The role of political will and commitment in improving access to family planning in Africa

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Abstract

A few countries in Eastern and Southern Africa - namely Ethiopia, Malawi, and Rwanda - have demonstrated a new wave of optimism and made good progress in addressing barriers of access to modern contraception over the past decade or so. Further, progress in contraceptive use in Kenya and Tanzania stalled in the 1990s, but both countries have recently demonstrated potential for recovery and good progress. The aim of this study was to explore the origin, architecture and role of political will in contributing to these largely unexpected successes. The objectives of this study were to investigate factors that have propelled changes in the attitudes of some political leaders to champion family planning; how such political will has manifested in the different contexts of these countries; and how political will impacts the policy and program environment. Mixed policy analysis methods including literature review, review of policy and program documents and semi-structured key informant interviews were used. The findings demonstrate that a critical influencer of political will was increased availability of evidence that convinced political leaders that family planning is central to achieving the MDGs by curbing high population growth, which undermines governments' efforts to transform the economies of least developed countries. Lessons from this study will help galvanize efforts to improve access to family planning services in countries where little progress is being made.

Introduction and background

The United Nations projects that sub-Saharan Africa's population will grow from the current 900 million to 1.2 billion by 2025, and to 2 billion by 2050 (UNPD, 2011). With an average population growth rate of more than 2 percent for most countries, the region has the fastest growing population in the world. Of the 2.4 billion people who are projected to be added to the world by 2050, 46 percent will be born in sub-Saharan Africa (Mutunga, Zulu, & Souza, 2012). The rapid population growth in SSA is mainly due to high fertility amidst declines in overall mortality. SSA has the highest fertility in the world (5.1 children per woman relative to the global average of 2.4) (PRB, 2012). Yet, only 26% of married women are using contraception relative to 56% in the world (PRB, 2012).

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 (FP), as an attempt to limit the number of Africans in the global population as it was largely introduced and financed by Western countries (Chimbwete & Zulu, 2003). They rejected the notion that rapid population growth was detrimental to development at key international meetings

including the 1974 Bucharest Population Conference and the 1984 International Conference on Population in Mexico (Finkle & McIntosh, 2002).

The tide turned at the 1994 International Conference on Population and Development (ICPD), where African leaders acknowledged that rapid population growth is an obstacle to their development efforts (UNFPA, 1995). The conference marked a major ideological shift from focusing on meeting demographic targets to meeting the socioeconomic and reproductive health needs of individuals, both women and men. The subsequent inclusion of universal SRH to the MDG framework significantly reinforced efforts to realize the ICPD program of action, to ensure that women and their partners 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 (ref).

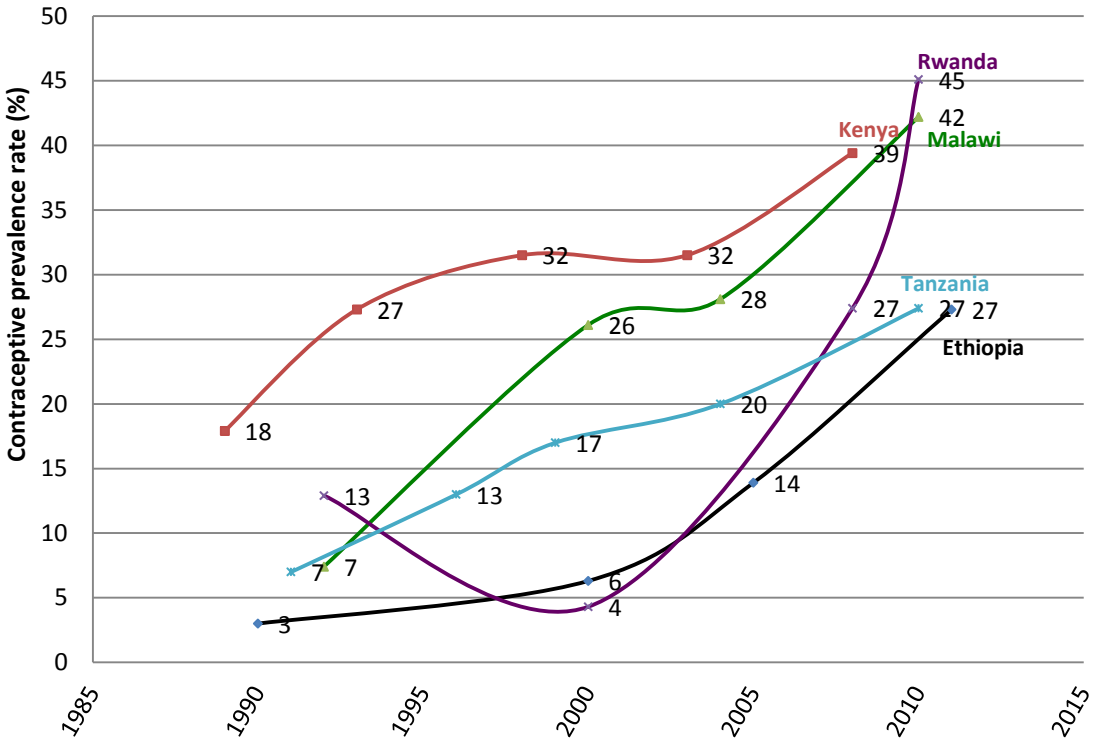
However, recent reviews of progress in achieving ICPD and related MDG objectives show that governments in sub-Saharan Africa (SSA) have had limited success in translating well-intended political and policy commitments into adequately resourced and effective programs to ensure universal access to FP and other RH services. Along with low contraceptive use, unmet need for FP is high; an estimated 53 million women in SSA have an "unmet need" for family planning, meaning they want to avoid pregnancy but lack effective contraception. Consequently, the region continues to harbour serious health challenges that have a direct effect on socio-economic development. In addition to high fertility, the region has high levels of unintended pregnancy and the highest maternal mortality rates, estimated at 500 per 100,000 live births relative to 210 for the world (WHO, UNICEF, UNFPA, & Bank, 2012). There is overwhelming evidence on the benefits of FP. Estimates in 2008, attributed FP to the prevention of about a third of maternal deaths and about a tenth of deaths of children under 5 years ((Ahmed, Li, Liu, & Tsui, 2012; Cleland, Conde-Agudelo, Peterson, Ross, & Tsui, 2012). Beyond these more widely acknowledged health benefits, FP can also help to slow population growth and promote economic productivity by allowing women and their partners to plan their family size and timing of their children, hence empowering women to participate as productive members of society (Ahmed, et al., 2012; Canning & Schultz, 2012; Cleland, et al., 2012; Ezeh, Bongaarts, & Mberu, 2012).

Numerous case studies documenting Family Planning programs in developing countries including a few in SSA countries demonstrate that implementation of FP programs are complex undertakings in difficult settings (Robinson & Ross, 2007). Not surprisingly, the case studies reveal that the feasibility of employing a single strategy and its impact differs from one country to another and that success is driven by the level of political will which take into account the social, economic, and cultural context of a particular country and makes the necessary resources available. Importantly, sustained political will and commitment of resources (finances, staff and infrastructure) emerge as important factors for the success of FP programs. In his study on the level of political priority given to maternal mortality reduction in 5 countries: Guatemala, Honduras, India, Indonesia, and Nigeria, Shiffman notes that priority is present when: (1) national political leaders publicly and privately express sustained concern for the issue; (2) the government, through an authoritative decisionmaking process, enacts policies that offer widely embraced strategies to address the problem; and (3) the government allocates and releases public budgets commensurate with the problem's gravity (Shiffman, 2007).

Given the slow progress in increasing contraceptive use in SSA and the political, economic and socio-cultural factors that have continued to hamper progress, there is a need for regional lessons to characterize the origin, manifestation and role of political will in increasing contraceptive use in SSA countries that are performing well relative to those that are lagging behind. However, there is limited evidence in this area, from which lessons can be drawn to inform current and future efforts.

To fill this knowledge gap, we conducted an assessment to document the factors that have promoted or hindered progress in increasing contraceptive use in 5 countries. We adopted a case study approach in which 3 countries (Ethiopia, Rwanda and Malawi) that have performed well in FP over the last decade and 2 countries (Kenya and Tanzania) that experienced a stall or deceleration in progress were selected (Figure 1).

