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The Role of Political Will and Commitment in Improving Access to Family Planning in Africa

By

Violet I Murunga, Nyokabi R Musila, Rose N Oronje and Eliya M Zulu of the African Institute for Development Policy, Nairobi, Kenya and the Institute for Development Studies, University of Sussex, Brighton, UK

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CONTENTS

I. ABSTRACT

Despite commitments to the program of action for the 1994 International Conference on Population and Development (ICPD) and MDG 5 (focused on maternal and reproductive health), little progress has been made in improving access to family planning and slowing rapid population growth in Africa. Lack of political will has been highlighted among the key factors behind the lackluster performance in addressing these 'sensitive' development issues. However, the situation is changing with some African governments embracing family planning as a key tool for improving child and maternal health, slowing population growth and preserving the environment, and enhancing broader efforts to alleviate poverty. This study examines factors that have propelled the change in attitudes of some political leaders to champion family planning, assesses how such political will has manifested in different contexts, and explores how political will affects the policy and program environment. Mixed policy analysis methods were employed, including desk review of policy and program documents and stakeholder interviews conducted in Ethiopia, Malawi, and Rwanda - three countries that have made phenomenal progress in increasing contraceptive use in the recent past.

Lessons from this study will help galvanize efforts to improve access to reproductive health services in countries where little progress is being made. The results provide useful insights on the dawn of a new Africa where strategic political leadership is playing an increasingly valuable role in overcoming the continent's longstanding development shackles. The study shows that political will is mainly changing due to increased availability of evidence showing that high population growth undermines efforts to alleviate poverty, hunger and invest in the quality human capital that least development countries desperately need in order to transform their economies. The high sensitivity about childbearing and suspicions regarding the intentions of western development partners in promoting family planning in order to slow population growth are dissipating as more Africans are opting to have fewer children and demanding family planning. This study points to the need for global development partners to be much more cognizant of the drivers of Africa's emerging success and focus their development assistance on enhancing, nurturing, and highlighting local leadership traits, capacities, and systems that are producing positive results, and support governments that have embraced family planning to ensure that no woman has an unwanted pregnancy due to lack of family planning.

II. BACKGROUND AND INTRODUCTION

The United Nations projects that the global population will stabilize at about 10 billion people by 2100 if the current fertility rate of 2.5 children per woman will fall to the replacement level fertility of 2.1 children per woman in the next few decades. However, if the level of fertility is above or below the replace level by about half a child, the global population will actually reach between 6.2 billion and 15.8 billion people by 2100. The UN projections further show that most of the growth in population during the rest of the century will be driven by the least developed countries. Most of these are in Africa, which has an average family size of 4.7 children per woman compared to the global average of 2.5.

In fact, Africa is the only major geographical region where population is estimated to continue growing beyond 2100. By then, Africa's share of global population will increase from the current 12% to about a third.

Africa remains the region with the lowest level of contraceptive use (29% versus the global average of 69%) and high demand for children (Population reference Bureau, 2011). Population growth and size have traditionally been sensitive and contentious issues among post-independence African leaders. During the 1970s and 1980s, African leaders perceived family planning, which was largely introduced and financed by Western countries, as an attempt to limit the number of Africans in the global population. At the 1974 Bucharest Population Conference, African policymakers joined their Southern Asia counterparts in rejecting calls for promotion of family planning to slow down population growth. Ten years later at the 1984 International Conference on Population in Mexico, African leaders maintained their views that population growth was not the major driver of underdevelopment. Apart from the suspicions that the African leaders had about the intentions of the Western development partners and experts, they believed they were protecting the reproductive aspirations of their constituents, who desired to have many children. Their position was bolstered by the surprising position adopted by the Reagan administration of the USA, who pushed the Mexico conference to adopt the position that population growth is not a major ingredient of development.

At the 1994 International Conference on Population and Development (ICPD), position papers from most African countries acknowledged that rapid population growth was detrimental to their development efforts. However, the conference marked a major ideological shift from focusing on addressing rapid population growth and meeting demographic targets to a new paradigm aimed at meeting the socioeconomic and reproductive health needs of individual women and men. The new approach highlighted the need to empower women and enhance their opportunities and choices through expanded access to education and health services, and promoting skills development and employment. While the prioritization of reproductive health and rights was positive, one of the negative unintended consequences of the ICPD has been diminished focus on family planning and tackling population growth in high fertility countries.

The 2005 United Nations Summit included universal access to sexual and reproductive health (SRH) as one of the Millennium Development Goal (MDG) targets because of the recognition that reproductive health is critical for the achievement of virtually all MDGs, particularly those focused on child health (MDG 4) and maternal health (MDG 5). The decision to include universal SRH under the MDG framework reinforced efforts to realize the ICPD program of action, whose cornerstone was the resolution that women and their partners should have universal access to the information and services they need to make informed and voluntary decisions about their reproduction and accordingly plan the number and timing of their pregnancies.

