised Abortion Law has been called an “uneasy compromise” (Horn, 2014) between the public health concerns of the government working to bring down maternal mortality on the one hand, and religious organisations allied with the protestant Christian Workers' Union for Health Care in Ethiopia, and pro-life groups with international ties on the other.

“The (abortion) law is one of the progressive abortion laws in Africa. Although it is not on demand, more or less every woman who requests safe abortion can access the service.”

²⁵ Over the different time periods since 1990, the highest rate of maternal mortality, as measured through maternal mortality ratio (MMR) (per 100 000 live births), occurred in the age group 20 and 39 years. In the year 2005, the MMR was highest in the age group 20–24 years whereas it became highest among the 25–29 age group from 2010 onwards (Tessema et al., 2017).

As much as possible barriers to services are reduced” – International NGO (INGO) reproductive health expert interviewed by Tadele et al. (2019).²⁶

By contrast, a study of health workers in Tigray²⁷ reported that 55% of the participants supported women's right to choose an abortion and that anti-abortion attitudes accounted for only 7% of the trained health practitioners. This is most likely not representative for Ethiopia as a whole, but it gives an indication of health workers' position as more open to abortion than the public at large (Tadele et al., 2019).

Expanding national availability of safe and affordable abortion services at public facilities is also offered by private NGOs, such as Marie Stopes International (MSI). This has reduced the number of unsafe procedures being done, and could also have reduced maternal mortality (Halperin, 2014). A generation ago, sub-standard abortions were the single biggest contributor to Ethiopia's sky-high maternal mortality rate. However, nowadays it's hard to find a health provider who's seen more than one abortion-related death in the past five years. Although access to safe procedures and high-quality care could still be expanded, doctors say that, increasingly, those who need an abortion can get one safely (Horn, 2014).

Compared to Ethiopia, Rwanda amended its Abortion Law later (in 2012), and only to allow for induced abortion under certain circumstances (Påfs et al., 2020). However, unlike Ethiopia, the lack of professional consensus is still creating barriers to the realisation of safe abortion care within the legal framework, and challenges patients' right for confidentiality.

Currently, in Malawi, there are talks for revising the very strict current Abortion Law. The Penal Code allows abortion only to save the life of the woman. The code, which dates back to 1930 in the colonial era, generally outlaws abortion and prescribes imprisonment for abortion providers and women seeking abortion. Hence, restricting NGOs and other private sector providers of entering the market. The law applies to all women, regardless of age and marital status. In 2015 the Malawi Law Commission released their draft Termination of Pregnancy bill that proposed liberal changes which, if implemented, would expand access to safe abortion (Daire et al., 2018). However, it has not yet been put to Parliament by the government. Consequently, eligible girls and women fail to access safe and legal abortion. Unsafe abortion continues to be a major public health challenge in Malawi. The first nationwide cross-sectional survey on the magnitude of unsafe abortion found that in 2015 141,000 women induced abortion, giving an abortion rate of 38 per 1000 women of reproductive age. In 2015, 53,600 women were treated for complications, thereby significantly increasing the cost of care since the previous survey of 2009 (Kangaude & Mhango, 2018). Abortion-related complications contribute to up to 18% of the maternal mortality ratio in Malawi (Kangaude & Mhango, 2018).

²⁶ This study may have missed out on important information and events related to the process of implementing the law, such as anti-abortion activities which the authors may have underestimated. However, the number and centrality of the organisations included, some of which have a very long history in the field, and the repeat interviews with core actors and triangulation with previous quantitative and qualitative studies, strengthen the study findings and conclusions.

²⁷ See Tsegay A., & San Sebastian, M. (2011). *Knowledge, attitude and practice of public health practitioners towards safe abortion care services in Tigray regional state*. Ethiopia: Sweden.

5. Develop coalitions of support

Religious and Community leaders

Programmes that aim to decrease fertility rates have taken place in Buddhist, Christian, and Muslim²⁸ countries alike (de Silva & Tenreyro, 2017: 12). Religion plays an important role in many FP2020 priority countries, where faith leaders influence health-seeking behaviour and faith-based organisations (FBOs) provide a notable share of healthcare information, services and supplies (FP2020, 2019: 1). Hence, to change social norms in communities it not only needs an individual approach towards men and women but also the involvement of community and religious leaders to find acceptance for changing social norms.

In Ghana, the 2007-2011 Reproductive Health Strategic Plan (RHSP) specifies religious groups and leaders as implementing partners for almost all of their Strategic Interventions and Implementation Activities (Allison & Foulkes, 2014). The 2007-2015 Under Five's Child Health Policy and Under 5 Child Health Strategy produced by Ghana's Ministry of Health, both emphasize the inclusion of community leaders and religious organizations in promoting community awareness of important post-natal practices, including family planning (Allison & Foulkes, 2014).

Aylward and Friedman (2014) provide comprehensive information on the role of faith leaders in family planning promotion in 24 countries around the world. Their overarching finding is that faith leaders and faith-inspired organisations (FIOs) are active in family planning in many areas and ways and have the potential to do more. Overall FIOs are less likely to be providers of direct services than of support services such as education and health worker training, where they are involved in direct provision of family planning methods and supplies, they provide a variety of methods, e.g., pills, IUDs, and injectables. Moreover, in several cases (e.g. Bwindi Community Hospital in Uganda, the Ethiopian Evangelical Church Mekane-Yesus South-Central Synod in Ethiopia), FIOs are the major or sole provider of reproductive health services in the region, offering a full range of contraceptive methods (Aylward & Friedman, 2014).

In particular, the Catholic Church has been an obstacle in promoting a mix of methods. Therefore, since Catholic facilities supply much of the health care in Rwanda, the government establishes secondary health posts in those areas where the Catholic clinic would otherwise be the only source of health care (often placing them right next to these facilities, to ensure that a range of options are visibly available). While Catholic institutions provide counselling for natural family planning methods, the presence of such a family planning clinic, which provides the full range of methods, allows for full service provision without ignoring the concerns of Catholic leadership (Aylward & Friedman, 2014).

One other important insight from the Aylward & Friedman (2014: 7) study is that faith actors tend to engage in family planning not as an end in itself but instead as “just one aspect of physical and spiritual health and an integral part of maternal and child health and survival, poverty reduction,

²⁸ The Quran neither prohibits birth control nor approves a husband or wife to space pregnancy or limit their number. However, some Muslims perceive it as a concept which is totally against the principles of Islam. For further reading see Ajani, T.S. (2013). Islamic perspectives on birth control. *American Journal of Contemporary Research*, 3:1; Shaikh, B.T., Azmat, S.K., & Mazhar, A. (2013). Family planning and contraception in Islamic countries: a critical review of the literatures. *J Pac Med Assoc*, 63(3):4.

and family well-being and stability". As faith leaders have strong grassroots networks of faith communities that make them effective messengers for behaviour change, it is important to understand what their message exactly is and who they exclude. For example, FIOs often hesitate to provide family planning to unmarried youths or specific methods (Aylward & Friedman, 2014: 7). Therefore, donors and governments need to balance the risks and opportunities of working together with FIOs (Walker, 2017)

Successful engagement with religious leaders is more of a top-down approach. Ethiopia has an **"unusual level of support for contraception"** among Ethiopia's religious leaders (Warshaw, 2014). Over the past 15 years, contraception use in Ethiopia has more than tripled, according to Ethiopia's DHS; this is thanks in no small part to endorsement by the country's imams and priests. Religious leaders have been persuaded by health workers, doctors, and NGOs that family planning promotes women's health and helps reduce poverty. However, this represents the exception rather than the norm (Warshaw, 2014).

Many, though not all, Orthodox leaders expressed opposition to the family planning programmes. However, in authoritarian, one-party Ethiopia, the church cannot openly oppose the state (Gaestel & Shelley, 2014). Although the church cannot directly advocate against government policies, it can promote alternatives. So, in the struggle against AIDS, the church could not stop government promotion of condoms (Gaestel & Shelley, 2014). To cite:

"[It's a] kind of gentleman's agreement we have with the church leaders" - Dr Kesetebirhan Admasu, Minister of Health (2014).

