K4D | Knowledge, evidence and learning for development

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

Ethiopia, Rwanda, and Malawi

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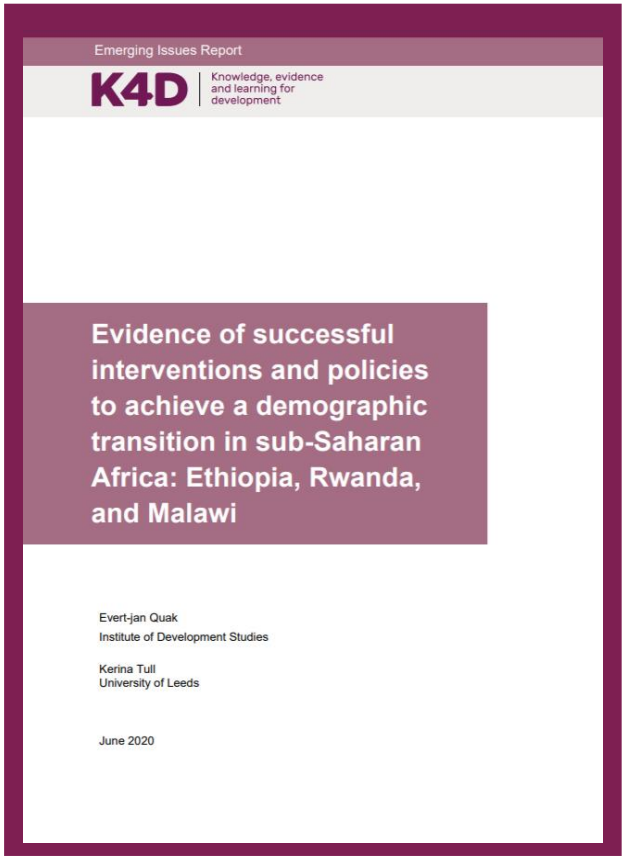


Contents

1. Introduction

What we mostly hear:

The Sub-Saharan African (SSA) population in 2018 was just over 1 billion (United Nations World Population Prospects). The current population growth rate is 2.3% so the prediction is a population between 2 and 2.5 billion by 2050 for the region.

What we do not often hear:

Most SSA countries are actually in the process of a demographic transition towards lower fertility rates. Some countries show a more advanced decline (e.g. Kenya, Rwanda, Ethiopia and Malawi), while others have started the transition later and at a much slower pace.

1. Introduction

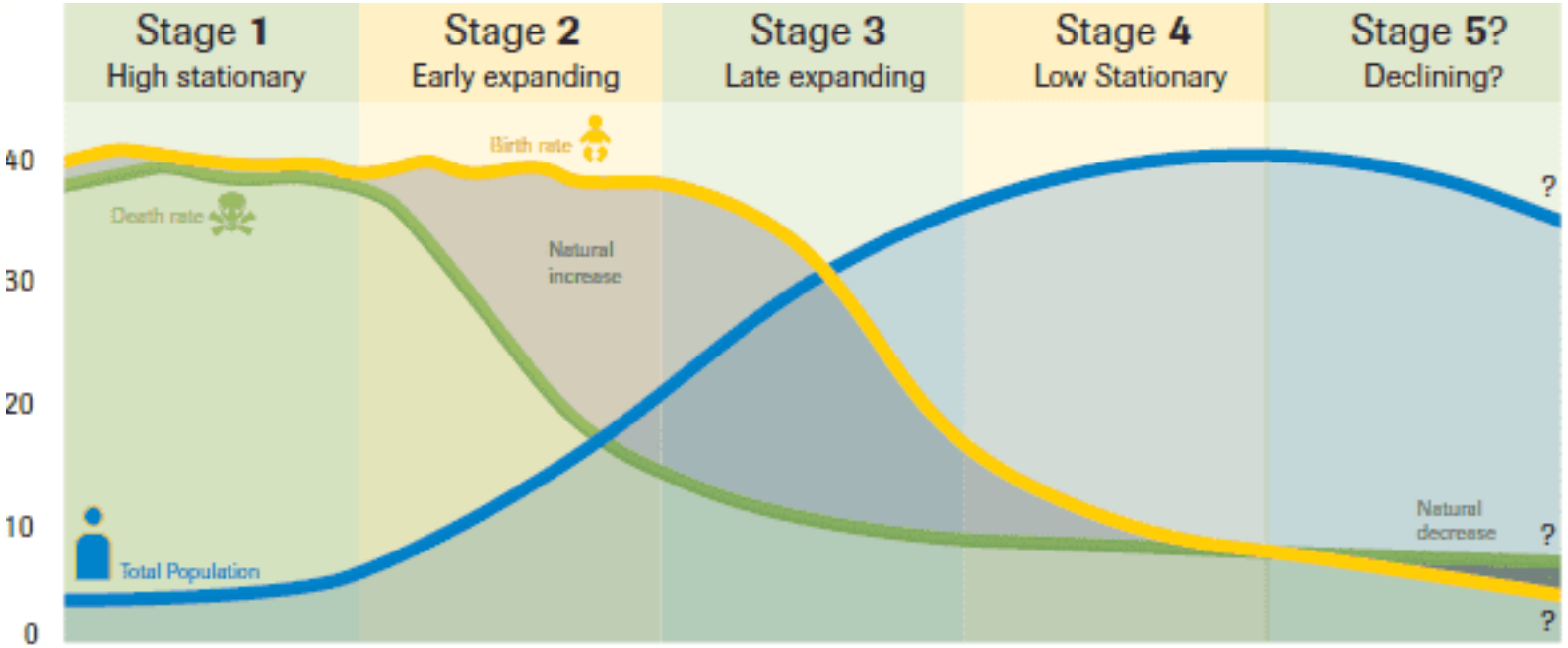
The aim of the report is to understand the processes, policies and investments that supported sustainable demographic transitions in the champion countries of the region and learn from them in the SSA context.