However, recent reviews of Africa's progress in achieving ICPD and related MDG objectives show that limited progress has been made in translating political and policy commitments into well-resourced and effective programs to ensure universal access to Family Planning (FP) and other Reproductive Health (RH) services. Apart from being the remaining hub of

high fertility, Africa continues to harbour serious health challenges that have a direct effect on socio-economic development. The continent has the highest maternal mortality rates. For instance, the 2008 estimates of the maternal mortality ratio (MMR) were 260 for the World, 290 for developing regions, 280 for South Asia, 590 for Africa, and 640 for Sub-Saharan Africa (WHO et al., 2010). The 2010 estimates of the proportion of married women using modern contraception followed the same trend: 55% globally, 44% for all developing countries (excluding China), 45% for South/Central Asia, 23% for Africa, and 17% for Sub-Saharan Africa (Population Reference Bureau, 2010). Yet, family planning has the potential to not only help slow population growth and ensure environmental preservation, it also contributes to reduction of child mortality by about a tenth and maternal mortality by about a third.

Despite the generally poor progress in Africa, things are beginning to change in concrete ways in Africa and a few countries have made phenomenal progress in increasing contraceptive use in the recent past. The emerging success gives hope that African countries can overcome the perennial challenges that have prevented them from achieving their development objectives. Nevertheless, the factors that are responsible for the progress are not well documented, and there are many unanswered questions regarding sustainability and potential application to other countries. Furthermore, the emerging changes in the attitudes of African leaders and policymakers on reproductive matters is not well understood in the global North, which still believes that African leaders are against slowing rapid population growth. Systematic documentation and dissemination of the nature of progress, and factors that are driving progress in well performing countries could go a long way in addressing these knowledge gaps.

This study examines factors that have propelled the change in attitudes of political leaders to champion family planning based on case studies of three relatively poor countries that have registered remarkable increases in contraceptive use over the last decade or so – Ethiopia, Malawi, and Rwanda. It also assesses how such political will has manifested in different contexts, and explores how political will affects the policy and program environment. Lessons from this study will help galvanize efforts to improve access to family planning in African countries where little progress is being made.

Rationale for the Study

Countries are beginning to feel the adverse effects of rapid population growth. As African governments are keen to put in place measures to slow down these effects, they are progressively recognizing family planning as a key intervention. Notably, with the financial challenges that African government face against many competing development issues, support from the global North is paramount. As a result, there is demand for evidence from multiple players on how African governments can successfully scale up FP programs.

Rwanda, Malawi and Ethiopia are countries that have been identified as emerging success stories in Sub-Saharan Africa in increasing family planning uptake and can serve as great examples for other countries in the region, as well as the Global North. These three countries possess histories marred with major obstacles, ranging from skepticism over FP and promoters of FP (Westerners) in Malawi that resulted in the eventual ban of FP in the

late 1960s through the early 1980s; a genocide in Rwanda which claimed nearly one million of its population, presenting a challenge of how to frame the benefits of FP in the aftermath; and decades of ethnic wars, famines and droughts in Ethiopia which consumed political support and resources away from health priorities in general, including FP. Furthermore, these challenges are notwithstanding the cultural and religious barriers, in favor of large families, that continue to exist in the three countries as they do in most Sub-Saharan countries.

However, in the last decade or so, these three countries have overcome some of their challenges and experienced dramatic increases in contraceptive use with Rwanda registering the fastest rate of increase in contraceptive use in Sub-Saharan Africa at 4.0 percentage points per year! In addition, an analysis of trends in contraceptive method mix in all three countries shows enhanced uptake of longer acting methods particularly injectables. There have also been rises in use of implants and intrauterine contraceptive devices (IUCDs).

Study Objectives

This study examines factors that have propelled the change in attitudes of some political leaders to champion family planning, assesses how such political will has manifested in different contexts, and explores how political will affects the policy and program environments for family planning. The study provides policy and program lessons for improving access to FP in other African countries where limited progress has been achieved.

The lessons will also help illustrate to Northern policymakers and development partners what works in order to galvanize concerted action with their African counterparts on contraceptive use and possibly other development issues in Africa.

Study Design and Methodology

The assessment consisted of a triangulation of three methods of data collection:

a) Document review in order to understand the nature of policy and program adjustments that the three study countries have made to increase contraceptive use over the past two decades;
b) Review of internal and external financial resources for FP and population issues, as well as commodity security over the past decade or so; and
c) Key informant interviews with policymakers, development partners, program managers, and key civil society stakeholders in each of the three countries to gain insights on what changes were made and who played what roles in driving the reproductive revolutions.