In Rwanda, four out of every 10 health facilities in Rwanda are run by the Catholic Church (Schwandt et al., 2018). In Catholic health facilities, only traditional contraceptive methods are offered; modern methods are not provided. In 2007, a major conference that was attended by 250 senior religious leaders (Catholic, Protestant, Anglican, Evangelical and Muslim) was organised. This resulted in a **signed common declaration of support for family planning and HIV prevention policies** (Zulu et al., 2012: 36-37). The two clauses agreed on were that (i) Child spacing of 3-5 years apart reduces maternal and child mortality, and that (ii) Contraceptive use should not be opposed.

Examples from Malawi show the importance of **donors to engage with faith leaders** on family planning to ensure family planning uptake happens in communities. Mbuya-Brown and McGinn (2015) show for Malawi that engagement with religious leaders may magnify the impacts of interventions.²⁹ However, their findings also suggest that religious affiliation may not constitute a significant barrier to accessing family planning information and services, and that many people are making family planning choices independent of formal guidance of religious institutions.³⁰

²⁹ See also <http://www.healthpolicyplus.com/religiousLeadersFP.cfm>

³⁰ For example, through an ACT Alliance project, faith-based organisations increased youth access to family planning services through community facilitators who provided basic family planning services and youth counselling door-to-door. They developed specific tools to institutionalise family planning through Muslim and Christian teaching guides for youth (retrieved from http://www.healthpolicyplus.com/ns/pubs/10269-10487_ICFPPPosterMalawi.pdf). Another example is the USAID Health Policy Plus (HP+) project in Malawi where Muslim, Catholic, and Protestant mothers groups have come together to learn about the benefits of family planning and the impact of population on development, and to spread the word on these issues. The Christian and Muslim mothers groups developed Faithful Voices advocacy guides to promote faith-based dialogue on population and family planning. Using these advocacy guides, the Malawi Council of Churches, Seventh Day Adventists, the Episcopal Conference of Malawi, the Evangelical Association of Malawi, Quadria Muslim Association, and the Muslim

Christian Health Association of Malawi (CHAM) facilities are for example contracted and are reimbursed for services provided on a fee-for-service basis; however, resource constraints mean that this arrangement does not always happen in practice. Furthermore, approximately half of CHAM facilities are affiliated with the Catholic Church and do not provide most modern family planning methods; this presents a major challenge for integrating family planning with public health centres (Rowan et al., 2019).

Involving NGOs and private sector

Demand for modern contraceptives has been increased by engaging not only with community-based and religious leaders but also by the involvement of civil society organisations and the private sector. NGOs and private sector actors provide specific services where governments are not able to provide them. NGOs and the private sector are also important actors in campaigns and spreading information (e.g. social marketing). Civil society and the private sector can also make financial commitments to family planning, reinforcing the idea that reproductive health goes beyond the responsibility of governments.

Where NGOs and private sector provide services, this is often linked with the term social franchise as a network of private-sector health care providers that are linked through agreements to provide socially beneficial health services under a common franchise brand. This type of network can be particularly important for expanding availability and improving the quality of family planning services in the private sector, particularly for provider-dependent methods such as intramuscular injectable contraceptives, contraceptive implants, and IUDs (USAID, 2018). Most social franchise networks are managed by an NGO (Franchisor). The franchisor provides several benefits to franchisees, which often include clinical training, supportive supervision, and quality assurance mechanisms; business skills development and mentoring; access to affordable contraceptive and other health commodities; and support for family planning awareness-raising and demand creation within the franchisees' catchment areas (USAID, 2018). Franchisors often brand franchises to signal to clients quality and affordability at franchisee clinics.

Studies in Kenya and Madagascar demonstrate that training franchisees on youth-friendly principles and including young people in the marketing strategy is particularly effective in increasing modern contraceptive use, including the voluntary use of LARCs among youth (Plautz et al., 2003; Chakraborty et al., 2016). Also, although not based on African studies but in Pakistan and the Philippines, there is evidence that social franchise programmes are most effective when they are combined with a voucher programme and national health insurance programmes (USAID, 2018).

The Federal Ministry of Health in Ethiopia recognised the important role and contribution of NGO and the private sector to Health (FMoH, 2011: 34). Non-profit organisations have supported government efforts with social marketing, behaviour change communications via HEWs, mobile clinics, and social franchising. Their predominant focus is procurement, management, and distribution of family planning commodities (Bolton, 2019: 8). They also provide supplies during periods of stock-outs (Halperin, 2014). Private NGOs, such as MSI, also offer safe and affordable

Association of Malawi have received small grants to undertake various types of sensitisation efforts, including community dialogues and meetings with traditional leaders, youth, and media to inform on modern family planning methods. Retrieved from <https://www.usaid.gov/malawi/news/family-planning-all>

abortion services at public facilities. By expanding such services, Halperin (2014) shows that numbers of unsafe abortion procedures can be reduced, which could reduce maternal mortality.

Since 2001, when the Ethiopian National Policy for Engagement of the Private Sector was introduced, there has been a rapid expansion of for-profit and NGO organisations within the public-private partnership for health. This has boosted health service coverage and utilisation. In relation to family planning services, many of the NGO and private sector service providers work with the government through participation on key coordinating and steering committees to ensure family planning services are well distributed across the country. By 2007, the government had signed into the International Health Partnership (IHP) promoting the One-Plan, One-Budget and One-Report approach at all levels of the health system (Zulu et al., 2012: 78-79). In this approach, all actors in the sector work together to harmonise and align their actions and procedures with the country's systems.

In Rwanda, NGOs are a key factor to the success of Rwanda's family planning programme (Schwandt et al., 2018). 40% of Rwanda's primary and secondary health facilities (dispensaries, health posts, health centres) are operated by NGOs, most of which were faith-based organisations (FBOs) and religious missions (Republic of Rwanda Ministry of Health, 2006: 24).

In Malawi, the FP-CIP highlights the engagement with NGOs to fulfil the goals. They are used to provide direct services, training of health workers, and advocacy. The government need international NGOs but recognises that their project-based work is often not sustainable for long-term service provision. However, it is worth saying that the exceptionally high acceptance of sterilization in Malawi is largely due to NGOs, particularly Marie Stopes International (Jacobstein, 2013). NGOs, such as the Marie Stopes International affiliate Banja La Mtsogolo (BLM) and PSI, offer standalone family planning services and use a "tent-based" outreach approach to fill the gaps in family planning services at Catholic CHAM facilities (Rowan et al., 2019). This approach entails setting up an area at or near the facility grounds, often in a tent, to provide family planning services. While these outreach services help ensure access for clients, the partnerships between CHAM, BLM, and PSI to deliver family planning are not well coordinated. According to one interviewee in the Rowan et al. (2019: 9) study, no formal agreements are in place detailing "what's offered and where things are offered."

This is a common feature in Malawi (and probably in more countries) that there is no central distribution information system that manages stocks between government, private sector and NGO service providers at the district level. Parallel distribution chains and multiple storage facilities exist because of different donor funding streams (Rowan et al., 2019). The complexity of the system is compounded by poor-quality stock data and the lack of a unified accountability system to monitor deliveries. One interviewee in the Rowan et al. (2019) study described a reverse logistics exercise in which an NGO collected family planning methods from facilities that had overstock and then redistributed it to facilities that had no stock. The same person said some facilities had years' worth of product (including "up to 11 years' worth of IUDs") while others were completely stocked out (Rowan et al., 2019: 8).

Support and create domestic institutions and research

Examples of institutional commitments include creating or upgrading a public agency (such as a national Population Council) or a permanent standing committee (such as a Family Planning Technical Working Group or Contraceptive Security Committee). Several countries in sub-Saharan Africa have introduced and support population institutions within the public

administration to address population issues within the wider context of socioeconomic development. Population commissions or secretariats were generally located in the Ministry of Planning, but sometimes in the Ministry of Finance, the Ministry in charge of the Economy, or even the Prime Minister's Office. The role of these bodies was to oversee and co-ordinate from a developmental perspective all national population-related activities (May, 2012: 62–64).

Such institutions that are working from within the government should be combined with more independent population institutions working outside the public administration such as the National Council for Population and Development (NCPD) in Kenya, which is well established and highly effective (May, 2017). NCPD is charged with providing leadership and mobilising support for population programmes, as well as creating public awareness on population and development issues.³¹ As Kenya's process of devolution moves forward, the NCPD is collaborating with stakeholders to support advocacy efforts for line items for family planning in county budgets (May, 2017).