Figure 1: Trends in modern FP use amongst married women

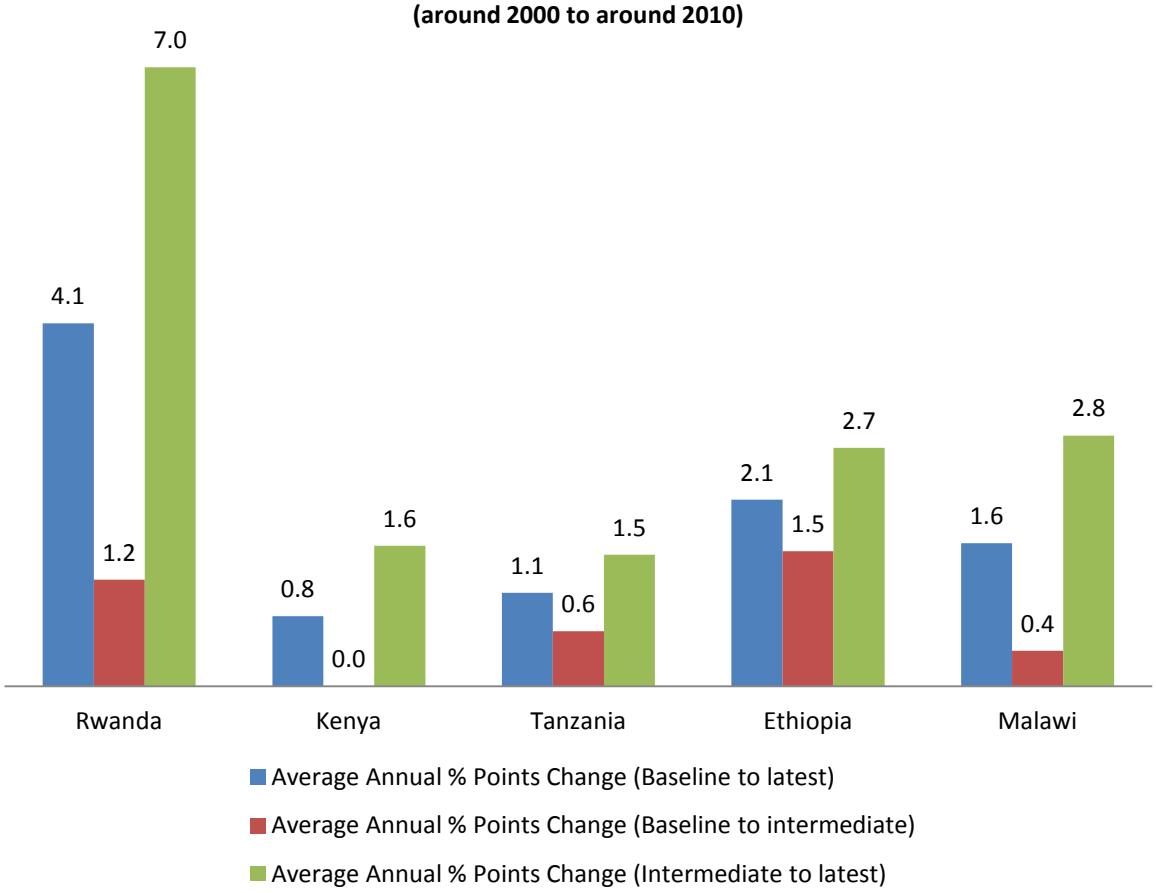


Data Source: Demographic and Health Survey

Ethiopia, Malawi, and Rwanda have registered remarkable increases in contraceptive use over the last decade or so. Use of modern contraceptives increased by 2.7, 2.8 and 7.0 percentage points per year in the last five years (about 2005 to about 2010) in Ethiopia, Malawi, and Rwanda, respectively (Figure 2). The progress in contraceptive use in 2 comparative countries, Kenya and Tanzania, momentarily stalled, but both countries have since demonstrated potential for recovery and good progress, with increased use of contraceptives of 1.6 and 1.5 percentage points per year in the last five years (about 2005 to about 2010). Kenya is historically recognized as a pioneer in implementing a successful FP program in the 1980s but did not live up to expectations following the stall in contraceptive use in the late 1990s, whereas Tanzania, has experienced slow progress over the last

two decades (1990 to 2010). Appendix 1 details the context of FP in the study countries.

Figure 2. Trends in annual rate of increase of modern contraceptive use (around 2000 to around 2010)



While the study identified a number of factors contributing to or hindering progress in the five countries, this paper focuses on highlighting the factors that have propelled the change in attitudes of some political leaders to champion family planning, how such political will has manifested in the different contexts of these countries, and how political will or lack thereof affects the policy and program environment. Given the many policy issues that compete for attention, generating political will for an issue is critical. Shiffman (2007: 796) found that various important factors were critical in generating political will for addressing high levels of maternal death in the five countries including: 'international agency efforts to establish a global norm about the unacceptability of maternal death; those agencies' provision of financial and technical resources; the degree of cohesion among national safe motherhood policy communities; the presence of national political champions to promote the cause; the deployment of credible evidence to show policymakers a problem existed; the generation of clear policy alternatives to demonstrate the problem was surmountable; and the organization of attention-generating events to create national visibility for the issue'. Kingdon (1984; 2003) argues that in policymaking, issues ('problems') exist alongside 'solutions' and 'politics' as three parallel streams, and that issues only rise to the top of the political agenda when the three streams merge. Kingdon argues that a 'problem' can become important to policymakers depending on how it is framed or brought to policy maker's attention (e.g., through data or focusing events). He

argues that a problem can rise on the agenda, if there are feasible 'solutions' that are compatible with policymaker's values, and appealing to the public. Furthermore, political factors such as changes in elected officials, political climate or mood, and the voices of advocacy or opposition groups can open up windows for issues to rise on the political agenda. This paper contributes to this literature on generating political will and agenda setting. Importantly, the lessons it presents on generating political will for FP in SSA contribute to the limited body of knowledge in this area and will help galvanize efforts to improve access to FP in SSA countries where little progress is being made.

Methodology

A triangulation of methods were used to assess the policy, systems and service delivery factors that contributed to the improvements in the FP programs of the 5 study countries: 1) Literature and policy and program documents review in order to understand the nature of policy and program adjustments that the study countries have made to increase contraceptive use over the past two decades; 2) Review of financial resource allocation and expenditure for FP and population issues; and 3) In-depth key informant interviews with policy makers, development partners, program managers, and civil society stakeholders using a semi-structured interview schedule (see Appendix 1) to gain insights into what changes were made and who played what roles in driving the reproductive revolutions.

Key-informants were identified from ministries of health, planning and finance, reproductive health units, non-governmental organizations (NGOs) and civil society organizations (CSOs) involved in RH/FP service delivery and development partners. Further interviewees were identified through snowballing. Interviews were conducted after verbal consent was obtained from all study participants. Table 1 lists the final list of stakeholder representation.

Table 1. **Key informants representation**

Key informants	Rwanda	Malawi	Ethiopia	Tanzania	Kenya
Government – policy makers	11	9	10	11	2
Government – service providers	3	1	-	1	3
Development partners	3	3	5	4	2
International NGOs/private implementers	4	7	11	12	5
Local NGOs/civil society	1	1	2	1	1
Faith-based organizations / leaders	1	3	2	2	-
Academic institution	-	1	-	1	1
Total	**23**	**25**	**30**	**33**	**14**

Interviews were recorded and transcribed. In Tanzania, the investigators were invited as non-participatory observers of the Family Planning Technical Working Group (FP TWG) during the field work period. A focus-group discussion was also held with the FP TWG in Rwanda. Two authors took elaborate field notes in these fora. Notably, fewer interviews were carried out in Kenya. However, the evolution and factors affecting the FP program in Kenya are relatively well documented.