A semi-structured interview guide was used for the stakeholder interviews. The stakeholders were identified through initial stakeholder analysis and a snowballing approach. In total, 23 individuals were interviewed in Rwanda, 25 in Malawi and 30 in Ethiopia (see Table 1).

Table 1. Key Informant Interviews by Group

	Rwanda	Malawi	Ethiopia
FP TWG focus group discussion	1	-	-
Key informant interviews			
Government – policymakers	11	9	10
Government – service providers	3	1	-
Development partners	3	3	5
International NGOs/private implementers	4	7	11
Local NGOs/civil society	1	1	2
Faith-based organizations / religious leaders	1	3	2
Academic institution	-	1	-
Total	**23**	**25**	**30**

Information garnered through the desk reviews and key informant interviews were synthesized to identify the factors that drove increases in contraceptive use in the 3 successful case study countries (Rwanda, Malawi and Ethiopia), the challenges experienced, how they were addressed and what measures are being implemented or planned, to ensure sustainability of the recorded progress. The key factors that propelled the phenomenal increases in use of FP in the three countries were:

- Political will and government commitment demonstrated by clear policies and implementation strategies;
- Sustained funding of FP and RH services;
- Strong healthcare infrastructure and system focusing on enhancing equitable access to quality services through task-shifting, improved referral system, well-trained health workers, and pro-poor health policies (including lost cost or free FP and other RH services);
- Strong community outreach activities focused on getting services closer to isolated, vulnerable and marginalized communities;
- Strong IEC programs to promote family planning and use of contraceptives, including promoting male involvement in RH and FP; and
- Strengthening public-private partnerships in provision of FP and other RH services.

This paper focuses on the origin, architecture and role of political will in facilitating the changes in the other factors and, ultimately, in increasing contraceptive use in the three case study countries.

Results

Table 2 shows trends in population, annual population growth rates, fertility rate, contraceptive use, and unmet need for family planning for the three countries between approximately 1990 and 2010.

Table 2. Population and FP Trends in Rwanda, Malawi and Ethiopia

Population Indicator	Ethiopia			Malawi			Rwanda		
	1990	2000	2011	1992	2000	2010	1992	2000	2010
Population Size (Millions)	51.7	65.6	83.0	9.7	11.2	14.9	6.5	8	10.6
Annual Population Growth Rate (%)	3.4	2.6	2.2	1.0	2.8	3.1	6.3	6.6	3.1
Total fertility rate	6.4	5.9	4.8	6.7	6.3	5.7	6.2	5.8	4.6
Contraceptive prevalence rate (%)	2.9	6.3	27.3	7.4	26.1	42.2	12.9	4.3	45.1
Unmet Need for family Planning (%)		35.8	25.3	36.3	29.7	26.1	40.4	48.8	-

Source: DHS. All population and population growth rates data is from World Development Indicators 2011 (World Bank), http://data.worldbank.org/data-catalog/world-development-indicators?cid=GPD_WDI

Rwanda is the most densily populated country in all of Sub-Saharan Africa. Rwanda's population has come close to doubling from 1992 to 2010, growing 1.7% from 6.5 million to 10.6 million. While the population growth rate has decreased substantially since its 1992 rate of 6.3% per year, it is still high at 3.1% per year in 2010. The reduced population growth rate may be partly credited to the increase in uptake of FP over the period. Rwanda's CPR was relatively low at 12.9% in 1992. Notably following the atrocities in 1994, this dipped further to an all-time recorded low of 4.3% in 2000. Thereafter, Rwanda's recorded CPR rose to closely mirror its predetermined level from 13 years ago, to 10.3% in 2005. However, there was a turning point in Rwanda which saw an outstanding increase in use of modern FP to 45.1% in 2010. This most recently recorded 5 year margin (2005-2010), represented a phenomenal increase of 4.1 percentage points per year, the highest on the continent. Rwanda's TFR also remained in the range of 6.2 to 6.1 between 1992 and 2005 (with an insignificant drop recorded at 5.8 in 2000). However, again the 5 year period 2005-2010 saw the TFR drop to 4.6 children per woman. The most popular FP method is longterm (26.3%; or 58.3% of all modern methods). Unmet need for FP, however, remains high, recorded at 37.9% in 2005. Of great concern, particularly in light of the limited unoccupied land mass, the UN population projections show that Rwanda's population will more than double (2.4%) to 26 million by 2050, and thus inflating its already high population density, if the current fertility rate is maintained.