At the national level in Malawi, the country has set up a Taskforce on Family Planning comprising 12 members from government, development partners and CSOs. Other sub-committees at the national level are relevant, such as the Family Planning subcommittee, the Safe Motherhood subcommittee, the Reproductive Health subcommittee, the Youth Friendly Health Services subcommittee and the Commodities subcommittee (Christian Aid et al., 2016). The relative power and influence of the task force and subcommittees would nevertheless need to be fully analysed to allow focus on key actors and influencers of change.

6. Create a supportive climate for family planning and the idea of smaller families

Mass media

As an intervention, mass media through the radio, television, or print media is an appealing strategy for the promotion of family planning (Cheng, 2011). This is because of its potential reach and ability to address often culturally taboo issues in an entertaining way (Mwaikambo et al., 2011). Donor programmes frequently use mass media as part of a package of interventions to influence the individual, family, peer group, and/or community simultaneously. Mass media programming can be designed to overcome lack of knowledge about fertility and contraception, correct misperceptions about one's risk for unintended pregnancy, allay concerns about side effects of contraceptive methods, increase self-efficacy or confidence to take action, and/or change perceived norms that discourage family planning and contraceptive use (USAID, 2017b).

Studies that have focused on behavioural changes due to mass media family planning campaigns have found that they are most effective when **combined** with other intervention components, such as social marketing or interpersonal communication interventions (Mwaikambo et al., 2011). A review of family planning interventions, including 33 quasi-experiments on mass media, many from Africa, provides support for their effectiveness (Weinberger et al., 2019).

³¹ See <https://ncpd.go.ke/>

In Uganda, a radio drama programme reached 60% of unmarried, married, or newly parenting adolescents within a community. Research shows that, combined with community-engagement and learning projects linked to services, this resulted in higher use of modern contraception methods (Wandiembe et al., 2015). A similar study in Burkina Faso shows that exposure to mass media (TV and radio) combined with social franchising increases uptake of modern contraception use (Babalola & Vonrasek, 2005).

Babalola et al. (2017) found for a meta-analysis of demographic and health surveys in sub-Saharan Africa that on average, 44% of women in sub-Saharan Africa were exposed to family planning-related mass media interventions in the year preceding the survey. Overall, exposure was associated with an effect size equivalent to an odds ratio of 1.93. More recent surveys demonstrated smaller effect sizes than earlier ones, while the effects were larger in lower contraceptive prevalence settings than in higher prevalence ones (Babalola et al., 2017). Digital services are increasingly important and give new ways to inform the population about family planning and service providers. One innovative tool in development is Nivi, recently piloted in rural Kenya, and currently being scaled up across Kenya as the first digital consumer-facing contraceptives screening and provider referral engine in East Africa.³²

A pilot study of women in Addis Ababa, Ethiopia, shows that most receive their family planning information from mass media sources, specifically television and radio (Sack et al., 2016). Key informant interviews with staff from DKT International, UNFPA, and the Population Directorate of the Ministry of Finance and Economic Development report the importance of using media, especially radio, to urge couples to plan their families.

TV programmes in Rwanda that intended to increase awareness of population problems and propose appropriate and lasting solutions, with a special emphasis on family planning, were first shown in 1992 (Munyanziza, 1993). However, access to television sets sharply limited by economic and geographic factors. Since then, **both government and private agencies** have been developing and implementing programmes through the use of media facilities (Mghweno et al., 2017: 336).

In Malawi, the 2011 Guidelines for Family Planning Communication are a framework for implementing family planning communication programmes, intended to ensure collaboration of all implementing partners (Rosen et al., 2017). The guidelines identify key issues such as early childbearing; including adolescent girls and boys as target audiences and in target groups; including both in- and out-of-school youth; and identifying barriers youth face in accessing family planning services, such as negative provider attitudes, stigma surrounding family planning use, and lack of knowledge of family planning and how to prevent pregnancy (Rosen et al., 2017).

Christian Aid et al. (2016) mention that although the Malawi media is ideally expected to play a watchdog role and facilitate robust engagement between duty-bearers and rights holders on family planning commitments and issues, it has not done much due to the lack of adequate knowledge, interest and understanding on family planning issues and FP2020. Therefore, the NGOs recommendation would be media empowerment to promote both coverage and accountability through capacity building on family planning, Sexual Reproductive Health and Rights issues and the Malawi government's commitments (Christian Aid et al., 2016).

³² <https://www.popcouncil.org/research/nivi-a-digital-marketplace-for-family-planning-in-kenya>

Interpersonal communication

Like mass media campaigns, interpersonal communication approaches are used to influence knowledge, attitudes and intentions regarding family planning. Interpersonal communication interventions can be delivered through healthcare or community-based settings. A systematic review of interpersonal communication interventions found that 86% reported improved knowledge and attitudes, 63% of those that measured family planning reported increased family planning use, and over half of those that measured fertility outcomes found a decline in fertility (Mwaikambo et al., 2011).

New technologies can increase interpersonal communication on family planning topics. SMS services, chat boxes and social media tools have the potential to give men and women more tailor-made advice on family planning, sexual reproductive health and rights.³³ However, Greenleaf et al. (2019) show that cell phone ownership is significantly associated with modern contraceptive use in Burkina Faso, even after adjusting for women's sociodemographic characteristics. These results suggest that cell phone ownership selectivity and associated biases need to be addressed when planning family planning programs or conducting surveys using cell phones. A study from Kenya on the impact of mobile health (Lee et al., 2019) shows the same conclusion. Furthermore, mobile health alone was limited to improve contraceptive knowledge and use, but led to intended outcomes when used together with other channels of service provision (Lee et al., 2019).

One more traditional way to do this is through **community group engagement** activities typically follow a defined process to identify and respond to perceived local drivers of and barriers to sexual and reproductive health. This approach seeks to maximise broad engagement and to move beyond conversations with decision-makers and leaders to better understand sexual and reproductive health from the perspective of the community. Communication among women about contraception and particular methods is a hugely important diffusion mechanism (Behrman et al. 2002 [Kenya]; Montgomery et al., 2001 [Ghana]). Satisfied users will influence friends, family and neighbours to try a method (dissatisfied users the reverse).³⁴

Activities may include mapping exercises, social network approaches, exploratory games, dramas, case studies, prioritization exercises, and coalition-building, to name a few (USAID, 2016). Although activities may be facilitated by outsiders, such as NGO staff, public servants, or extension workers, they rely on active participation of local community groups and members to catalyse change.

In Kenya, 150 trained community-based facilitators held ongoing community dialogues with men and women about gender, sexuality, and family planning over three and a half years. Women who participated in these dialogues were nearly 80% more likely to be using modern contraceptives compared with women who did not participate in dialogues (Wegs et al., 2016).

³³ For example, Mobile for Reproductive Health (m4RH) in Tanzania, Kenya and Rwanda. Research has shown that m4RH can reach populations that are often underserved by reproductive health programmes, including those in rural areas, as well as men and youth via SMS messages. About half of m4RH users in Kenya and Tanzania are young people, with roughly equal numbers of women and men. In Tanzania, m4RH is accessed in 98% of all districts (source: WHO retrieved from <https://www.who.int/reproductivehealth/publications/mhealth/sms-based-fp/en/>)

³⁴ Evidence to support the view that contraceptive practice spreads by word of mouth comes from statistical modelling and from ethnographic studies.

Community group engagement is also a common approach for engaging men. In Malawi, nearly 80% of men participating in a community group engagement program reported modern contraceptive use (Shattuck et al., 2011). Community group engagement can facilitate dialogue with influential individuals to identify and clarify values around adolescent marriage and childbearing and to address norms, myths, and misconceptions about adolescent sexuality (USAID, 2016).

As has been mentioned earlier, the primary means for promoting family planning in Ethiopia is through **interpersonal communication by HEWs** (USAID, 2012a: 10). In Rwanda, the dissemination of information about family planning through **personal contact at health centres** has been found to contribute to a higher level of desire for family limitation, and a substantially lower level of unmet need (Muhoza, 2014: 48). And the 2007 Guidelines for Community Initiatives for Reproductive Health in Malawi outline actions to provide a standardised method of implementing community interventions for reproductive health to accelerate the reduction of maternal and neonatal mortality. Actions include increasing access to and use of family planning services. The guidelines mention the need to include boys and girls ages 15–24 in focus group discussions for intervention design.

