Family planning policies in sub-saharan Africa: failure of policy transfer

by

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ABSTRACT

After Colonization and since the beginning of the globalization era, governments in developing countries have been restricted in implementing certain policies and reforms, often being forced to accept or borrow policies from former colonizers or other developed countries and non-governmental organizations (NGOs). Previous studies found that borrowing policy often leads to failure because every country's policy environment is unique and that a "one size fits all" solution cannot produce the same outcomes in different settings. This study aims to understand why transfer of family planning (FP) policy is not successful in sub-Saharan Africa. To answer this research question, this study gathers qualitative evidence and uses the so-called "policy transfer framework"in order to understand who are involved in the transfer, what was transferred, from where the lessons are drawn, what is the degree of transfer and why countries still choose to transfer FP policies. This study also identifies the constraints and barriers that prevent the success of the transfer. This study finds that FP policies in Sub-Saharan Africa are inappropriate, incomplete or uninformed because variables like culture, structural feasibility, and policy complexity were not taken into account while implementing the policy.

Keywords: Sub-Saharan Africa, Family Planning policy, Madagascar, Mali, Benin, Ethiopia, Tanzania, Malawi, Policy transfer, Globalization

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INTRODUCTION

With globalization, international organizations have operated as institutional entrepreneurs promoting reforms in African countries as a condition for development aid (Tambulasi, 2015). Poverty reduction became not only the main preoccupation of developing country governments, but it also caught the attention many international organizations like the World Bank or the United Nations. Debates among scholars and development specialists persist about the role of those international organizations in global poverty alleviation (Barnett, Finnemore, 2004; Tambulasi, 2015, Dolowitz, Marsh, 1996, 2000). However, despite the efforts made toward poverty reduction, the number of people living in extreme poverty[1] worldwide (from 37.1% in 1990 to 9.6% of the world population in 2015), is still unacceptably high. Recognizing the tight relationship between poverty and outcomes in health is crucial when conducting research on this area- especially when it comes to countries in sub-Saharan Africa (SSA). Of the 702 million living in extreme poverty in 2015, 70% are women, and about 347.1 million are in SSA (World Bank, 2015). Family planning (FP) and promotion of contraceptives are considered by development specialists and scholars to be the most cost-effective development investments available, especially in SSA (Cates, 2010). Even though a lot of effort has been made to improve maternal health, nearly 830 women die every day from preventable causes related to pregnancy and childbirth, and 99% of those deaths occur in developing countries (WHO, 2015). This study examines six low-income[2] countries in SSA (Benin, Ethiopia, Madagascar, Malawi, Mali, and Tanzania) to understand why FP policies are not successful in SSA.

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[1]The World Bank, which gathers data on income from people around the world, defined absolute poverty as living on less than **$1.90 per day**

[2]As of 1 July 2015, low-income economies are defined as those with a GNI per capita, calculated using the *World Bank Atlas* method, of $1,045 or less in 2014

FP has health, demographic, and human right rationales (Seltzer, 2002). The Neo-Malthusianism[3]perspective argues that rapid population growth is a barrier to economic development. Studies also agree about the health benefits of FP and considered that high fertility rate is a menace for women and child's health in the poorest countries (Ezeh, Bongaarts, & Mberu, 2012; Seltzer, 2002). After the International Conference on Population and development[4], in Cairo Egypt in 1994, family planning also became preeminent as a human right. It was specifiedthat individuals and couples have a fundamental right to control their reproductive choices, including family size and timing of birth (Seltzer, 2002). Family planning has been criticized by social scientists, feminists and women rights activists because of concerns about the effectiveness of programs encouraging birth control in developing countries. They claim that the success of family planning policies and programs is based on the assumption that couples in those countries want fewer children; and, that to reduce their family size, they will resort to contraception (Campbell, Bedford, 2009, Seltzer, 2002).This paper argues thatFP policies implemented in SSA areinappropriate; and that, because of the culture and ideology, the population in SSA is less likely to reduce their fertility preferences.