Two authors conducted thematic analysis of the field notes and transcripts. Initial descriptive themes were derived according to the interview guide framework and then discussed iteratively among the

four authors to produce a final set of descriptive themes. Literature reviews and emergent descriptive themes were synthesized to identify the key factors that contributed to the successes of the FP programs in the five countries. In order to better understand the interplay between political will and contraceptive use, a second level of thematic analysis of data pertaining to the "political will and commitment to FP" descriptive theme was carried out in order to draw out the origin, architecture and role of political will in increasing contraceptive use. The analysis was loosely guided by theoretical concepts of political will generation and agenda setting from the works of Shiffman (2007) and Kingdon (1984; 2003). The concepts suggest that multiple factors play a role in generating political will, including: advocacy by well-networked policy actors and institutions; framing of the issue alongside national and global priorities and socio-cultural norms; the political context (policy space and process); and sound research evidence.

This paper therefore focuses on one of the five common factors that were identified across the study countries – political will and commitment to FP. We characterize the origin, manifestation and impact of political will on FP policies and programs.

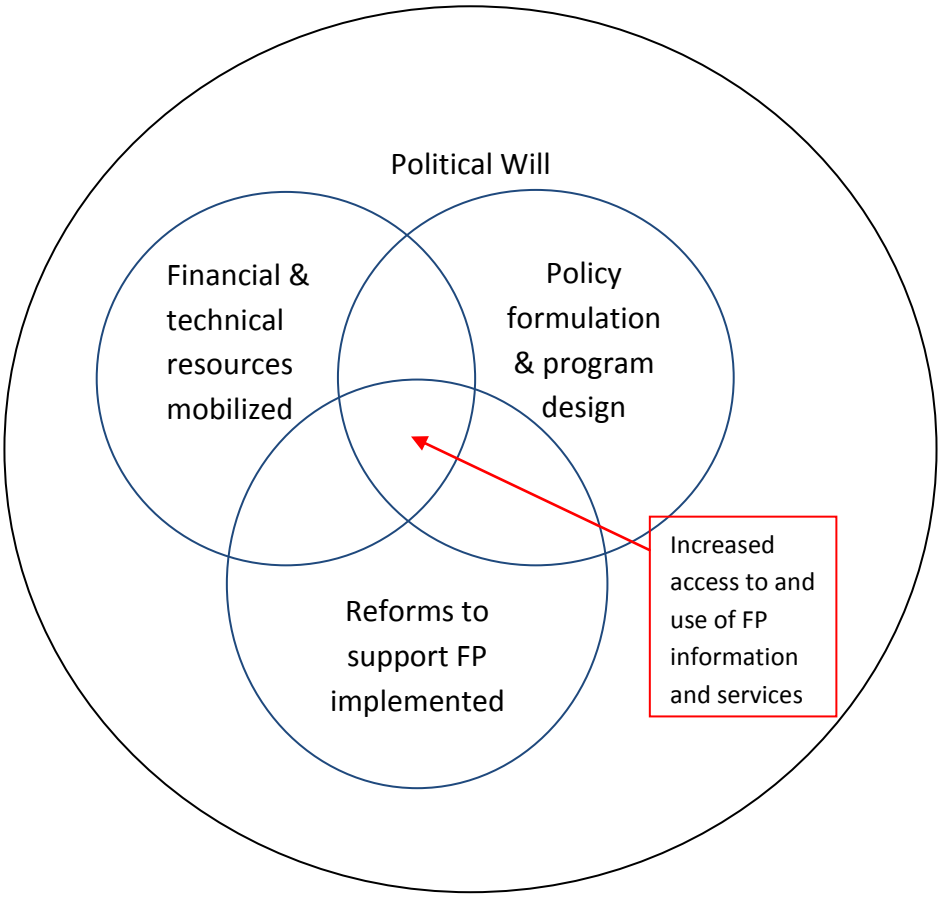
Findings

The origin and architecture of political will and its impact on FP programs

Experiences in Ethiopia, Malawi and Rwanda over the last decade or so demonstrate that political will was a precursor to the exceptional progress in increasing contraceptive use. On the other hand, Kenya and Tanzania, offer lessons on the importance of sustained political will and commitment in maintaining progress. They demonstrate how gains made in increasing contraceptive use can be slowed or reversed if political will and commitment wanes.

Political will is critical for the success of FP programs and facilitates the development of an enabling policy framework, and program implementation. It also facilitates mobilization of financial and technical resources from multilateral and bilateral development partners, and consequently enables increased local budgetary allocation for family planning programs. These ultimately, increase access to, and use of, FP information and services. The impact of political will is depicted in Figure 3.

Figure 3: The impact of political will on FP programs



Notably, the origin and manifestation of political will and the level of its impact on the FP policy and program environment differs uniquely in the five countries as a result of unique historical and current contextual circumstances. These findings are presented below.

1. How political will was generated

As leaders were motivated to stimulate socio-economic development, a window of opportunity emerged for evidence-informed policy influence, which demonstrated to government officials, that family planning is central to achieving health and development goals. The evidence helped to increase attention for FP among political elites who were keen on advancing socio-economic development. In addition, it was emergent local FP experts and champions who were knowledgeable of the country contexts and policy processes that led advocacy efforts, and thus helped to allay any suspicions that FP is a Western agenda. Hence, two key factors emerge as important to generating political will in the five countries: 1) use of evidence and consideration of the socio-cultural, political and economic context to frame FP and 2) well networked FP champions and strong national advocacy institutions familiar with the salient socio-cultural and political sensitivities and concerns related to FP and how to effectively participate in the policy process.

1.1. Use of evidence and framing of the message

At the time the five study countries embraced national FP programs, the persistent development problems they were all grappling with were rapid population growth, diminishing resources and increasing poverty amidst pervasive socio-cultural practices that promoted pronatalism. Sensitization of political leaders on the importance of reducing high fertility and rapid population growth in order to meet global and national health and development plans such as the ICPD program of action, the MDGs, and country development blueprints and health plans increased attention and support for FP. Political leaders increasingly became aware that development goals are more likely to be achieved by a skilled and healthy population, rather than large populations dominated by uneducated, hunger stricken and unhealthy citizens, who do not contribute to the economy. As a result, FP targets have been included in development blue prints of virtually all of the five countries. Further, the evidence from Demographic and Health Survey (DHS) reports showing the high unmet need for FP in these countries continues to provide a case for the need for governments to address the barriers to access and use of FP. Of importance, framing of FP differs from country to country with some political leaders being sympathetic to the health narrative while others are partial to the family welfare/economic benefits narrative. Still, the rights narrative has prevailed as an overarching narrative that has guided implementation of voluntary FP programming in the five countries.

In 1967, Kenya adopted its first population policy which led to a national FP program. However, support for FP by President Mzee Jomo Kenyatta was weak. FP was not high on Kenyatta's government priorities and even the evidence that the country's population was rapidly growing did not sway the government. The population growth rate which was about 2.5% per annum in 1969 increased to a peak of 3.8% per annum in 1979 (NCPD, 2012). Moreover, FP was an unpopular concept among many politicians. Political leaders from communities with a preference for large families did not want to go against the beliefs and practices of their electoral based and risk chances for re-election. Consequently, the program's impact was dismal. However, the beginning of the 1980s presented an opportune time, when President Moi was embarrassed at an international meeting where the country's fertility of 8.1, as recorded in the 1978 KDHS, was highlighted as the highest in the world. Moi was motivated to position Kenya in line with the international development standards of curbing high fertility. He explicitly promoted FP and directed leaders at all levels to promote FP. His dictatorial approach to leadership that had been triggered by an attempted coup in 1982 meant that the socio-cultural, political and religious concerns that had dominated the 1970s FP program were repressed. In fact, the program promoted the economic benefits (family welfare) of FP in addition to the maternal and child health benefits, which had been the focus of messages in the 1970s program. The FP program was a success leading to a steady increase in contraceptive use throughout the 1980s until the late-1990s when progress stagnated as a result of a decline in political will for FP in the Moi government.

> *"I think it was in 1981 when President Moi happened to attend the meeting I think it was in China or somewhere and he was really embarrassed because he was told that it [Kenya] was the country that was the fastest growing in the world. Around then the children were 8.1 per woman and the doubling time of the population was 17 years. So I think he came with a real momentum and really showed good political will ….. He came with a threat especially to the civil servants… they were required to promote I think it was 4 children or 3 children."* Academic representative

In Rwanda, the persistent struggle with rapid population growth and diminishing land mass prompted the 1980s national child spacing program. Likely because of the strong influence of religious leaders, the FP program focused on maternal and child health rather than promoting smaller family norms.