Changing gender norms

In sub-Saharan Africa husbands usually exert decision-making power, but many do not have a good understanding of family planning because they perceive it as a woman's matter (FMoH, 2011; Farmer et al., 2015). **Male-dominated decision making** about fertility preference was associated with lower use of contraceptives in Ethiopia (Berhane et al., 2011). The government recognised this (Manyazewal, 1999). Involving men in family planning discussions was found to increase the uptake of modern contraceptives (Terefe & Larson, 1993). Family planning programmes have shifted away from strictly focusing upon women to working with men individually, and more towards consulting with both partners at the same time (Berhane et al., 2011). Family planning advice now also includes vasectomy information.³⁵

An education intervention based quasi-experimental study was conducted on 811 married couples in Jimma Zone, southwest Ethiopia (Tilahun et al., 2015). The intervention consisted of family planning education, given to **both men and women** at the household level, in addition to monthly community gatherings. This study showed that family planning educational intervention, which includes both spouses and promotes spousal communication, is useful to foster contraceptive practice among couples. The results also offer practical information on the **benefits of male involvement** in family planning as the best means to increase contraceptive use, e.g. by strengthening the existing family planning service delivery system.

In Rwanda, apart from the fact that people might have simply taken the opportunity to use contraception now that it became more readily available, shifts in attitudes (among Rwandan husbands) might also have contributed (Muhoza, 2014: 10). The government realised that men are found in different sub-groups: e.g. singles, married, military, urban, rural. Therefore, they are targeted with **different messages and media** in order to change contraceptive behaviour (Republic of Rwanda Ministry of Health, 2006: 31).

³⁵ In Ethiopia, vasectomies are still rare. Perceptions about masculinity prevent many men from considering it as a contraceptive option: <https://www.unfpa.org/news/men-rural-ethiopia-show-family-planning-not-just-womens-issue>

In Malawi, the 2009 Sexual and Reproductive Health Advocacy and Communication Strategy aims to guide systematic and strategic programming in advocacy and communication for SRHR at all service delivery points targeting different groups of men and women. It neither defines youth nor distinguishes between married and unmarried young women. Because of its aims to increase access to youth-friendly health services, increase men's participation, address gender relations, and reduce the vulnerabilities of women and girls, the strategy should have a positive impact on access to family planning services (Rosen et al., 2017).

Local resource mobilisation

Political will is a key determinant for an enabling policy and programme environment, and facilitates a mobilisation of resources, which is a factor to successful family planning programmes in its own right (Zulu et al., 2012: 14). Effective mobilisation of financial and technical resources to support the implementation of family planning programmes is also necessary to ensure ownership (e.g. willingness to act), increase the effectiveness of the interventions (e.g. integrate different finance structures), and sustainability of public spending on family planning activities (e.g. earmarking). This effective mobilisation of resources needs improved public financial management systems.³⁶

In Ethiopia, funding for family planning commodities has been on an increasing trend. Before 2007, almost all contraceptives had been donated to Ethiopia by major donors (USAID, UNFPA and DFID). In 2007, the government created a budget line for contraceptives enabling better tracking of funds from donors and government towards family planning commodities. Most of the funds originate from basket funds or pooled funds from donors. However, between 2007/08 and 2010, the government contributed nearly USD 2 million (Zulu et al., 2012: 72-73).

Political will in Rwanda has invariably resulted in an enabling policy environment to improve contraceptive uptake (Zulu et al., 2012: 29). Financing for the National Family Planning Programme comes predominantly from two sources – the Health Sector Wide Approach (SWAp) (indiscrete funding mechanism) and donors direct funding to programmes (discrete funding mechanism) (Zulu et al., 2012: 47).

7. Pursue supportive agendas in other sectors

Gender-equitable education

Research shows that improving education, in particular for girls, leads to fertility decline (Shapiro, 2017; Kebede et al., 2019). Although the causality is clear, the interpretation is not. Kim (2016:1) explains three mechanisms that can influence the fertility decision of educated women:

1. Childbearing could significantly impact their comparatively higher incomes. Higher incomes additionally allow them to provide better care at home for their children, thus, reducing the economic need for more.
2. Education often has “positive health impacts...on both women and their children”. They are more physically able to give birth and a higher survival rate increases the desire for fewer children.

³⁶ See for example <https://www.fphighimpactpractices.org/briefs/domestic-public-financing/>

3. They have better knowledge of how to use modern contraceptive methods.

Shapiro (2017) also shows that **a more educated population in sub-Saharan Africa results in lower child mortality**. For developing population policies, it is thus important to understand these impacts of education on income, health, and knowledge, and their influence on fertility decisions in the specific country context. Hence Shapiro (2017: 28) concludes that “improved opportunities for schooling and greater access to modern contraception, especially in rural places, have the potential to accelerate fertility decline in the coming decades”.

Although enrolment of boys and girls in primary and secondary education has improved significantly over the last decades in sub-Saharan Africa, increasing gender parity in education, quality learning is still a concern (World Bank, 2017). Pritchett (2015) and Watkins and Kaler (2016) show that well-intended single-issue approaches that are implemented in ineffective education systems may not be successful in developing countries unless fundamental features are addressed. For example, the introduction of free primary school in Kenya in 2003 did not increase the net enrolment in public primary schools while enrolment in private primary schools doubled (Bold et al., 2013, as cited by Pritchett, 2015: 6). Bruns and Schneider (2016) conclude that education reforms are very politicised processes. For primary schools in developing countries, physical expansion of education (e.g. more teachers and schools) has been easily measurable and therefore comparatively popular amongst policymakers. In comparison, improving quality learning for all is seen as complex with successes being measured over the long-term, meaning governments embracing such policies do so far less enthusiastically.

The high level of out of school youth in sub-Saharan Africa is still a problem. In the context where disparity is high for quality learning, it is necessary to understand the effectiveness of catch-up programmes for groups of children that have fallen out of the education system. However, as Ngware (2019) shows, the current evidence base for out of school youth in sub-Saharan Africa such as alternative education, catch up programmes, accelerated learning programmes and equivalency education programmes is still low.

Quality learning, girl-friendly school environments, affordability (not only school fees, but also in transportation, books, and uniforms), and a comprehensive Sexuality Education that is part of the school curriculum (it is for many adolescents the only way to get information on sexual reproductive health and rights) all seem important in increasing the effectiveness of education on fertility rates. However, as Channon and Harper (2019) argue underachieving fertility ideals (unrealised fertility) is of particular importance for the ongoing fertility transition throughout sub-Saharan Africa because highly educated groups might want smaller families, but still far more than observed elsewhere in the world.

In Ethiopia, 2016 DHS data³⁷ shows that TFR changes from high to low by women’s education level: 5.7 (no education) to 1.9 (more than secondary education). The Population Policy also aimed to increase female participation at all levels of the educational system (Hailemariam, 2016: 20). The DHS data, which reports the number of primary school children out of school over time and nationally, shows improvement in the gender gap between 2001 and 2016. However, the Ministry of Education Annual Abstracts enrolment data and Education Sector Development Policy Review data from more recent years suggests the gap is widening again slightly. Data on

³⁷ Ethiopia DHS 2016: <https://dhsprogram.com/pubs/pdf/FR328/FR328.pdf>

secondary school enrolment show the same trend that gender parity in education in more recent years has stalled or even worsened. Economic constraints are widely cited as a barrier to girls' education and the political instability in recent years is likely to have had a negative effect on school enrolment of girls (Bolton, 2019). Regional disparities are pronounced in Ethiopia. Aggregate figures can mask the reality for rural areas. Factors influencing girls' access to primary and secondary education include early marriage, living in rural areas, financial barriers, cultural barriers, gender insensitive school-environments, and political will (Bolton, 2019).

In Rwanda gender parity in primary education was achieved in 2004. The Girls' Education Task Force (GETF) of the Ministry of Education, established in 2004 and working within the United Nations Girls' Education Initiative (UNGEI) framework, comprises the Ministry of Education (MINEDUC), Ministry of Gender and Family Promotion (MIGEPROF), DFID, UNICEF, Forum for African Women Educationalists (FAWE), National Women Council, National Youth Council, and Pro-Femmes.³⁸ Rwanda continues to refine its family planning policies and programmes by including both men and women (Farmer et al., 2015).