This fits within **two important shifts in SSA**:

- Increased political engagement due to the idea of reaping the economic benefits from a demographic dividend, when population growth slows following an accelerated demographic transition.
- The young population of SSA increasingly recognises that their demand for sexual reproductive health information and distribution of contraceptives is not met by the current supply.

2. Demographic transition in SSA

Stages of the Demographic Transition Model



Source: Grover, D. "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.

2. Demographic transition in SSA

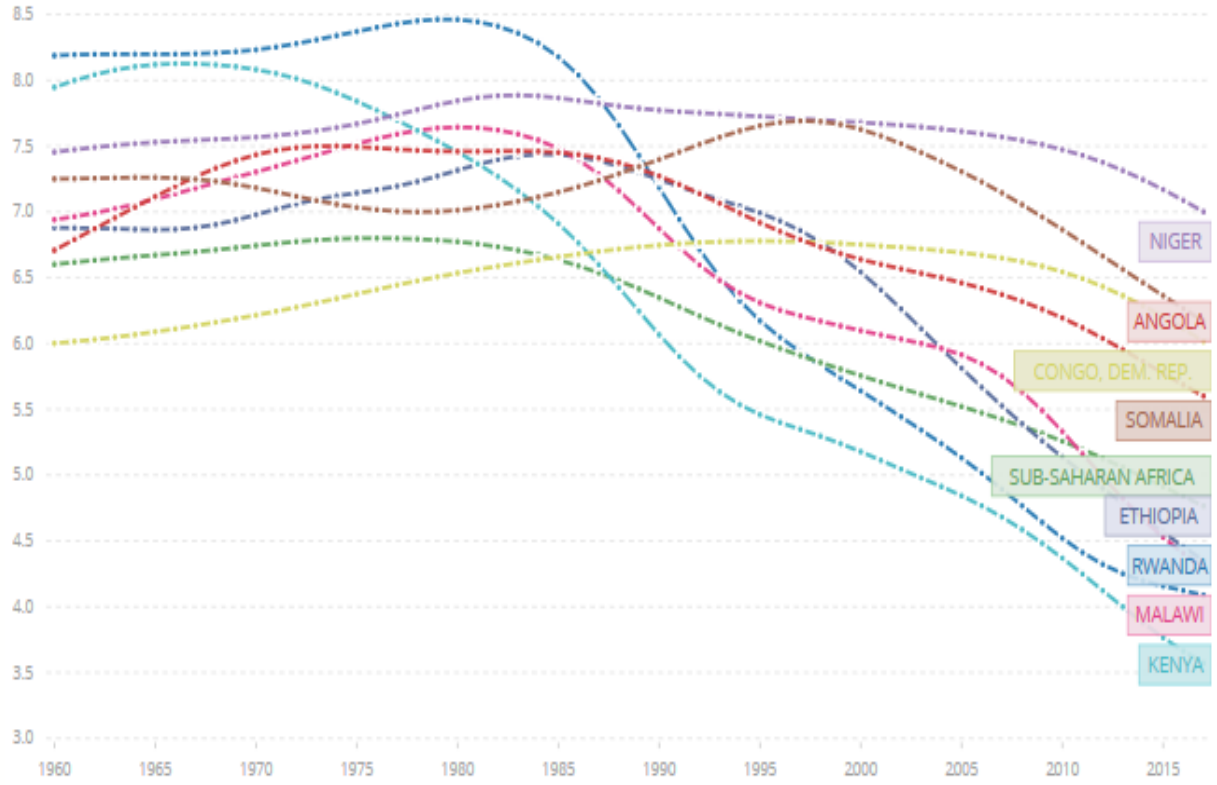
- Fertility decline in SSA has started later and has been comparatively slow relative to countries in Asia and Latin America.
- The current average fertility rate for all SSA countries is around 5 births per woman (Gerland et al., 2017) and 30% of women use modern methods of contraception (Cleland & Potter, 2019).
- It took SSA 20 years following peak fertility before the fertility rate for the region had declined by 10% (10 years for both Asia and Latin America) (Shapiro & Hinde, 2017).