Malawi has been feeling the effects of rapid population growth since its economy started to deteriorate in the late 1970s (Chimbwete, Watkins and Zulu 2003). Malawi's population has increased from 9.7 million in 1992 to nearly 15 million in 2010. Unlike Rwanda's decreasing population growth rate, Malawi's population growth rate increased from 1% per year in 1992 to 3.1% per year in 2010. Of note, the population growth rate has stagnated at about 3% per year since 2000, despite the increasing uptake of FP over the period. Malawi's CPR more than tripled between 1992 and 2000 from 7.4% to 26.1%. This phenomenal upward

trend is evidently aligned to the reorientation of the FP program in 1992 from a child spacing program to one focusing on family welfare. This upward trend continued to a CPR of 42.2% in 2010. However, Malawi's fertility remained persistently high (about 6 children per woman in 2010). The most popular FP method is long-term (25.8%; or 61.1% of all modern methods). Of note, unmet need for FP has not change much in the past decade averaging at 1 in 4 women (26.1%) having unmet need for FP. Of concern, the UN population projections show that Malawi's population will more than triple to 49.7 million by 2050, if the current fertility rate is maintained, thereby augmenting Malawi's already present development challenges.

Ethiopia has the second largest population size in Sub-Saharan Africa after Nigeria. Its population has grown from 51.7 million in 1990 to 82.9 million in 2011. The population growth rate decreased from 3.4% per year in 1990 leveling off at about 2.2% per year in 2011 in part owing to the increase in uptake of FP over the period. Ethiopia's CPR in 1990 was incredibly low at 2.9%, and barely rose in the course of the next decade to 6.3% in 2000. The latter decade, however, has exhibited an outstanding 4-fold increment in FP uptake to 27.3% in 2011. In the same time period, Ethiopia's fertility has dropped by 2 children from about 7 in 1990 to about 5 children per woman in 2011. Unmet need for FP has reduced, but remains high at 25.3% in 2011. The UN population projections show that Ethiopia's population will nearly double (1.8%) to 145 million people by 2050 if the current fertility rate is maintained.

III. INCREASING CONTRACEPTIVE USE IN RWANDA, MALAWI AND ETHIOPIA: ORIGINS, ARCHITECTURE AND POLITICAL WILL

Experience in the three countries – Rwanda, Malawi and Ethiopia – over the last decade or so demonstrates that political will was a precursor to the exceptional progress in increasing demand and supply of FP commodities. Indeed, while political will did not independently bring about increased FP uptake, it translated into FP/population policy formulation, prioritization of funding, program implementation, and created a conducive political and social environment for health system/service reforms. Interestingly, what emerges is that in all three countries, despite the common success in FP uptake, the form, architecture and impact of political will differ uniquely.

The three case study countries ably demonstrate actors and specific in-country circumstances that propelled the change in attitudes of significant political leaders in Rwanda, Malawi and Ethiopia to champion FP (in other words why is political will changing), how such political will manifests and invariably opens the policy window to develop new policies or enables the implementation of existing policies to change the program environment. This is further discussed below.

Why is political will for FP changing?

Intensive advocacy by local and international experts and champions was essential for national adoption and sustainability of the FP agenda in the three case study countries. Local advocates led domestic advocacy efforts for the adoption of population policies while international advocates provided financial and technical support for initiating and sustaining domestic advocacy efforts and continue to play this role. In all three countries, local FP advocates include FP experts or champions in government like the Ministers of Health and non-government organizations, mainly comprising International Planned Parenthood Federation (IPPF) affiliates. In the case of Rwanda, the head of state, President Paul Kagame 2000- present, emerged as a key local advocate. A key characteristic of local advocates is their grasp of the importance of FP, their ability to convince political elites and top level leadership about the importance of FP, and galvanize commitment and support for FP at all levels of leadership.

In Rwanda, Dr. Jean Damascene Ntawukuriryayo, former Minister of Health and current president of the Senate, emerged as an early key local advocate at the center of domestic advocacy efforts. He is well educated and knowleadgeable about FP; he perceived rapid population growth as an obstacle to development; he was knowledgeable of the impact of the genocide, as well as the policy process in Rwanda; and he helped position FP in a way that resonated with fellow political elites in Rwanda. Dr Ntawukuriryayo earned the nickname 'Mr. Family Planning' from his consistent and sometimes controversial advocacy efforts to galvanize support from parliamentarians and the public. Of importance, President Kagame's keen interest in development further catalyzed prioritization of FP in Rwanda and he, in turn, emerged as a key local FP advocate, placing FP at the center of Rwanda's development agenda and speaking out publicly on the importance of FP for health and development.