The Malawi Growth and Development Strategy advocates for girls' education, in combination with the aim to delay marriage and promote the small family concept. This strategy acknowledges the need to improve access to quality and relevant education, including providing a conducive environment for girls' education (Ministry of Economic Planning and Development [Malawi], 2017). This strategy is based on the evidence that gender parity in education in Malawi is still high (especially in comparison with Rwanda and Ethiopia). National education data for Malawi show that 62% of girls who enrol in Standard 1 continue to Standard 5 and only 29% remain enrolled from Standard 1 to Standard 8. In 2016, less than 40% of those who enrolled in Standard 8 in the previous academic year transitioned to Form 1, the first year of secondary school. Even fewer girls access higher education. In 2016, for every female enrolled, 1.7 males were enrolled in higher education. The top three reasons why girls drop out of school are marriage, pregnancy, and family responsibilities (USAID, 2019). Measures to improve this should not only focus on capital investments, but also recognise the political economy in the education sector (Watkins & Ashforth, 2019).

Improvement of health services

Health system improvements also link directly to lower fertility rates, mainly due to lower child mortality rates and mortality rates in general, which lower the need for larger families. Further, as mentioned earlier in this literature review, health services provide direct opportunities to link with family planning services. However, it seems that there is an emphasis on quantity sometimes at the expense of quality of programmes. Potential users of family planning, for example, do not always get full information especially relating to side effects or side effects of the methods being downplayed. This, together with inadequate training of service providers, contributes significantly to relatively high discontinuation rates of reversible methods.³⁹ Therefore, as in education systems, understanding how health services work depend on political economy decision-making

³⁸ Eight key initiatives involving the Ministry of Education are listed in: http://www.ungei.org/infobycountry/rwanda_363.html

³⁹ Information comes from the session Family Planning: Policy and Practice at the 8th African Population Conference in 2019 <http://uaps2019.popconf.org/sessions/27>

processes, governance structures for effective public investments and quality in the sector (Piatti-Fünfkirchen & Schneider, 2018).

HEP is now recognised as the single most important reform in the health sector of Ethiopia that has brought family planning services and other essential health services to the “door step of the community” (Zulu et al., 2012: 71). As well as the NPPE adopted in 1993, several supporting policies were also developed. The Health Policy emphasised the need to improve the coverage and quality of family planning services in the country; the Women Policy acknowledged the need to ensure women’s access to family planning and other reproductive health services as one of the strategies to empower women. Since 2001, when the National Policy for Engagement of the private sector was introduced, there has been a rapid expansion of the private-for-profit and NGO organisations which has augmented the public-private-NGO partnership for health, as well as boosted health service coverage and utilisation.

The Rwanda Maternal, Newborn, Adolescent and Child Health (RMNACH) policy is the **first-ever integrated policy** in Rwanda. **Integration** of maternal and child health, and disease-specific health services is already effective but was strengthened through strong leadership at the central level, support and advocacy by district authorities and health facility managers (Republic of Rwanda Ministry of Health, 2015: 16). As Crigler (2014: 5) mentions, the introduction of community-based health insurance schemes in Rwanda, which resulted in 92% of the population being insured, has increased access to health care services and drugs significantly.

Malawi has a free public health system with district hospitals and health centres. Nurses in health centres deal largely with primary maternal and child health services. The community links with the primary care facility are via a team of health surveillance assistants (HSAs) and CHWs. HSAs are a community level cadre who received six weeks of initial health preservice training and ideally reside in the community they serve. HSAs mainly provide health promotion and preventive health care through door-to-door visitations and outreach clinics. The clinician and nursing roles at the health centre are largely curative, with minimal health promotion and preventive responsibilities (Makwero, 2018).

In practice, this primary health system is marked by lack of resources, maldistribution of staff and funding between rural and urban settings and across tiers of care. For example, maldistribution of resources is evidenced in staff deployment where 50% of doctors and nurses are stationed in the four central hospitals (Makwero, 2018). Furthermore, the decentralisation of working with HSAs and CHWs is poorly coordinated. Health care provision in Malawi is highly dependent on external financing. Local and international partners’ budgetary and service support to districts and health centres ought to be coordinated in pursuit of priority district health goals. This requires high-levelled political commitment and support for cost-effectiveness and quality services. The Health Sector Strategic Plan (HSSP) II has, therefore, focused on strengthening governance of the health sector in order to improve efficiency and get the maximum out of existing human, financial and material resources (Makwero, 2018).

Poverty alleviation and job creation

Poverty is not a barrier to contraceptive adoption and lower fertility. Poor women are aware that they do not have the means to support large families. Ndaruhuye et al. (2009) found

evidence for 'poverty-Malthusianism'⁴⁰ in Rwanda. Even among the poor, the readiness to limit the number of offspring turned out to be large, which the authors relate to the land pressure in the country. In Ethiopia, by 2011, the average number of desired children (from women asked how many children they would ideally like to have) declined from about five in 2001 to fewer than four.⁴¹ Studies show that the main reasons for this shift in a decade relate to the increasingly high cost of raising children, the scarcity of arable land, and women's perceptions that their educational, and economic prospects would be encumbered by needing to care for a larger family (Halperin, 2014).

On the other hand, the literature is also clear that when poverty levels go sharply down this often results in further fertility declines. The literature shows that **anti-poverty strategies and policies that improve objective conditions for women – i.e. increasing their education, as well as raising their income (such as promoting policies that favour female participation in the labour force), social protection schemes,⁴² and encouraging empowerment - are probably the most important voluntary and sustainable way to achieve the reductions in fertility necessary to slow population growth** (Pritchett, 1994: 2; Leburu et al., 2009: vii).⁴³

Economic progress is often mentioned as one of the most important contributors to the demographic transition, mostly through better-quality and paid jobs in relation to higher productivity. However, evidence from the literature is ambivalent. There is no doubt that economic development triggers social dynamics that influences decisions on family size, however, the exact interpretation of such complex relations is still work in progress. What is known is that there is a delicate two-way link. Studies, for example, show that **sustained high fertility has a negative impact on labour productivity in sub-Saharan Africa. Even with enhanced investments in education and health systems** the prediction is that labour productivity per capita is projected to decline in many African countries, like Ghana and Nigeria, in the next decades due to high fertility rates. This means the link between interventions that aim for better-quality job creation need to be aware of such demographic trends and should link their efforts with family planning efforts. As earlier said, the hope of a demographic dividend in sub-Saharan African countries already has triggered more commitment from policymakers for family planning.

⁴⁰ Malthusianism is the idea that population growth is potentially exponential while the growth of the food supply is linear. The term 'Malthusian' can also refer more specifically to arguments made in favour of preventive birth control. *Neo-Malthusianism* is the advocacy of human population planning to ensure resources and environmental integrities for current and future human populations as well as for other species.

⁴¹ Ethiopia Demographic and Health Survey 2011. Central Statistical Agency, Addis Ababa, Ethiopia, ICT International, Calverton, MD, USA. http://www.unicef.org/ethiopia/ET_2011_EDHS.pdf

⁴² Ethiopia's Productivity Safety Nets Programme (PSNP) offers cash or food transfers to 6-8 million vulnerable households. In Kenya an unconditional cash transfer programme for female orphans ages 15–24 demonstrated a reduction in pregnancy, even after controlling for schooling, but not early marriage (Handa et al., 2015). Interviews with beneficiaries indicate the girls used cash for food, health, and clothing. In the absence on the cash transfer, beneficiaries may have resorted to transactional sex to obtain these goods.

⁴³ See also: High Impact Practices in Family Planning (HIPs). (2017). *Economic empowerment: a pathway for women and girls to gain control over their sexual and reproductive health*. Evidence Summary. Washington, DC: USAID. Available from: <https://www.fphighimpactpractices.org/briefs/economic-empowerment/>

The champion countries indeed link economic development and poverty reduction strategies with family planning interventions. They acknowledge that high fertility is a barrier for economic and productivity growth, while at the same time using the prospect of economic development and poverty alleviation (through different means) as a driver for a demographic transition. For example, the government of Rwanda in the 2008–2012 Economic Development and Poverty Reduction Strategy (EDPRS) highlight family planning as a key intervention, while identifying high population growth as a major challenge (FP2020, 2012; Republic of Rwanda Ministry of Health, 2012: 5).