The definition of "successful" family planning policies and programs has varied throughtime and mostly dependson the views of researchers.The majority of studies conducted on the FPevaluation are mostly performance-oriented assessing inputs, process, and outputs of the programs implemented; while, just a fewconsidered a population-based approach. The performance-based approach is preferred if scholars want to know how well the programs are doing to reach the goal fixed by the government and meet the standards of donor institutions.

[3]**Neo-Malthusianism** generally refers to people with the same basic concerns as Malthus, who advocate population control programs, to ensure resources for current and future populations
[4]ICPD Programme of Action, which was adopted by 179 governments in 1994

However, the focus on performance gives less consideration of the impact of the policy on the general population (Bertrand, Magnani, & Knowles, 1994). The literature is also vague on how to claim the extent of which policies are successful or not, mainly due to the absence of scoring or scaling of indicators; which makes it more difficult to conclude if the national policy successfully achieved its goals.

In developing countries, more particularly in sub-Saharan Africa, primary policy instruments advocated by supra-national institutions like the World Bank or the UN, seeking to improve maternal and child health as well as to reduce poverty, are programs organized to promote the practice of contraception (Mauldin, Segal, 1988). In this perspective, similar programs and policies are implemented in most of the countries in Sub-Saharan Africa, since the beginning of the globalization era (Bertrand, Magnani, & Knowles, 1994; Campbell, Bedford, 2009; Seltzer, 2002). However, despite considerable overlap in activities and measures taken for each country, several studies on family planning policies show that there are some inconsistency in the relationship between contraceptive prevalence and fertility rate, and that in some developing countries, the fertility rate does not tangibly decrease despite the rise of contraceptive use (Saha & Bairagi, 2007). Policies are often not well received in the recipient country. With the omnipresence of globalization, it is crucial to understand the importance of international community involvement as well as international organizations like the United Nation, the World Bank and the IMF, and their active role in shaping policies in developing countries, especially sub-Saharan Africa. Since colonization, governments of low-income countries in sub-Saharan Africa, "choose" to implement existing policies, or import policy instruments rather than designing their own strategies in family planning. That is why, conferences like Alma Ata (1978), the second African Population Conference (1984), the International Conference on Population and development (1994) or the

Millennium Development Goals (MDGs) in 2000, became the main policy change driver on FP for low-income countries in Sub-Saharan Africa. Developing countries have great incentives to borrow policies but, according to several studies, policy borrowing disconnects the country from their roots and often leads to unexpected outcomes (Robertson,Waltman, 1992; Dolowitz, Marsh, 1996).

This is why similar programs and policies are implemented in most of the countries in Sub-Saharan Africa. However, despite the resemblance of activities and measures taken for each country, several studies on family planning policies show that there are some inconsistenciesin the relationship between contraceptive prevalence and fertility rate acriss countries. And in some developing countries, the fertility rate does not tangibly decrease despite the rise of contraceptive use (Saha & Bairagi, 2007). Strong disparities exist and persist not only between countries but also within countries. Some policies are better received in one region while tough resistance in implementing the policy occurs in another area of the same country.

The family planning effort index, created by Mauldin and Berelson in 1978, aims to capture the efforts of the national public family planning programs, in other words inputs regarding family planning not outcomes. (Ross, Smith, 2010). The effort index is useful in highlighting the measures taken by the main actors, in hopes that government will improve their policy making and policy outcomes through the accurate anticipation of the consequences of government action. This paper wants to understand the reasons why FP policies in sub-Saharan are not successful; by first, focusing on population-based outcomes to measure the effect of policies/programs. Second, the purpose of this study is also to contribute to the gap regarding the categorization of countries whether they fail or succeed in the implementation of the policy.