Later on, in the mid-2000s, the RAPID advocacy tool developed by the Futures Group in collaboration with national advocacy institutions played a role in captivating the attention of the political elites in Kenya and Rwanda to intensify their support for FP and promote its positioning at the center of their country development agendas. By mid-2000s Kenya and Rwanda DHS findings demonstrated a stall and decline in progress towards increasing contraceptive use, respectively. Kenya's fertility was in fact on the rise while experts in Rwanda were aware that the country's recorded decline in the population growth rate was being masked by the effects of the genocide which included the death of nearly 1 million people and mass migration out of Rwanda. The RAPID evidence demonstrated how rapid population growth would make it difficult for government to make the necessary human capital investments needed to spur economic development. The evidence also demonstrated the urgent need to slow down population growth in order to reap the largest benefits for socio-economic development as seen with the Asian Tigers. A key feature of the RAPID tool is the evidence demonstrating the financial savings that a country can accrue by investing in family planning and how it translates to savings towards other public sectors. In essence, FP was framed as a development tool, emphasizing the health, economic and environmental benefits.

In Kenya, the presentation was developed in 2010 and used to mobilize support and resources for FP. Similarly, in Rwanda, presentation of the RAPID to the president and parliamentarians in 2005 helped to obtain and solidify political support for FP, leading to the inclusion of FP targets in the country's poverty reduction strategy, Economic Development and Poverty Reduction Strategy (EDPRS), designed to translate the country's Vision 2020. This was an unlikely achievement, given that Rwanda had lost nearly 1 million people during the 1994 genocide and it was expected that the notion of limiting child bearing would not be acceptable. However, among the political elite, it was clear that their development goals would be unattainable if Rwanda's population continued at the same high rate.

> *"After looking at all the data and closely examining our situation, we came to the conclusion that we cannot develop into a middle income country without addressing high population growth and prioritizing family planning. FP is a key tool for developing the quality of our population, improving the health of mothers and children, and to address the poverty challenges that we face"*
> (Dr Ntawukuliryayo, President of the Senate, Rwanda).

In Malawi, despite the need to manage population growth, the strong pronatalist attitudes of the political establishment in the 1960s translated to intolerance for FP. Furthermore, Banda believed that the country needed to have a large population to fully realize its agricultural potential and that with improvements in education and literacy; Malawians would decide for themselves how many children to have. He was once quoted asking the Germany Ambassador to Malawi *"... did the German Government tell people to have two children in Germany ... who are you to tell us what to do on the number of children?"*. FP was subsequently banned until the early 1980s. By then President Hastings Banda had developed a soft spot for mothers, therefore, when evidence linking FP to

reducing maternal and child deaths was presented to him, it prompted the approval and establishment of Malawi's national child spacing program.

Similarly, in Ethiopia and Tanzania, where there were strong perceptions that a large population was necessary to stimulate economic development, the health narrative also emerged as more acceptable. In fact, the late Prime Minister (Meles Zenawi) of Ethiopia,who came into office in 1995, was not supportive of FP for limiting child bearing and was often quoted saying "*people are coming to this planet with working hands not only empty stomachs*" (Translated from Amharic). However, evidence showing the link of FP to maternal and child health prompted a national FP program in Ethiopia in 1990s, focusing on improving maternal and child health. A child spacing program was initiated in Tanzania around the same time. Notably, the close scrutiny on performance of countries towards achieving the MDGs coupled with the increasing evidence on the central role of family planning in improving maternal and child health strengthened support of FP among political leaders from all five countries and also motivated support by those who were previously uncomfortable with promoting FP to reduce fertility levels. A close look at the contraceptive use trends in all five countries show either improvements in progress following the 2005 inclusion of FP in the MDGs (Figure 3). The rate of increase in uptake of contraceptives accelerated between 2005 and 2010 in all five countries.

Since 2010, the RAPID tool has also been developed for Ethiopia and Malawi, and has become a key tool for lobbying political leaders to support and mobilize resources for FP. The two countries have recently started focusing on the health and economic benefits of FP, promoting maternal and child health, as well as the benefits of smaller families. Notably, the RAPID tool was also developed for Tanzania in 2006, however, its impact on increasing political support and funding for FP is yet to be realized. In fact, Tanzania's progress has been generally slow since the establishment of the FP program. This may largely be explained by the fact that robust and well presented research evidence alone cannot generate political commitment for RH issues and decisions in support of FP uptake, but rather works in concert with other factors, such as respected FP champions, to do so. This is further discussed below.

1.2. Well networked and respected FP champions and national advocacy institutions

In the 1960s, international efforts promoting the adoption of neo-Malthusian population policies and programs resulted in a backlash from African leaders who suspected their motives. Over the past two decades, there has been an emergence of national actors and institutions leading domestic advocacy efforts for the adoption of FP and population policies and programs. This has helped allay these suspicions. International advocates have for the most part resigned to provide financial and technical support for initiating and sustaining domestic advocacy efforts. It emerges that recognized persons with expertise in FP/RH in relevant government agencies (Ministers of Health and Directors of Planning Units or Divisions) and civil society organizations (CSOs), their networks with political allies and access to the political process, has been critical in captivating and sustaining political support for FP. Development partners such as Futures Group, PRB, USAID and UNFPA have been the major providers of technical and financial support in these countries.

In Kenya, President Moi emerged as the key FP champion during the 1980s when he directed the Ministry of Health and leaders at all levels of government, to promote FP and ensure availability of

FP services. As noted in the section on evidence and framing, his dictatorial approach to leadership at the time meant that government decision was implemented without much opposition; any political, socio-cultural and religious resistance to FP was not clearly apparent during this period. Further, couples were ready to control their fertility. In fact, the 1984 Kenya Contraceptive Prevalence Survey (KCPS) recorded contraceptive use at 17% and a very high unmet need for FP (60%). In the 1990s, Moi's attention shifted to address other perceived urgent issues, and hence he ceased to be at the forefront of FP advocacy. During the past decade, the semi-autonomous population agency, National Council for Population and Development (NCPD) housed in the Ministry of Planning, National Development and Vision 2030, first established in 1982 and then revived in 2004 by an Act of Parliament, emerged as a strong national advocacy agency. NCPD is mandated to develop and support the implementation of population programs, including repositioning FP as a development priority. The agency has earned respect among parliamentarians and other government officials and key stakeholders as the national institution with expertise on population issues. Owing to its established strong networks with parliament, NCPD has been successful in mobilising renewed political support for FP. A key strategy of NCPD was to form a core group of parliamentarians '*parliamentary committee to reposition family planning*' and nurture them into FP champions, who then assisted with mobilization of other parliamentarians and high level decision makers in government including treasury. In 2010, NCPD mobilized more than 1000 decision makers from various Ministries and politicians at the 2nd National Leader's Conference to highlight the central role of family planning in achieving Kenya's development blueprint, Vision 2030. At the meeting, NCPD also obtained input into the development of the 3rd population policy which was later passed by parliament and launched in 2012. This was a crucial move given the political concerns in relation to population-based resource allocation to decentralized county governments in the imminent devolved government structure.

In Ethiopia, the Minister of Health, Dr. Adhanom, has been the main advocate for FP since his appointment in 2005. The late Prime Minister Meles Zenawi took Dr. Adhanom's advice on solutions to address the country's health priorities as credible. Notably, Dr. Adhanom is a trained physician and seasoned researcher which may explain this. Meles thus allowed Dr. Adhanom to implement recommended interventions including the health extension program, a health service delivery model designed to reach rural women, which included FP as one of the packages of care. In Rwanda, Dr. Ntawukuliryayo, who was the Minister of Health in 2005, convinced President Kagame and the Prime Minister to support FP. Subsequently, President Kagame emerged as the key FP champion, approved FP as a development intervention and openly speaks out about the benefits of FP. Dr. Ntawukuliryayo, now President of the Senate, has served as the Chairperson of the Rwandan Parliamentarians' Network on Population and Development (RPRPD), earned the nickname "*Mr Family Planning*", and continues to rally support and resources for FP. RPRPD is a key institution in Rwanda that was formed by an Act of Parliament to advance population and FP issues. RPRPD constitutes of parliamentarians who are advocates of FP, and sensitizes other parliamentarians on population and FP issues.