Malawi's development is guided by the Malawi Growth and Development Strategy (MGDS), a series of five-year plans that contribute to the long-term goals outlined in Vision 2020. The current MGDS III, 'Building a Productive, Competitive and Resilient Nation', will run through 2022 and focuses on education, energy, agriculture, health and tourism. The strategy, like in Rwanda, clearly links economic development with the desire of lower fertility rates. It calls for further investment in "the factors that help families achieve their reproductive intentions, such as girls' education, child mortality, and family planning services" (The Ministry of Economic Planning and Development [Malawi], 2017: 37-38).⁴⁴

The three champion countries try to enhance a demographic dividend through employment promotion in productive sectors outside agriculture. Rwanda, Ethiopia and Malawi all have high employment in the low-productivity agriculture sector. Their economic development strategies aim to diversify employment opportunities. While the decrease in the agricultural sector's share of the labour force in for example Ethiopia is encouraging, a clear transfer of labour to productive industrial (mainly manufacturing, construction, mining, and quarrying) and service sectors is still not happening. By contrast, manufacturing decreased slightly. Admassie et al. (2017), therefore, state that policy interventions should emphasise the increase of jobs in more productive sectors to maximise the potential to reap a demographic dividend: "Since healthy and educated youth require decent and sustainable jobs through increased productivity, efforts at expanding jobs in the manufacturing and technology-related service sectors are critically important".

Also important is a focus on gender in employment strategies and interventions. Revision of the Family Law in Ethiopia in the year 2000 eradicated the legal obstacles to women's employment outside the home. After this legal change, more women entered the workforce (Central Statistical Agency [Ethiopia] & ICF, 2016). In Rwanda, following peace and reconstruction efforts after the 1994 genocide, the country has been named as one of the world's top five countries in closing gender gaps due to its **high female labour force and female political participation**.⁴⁵ After the war, many policies were put in place to help keep women in work (e.g. three months of paid maternity leave, making it much easier for them to **stay in the labour market once they've started a family**). In fact, every year for over a decade, Rwanda has topped the global list of countries with the most female political parliamentarians.⁴⁶

⁴⁴ Family planning is mentioned 12 times in the MGDS.

⁴⁵ At 86%, it has one of the highest rates of female labour force participation in the world. Women earn 88 cents for every USD1 men do; in the US, it's just 74 cents. <https://www.weforum.org/agenda/2017/05/how-rwanda-beats-almost-every-other-country-in-gender-equality/>

⁴⁶ <http://archive.ipu.org/wmn-e/classif-arc.htm>

Discourage early and polygynous marriage

Research in Ghana **shows that delaying marriage declines fertility levels significantly** (Odame et al., 2019). Delayed marriage was also the biggest contributor to a fertility decline in Egypt in the 1960s and 1970s. A study in Uganda underscores the need to strengthen strategies that promote girls' education, delayed initiation of sexual intercourse and childbirth as measures for addressing early marriage across regions (Otim & Wamala, 2019). Scholars often use this evidence to make the case to policymakers to delay the age of marriage, in particular by demonstrating the benefits of women who marry later.

Both Ethiopia and Rwanda have exceptionally low reported levels of pre-marital sex and childbearing (Reda & Lindstrom, 2014 [Ethiopia]; Michielssen et al., 2014 [Rwanda]). A rise in adolescent premarital sexual activity in the context of delayed marriage, however, is far from universal in African countries (Lindstrom et al., 2009: 45). Child marriage, defined as marriage before the age of 18 years, is driven by gender inequality. These girls do not always realise they have a right to contraception, and the right to choose if, when and how many children to have.

In Ethiopia, child marriage affects girls to a far greater extent than boys. Among married girls, those residing in the well-respected Berhane Hewan⁴⁷ project site were three times more likely to be using family planning, compared to their counterparts in the control site (Erulkar & Muthengi, 2009: 12). Age at marriage for women has certainly increased in Ethiopia, from a median of 16.5 years for women aged 45-49, to 19.0 for women aged 20-24. There is also a low level of polygynous marriage: women are less likely to have entered into such unions before the age of 15 than after their 20th birthday (UNICEF, 2005: 18). Ethiopia has the lowest age of first marriage in eastern Africa; and only 5% of women give birth before marriage (Clark & Hamplová, 2013).

Rwanda co-sponsored the 2017 Human Rights Council resolution, recognising the need to address child, early and forced marriage in humanitarian contexts.⁴⁸ The country is committed to eliminating child, early and forced marriage by 2030, in line with target 5.3 of the Sustainable Development Goals (SDGs). The fourth Population and Housing Census conducted in August 2012 (2012RPHC) realised that the average age of first marriage for women climbed from 22.9 years in 1991 to 25 years in 2012. While women without education get their first marriage at 23.2 years on average, the women with university degree get their first marriage at 28 years on average, almost five years of difference.⁴⁹ Twelve percent of women are in polygynous marriages (UNICEF, 2005: 38).

The 2015 Marriage, Divorce and Family Relations Act in Malawi raised the minimum legal age of marriage to 18. Essentially, the law bans child marriage by raising the minimum legal age of marriage for all statutory and customary marriages. It also explicitly acknowledges the negative health implications of early marriage for young women (Rosen et al., 2017). However, Parliament still must change the Constitution for the law to be properly upheld. The Malawi Constitution

⁴⁷ Berhane Hewan was a two-year pilot project conducted in 2004–2006 that aimed to reduce the prevalence of child marriage in rural Ethiopia, through a combination of group formation, support for girls to remain in school, and community awareness. It was one of the first rigorously evaluated interventions to delay marriage in Sub-Saharan Africa.

⁴⁸ <https://www.girlsnotbrides.org/child-marriage/rwanda/>

⁴⁹ <http://statistics.gov.rw/publications/article/average-age-first-marriage-increased-rwanda-last-three-decades>

states that no person shall be forced to enter into marriage and then outlines various provisions by age. Youth between ages 15–18 can be married only with the consent of their parents or guardians, whereas the marriage of persons under age 15 is actively discouraged.

8. Develop an effective information system

Information systems should ensure that policies and strategic plans are periodically reviewed and kept up to date. If policies and strategic plans are not sufficiently current, they will not be responsive to societal, cultural, or environmental changes. The strategic plan guiding family planning should be adjusted annually based on updated information on health status, services, and the political environment (May, 2017). Family Planning systems audit at the local and national level (such as budget monitoring, citizen report cards, and annual surveys) would draw attention to disparities between different groups or regions, and help solve local service delivery issues such as youth-friendly services. Local trackable budgets will always need to be presented in tandem with national level budget analysis (Christian Aid et al., 2016).

The challenge is to get government officials to think in a prospective/projection manner. This is now more prominently due to the enthusiasm for the demographic dividend. For example, the African Union is working with members to guide them to construct roadmaps to achieve a demographic dividend. Kenya developed a theory of change which was used to raise the awareness of planners and develop a roadmap and integrated results framework, over a five-year period. This was supported by programme-based budgeting and criteria to review which sectors are complying with the demographic dividend agenda. Challenge for Kenya now is to get the demographic transition policies owned and budgeted at subnational levels and translate them into more localised language (K4D, 2019).

Quality, timely, aggregated and accessible data from surveys and other sources and sufficient capacities within government and institutions to analyse data is also important to understand trends and outcomes. Aggregated data is necessary to understand specific trends and outcomes for regions and groups. For example, tracking data on adolescents could be used to see who within local groups are left behind. Tracking data on the facility level is also important to understand where women cannot access care.⁵⁰ **UNFPA advocates for the registration of all births and marriages to give women more rights and to use the data for gender analysis.**

Monitor policy implementation is the next step, as the implementation of laws, policies and programmes are often an obstacle for improved service delivery. Civil society and advocates should be supported to monitor policies and ensure they are translated into action. Indicators, benchmarks, and reporting requirements should be included in policy and implementation documents (May, 2017). New policies should be monitored for unintended consequences using validated methods and by employing social auditing methodology. Evaluation of new policies

⁵⁰ During the 8th African Population Conference in 2019 several initiatives were presented that stimulate using census data for diagnostics (see: <http://uaps2019.popconf.org/sessions/37>). One step is to turn to electronic data collection (see: <http://uaps2019.popconf.org/sessions/23>). African countries can learn from other countries to achieve this transition away from paper, for example from IBGE in Brazil. Senegal, who received capacity building from Brazil are now sending teams to Guinea Bissau and Mali (backstopped by UNFPA). However, there is some resistance from staff in National Statistics Offices whose jobs become redundant with e-collection and others who resist to use the census.

should include evaluations of decentralised financing, performance-based incentives, removal of user fees, and voucher strategies, among others (May, 2017).⁵¹

In Ethiopia the year after NPPE was established, the Ethiopian government allocated over USD20 million for the second National Population and Housing Census of 1994 in order to obtain trusted information. Also, a new integrated commodity supply logistics system - the Integrated Pharmaceutical Logistics System (IPLS) - was launched in 2010.