Regardless of the status of their population policies (or lack thereof), almost all African countries now provide either direct or indirect support for family planning programs (United Nations, 1989b; Population Reference Bureau, 1990). Developing countries have a great incentive to borrow policies but according to several studies, policy borrowing disconnects the country from their roots and often lead to unexpected outcomes (Robertson,Waltman, 1992; Dolowitz, Marsh, 1996). The process by which 'knowledge about how policies, administrative arrangements, institutions and ideas in one political setting (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political setting' is understood as policy transfer (Dolowitz & Marsh, 2000: Stone, 2004). It has been observed that most countries in sub-Saharan Africa cannot function without external aid due to extreme levels of poverty (Burnside and Dollar, 2000; Easterly, 2003). Few studies are dedicated to policy transfer in developing countries because most of the scholarsare always supposed that policy transfer only happened in developed countries (Dolowitz & Marsh, 2000: Stone, 2004). It is also the case because, studies related to public policy are relatively new in sub-SaharanAfrica and that previous studies are made only based on existing frameworks and indicators implemented by NGOs or international organizations reports.

This paper contributes to the received research on family planning policy in sub-Saharan Africa by answering this main research question: why family planning policies in sub-Saharan Africa are not successful. By using a comparative case study of six low-income countries in sub-Saharan Africa, this paper aims to identify the main causes of the success or failure of family planning policy, with a perspective on policy transfer. The first part of this essay consists on defining what successful family planning is based on FP outcomes on population. The categorization of countries contributes to knowing at which extend the FP policy is failing or

succeeding. The second part consists of the analysis of Policy transfer where a chronological analysis of policies related to family planning in SSA will be elaborated. This section describes who are the actors involved in the transfer, what are transferred in the policy, from where the lesson was drawn, the degree of transfer of the policies to assert finally why the designated countries choose to transfer policies. After that, this research attempts to collect evidence on the main cultural, structural and the other barriers of a successful FP in SSA, before concluding on how the policy transfer leads to an inappropriate, incomplete and uninformed policy according to Dolowitz and Marsh's framework.

FAMILY PLANNING POLICIES AND PROGRAMS

Studies agree that FP programs are the most cost-effective investment to improve maternal health and also to reduce poverty. "Family planning is one of the most successful development interventions of the past 50 years. It is unique in its range of potential benefits, encompassing economic development, maternal and child health, educational advances, and women's empowerment. Research shows that with high-quality voluntary family planning programs, governments are able to reduce fertility and produce large scale improvements in health, wealth, human rights, and education" (Bongaarts et al., 2012, pp. 77). Indeed, FP has three different but interrelated rationales and is considered to satisfy several objectives as: population growth reduction and improve the lives of a population (demographic rationale), improve maternal and child health (health rationale) and ensure the right of couples to plan their families (human right rationale). Each rationale can be viewed as a goal of FP policies because it suggests the implementation of some changes in health, economy and human right (Seltzer, 2002). For instance,

countries like Benin or Mali use health and human right rationales for their FP policies, which do not necessarily imply fertility reduction. Instead those countries encourage birth spacing to improve maternal health and the well-being of the family. Population policies and policies on birth control have been influenced by global initiatives overtime.

Impact and effect of family planning program

This part of the research attempt to define successful FP policy in SSA, by constructing an argument around the assumption that, the primary goal of any FP policies is to promote and encourage the use of contraception among the population, by ensuring that the latter recognizes the health and economic benefits of using contraception, as well as to provide a suitable environment, so that any women who desires to control her fertility will have access to any method shechooses in order to meet their fertility preference.Even though the quasi-totality of countries in SSA support FP and have policies that promote the use of birth control, some countries like Benin, never focus their policies on reducing birth or fertility rate, but instead promoted FP for spacing pregnancy. Viewed in this way, any FP policy can be successful regardless of whether they choose to promote birth spacing or birth limitation if they do reach their goals mentioned earlier. Defining "success" in the implementation of FP policies is not enough, it is also important to investigate how successful the policies is, according to the previous assumptions made earlier, by categorizing population-based indicators for each country. Indicators used for this categorization were collected from DHS in the six respective countries.