2. Demographic transition in SSA

However, it is important to understand that there is considerable variation among countries and between regions within countries.

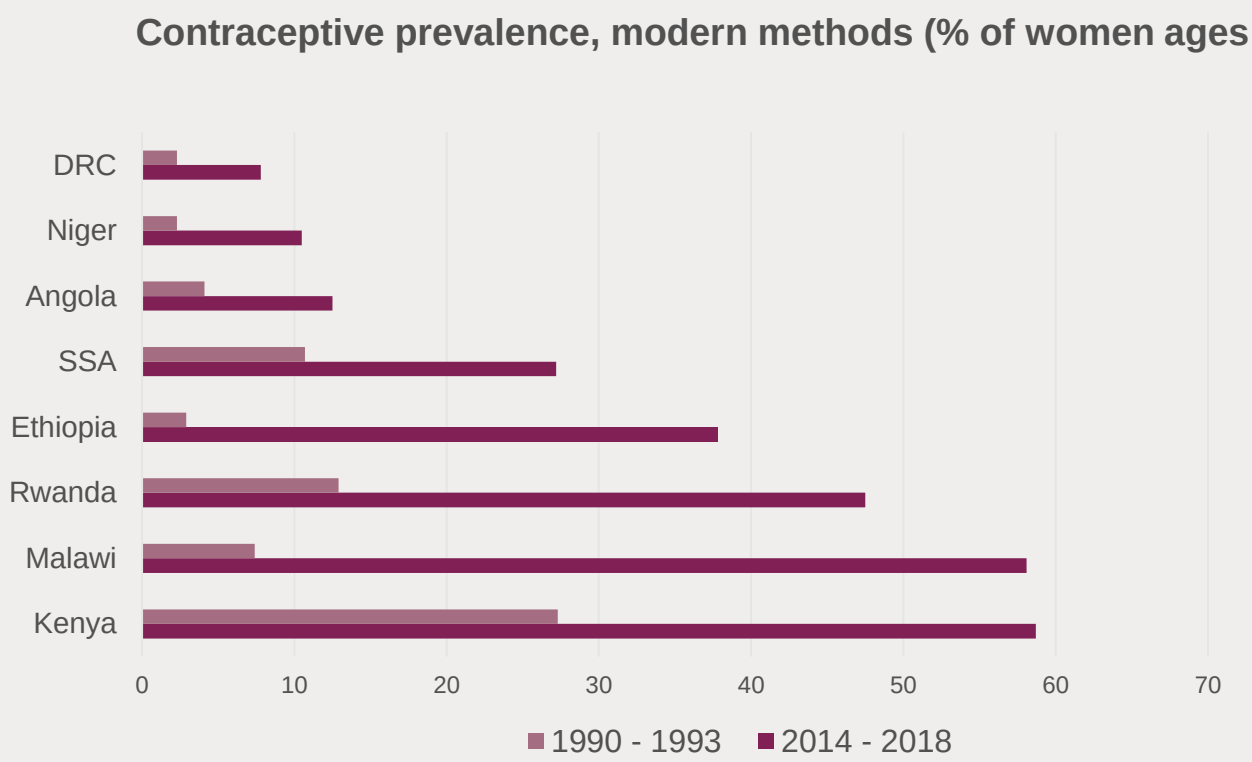
2. Demographic transition in SSA

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



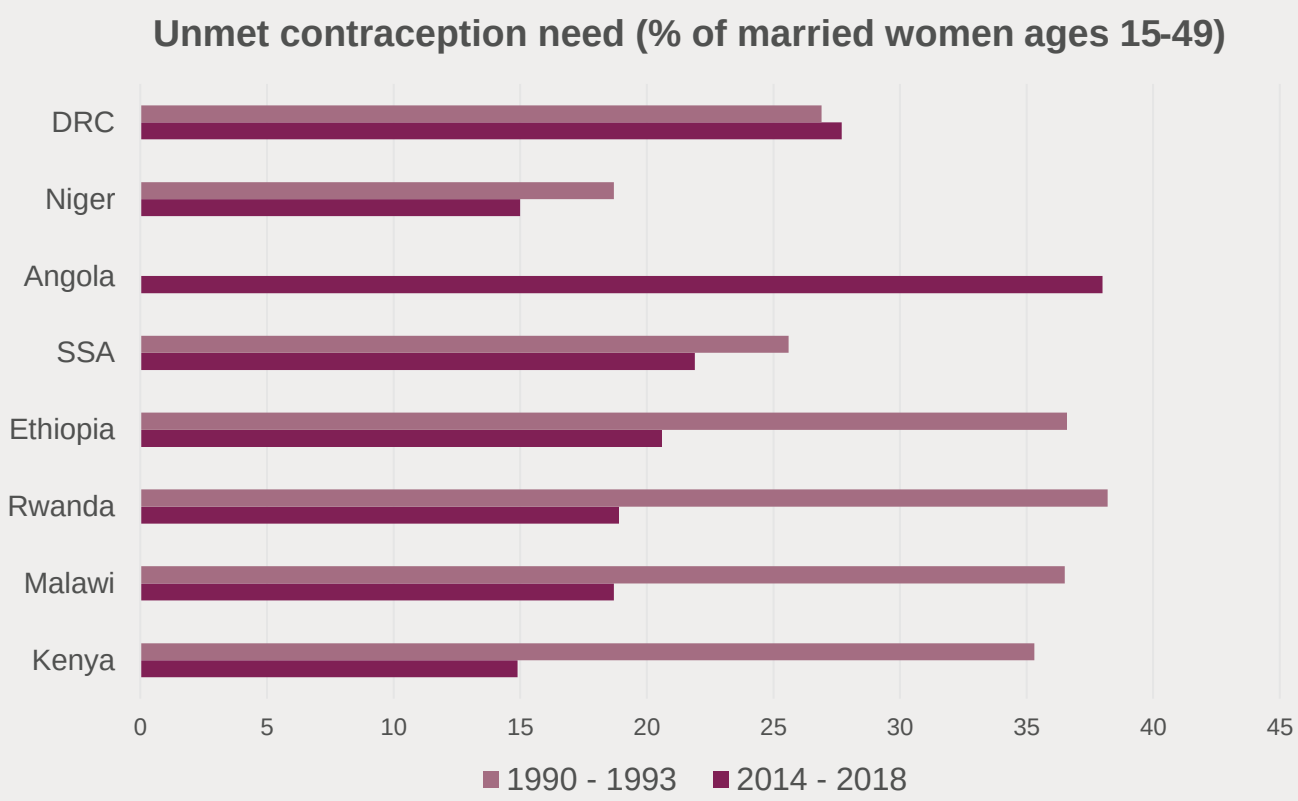
Source: Authors' own, based on data from the World Bank. Dataset name: Fertility rates (birth per woman). Data source: (1) United Nations Population Division. World Population Prospects: 2019 Revision. (2) Census reports and other statistical publications from national statistical offices, (3) Eurostat: 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.

2. Demographic transition in SSA



Source: Authors' own based on data from World Bank. 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. Retrieved from https://data.worldbank.org/. Accessed February 2020.