The Rwandan government **monitors the family planning programmes at all levels**. The National Education Statistical Information System was set up to provide data collection and analysis disaggregated by gender.⁵² As a result, districts are motivated to perform well and have the support from the government to do so (Schwandt et al., 2018).

Malawi has the Demographic and Health Survey and has put systems in place for regular monitoring management, coordination and outcomes of the family planning and population policies and programmes. Data are used to improve access to higher-quality family planning services.⁵³ Designated Reproductive Health Directorate staff will monitor the activities semi-annually through an electronic database and track for performance and planning. At the district level, family planning coordinators will monitor and track progress. A mid-term and end-line evaluation of FP-CIP implementation will be conducted to identify how priorities in family planning have shifted and what activities need to be adjusted, revised, or reprioritised. Following the final evaluation of the plan, new family planning objectives will be identified, and a new five-year plan will be developed to coordinate and guide Malawi towards its new goals. Extra attention goes to strengthening the capacity of the Reproductive Health Directorate to effectively lead, manage, and coordinate the family planning programme. Family planning coordinators and District Health Office managers will be oriented on data management and advocacy for family planning, and a semi-annual meeting will be held nationally with all family planning coordinators to monitor each district's implementation of the FP-CIP and progress towards achieving family planning commitments.

9. Embrace bilateral and multilateral funding

The role of the donor community has been important on several fronts, including the **funding of family planning programmes, supporting national population policies, and advocacy and policy dialogue on population and development issues** (May, 2017). Donors have also played a significant role in **demographic data collection**, including funding two major series of demographic surveys, namely the World Fertility Surveys (WFS)⁵⁴ and, thereafter, the DHSs (the

⁵¹ May (2017) shows in Table 4 illustrative indicators for this process.

⁵² http://www.ungei.org/infobycountry/rwanda_363.html

⁵³ See for example, the article by Kawale P., Pagliari, C. & Grant, L. (2019) in the *Journal of Global Health: What does the Malawi Demographic and Health Survey say about the country's first Health Sector Strategic Plan?* <http://www.jogh.org/documents/issue201901/jogh-09-010314.htm>

⁵⁴ It is important to note that available fertility survey data provides only a partial snapshot of the entire fertility transition in a country. In many Latin American and Asian countries, fertility transition was well underway a decade before they first conducted a fertility survey (Timæus & Moultrie, 2020: 25).

bulk of the funding coming from USAID (May, 2017). Some donors, such as GIZ,⁵⁵ have also been supporting family planning projects at the local level in several sub-Saharan countries (May, 2017).

After almost two decades of reduced international commitments to family planning, major donors, including UNFPA, USAID, the World Bank, DFID, the Bill & Melinda Gates Foundation, and the William and Flora Hewlett Foundation, have strengthened their family planning activities (Bongaarts et al., 2012: vi-vii; May, 2017). However, as a study on Kenya and Ghana shows, the countries have created a highly supportive environment for family planning programme implementation, however, continued reliance on donor funding for commodity security, in-service training, and other system strengthening and community engagement interventions has left both countries highly vulnerable to resource gaps and sudden disruptions when donors change commitments and priorities (Askew et al., 2017). These vulnerabilities have increased with the devolution of governmental responsibility for family planning to sub-national levels in countries like Kenya, Malawi, Ethiopia (Askew et al., 2017).

Although the governments in champion countries have been very active in advocacy and policy dialogue with international and bilateral donors, governments in other countries have not always resulted in increased dialogues on supporting the demographic transition. In several instances, policy reforms proposed by donors have been opposed by governments (as in Uganda until recently). Reforms endorsed by African governments have sometimes also been opposed by national constituencies, such as citizens, intellectuals, pressure groups, or communities (May, 2012: 59). **The challenge for donors** is that they need to understand how and by who the message can be put forward the best to influence policy (e.g. demographic diplomacy).

In Ethiopia, Rwanda and Malawi the family planning system is extremely dependent on donors for contraceptives. Ethiopia has been amongst the largest recipient of family planning assistance in sub-Saharan Africa since 2000 (Gaestel & Shelley, 2014; Bremner et al., 2015: 2). Funds from the UK, USA and UN support commodity purchase and government capacity building. USD173 million was received between 2000 and 2010 (Bolton, 2019: 8).

The government has made large investments in human resources to extend outreach. The Health Extension Plan in 2003 was significant for delivering services and information to the most neglected areas of the country (Bolton, 2019: 8).

The family planning programme in Rwanda is funded primarily through international donor organisations: USAID, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), Belgian Technical Cooperation (BTC), UNFPA, DFID, and The William and Flora Hewlett Foundation. The main financial donors providing contraceptive procurement are USAID and UNFPA.

“Most of the funding to family services has been...from external donors... and that is... a major challenge. Although the government has been increasing its budget support to the health sector, it will take considerable time until they at least break even to what our funders are providing.” - Family planning programme expert - interviewed by Schwandt et al.(2018).

⁵⁵ Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH or GIZ

The government has included the family planning programme in the national budget and partially funds the programme. This international financial support has strengthened existing government implementations in family planning (Lantos, 2019). The government's role in funding has increased over the last decade.

Part III. Lessons learned, opportunities and risks

10. Lessons learned from Ethiopia, Rwanda, and Malawi

There are three main factors that have been credited for accelerating the demographic transition: **(i) fewer deaths in childhood; (ii) greater access and use of contraception, and (iii) more women are getting an education⁵⁶ and joining the workforce** (World Population Review, 2019). A series of case studies concludes that “overall well-being of women and girls improves as fertility declines, especially as it relates to their maternal health, educational attainment, and workforce participation,” and fertility decline has had a more positive impact on girls’ education than it has had on boys’ education (Stoebenau et al., 2013: 3).

The number of children per women in Ethiopia fell from 7 to 4.5, mainly because the government has focused on the three core areas of **health, education,⁵⁷ and job creation⁵⁸** (Kaps et al., 2018). However, the pace of implementation has been slow, and there are areas where not much progress was made. There is a need to revise the policy and address these impediments, as well as continuing and evolving challenges (Hailemariam, 2016: 19).

The rapid rise in CPR and drop in TFR during the past two decades in Ethiopia, Rwanda, and Malawi show what is possible when government, donors, and civil society work together to achieve a common goal. Olson and Piller (2013: 445) state that the four most significant factors are: **(i) political will; (ii) generous donor support; (iii) non-governmental and public-private partnerships, and (iv) the government’s establishment of a network of HEWs.**

Another lesson learned from Ethiopia, Rwanda and Malawi is that **determined government initiatives can bring about rapid reproductive change as part of a wider agenda of health improvements, educational expansion, and economic vibrancy** (Cleland & Potter, 2019: 26-27; May, 2017). In 2002, to advocate for accountability to family planning and reproductive health commitments, the Rwandan Parliamentarians’ Network for Population and Development was created. This all-party group is 60% female;⁵⁹ and is a model that could guide other parliaments to advocate for family planning. The network took leadership in the advocacy by taking family planning down to district and sector level. District and sector leaders were made responsible in their respective administrative units to put into action this ‘number one programme’ and family planning was included in their performance contracts. The objective of the public campaign was to raise or reinforce the readiness and willingness to use modern contraceptive methods by addressing social and cultural barriers. This approach proved successful, as the reported ideal

⁵⁶ However, fertility has fallen significantly even in countries and rural areas where educational attainment still remains low (de Silva & Tenreyro, 2017: 21).

⁵⁷ The point about poor education in Ethiopia is important. According to the series of DHSs, the percentage of women aged 15-49 who are literate was 24% in 2000, rising to 42% in 2016. In neighbouring countries, the literate percentage is well above 60%.