Bertrand, J. T., Magnani, R. J., & Knowles, J. C. (1994), in their handbook of indicators for family planning program evaluation, argued that evaluation is often discussedin terms of performance versus impact evaluation of FP policies, especially within the donor organizations like USAID. The main difference between the two approaches is found in data sources where

performance-based evaluation requires program–based data, while impact evaluation, which is focusing on outcome measurement (e.g., contraceptive prevalence as an intermediate outcome or fertility as a long– term outcome), requires population–based data.

Mauldin and Berelson (1978), for instance, conducted a performance-based evaluation which aims to measure capture the efforts of the national public family planning program, and focuses more on inputs regarding family planning, than on outcomes. The effort index was designed to rate the strength of family planning program effort by scoring thirty indicators gathered into four components: policies and stage-setting activities, service and service related activities, record keeping and evaluation, and availability of contraceptive methods. Mauldin and Berelson (1978) obtained those scores through detailed questionnaires sent to government officials, donor agency personnel, knowledgeable citizens, and foreigners. The family planning program effort scores has been criticized as biased since data collection and calculation were completed by individuals who were aware of fertility trends and levels of contraceptive use and who assumed that the success or failure of FP policy depends mainly on whether fertility is declining (Lee et al. 1998). Moreover, there is a risk of overestimation or underestimation of the scores.While some researchers based their idea of successful family planning on program input and outcomes (Mauldin, Berelson, 1978; Lee et al., 1998; Ross, Smith, 2010), otherscholars focused on the effect and impact of policy, and used population-based data, like DHS to assess success of FP policy.Similarly to Mauldin and Berelson's method, this research aims to score 12 indicators which are assumed to determine whether the FP policy implemented in countries in SSA are successful or not but instead of using data on policy input and output, this paper will use data on population to investigate whether the FP policy has produced outcomes expected to be called "successful"

In their study on the factors affecting contraceptive use, Cleland, Ndungwa, Zulu (2001), examine the progress towards the acceptance of modern contraception in Africa by using a framework based on the assumption that fertility is not likely to decline at a fast sustained pace, unless, a large and growing number of couples is "ready, willing and able" to use modern contraception and used data from DHS to extract the indicators."Readiness" in use of contraceptive, defined as the subjective need or desire to space or limit birth, is represented by the percentage of women who wanted to have no more children or who wished to postpone childbearing for at least two years, while the determinant "Willingness" reflects a favorable attitude of a couple to use contraceptive is represented by the percentage of women who expressed their approval of family planning and who believed that their partners were also in favor of it.Clealand, Ndungwa, Zulu (2001) also claim that adding with readiness and willingness, the familiarity with contraceptive methods and their supply sources and having reasonable access to them, determined by the percentage of women who knew about contraceptives methods as well as the place to seek family planning services, which reflect Ability to use, are obvious preconditions for use of FP methods. They also illustrate the interaction and the link between the three conditions, and explain that readiness may lead a woman to learn about methods and supply sources, or access to FP can stimulate a favorable attitude of women and men towards the use of contraceptive.

The simplified framework adopted by Clealand, Ndungwa, Zulu (2001), shows that the conditions in the use of contraceptive also reflect the constraining factors, in individual, social and program level, that are standing between people's preferences on the number and timing of pregnancies and the adoption of behavior to achieve these. The subjective and voluntary condition of the use, adding with social acceptance, knowledge on FP and availability of FP increase the complexity and the uncertainty regarding the success of a policy implemented. Contraceptive use

is the expression of individual desires to space or to limit births. In their research, Clealand, Ndungwa, Zulu (2001) failed to mention whether the use of FP as a means to space birth, would inevitably imply failure of the policy as they assumed that drop of total fertility rate (TFR) is a compulsory result of a successful FP policy.