In Malawi, in the 1980s, FP experts and practitioners from the Family Planning Association of Malawi (FPAM) and the Ministry of Health with close links to the political establishment convinced President Banda, an advocate of maternal health, to establish the child spacing program. This move overturned the more than a decade long ban on FP. The same individuals convinced President Banda to review

Malawi's first population policy which focused on promoting FP to improve family welfare which was subsequently approved by President Bakili Muluzi, Banda's immediate successor.

2. How political will for FP manifests

Two types of manifestation of political will for FP are emergent among the five countries. The first and most unlikely is top level leadership support whereby the President emerges as the FP champion and promotes the entrenchment of FP throughout the political establishment and the communities, as currently seen in Rwanda, and was the case in Kenya during the 1980s. The second, which is common to Ethiopia, Malawi, Tanzania and now Kenya, is when top level leadership provides an enabling policy and program environment for the institution with the mandate to promote FP, to fully expel its duties. While countries may share a common style of political support for FP, the impact differs at country level based on contextual differences.

2.1. Top level leadership

In Rwanda, political will is currently driven by President Kagame who openly promotes FP. Notably, Rwanda's explicit top level leadership support for FP has resulted in its inclusion on the national development agenda and thus the institutionalization of promotion of FP throughout all levels of leadership. Increasing contraceptive use is one of the performance goals for leaders in the political hierarchy, including District Mayors and relevant ministers such as the Minister of Health. Such political will has created a common vision on promotion of FP as a development intervention among leaders and the public alike. While this style of political will has raised questions about the potential for coercion, the phenomenal increase in contraceptive use has been credited to this type of political will. Notably, analysts suggest that a big contributor to the current development progress in Rwanda is Kagame's benevolent dictatorial style of leadership (ref).

In the 1980s, Kenya's President Moi explicitly promoted family planning. He directed leaders at all levels of government to promote FP. However, unlike Rwanda, FP was not included as a target on leaders' performance contracts. Nevertheless, the FP program gained recognition as a pioneer and successful program as it resulted in a phenomenal increase in contraceptive use (ref). The importance of sustained political will is demonstrated in the case of Kenya, where a shift in attention away from FP by the Moi government resulted in a stall in progress towards increasing contraceptive uptake between 1998 and 2003. This is discussed further under the section '*The importance of sustained political will and commitment'*.

2.2. Leadership at Ministry level

In Ethiopia, Malawi, Tanzania and Kenya, political will manifests at the Ministry of Health (MOH) and Ministry of Planning in Kenya. Although neither of the Heads of State of these countries is vocal about supporting FP, there is recognition of the enabling environment to implement the national FP programs. While this is a common style of leadership in the four countries, the impact still differs significantly at country level because a number of factors in addition to political will mutually reinforce each other to increase contraceptive uptake.

After the collapse of Kenya's successful FP program, President Kibaki maintained a silent role whilst creating an enabling environment for NCPD within the Ministry of Planning and top officials at the

Division of Reproductive Health (DRH) within the MOH to lead the FP agenda. Kibaki's government relaunched NCPD as a semi-autonomous entity that could operate with more flexibility. NCPD has the mandate to ensure multisectoral implementation of population and FP activities. NCPD works with the implementers of the FP program, DRH, under the leadership of its Director (Dr Isaak Bashir) to formulate policies, identify inequities in contraceptive use and develop advocacy strategies. The immediate past Minister of Planning (Hon. Wycliffe Oparanya) and the current director of NCPD (Dr. Boniface K'Oyugi) have been at the fore-front leading efforts during the past decade to refocus the FP program as a development intervention towards meeting Vision 2030 goals. Having leadership with technical expertise in the area of demography affording him good understanding of the role of population in development has also been a plus. The rejuvenation of political will for FP in Kenya has resulted in recovery from the stall in progress experienced between 1998 and 2003. Despite having been successful in increasing political support for FP over the past decade, there is a common view among RH/FP experts, that there is need to sustain efforts to increase political will to the level of the 1980s and 90s where top level leadership explicitly promotes FP. Notably, President Mwai Kibaki, the current president of Kenya, worked with Mr. Tom Mboya in the 1960s to convince Kenya's first president Mzee Jomo Kenyatta to adopt a population policy. One would have therefore presumed that Kibaki would explicitly promote FP during his tenure as President given this historical context. But the importance of the effect of prevailing competing priorities and contextual factors on agenda setting at the highest level are apparent in this case.

> *'In the 80s and 90s they talked about it all the time - small family for better health. You don't hear that now. I would say political will is there but it's not to the level where we had it in the 90s.'*
> (Local RH expert and advocate)

In Ethiopia, the FP program has been driven from the Federal Ministry of Health (FMOH) with the Minister of Health, Dr. Adhanom, at the fore front of the efforts. Of note, the Ethiopian FMOH is structurally different to the Ministries of Health in Malawi, Kenya and Tanzania, and may explain the difference in level of support at the Ministry level. Whereas, the Ethiopian FMOH is structured on the basis of place of residence (urban, rural and pastoral), the Ministries in the other 3 countries have disease-oriented departments. The apparent political will, coming from the highest office in the Ministry, has led to notable progress in increasing contraceptive use in Ethiopia. Recently, the Federal Ministry of Finance and Economic Development (MOFED) has been assigned a more prominent role in promoting FP and is now the only agency that can advocate for FP. In fact, Civil Society Organizations are now not allowed to advocate, rather can only support the government's efforts e.g. provide evidence. The impact of this change will be assessed during the next Demographic and Health Survey report in 2016 or so.

In Malawi and Tanzania, political support is apparent from the leadership of the Reproductive Health Unit or Department in the MOH. Over the past 5 years, the population unit of the Malawian Ministry of Economic Planning and Development has been successful in integrating FP in the development blueprint. The country has been moving towards multi-sectoral implementation of FP and population activities with a new population policy released in 2012. The model of FP promotion and implementation of FP and population activities is evolving to mirror that of Kenya and Ethiopia. Further, in 2012, the government elevated the Reproductive Health Unit into a directorate, which reflects the increasing prioritization of RH issues in Malawi. Notably, progress in increasing

contraceptive use in Tanzania has been much slower in comparison to Malawi. Over the past 5 years, Malawi has emerged as having made phenomenal progress in increasing contraceptive use.

3. *How political will for FP impacts the policy and program environment*

While countries may share a style of political will, the impact at country level may very well vary due to other factors. Nevertheless, while political will did not independently bring about increased FP uptake, it translated into an enabling environment for FP and population policy formulation, prioritization of funding for FP and population programs, implementation of programs and health service reforms to support FP programs as depicted in Figure 3.

Notably, political will does not necessarily translate into domestic resource mobilization, which is critical for the sustainability of the program. The governments of the five countries rely heavily on external financial resources to procure FP commodities, train health workers and equip health facilities while contributing relatively less support from domestic revenue which could compromise the sustainability of FP programs. For example, Kenya's successful FP program of the 1980s was funded entirely by donors, which largely explains why the program collapsed when donors shifted attention to HIV/AIDS in the 1990s. Nevertheless, the creation of budget lines for FP commodities as in all five countries may indicate some level of government commitment to the program and an opportunity for an increase in government contributions. In addition, government prioritization of allocation of funds to the health sector and policy direction in favor of integration of FP with other key health services that have strong political backing, such as maternal and child health services and HIV/AIDS services, has also played a role in increasing access to and use of FP in some of these countries.