In Malawi, two Malawian medical elites, Dr. Chiphangwi and Dr. Lucy Kadzamira, knowlegeable about FP and with close ties to President Banda, emerged as early key FP advocates. They began lobbying for family planning at the end of the 1970s; by early 1980s, their efforts resulted in the end of a more than a decade long ban on FP and the introduction of a Child Spacing Program. Dr. Kadzamira was at the time the Controller (Director) of Nursing Services in the Ministry of Health. Both Dr. Chiphangwi and Dr. Kadzamira attributed their concern to women not having access to modern FP to their encounters with women who had an unmet need for FP, which had fueled their advocacy efforts.

> "….*Women come to the clinic, yet they have strings* [a traditional method of child spacing] *around their waist, they don't help."*
>
> - Dr. Kadzamira (Chimbwete, Zulu and Watkins 2003)

Furthermore, their links with the international community including their educational background being from the west helped leverage their advocacy efforts.

In Ethiopia, the Minister of Health in 2005, Dr Tedros Adhanom Ghebreyesus, lead the health sector through a number of reforms, which facilitated prioritization and enhancement of the FP program. Dr Tedros Adhanom Ghebreyesus held several offices within the Ministry since the late 1980s. His long tenure within the Ministry of Health and the fact that he is well-educated and a seasoned researcher enabled him to lead the

necessary reforms and activities needed to prioritize FP and expand the FP program. He was able to advocate for and mobilize a fair amount of financial and technical resources from international partners which benefited the FP program, leading to its expansion. This is articulated in the following excerpt from a recent interview an AFIDEP staff member had with a key informant from the Federal Ministry of Health:

> *"We believe the credit should be given to the people themselves and to the Ministry of Health, which was the coordinating body. We also enjoyed a number of partners in the process. We had a long list of family planning partners in the country but the main role was played by the government itself."*

International FP advocates who have been at the forefront providing technical and financial assistance for local FP advocacy in these three countries include UNFPA, USAID, World Bank, Futures Group, Packard Foundation and Population Reference Bureau. A key approach which these entities have used is working as partners with relevant government agencies to build capacity for continued domestic advocacy, as well as funding supply side (training, health systems strengthening and contraceptive security) and demand side (public education) activities to increase access and utilization of FP services.

While many African leaders could argue that in the past that it was against the African culture to promote family planning, the evidence collected from both men and women over the past two decades shows overwhelmingly that most women are having more children than they would like to, and that many of them would like to postpone their next birth, but are not using family planning methods. Furthermore, improvement of child survival in Sub-Saharan Africa coupled with the worsening economic hardships being experienced by many in the region has resulted in men and women preferring to have fewer children they can afford to care for. Across the globe, 215 million women report having unmet need for family planning, while in Sub-Saharan Africa, 42 million of the 78 million women who need to use family planning are not using a modern method of contraception. About two in five women in Ghana, Zambia, Malawi, and Togo reported that their last birth was unplanned. In most African countries, there are more women with unmet need for family planning than those with met need.

There are many reasons why women have unmet need for family planning - lack of services, disapproval of family planning, misinformation and misconceptions about effects of family planning, and imposition of unjustified medical barriers, such as limiting oral contraceptive use to medical prescription. These barriers can be addressed through well-planned, appropriately funded family planning program, with strong community involvement and mobilization.

The role of family planning in improving maternal and child health

The close scrutiny on performance of countries towards achieving the Millennium Development Goals (MDGs) coupled with the increasing evidence on the central role of family planning in improving maternal and child health, have allowed leaders who are uncomfortable with the promotion of family planning for slowing down population growth to join the family planning bandwagon.

Malawi started as a child spacing program after President Banda was convinced that modern contraceptives could be used to reinforce traditional child spacing to save the lives of mothers who were dying from having children too close together. This continues to be a big selling point for FP in Malawi, as well as Rwanda, Ethiopia and the rest of Sub-Saharan Africa.

The role of population in undermining efforts to sustainably improve economic performance and alleviate poverty

The economic turbulence that most of these countries have experienced since the 1980s has also made it clear that it will be difficult or impossible to break their development shackles without slowing rapid population growth. For instance, although some countries are meeting Millennium Development Goal number one, – to halve the percentage of people living in poverty between 1990 and 2015 –more Africans are living in extreme poverty today than in 1990 as a result of rapid population growth. Additionally, agricultural land size is decreasing, perpetuating food insecurity and rising unemployment lends itself to political instability, war and conflict. There is also stagnation of school outcomes leading to populations with low education levels and a strained health care system, resulting in populations with declining health outcomes, both of which have implications on development.