⁵⁸ The evidence for this is thin. Typically, women’s labour force participation follows rather than precedes fertility decline. Moreover, in most of Africa, unlike Asia, women already work, though not much in the formal sector.

⁵⁹ <https://www.mcsprogram.org/wp-content/uploads/2018/11/Role-of-Rwanda%E2%80%99s-Parliament.pdf>

family size dropped from 4.3 children in 2005 to 3.3 in 2010 (NISR et al., 2012 in Muhoza, 2014: 91).

Both Ethiopia and Rwanda were recovering from major disruptions, the Eritrean war, prolonged drought, food shortages in Ethiopia, and the genocide in Rwanda. Although both had strong leaders determined to improve their citizens' health and their country's international reputation (USAID, 2012a: 26), the success of family planning programmes was not uniform in all locales (DaVanzo & Adamson, 1998).⁶⁰

Success depends on several factors, including **well-designed and implemented programmes; the availability of quality services and a wide range of methods; flexibility and responsiveness in adapting to local conditions, and adequate funding sources** e.g. ideally through national governments (long-term ownership) and in combination with multilateral, bilateral, and NGOs funding (May, 2017). According to the socioeconomic theory, variations in contraceptive prevalence are due to the differences in the levels of socioeconomic development between regions. The cultural explanation suggests that across societies, tradition and culture respond differently to contraception adoption and then to the difference in contraceptive use. A third explanation is related to differences in family planning programme implementation. Some regions may run stronger and more efficient programmes than others, creating a difference in access, costs and acceptability of contraceptive services, and therefore a difference in contraceptive uptake (Muhoza, 2014: 10-11).

The three champion countries have been leaders in developing new innovative systems and strengthening existing systems (USAID, 2012b: 28). **Strong logistics** for contraceptive security has greatly reduced stock-outs in Ethiopia and Rwanda but are less efficient in Malawi. The countries have **substantial decentralisation**, with national leadership also needed to support and guide the family planning systems. **Expanded services** for maternal and child health have also brought more women into contact with family planning systems, through postpartum, child immunisation, and other services. **Public-private partnerships**, including mobile services and social marketing, have substantially contributed to success in these countries. Performance-based contracts for programme managers and government staff in Rwanda contribute to **accountability** and a norm of good practice.

There is a diversity of conditions under which fertility decline can take place in low-income countries (Parrado, 2000: 449). This emphasises the importance of family planning and other policy initiatives to fertility transition (Cleland, 1994). The encouraging experiences from Ethiopia, Rwanda and Malawi could challenge the widely held assumption that a decline in fertility must be preceded by **sweeping economic and educational advancement**, and offers other useful policy and programmatic lessons for other low-income countries, especially in sub-Saharan Africa (Grant & Bhardwaj, 2016: 5).

In Ethiopia, fertility fell rather abruptly. Birth intervals have not lengthened at all in populous Ethiopia, and there is also no evidence of an increase in the postponement of childbearing (Timæus & Moultrie, 2020: 22). In such countries, the pattern of decline in parity progression might result from the initial take up, at a relatively late date in global terms, of birth control by a population that previously either **lacked access to contraceptives** or **never realised that they**

⁶⁰ It is possible that the high-profile support given to FP by Rwanda's President boosted use generally, masking intervention impact (Blacklock et al., 2016: 321).

could control their fertility. In other words, women started to limit their fertility at whatever family size they had reached at the time when contraception became available and, as younger cohorts build up their families, a more typical pattern of parity-specific limitation may arise (Timæus & Moultrie, 2020: 22).

Analysis using microdata from countries in the Middle East and North Africa (MENA) region shows that there are a number of other factors that may be explaining fertility behaviour (Tosun & Yang, 2018: 11). These include **increased age at first birth; prolonged breastfeeding** intended to benefit the health of young children, and **improved survival of children** (Timæus & Moultrie, 2008: 485; Leburu et al., 2009: vi). Also, women may stop childbearing at low parities not because they have achieved their desired family size, but because of **widowhood or divorce** (Timæus & Moultrie, 2008: 485).

11. Consideration for interventions

Nature of demand/need for family planning: There are huge differences between East and West African countries in terms of (married) women using modern contraception, the total desired number of children, and unmet need for family planning.⁶¹ The demand for family planning in West Africa comes mainly from spacing, whereas increasingly in East Africa it comes from the desire to limit. This should influence communication about family planning. Furthermore, in countries like Burkina Faso and Ghana, even in urban areas women are avoiding modern methods in favour of traditional ones (or a mixture of both).⁶² In Ghana, educated urban women use the safe period in conjunction with withdrawal, condoms and emergency contraception. The policy implication is to avoid single-mindedness with modern methods only as natural methods should be considered.

Health service coverage: The coverage of public sector health services varies widely, and this will influence service delivery potential, e.g. percentage of births delivered in a facility will determine the potential for postpartum family planning; the percentage of children immunised will determine the potential for family planning-immunisation integration.

Length of natural protection following childbirth from sexual abstinence and/or lactational amenorrhoea: Lactational amenorrhoea⁶³ is prolonged in many West African countries: this is important to consider because it should influence the delivery of postpartum family planning.

Informal urban settlement populations: The percentage of the population living in informal urban settlements (i.e. slums) where public sector health/family planning services are often non-existent. There is often a focus on the obstacles for rural populations to access family planning services, but research shows that equally poor informal urban areas need attention. High fertility rates are still concentrated in some of the poorest urban areas.

⁶¹ See series of graphs comparing East and West African countries in (a) % married women using a modern method (b) % married women with 4 living children who want no more; (c) Total desired number of children among all women aged 20-29; (d) unmet need for FP among married women: <https://dhsprogram.com/data/STATcompiler.cfm>

⁶² e.g. Rossier et al., 2014; and Marston et al., 2017.

⁶³ Also called postpartum infertility. This is the temporary postnatal infertility that occurs when a woman is amenorrheic (not menstruating) and fully breastfeeding. It can be considered as natural family planning.

Premarital sex and childbearing: Premarital fertility rates vary greatly across Africa. In Ethiopia and Rwanda, levels are low (see Figure 3, Clark et al., 2017: 12). In Malawi the premarital fertility rate is higher, making it a priority area for the government. However, addressing this requires much more than focusing on the supply of public services.

Major risks to consider

Donor focus on “population control”: Many African leaders see a growing population as an asset. However, the concept of a demographic dividend resonates.

Government ability: The organisational ability of a government may be so weak that it cannot deliver any policy in a more integrated or comprehensive approach.

Poor organisational capacity of governments: The organisational capacity of governments will determine the likely impact of any policy or programme and the need to rely on big national NGOs, such as MSI and PSI.

Civil unrest: Civil strife is currently occurring in Mali, Niger (West Africa), and Cameroon (central Africa). This will limit possible avenues of action.⁶⁴

HIV/AIDS: The HIV/AIDS epidemic has over-shadowed fertility control, particularly in African countries (Robinson and Ross 2007 in de Silva & Tenreyro, 2017: 12). However, there is a view that there is too much emphasis on HIV-family planning integration, based on the fact that only a small minority of the adult population in most African countries is HIV+, as the incidence of new infections has fallen dramatically.⁶⁵ In countries, mainly in East/Southern Africa, where HIV remains a considerable risk, family planning services for adolescents should place prime emphasis on condoms.

⁶⁴ For example, Curry et al. 2015.

⁶⁵ <https://www.un.org/africarenewal/web-features/new-hiv-infections-are-falling-dramatically-africa>

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Websites with key resources

- Advance Family Planning (AFP): <https://www.advancefamilyplanning.org/>
- Family Planning 2020: <http://www.familyplanning2020.org>
- Fertility Transition (2014): A Selection from Population and Development Review: <https://www.popcouncil.org/research/special-issue-of-population-and-development-review-honoring-40-years-of-adv>
- Fertility Transition in Sub-Saharan Africa (2017): Population and Development Review: <https://www.popcouncil.org/research/fertility-transition-in-sub-saharan-africa>
- United Nations Population Division - Expert Group Meeting on Completing the Fertility Transition (11-14 March 2002) Guidelines: <https://www.un.org/en/development/desa/population/publications/fertility/fertility-transition.asp>
- USAID Family Planning High Impact Practices: <https://www.fphighimpactpractices.org/briefs/>