In Rwanda, FP was included as one of the national development targets in 2009 within the Economic Development and Poverty Reduction Strategy (EDPRS). As a national development target, FP was institutionalized at all levels of leadership, and at health facility, community and family levels through performance contracts, performance based incentives and mandatory monthly community meetings. This resulted in its rapid scale-up and uptake of FP nationally. The establishment of this governance and accountability mechanism for monitoring and evaluating achievement of key development targets, including FP, demonstrated Rwanda's commitment to making progress towards addressing its development challenges and has attracted a substantial amount of donor funding to support Rwanda's efforts. The creation of a budget line for contraceptives also demonstrates Rwanda's commitment to ensuring supplies to meet the FP needs of the population. Consequently, FP information and services have become available and accessible to a large proportion of people. Donors help Rwanda strengthen the health system to enhance access to FP services including training health workers in provision of all contraceptive methods, building and equipping health care infrastructure, and strengthening the commodity supply chain. The policy space also encourages the adoption or adaptation of innovative interventions to make information and services available to vulnerable and underserved population. For instance, a large proportion of health facilities in Rwanda are operated by the Catholic Church, which has a policy not to provide modern contraceptives. Rwanda established an agreement with the Catholic Church leaders to build secondary posts adjacent to Catholic health facilities so as to increase access to modern FP methods to community members who wish to use them. Further, by the end of 2011, Rwanda was scaling up various interventions to increase access to modern contraceptives to underserved communities

including community based distribution of injectable contraceptives, establishment of youth friendly spaces at existing health facilities and training health workers to provide SRHR services to youth.

In Ethiopia, including FP in the package of essential services delivered through the health extension program (HEP) countrywide, particularly in rural areas, means that FP information and services have become accessible to a large proportion of the people. The HEP established in 2003, is essentially the bedrock of the Ethiopia health system. It has high level government political backing and is accredited by the international community as a model intervention. Hence, it has attracted a significant amount of both domestic and donor funding. By 2005, FP targets were included in Ethiopia's Plan for Accelerated and Sustained Development to End Poverty (PASDEP) and the follow-up Growth and Transformation Plan (GTP) demonstrating the government's commitment to ensuring access to FP. Further, the creation of a budget line for FP commodities and the removal of the import tax on contraceptives, both in 2007, also demonstrate Ethiopia's commitment to ensuring supplies to meet the FP needs of the population. Like Rwanda, the policy space also encourages the adoption or adaptation of innovative interventions to make information and services available to vulnerable and underserved population. For instance, Ethiopia's health extension workers provide both injectables and implants to women in rural Ethiopia. By 2011, they were also being trained to provide pre and post counseling for IUD. Ethiopia is reaching out to youth and pastoral communities using modified versions of HEP – the urban HEP for youth and the Pastoralist HEP. Youth are also being reached through social marketing.

Malawi's initially tumultuous experience with promotion of FP put it in the spot light so that when the policy environment improved, there was increased international goodwill to help Malawi address its high fertility and population growth rate. The policy space allowed for the creation of strong public-private partnerships to ensure information and services were expanded country-wide. Malawi has also been able to further expand reach by establishing community based distribution of injectable contraceptives. Recently, a budget line for FP commodities has been created further demonstrating Malawi's commitment to ensuring supplies to meet the FP needs of the population. In 2012, Malawi integrated population into the second installment of the Malawi Growth and Development Strategy (MGDS) 2012-2016, which will ensure multi-sectoral implementation of the FP program further expanding its impact. Efforts to ensure girls stay in school longer and youth have access to SRHR services are also being intensified. The Malawi government believes these strategies will curb the country's high teenage pregnancies, which are contributing to the country's high fertility.

Kenya's and Tanzania's FP programs between the 1980s and 1990s also benefited from immense donor support. In fact, in both cases government financial contribution to programs was very little. Strong political will and financial support translated to implementation of effective nation-wide information, educational and communication campaigns (IEC) and community based distribution programs. The policy environment allowed for the creation of strong public-private partnerships to support the two governments to expand information and services country-wide. Notably, the impact of the Kenya FP program was much higher than that of Tanzania's likely due to the difference in level of political will in the two countries. Kenya's contraceptive prevalence rate peaked at 39% in 1998, the year the stall begun, compared to Tanzania's 16.9% in 1999, the year progress begun to decelerate.

The recent recovery from the stalled progress between 1998 and 2003 in Kenya, and the relaunch of NCPD as a semi-autonomous institution responsible for repositioning FP, led to the establishment of a budget line for FP commodities in 2005, inclusion of population targets in the Vision 2030 first medium term plan (2008-2012), a doubling of funding for population activities in 2011 and the launch of Kenya's 3rd population policy for national development in 2012. Kenya's program also has significant support from donors. However, at the same time, learning from past experience, Kenya now makes a significant contribution to the program. Key informants stated that by 2012, the government was contributing 60% of the contraceptives budget. In fact, funding allocation for contraceptives has increased incrementally every year since the establishment of the budget line. Kenya has adapted its strong IEC campaigns and strong public-private partnerships that contributed to the success of the program during the 1980s and 1990s. Recently, a policy has been formulated to allow provision of community based distribution of injectable contraceptives in selected parts of the country defined as 'hard to reach'. Efforts to expand SRHR services to youth and the urban poor have also intensified. Further, other policy options such as performance based financing are being explored for scale up nationally.

Likewise, in Tanzania, with the recent recovery from the decelerated progress that occurred during the early part of the 2000s, Tanzania has demonstrated its renewed commitment to FP by integrating it into the national development plans – the development blueprint, Vision 2025, and the National Strategy for Growth and Reduction of Poverty, MKUKUTA I (2005-2010), MKUKUTA II (2010/11-2014/15). IEC campaigns, social marketing and public-private partnerships have been revived and are being strengthened. However, unlike Kenya, Tanzania still relies on donors for most of the funding for the program with little contribution from domestic resources. Tanzania is also in the process of scaling up the community based distribution program, however, there is an ongoing debate on community based distribution of injectable contraceptives. In addition, there are other policy options being explored such as performance based financing and innovative models of public-private partnerships e.g. the ADDO program which aims to increase access to contraceptives through accreditation of retail drug outlets in areas where few or no registered pharmacies exist.

4. The importance of sustained political will and commitment

The experiences of Kenya and Tanzania demonstrate the importance of sustained political will in increasing contraceptive use. Shifts in political will from FP to HIV/AIDS prevention and treatment efforts and other priorities deemed more important led to under-resourced national FP programs, both in terms of financing and services in both Tanzania and Kenya. The overdependence of programs on donor funds, which shifted to address HIV/AIDS worsened the situation. The two governments were unprepared to take full responsibility of the program. The national institutions with the mandate to implement FP activities had weak capacity to continue providing information and services with minimal to no resources allocated to the programs. This led to a decline in contraceptive commodity security, and in the number of trained health workers as they shifted to vertical HIV programs. The community based distribution of FP information and services also collapsed as programs evolved to provide HIV/AIDS services. The impact would have been less significant if there were dedicated domestic resources to sustain the programs. What emerges is the importance of framing FP in the context of sustainable development to sustain political will.

Discussion and Conclusions

Understanding the main factors that influence the generation of political will through the characterization of its origin and manifestation as well as understanding its impact on FP policies and programs can provide useful lessons for countries in the region.

The shift by few African governments who have supported FP and been receptive to slowing down population growth including Kenya, Zimbabwe, Botswana, Rwanda, Ethiopia, and Malawi gives hope that African countries can overcome the perennial challenges that have prevented them from achieving their development objectives. They demonstrate that better understanding among African leaders of the role of FP in improving the quality of life of their citizenry can generate political will for FP and motivate the positioning of FP as a national development intervention as was the case among the Asian tigers in the mid-60s (Robinson & Ross, 2007). Our findings are in agreement with other analysis in this field that multiple factors interact to captivate political will and commitment for FP. We found that the intention of leaders to advance development presented as a window of opportunity which opened the policy space for FP advocacy. Sound evidence which responded to the development needs of SSA leaders captivated their attention to prioritize FP. Considerations of the socio-cultural, religious and political sensitivities to limiting child bearing was important for framing of FP was key in presenting the evidence. Learned national actors at the forefront of advocacy efforts, who served as advisors to top level leaders, helped to allay the notion that this is a western agenda. Further, presenting FP as impacting on a broad range of development targets helped to bring to perspective the urgency of the need to prioritize FP.