While big populations have traditionally been embraced by leaders as symbols of political power, sources of influence on the global stage, and potential assets for economic prosperity, it is becoming increasingly apparent that development goals will be better met through high quality populations rather than big populations dominated by uneducated and impoverished citizens. The emerging thought of many African leaders could be best summarized by the excerpt from a recent interview an AFIDEP staff member had with the President of the Senate in Rwanda, Dr Ntawukuliryayo. When asked why Rwanda decided to put family planning and slowing population growth at the center of their development soon after experiencing the unfortunate genocide of 1994, he said:

> *"We did this after coming to the realization that we could not develop into a middle income country with a quality and productive population without addressing the rapid population growth in Rwanda. "*

As a result of this commitment and financial support from development partners, Rwanda has managed to register one of the fastest increases in use of modern contraceptives in human history, from 4% in 2000 to 45% in 2010. Another example is Malawi, which went to the extent of banning family planning between 1969 and 1984, but has turned around to record one of the highest levels of modern contraceptive use (42.2%) in Africa in 2010. Likewise, Ethiopia's contraceptive use has increased from one of the lowest levels in Sub-Saharan Africa in the 1990s (2.9%) to 27.3% in 2011.

The role of family planning on development

Demonstrating the long-term effects of not putting in place interventions to slow down population growth and how efforts to improve quality of social services that are needed for development will increasingly be undermined by rapid population growth has played a key role in increasing attention to FP among political elites keen on advancing development.

There is increasing evidence showing that rapid population growth is associated with: a decline in agricultural productivity increasing in food insecurity; high population density leading to environmental degradation; increased demand and competition for water resources, perpetuating water scarcity; low education levels which drives high fertility rates; limited health services resulting in poor health outcomes - high maternal and child morbidity and mortality and low life expectancy.

Analyses linking FP to key social and economic indicators helped policymakers understand the importance of FP in Rwanda, Malawi and Ethiopia, thus strengthening the case for FP. In linking FP to national development blueprints, advocates demonstrated the monetary savings that a country can gain in slowing population growth, which translate to development gains through investments of savings in other key sectors – the RAPID and ENGAGE tools by Futures Group and Population Reference Bureau respectively, which are widely promoted and used by FP advocates are examples. In Rwanda, the RAPID tool was instrumental in generating political attention for FP in Rwanda. In Ethiopia, top leadership recognizes FP as a critical tool if the country is to achieve its development goals. In Malawi, the concept of FP as a development tool is also catching on, albeit at a much slower pace than its counterparts.

In all the three countries, the manifestation of political will has been markedly different. In Rwanda, political will is explicit from top level leadership. In Ethiopia and Malawi, top level leadership has created an enabling environment for the Ministry of Health to develop and implement FP policies and programs, thereby dispelling the myth that FP uptake needs a voice at top-level leadership who can exist as a 'silent partner.'

The role of political will has been most dominant and explicit in Rwanda, where strong commitment and leadership has been exhibited throughout the entire political establishment, starting with the President, all the way to leadership at the lowest administrative level. The Rwandan President's personal stewardship of the implementation of FP policies has been a unique and key driving force for the Rwandan national FP program. President Kagame talks about FP in various public fora and has gone to the extent of institutionalizing FP by establishing progress in increasing contraceptive use as one of the performance goals for other leaders, including District Mayors and relevant ministers such as the Minister of Health. Such political will has, therefore shifted from a seemingly personalized view and has traversed to bottom level leadership, thereby creating a common vision on promotion of FP in the country among leaders and the public alike. In 2007, President Paul Kagame was quoted stating,

> "*Family planning is priority number one—not just talking about it, but implementing it.*" (Solo J., 2008)

Crucially, at the center of Rwanda's political will is a strong drive to promote accountability for resources and targeted performance for all public workers. The performance contracts that the President signs with the Ministers and District Mayors in relation to FP are part of this process. The system is entrenched in the public service system with the Ministers and Mayors designing performance contracts with their own staff and so on. This concept has

trickled down to communities, where individual families are also being called upon to draw performance contracts, some of which include family size goals.

In Ethiopia, although consideration of population pressure and concerns about rapid population growth are central in the minds of top leaders and the government's decision to prioritize FP, these issues are not explicitly highlighted in public discussions on FP or development. In fact, the political establishment in Ethiopia does not publically promote FP as is the case in Rwanda. The FP program's messaging is heavily focused on the role of FP on maternal and child health, with reference to development taking root rather slowly. The cornerstone of Ethiopia's political will is the full empowerment of the Ministry of Health to develop and implement a successful FP program. The main champion of FP in the country is the Minister of Health, who has masterminded and promoted the program within the Ministry and with development partners. It is worth noting that although Ethiopia is considered among countries that have made good progress based on the rate at which uptake of FP has increased, the overall level of contraceptive use is still below 30%. A more public exhibition of the political will and the rise of more FP champions who would directly sensitize the public on FP are bound to help propel further improvement in contraceptive use to the absolute levels observed in Rwanda and Malawi.