2. Demographic transition in SSA



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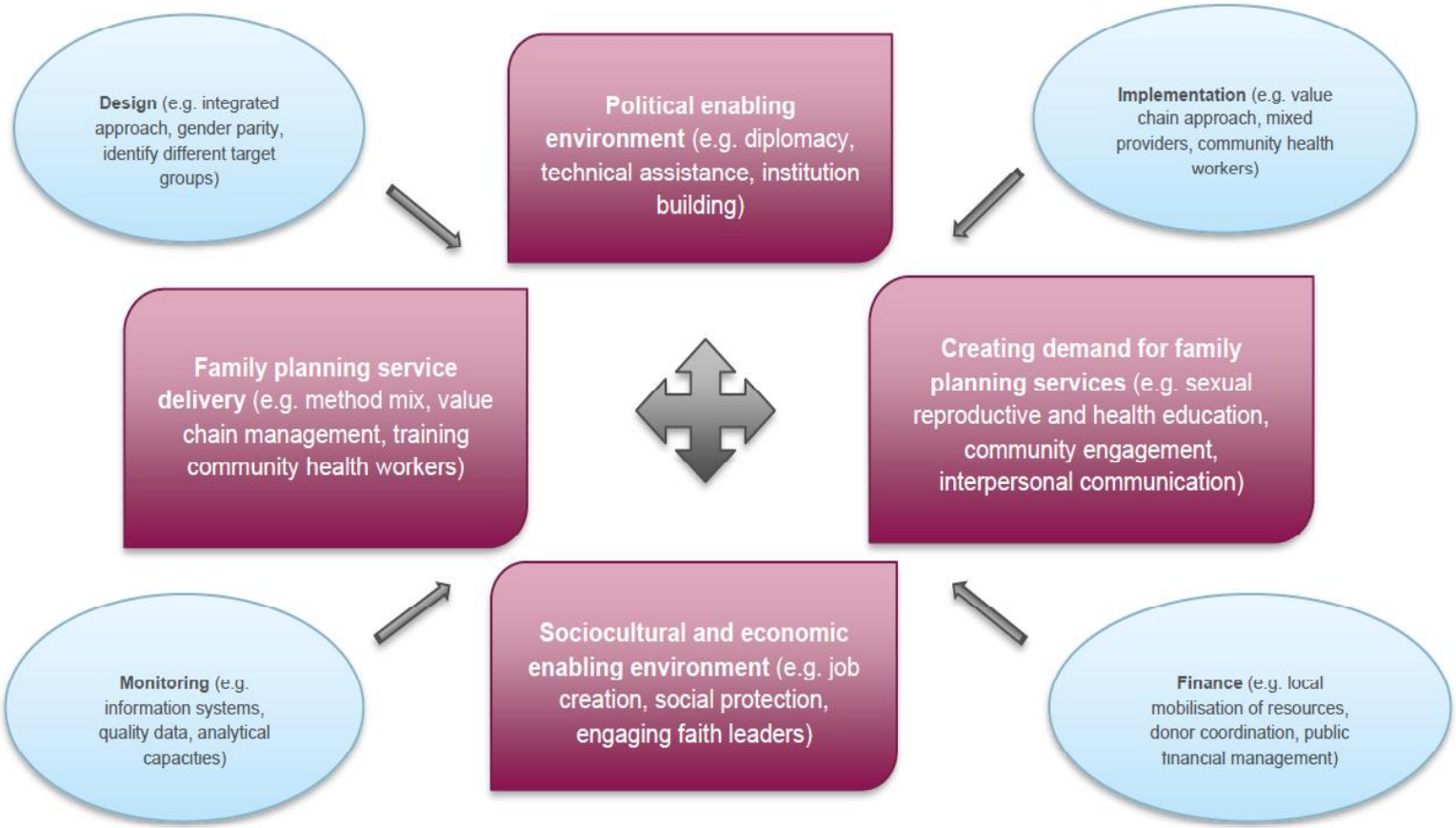
3. Framework

Important **building blocks** for achieving an accelerated demographic transition. What we know from the literature:

- It is 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).
- Family planning must be embedded in sociocultural and economic changes (enabling environment). However, this does not mean that the demographic transition is the result of economic growth!
- Success will depend 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.