In their early population programs, African leaders adopted neo-Malthusian population policies to conform to international standards and the concept was largely considered a Western agenda with no place in the African context. However, it is not until African leaders begun grappling with the challenge of achieving ambitious development plans that a window of opportunity for FP seems to have been created. Evidence-based advocacy highlighting the role of FP to achieving development goals has been an important factor in captivating high level political will for FP among countries that have had successful FP programs. Thus, FP was presented to countries that eventually adopted national FP programs as a policy option for either reducing rapid population growth in order to stimulate socio-economic development, or improving maternal and child health. Evidence showing how rapid population growth is an impediment to meeting national development goals and the role that FP could play in managing the population growth rate is increasingly convincing the political establishments of African countries to support and prioritize FP.

Considerations of socio-cultural beliefs and practices such as early marriage and preference for large families, and political and religious opposition to FP also determines the success of generating political will for FP. Case study countries demonstrate that, in the African setting, where these factors are influential in decision making, the health benefits of FP particularly in relation to maternal and child health was critical in mobilizing initial political support for FP. Earlier FP programs in Asia, show a similar trend e.g. in Malaysia. Generating this initial political will based on the health narrative then creates an opportunity for presentation of evidence on the economic and environmental benefits of FP particularly in the face of challenges in achieving the desired national development goals. Close scrutiny of the MDGs as a yard stick for development, which emphasizes

FP as a key intervention for the achievement of maternal health targets, has further motivated SSA leaders of countries that have been lagging, to prioritize FP.

The manifestation of political will is also critical because it determines the level of success of national FP programs. Support for FP by top government officials such as Presidents and Prime Ministers explains the phenomenal progress in increasing contraceptive use among the Asian Tigers and some African countries (Kenya and more recently Rwanda). Strong political will from institutions mandated to promote use of FP and provide FP services can substitute top level leadership political will and result in strong FP programs as in Ethiopia and Rwanda. In this case, an enabling policy and program environment exists for promotion of FP and ensuring access to FP services, implying silent top level leadership support. In this case, power relationships play a critical role where top level leadership have confidence in the recommendations made by their Ministers despite their position on the matter. The importance of sustained political support is demonstrated in Kenya, Tanzania and Ghana where waning support from the political establishment led to the collapse of a successful program in the case of Kenya and a promising program in the case of Ghana and a deceleration in progress in Tanzania and consequently, a retardation in progress in increasing contraceptive use. Evidently, weak political will also results in general slow progress as in the case of Tanzania where there is general agreement that FP is important, but the push is not strong enough to translate to phenomenal FP uptake.

The emergent high level support emanating from successful advocacy efforts, leads to well resourced national FP programs. The case study countries demonstrate that programs initially promoted maternal and child health and evolved to promote smaller family size norms. Countries have implemented intensive Information, Education and Communication (IEC) campaigns and made efforts to increase access to services and a wide range of contraceptive methods. Various models of community based programs have been a major part of the programs in order to reach the rural populations. Political will and commitment for FP has provided an impetus for increased technical and financial assistance from donors. Successful FP programs have led to significant increases in contraceptive use and notable decline in fertility. Ultimately, further decline in fertility will result in a reduction in the population growth rate and accelerate socio-economic development as was the case with the Asian Tigers. However, this will only occur with sustained political will for FP which emerges as the central tenet in the success of FP programs because it enables the development of key policies and programs, mobilization of resources and implementation of programs.

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Appendix 1: Study Country Contexts

In this section, we describe the trends in population growth, fertility, and contraceptive use in the five countries.

Rwanda

Rwanda's population increased from 6.5 million to 10.6 million between 1992 and 2010. The population growth rate has decreased substantially since its 1992 rate of 6.3% per year but remains high at 3.1% per year in 2010. Currently, it is the most densely populated country in SSA. Because of its small size, Rwanda has historically struggled with the challenge of rapid population growth and diminishing land mass, which has been linked to the 1994 genocide (Prunier, 1995). However, it is only until the late 1970s that the government included child spacing as an intervention to curb high fertility and rapid population growth in the 1977-1981 5-year development plan (Tallon, 1989). The pursuant development plan (1982-1986) was based on data from the 1978 census which showed a large population size and more rapid growth than had been expected. The government therefore sought to reduce the population growth rate from 3.7% by raising the age at first birth and limiting childbearing after age 40 (McNamara, 1992). Subsequently, in 1990, Rwanda launched its first population policy. Modern CPR rose significantly from 1% to 12.9% between 1983 and 1992 (Ministry of Health (MOH) [Rwanda], National Institute of Statistics of Rwanda (NISR), and ICF Macro, 2009). However, in the aftermath of the 1994 genocide, it declined to 4.3% in 2000. A recovery was recorded in 2005 when Rwanda's modern CPR rose to 10.3% and this rise continued to a phenomenally high level of 45.1% in 2010 (NISR [Rwanda], MOH [Rwanda], and ICF International, 2012). This most recently recorded 5 year rise (2005-2010), represented an increase of 4.1 percentage points per year, the highest recorded in SSA. Consequently, Rwanda's TFR has declined from 6.2 children per woman in 1992 to 4.6 in 2010 while unmet need for FP has dramatically reduced from 40% in 1992 to 17% in 2010. The UN Division Population Division projections estimate that Rwanda's population will more than double to 26 million by 2050 if the current fertility rate is maintained (UNPD, 2011).

Ethiopia

Ethiopia has the second largest population in SSA 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. After the1984 census which demonstrated that the country's population was growing rapidly amidst poor maternal and child health, the idea of a national population policy gained credence. The federal government of Ethiopia launched their first population policy in 1993 but progress in increasing contraceptive use remained very slow in the ensuing decade. In 1990, Ethiopia's modern CPR was incredibly low at 2.9%, and barely rose to 6.3% in 2000 (Central Statistical Agency (CSA) [Ethiopia] and ICF International, 2012). The last decade, however, has exhibited an outstanding 4-fold increment in modern FP uptake to 27.3% in 2011 (CSA [Ethiopia] and ICF International, 2012). 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 (UNPD, 2011).

Malawi

Malawi has been experiencing the effects of rapid population growth since the late 1970s when its economy started to deteriorate (Chimbwete & Zulu, 2003). Malawi's population has increased from 9.7 million in 1992 to nearly 15 million in 2010. Of concern, Malawi's population growth rate increased from 1% per year in 1992 to 3.1% per year in 2010. This is probably due to the active promotion of pro-natalist views by Malawian leaders during the 1960s, 70s and 80s who believed that the country needed a large population to spur economic development(Chimbwete & Zulu, 2003). Malawi's President Banda and his government perceived FP as a western agenda and were sceptical about their motives resulting in the ban of FP in the late 1960s until the early 1980s when a child spacing program was approved(Chimbwete & Zulu, 2003). However, the program had little impact on increasing contraceptive use and by 1992, modern CPR was still low at 7.2% (National Statistical Office (NSO) and ICF Macro, 2011). Following the launch of Malawi's first population policy (1992) the child spacing program was reoriented to an FP program promoting family welfare. Subsequently, modern CPR more than tripled to 26% in 2000 then increased further to 42.2% in 2010 (NSO and ICF Macro, 2011). However, Malawi's fertility has remained persistently high (about 6 children per woman in 2010). 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(UNPD, 2011).

Kenya

Kenya's population grew from 23.2 million to 38.6 million between 1989 and 2009 and in the same period the annual population growth rate decreased from 3.4% to 2.9%. Rapid population growth has been a concern in Kenya since independence. Kenya was among few countries in SSA to launch a population policy by the end of the 1960s. While the government put in place a national FP program in the mid 1960s, the program was weak and unsuccessful, failing to meet its targets(Toroitich-Ruto, 2001). Consequently, Kenya's fertility rate rose to 8.1 in 1978, the highest ever recorded in the world. The population growth rate at the time was recorded at 3.8% per year. A revival of the national FP program in the 1980s successfully led to an impressive increase in CPR and decline in fertility between 1989 and 1998. Modern CPR increased from 17.5% to 31.5% while fertility declined by 2 children from 6.7 to 4.7 children per woman (Kenya National Bureau of Statistics (KNBS) and ICF Macro, 2010). However, Kenya's progress stalled between 1998 and 2003 when modern CPR stagnated at 31.5% and fertility actually increased to 4.9 (KNBS and ICF Macro, 2010). During the past 5 years, Kenya has recovered from the stall. In 2008, modern CPR increased to 39.4% and fertility declined to 4.6 (KNBS and ICF Macro, 2010). The UN population projections show that Kenya's population will more than double to 97 million by 2050, if the current fertility rate is maintained(UNPD, 2011).