Malawi's path to progress in increasing contraceptive use has undergone the most turbulent route of the study countries. Perhaps because of the sensitivities that led to the banning of FP in the 1990s, there is no distinct champion or explicit support for FP from top-level leadership in the country. The success has been achieved mostly through the leadership and drive of the Reproductive Health Unit of the Ministry of Health and strong public IEC campaigns that promoted FP for child and maternal health as well. IEC campaigns have also increasingly highlighted the need to address population growth to ease pressure on land, given that the agriculture-dependent Malawi has one of the highest population densities in Africa. Within the MOH, FP support is not prioritized highly. Family planning does not yet have a budget line item and therefore government's own expenditure on FP commodities may not be easily monitored. Given that Malawi has done relatively well to increase contraceptive use in a challenging cultural and political environment, further increase in budget allocation to FP is bound to help boost further improvement in contraceptive use in Malawi.

VI. HOW POLITICAL WILL FOR FP IMPACTS THE POLICY AND PROGRAM ENVIRONMENT

The strong political will and commitment in Rwanda has enabled government, in partnership with development organizations, to develop FP policies and programs and pour in massive resources and technical input to support Rwanda's FP program. However, the program is heavily dependent on foreign financial resources and strong political will has not yet translated into domestic resource mobilization, which is very critical for the sustainability of the program.

A similar scenario has played out in Ethiopia with regard to the development of policies and programs, and massive resources and technical input to support the FP program. Several

financing mechanisms with contributions from government and development partners support the FP program through supporting the Health Extension Program, an innovative health service delivery program aimed at ensuring universal access to primary health care and which include FP as one of the 17 health packages offered, pre-service and in-service training in FP and FP commodities. The Ministry of Health included ambitious targets for family planning in its five-year Health Sector Development Plans (HSDP III and IV). Healthcare reforms were implemented to achieve these and other health sector targets. The most important of the reforms was the development of the Health Extension Program (HEP). The HEP was established in 2003 and helped bring FP services among other key primary healthcare services to the community. It is attributed to the rapid increase in use of modern contraceptives in Ethiopia.

The government is seen as committed to the Health Extension Program. It provides support to the HEP by providing salaries for the more than 33,000 Health Extension Workers. In addition, in 2007, the government waived the import tax on contraceptives and allocated a budget line for contraceptives. The two decisions essentially improved commodity security in Ethiopia by increasing the flow of supply and ensuring dedicated funds from the federal budget.

In Malawi, suspicions that the West was introducing FP in order to force Malawians to limit family size against their will led to the government affecting a ban on provision of FP in its facilities in 1969. The ban on provision of FP was lifted in 1982, but FP was introduced under the "Child Spacing Program" to avoid the tensions that led to the banning of FP. Despite dropping the child spacing label in 1994, the historical orientation of FP policies and programs has had a profound impact and use of FP for child spacing appears to be etched in the psyche of the population. This appears to be part of the explanation for the country's unusual demographic scenario where women continue to bear an average of about six children amidst a relatively high modern contraceptive prevalence rate of 42%.

The basket funding through the Sector Wide Approach (SWAP) funds have been allocated to purchasing FP commodities as part of the Essential Health Package. Support for FP from top-level leadership and a multi-sectoral approach to increasing contraceptive uptake may therefore help sustain this phenomenal gain in contraceptive use, and possibly in shifting the mindset of users from child spacing towards fertility limitation.

V. CONCLUSIONS AND RECOMMENDATIONS

Political will in the three case study countries is demonstrated by political commitment to the FP program either through top leadership championship and stewardship (Rwanda) and/or top leadership creation of a policy environment to support the FP program (Malawi and Ethiopia). Notably, political will was influenced by differences in context and circumstances (political, economic and culture) within the three countries and as a result, they manifested uniquely in each of the countries to achieve the common goal of increased FP uptake.

The findings demonstrate that despite previous opposition to FP by African governments, there are signs of a shift towards understanding and acceptance of FP that has kick-started

an FP revolution in Africa, resulting in prioritization and increase of resources towards FP. Majority of African governments are beginning to recognize the adverse effects of rapid population growth and are keen to put in place measures to slow down the effects, as well as embracing family planning as one of the key interventions. In addition, there are different reasons for how political will for FP was generated and different ways in which political will manifests and affects FP policies and programs. Relatedly, political, economic and cultural circumstances of countries play a major role in how FP was and is perceived, how political will was generated, how it was manifested and the resulting design of FP policies and programs. Furthermore, political will works collectively with a number of other factors to contribute to increased FP uptake including financing, governance, decentralization and health sector reforms.

There is demand for evidence from multiple players (including Africa governments and the global North) on how Africa governments can successfully prioritize and scale up FP programs. The findings of the assessment draw out the following recommendations for South-South and North-South learning and collaboration.