3. Framework



Source: Authors' own

4. What do we know from the champion countries: Ethiopia, Rwanda and Malawi

- Strong government involvement
- Link with health, sociocultural and economic policy agendas
- Create an effective service delivery system (supply side)
- Create supportive climate for the idea of family planning (demand)
- Develop coalitions of support
- Develop an effective information and communication system
- Engage with external funders

4.1 Top level political commitment

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).

Ethiopia: Prime Minister Meles Zenawi was looking for a way to improve the country. In 2005, this resulted in a major expansion of the Health Extension Programme, and focused on increasing the quality of the family planning programme. 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.

Malawi: The government prioritised family planning as a way to achieve a better quality of life for its people. 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.

4.2 Linking family planning with policy and laws

Sub-Saharan African champion countries all show clear legal and regulatory framework, defined goals and indicators. Laws (e.g. against child marriage) and policies can codify and articulate the commitment of countries to respect, protect, and fulfil reproductive rights, they play a role in scaling up health interventions, and comprehensive national guidelines clarify standards for service providers.

Rwanda: The government formulated the first National Family Planning Policy (2006–2010) and a multi-sectoral approach to improving the quality of and access to family planning. The message for the population is “produce children you are able to raise”.

Malawi: The 2013 Gender Equality Act guarantees access to reproductive healthcare and bars discrimination in providing services based on marital status.

4.3 Gender-equitable education

SSA 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.

Ethiopia: The Population Policy aimed to increase female participation at all levels of the educational system. 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.

Malawi: The Growth and Development Strategy advocates for girls' education, in combination with the aim to delay marriage and promote the small family concept.

Measures to improve this should not only focus on capital investments, but also recognise the political economy in the education sector (Watkins & Ashforth, 2019).

4.4 Employment

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 in the next decades due to high fertility rates. 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.

The champion countries link economic development and poverty reduction strategies with family planning interventions and women's employment. They acknowledge that high fertility is a barrier for economic and productivity growth.

Ethiopia: 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.

Rwanda: Many policies were put in place to help keep women in work (e.g. three months of paid maternity leave)

4.5 Effective delivery system

Mobile services:

Malawi: A case study of Malawi's experience concluded that the mobile outreach service delivery programme played a key role in achieving increase in modern contraceptive prevalence among married women—from 28% to 42% (2004-2010) (USAID, 2014).

Integrate in health services:

Malawi: Family planning policies 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).

4.5 Effective delivery system

Community-based workers:

Ethiopia: HEP 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.

Supply chain:

Ethiopia: In 2004, the Ethiopia Contraceptive Logistics System (ECLS) managed by the government with technical support from USAID DELIVER, was developed to improve the contraceptive supply chain. This was as a result of the 2001 study that showed stock outs ranging from 30-60% despite adequate supplies in the system.

4.5 Effective delivery system

Social marketing:

Ethiopia: Social marketing has been used for condoms, pills and injectables promotion and sales. Other family planning commodities, e.g. emergency contraceptives pills, can be distributed through social marketing involving private, and NGO health institutions (pharmacies, drug stores, and rural drug vendors).

Youth and adolescent specific services:

Rwanda: Traditional avenues of receiving family planning care offered little privacy to unmarried adolescents. Expansion of family planning services was necessary as this group was underserved and was done with standalone “youth centres” as well as “youth corners” integrated into existing health facilities (Schwandt et al., 2018).

4.6 Coalitions of support

Religion leaders:

Rwanda: 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. 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.

NGOs and private sector:

Ethiopia: Non-profit organisations have supported government efforts with social marketing, behaviour change communications via HEWs, mobile clinics, and social franchising.

4.7 Clear communication

Champion countries have used mass media and digital platforms as well as more traditional face to face community level dialogues to increase demand side.

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.

5. Lessons

- The demographic transition can be initiated before having achieved a significant economic transition, and has the potential of a demographic dividend to spur economic growth.

- 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. It should not be the aim to reduce population size!

- Ethiopia, Rwanda, and Malawi show strong and continued top-level government support and commitment in terms of population and family planning programmes.

5. Lessons

- Support is delivered through a comprehensive approach linking family planning with health, education, and job creation.
- 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.
- Demand-side and supply-side interventions in family planning services should both be prioritised.
- Decentralisation has increased access to services by bringing the infrastructure closer to the people in rural areas and urban slums.

5. Lessons

- 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 flexibility and responsiveness in adapting to local conditions, adequate monitoring and information systems combined with funding sources.

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