Tanzania

Tanzania's population has increased from 23.1 million to 44.9 million between 1988 and 2012. The population growth rate decreased from 2.8% to 2.6% during that period. Upon independence in 1961, the Tanzania government did not appreciate the need for FP. The Tanzania government perception was that the country had large tracks of land that needed a large population that would stimulate economic growth. At the time, the population was growing at 2.6% per year (1967). During the early-1970s, the government was convinced to establish a child spacing program but progress in

increasing contraceptive use was slow through the 1970s and 1980s. However, the population growth rate reduced from 3.2% in 1978 to 2.8% in 1988. After the fall of the Soviet Union in1989, Tanzania launched its first population program in 1990. Subsequently, the child spacing program was reoriented to an FP program promoting the small family norm. The program performed moderately well. Modern CPR increased at an average of 1.5 percentage points per annum between 1992 and 1999 from 6.6% to 16.9% (National Bureau of Statistics (NBS) [Tanzania] and ICF Macro. 2011). However, this momentum declined between 1999 and 2004 with modern CPR increasing at a rate of 0.6 percentage points per annum to 20% (NBS [Tanzania] and ICF Macro, 2011). According to the 2010 DHS report, Tanzania appears to have recovered from this deceleration, with an average increase of contraceptive use of 1.5 percentage points per annum bringing modern CPR up to 27.4% (NBS [Tanzania] and ICF Macro, 2011). Overall, the Tanzania's progress in increasing contraceptive use has been relatively slow in relative to other countries in the East Africa region. Fertility remains high at 5.4 children per woman. Unmet need for FP decreased from 30% in 1992 to 22% in 1999 but increased to 25% in 2010. The UN population projections show that Tanzania's population will triple to 138 million by 2050, if the current fertility rate is maintained(UNPD, 2011).

Table 1. Population and FP Trends in Rwanda, Malawi and Ethiopia

Population Indicator	Ethiopia			Malawi			Rwanda			Kenya			Tanzania		
	1990s	2000s	2010s	1990s	2000s	2010s	1990s	2000s	2010s	1990s	2000s	2010s	1990s	2000s	2010s
Population Size (Millions)	51.7	65.6	83.0	9.7	11.2	14.9	7.2	8.1	10.5	23.2	29.7	38.6	23.1	34.4	44.9
Annual Population Growth Rate (%)	3.4	2.6	2.2	1.0	2.8	3.1	3.1	1.2	2.6	3.4	2.5	2.9	2.8	2.9	2.6
Total fertility rate	6.4	5.9	4.8	6.7	6.3	5.7	6.2	5.8	4.6	6.7	4.7	4.6	6.3	5.6	5.4
Modern Contraceptive prevalence rate (%)	2.9	6.3	27.3	7.4	26.1	42.2	12.9	4.3	45.1	24	31.5	39.4	6.6	16.9	27.4
Unmet Need for family Planning (%)		35.8	25.3	36.3	29.7	26.1	40.4	48.8	18.9	17.5	23.9	25.6	30.1	21.8	25.3

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

Appendix 2: Interview Guide

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Rapid Assessment of Drivers of Progress in Increasing Contraceptive use in sub-Saharan Africa – Case Studies from Eastern and Southern Africa

Field Guide for Policy Makers, Program Managers, Development Partners, Service Providers and other Stakeholders

Background Information

Name of Interviewee	Date of Interview ____/10/2011
Position of Interviewee	Name of Interviewer
Interviewee's Institution	Interviewee's ID No.

Thank you so much for meeting with me today. My name is **[Name]**. The African Institute for Development Policy (AFIDEP), based in Nairobi, Kenya has identified the top performing countries in increasing contraceptive use. **[Country name]** is recognised as one of those top performers and therefore we are conducting a study to identify **drivers of change in sexual and reproductive health (SRH) and population policies and programs in [country].** As part of this study, we are talking to a range stakeholders including policy makers, program managers, donors, civil society organizations in order to gain an in-depth understanding of the status of family planning (FP) / contraceptive use and acceptance, identify key challenges affecting FP uptake, and make recommendations for improving FP uptake in other African countries at policy, system, and service delivery levels. The information obtained will also be used to make recommendations to reinforce FP uptake in **[country name]**.

I have requested an interview with you because we believe that in your position as a **[Position/Job Title]** in the **[Name of Office]**, you will provide useful perspectives and insights on these issues, and I look forward to learning from you today. I have some guiding questions, but want you to feel free to talk about anything you think is important for us to know. I will be taking notes as we talk to be sure I don't miss anything. Is that alright?

Before we get started, I just want to emphasize that everything we talk about today is confidential. No one will have access to the notes I am taking except for those of us working on the project. When we write up our report, we will not use the names of any interviewees so that no one can be identified. Also, if at any point during the interview you would like to stop, or if there are any questions you would rather not answer, just let me know -- that's fine. Is there anything you'd like to ask me at this point? [**Answer any questions regarding the interview**].

I. Context-setting on prioritisation of FP

a. When did it happen?
b. Who led the policy changes?
c. What prompted the policy changes? (i.e. why)
   Prompt: Was it poverty or population or child mortality or health driven? (is there an impact of child mortality on FP use?)
d. What were the challenges experienced when making the policy changes?
   Prompt: Was there opposition from certain groups e.g. religious leaders?
e. How did the policy changes occur? (What was the process?)

II. Policy Framework

a. What new policies were put in place?
b. What was the strategy for implementation of new policies?
   Prompt: at a systems/infrastructure level
   Prompt: at a service level
c. What were the challenges faced with implementation of the new policies?
d. What were the identified gaps in the new policies?

III. Funding / Resource allocation

a. What is the proportion of government funding?
b. What measures have been taken to ensure the sustainability of funding for SRH, specifically FP programs?

IV. Co-ordination

a. Is there a recognised link between SRH/FP and population?
b. Where does the Population Unit sit? Since when?
c. How can you ensure that key messages are common and synergistically relayed by both units?
d. Are there programs that integrate SRH and HIV?

V. Health System Strengthening

(i) Supply Chain Management

a. What is the current status of procurement and supply of FP commodities?
b. What changes have been made to meet requirements of new SRH/FP policies?
c. How often and how is forecasting for FP needs conducted? Are there reported stock outs? (Assuming there is a monitoring system; e.g. in Lesotho and Ethiopia it is based on annual use patterns)
d. Are contraceptives on the Essential Medicines List?

(ii) Human Resource Capacity (Public and Non-public)

a. Are there challenges with staffing to meet SRH/FP needs
b. Are there any changes in pre-service and in-service training?
c. Is there task shifting to meet SRH/FP demand?
d. Are there restrictions on the care that Community Health Workers can give? (e.g. injectable contraceptives)
e. Is there an effect on quality of care with increased FP uptake?

VI. Role of Non-Public Organisations (FBOs, CBOs, CSOs, etc)

a. How have non-public organisations / development partners influenced the policy changes?
b. How have non-public organisations / development partners supported the policy changes?

VII. Abortion Laws

a. Have there been changes on abortion restrictions?
b. What is the status of post-abortion care?

VIII. Monitoring and Evaluation

a. How do you monitor progress/impact of policy changes?
b. What systems are in place to monitor the impact of policy changes? (Give indicators)
c. What challenges do you face in monitoring?
d. How are you addressing these challenges?

IX. Contentious issues

a. What is the attitude towards access for youth to FP?
b. What is the status and attitude towards sex education for the youth?
c. What is the attitude to FP? Has there been a demedicalisation of contraceptives? (i.e. not medicinal products limited to health workers[1])

[1] Linked to question on restrictions on the care that Community Health Workers can give (e.g. injectable contraceptives)

X. Concluding remarks

If there is one thing you can name that has really made a difference in this country, that others can learn from, what would it be?

Prompt: it can be a policy, a process, an event, an FP champion, etc.