South-South Recommendations

Regardless of intra-country differences, countries can use lessons from Rwanda, Malawi and Ethiopia on how to galvanize political will by adopting or adapting lessons based on their specific country contexts and circumstances. The following are some key lessons emerging from the analysis of the three countries for policy actors interested in influencing FP policy and other policies:

1. National priorities and interests of political elites play a key role in whether FP will be given political attention.
2. Sound research is essential to show the health and development benefits of FP programs.
3. Advocacy tools such as the RAPID and ENGAGE by Futures Group and Population Reference Bureau can be used to help frame the policy narrative using country-specific contexts and circumstances and portraying FP in a way which resonate with political elites and their constituencies.
4. Local advocacy networks involving several players with shared beliefs and ideas strengthen the impact of advocacy efforts.
5. Involvement of political elites in advocacy efforts brings a unique strength to advocacy efforts leveraging the impact of the advocacy network.
6. Knowledge of the social, cultural, economic and political environment is crucial and facilitates development of advocacy and communication messages on the importance of FP.

North-South Recommendations

With the emerging changes in the attitudes of African leaders and policymakers on reproductive matters, it is hoped that the global North can see that African leaders are increasingly becoming aware of the adverse effects of rapid population growth at national and global levels, and are starting to make concerted efforts towards managing their

populations.

African populations are starting to feel the effects of over-population and rapid population growth, coupled with scarce resources and slow economic growth at both national and household levels. Rwanda has the highest population density in Sub-Saharan Africa with a current population growth rate of 3.1% per year; Ethiopia has the second largest population in Sub-Saharan Africa with a current population growth rate at 2.1% per year; and Malawi's population is currently increasing at 3.1% per year.

While Sub-Saharan governments are challenged to commit more domestic resources towards reproductive health and family planning programs, they continue to struggle with competing development priorities compounded with scarce resources. There is strong evidence showing that increased investment in reproductive health programs translates to increase in contraceptive use and decline in fertility through developing enabling FP policies and effective FP programs, improving service delivery, increasing public education, improving the contraceptive supply chain and continued research and development of contraceptive technology and operations research (USAID 2011). This means that the global North stands to obtain positive results from investments in reproductive health and family planning in Sub-Saharan Africa.

Hence, the evidence presented here seeks to galvanize additional development assistance from the North for support of family planning and reproductive health programs in Sub-Saharan Africa with particular focus on enhancing, nurturing, and highlighting local leadership traits, capacities, and systems that are producing positive results; and support governments that have embraced family planning to ensure that no woman has an unwanted pregnancy due to lack of family planning.

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The African Institute for Development Policy (AFIDEP)

AFIDEP is non-profit policy think tank whose purpose is to translate research evidence and use it to advocate for improved policies and program effectiveness in Africa. The Institute seeks to ensure that policy makers and program managers at national, regional, and international levels have consistent and sustained availability of timely, relevant, trusted, and accessible evidence to enable them to set proper priorities, increase investment, and enhance effectiveness of intervention programs in these areas. The ultimate goals are to contribute to the improvement of the wellbeing of Africans by reducing unplanned pregnancies, reducing maternal and child deaths, slowing population growth, and improving sexual and reproductive health outcomes of young people. AFIDEP's work currently focuses on three issues: 1) Population change and development; 2) Maternal and child health; and 3) Adolescent Reproductive Health and Development. AFIDEP works various partners to advocate for investment and action in addressing population and health issues in Africa in selected countries (currently Kenya, Malawi, Ethiopia, Uganda, and Rwanda) and at regional level. It facilitates knowledge transfer at the regional level through its involvement in and partnership with key regional networks and organizations such as the African Union, regional development communities, parliamentary health committee networks, and reproductive health networks. At the international level, AFIDEP participates in international conferences, high-level experts panels, and organizes meetings with key development partners to ensure that evidence and perspectives of African professionals inform their programs for Africa. In order to have sustained evidence-based decision-making in Africa, AFIDEP optimizes the capacity of researchers, advocates, and policymakers in translating and using research and related forms of evidence through training workshops, fellowships, and direct knowledge transfer during collaboration. AFIDEP strengthens skills of researchers in knowledge translation, policy analysis, scenario building, and effective communication; and works with advocates and end users of evidence to optimize their capacity in accessing and using research information. AFIDEP brings together a multidisciplinary team of scholars that constitute its core staff as well as a network of Associate Fellows who contribute to the Institute's work and seek to strengthen the impact of their own work through AFIDEP's programs and connections. A Board of Directors, composed of a multidisciplinary team of internationally reputable professionals, provides advice to the leadership of AFIDEP on institutional development issues, program development, and fund-raising.

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