According to Bertrand et al. (1993), individual demands for birth spacing and limitation are shaped by the surrounding social, economic, and policy environment. They also point out the importance of understanding the motivations for contraceptive use. In other words, to what extent is contraceptive use motivated by a desire to limit family size versus the desire to space births. Unlike Clealand, Ndungwa, Zulu (2001), this paper attempts to show that, even though the contraceptive prevalence rate – mostly modern contraceptive prevalence rate (CPR) – and fertility rate are the main indicators of the success of FP, the two indicators alone, cannot prove the success and effectiveness of policy/ programs (Bertrand, et. al 1993). In addition to CPR and TFR, indicators displaying a greater acceptance FP, as well as indicators expressing individual preferences for fertility are integrated.

POLICY TRANSFER

This study mainly seeks to examine the reasons behind the success or failure of PF policy in SSA, under the assumption that, most of the policies on FP in this region were imported from overseas, more specifically from international organizations like USAID, UN, World Bank. To demonstrate the transfer of population and birth control policies in Benin, Ethiopia, Madagascar, Malawi, Mali, and Tanzania, this study uses the framework elaborated by Dolowitz & Marsh, (1996, 2000). This section will offer an overview of the policy transfer framework, and will provide some justifications for the use of the conceptual framework to explain the transfer of FP in sub-Saharan Africa.

Due to the increasing number of International institutions, private sectors and non-governmental organizations (NGOs) involved in shaping policies, adding with the heavy reliance of African countries in external aid, low-income countries in SSA, governments are constrained not only in what they do but also how they were implementing FP policies (Cerny, 1996). In the era of globalization, governments are losing more and more of its autonomy and its decision-making capacity, as the policy environment is getting more complex. Around 1990, the government in SSA started to implement reforms in their health system as well as in their FP policies because of requirement from international donor organizations like the World Bank, the UN, or the IMF.As a part of the 'knowledge about how policies, administrative arrangements, institutions and ideas in one political setting (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political setting' described by Dolowitz and Marsh (2000), similar FP policies started to be implemented in the majority of low-income countries in SSA, with the assumption that policy implemented in one country can also work in others. However, studiesdemonstrate that it is not the case, and that 'one-fits-all' policy fails to consider the policy environment of each country.

To understand why FP policy fails or succeed in SSA, it is important to know who the main actors in FP policy transfer are, what have been transferred, from where the lessons were drawn, and to what degree the policy was transferred Dolowitz and Marsh (2000) in the first place. The framework also put a special attention on the reason why countries are importing policy from overseas and mostly highlight the fact that transfer is not only volunteer or coercive but occurs in a continuum that can change over time and depends on what policy was transferred. Finally, the framework wants to define what constraints or instead was beneficial to the policy transfer process

to explain the success or failure of policy transfer and to determine whether the transfer was uninformed, inappropriate, or incomplete.

Policy transfer, policy diffusion and policy learning

While most studies of policy transfer focus on the transfer of knowledge between developed countries , there is a consensus that transfers from a Western to a developing country are more complicated. Compared to the other similar frameworks available to explain the failure or success of FP policies in SSA, Dolowitz, and Marsh's framework is more appropriate for analysis policy in a global context. Appuhami, et. Al, (2011) used the policy diffusion framework, which by definition is ''as a process through which policy choices in one country affect those made in a second country'', to highlight the coercive Policy diffusion indeveloping countries by using the case of Public-Private Partnerships in Sri Lanka. The authors stated that international organizations as IMF, World Bank or even countries like the US have used conditionality to influence developing countries to adopt market-orientated reforms, including liberalization and privatization. Like the policy transfer framework, the policy diffusion shows how policies in one country or region, affect the policy design is some other places. However, a lot ofcritics regarding this approach remain because it ignores the multiplicity of transfer processes associated with diffusion activities (Dolowitz and Marsh, 1996)

Marsh & Sharman (2009) reviewed the existing literature on both policy transfer and policy diffusion and argued thatliterature on policy transfer and policy diffusion are complimentary, but need to put more attention on five key issues drawing insights from both strands of literature. According to Marsh & Sharman (2009), both frameworks need to focus on the changing interactions between the various mechanisms, and should also concentrate more on the case of developing countries. They also assert that both kinds of literature need to emphasis on the success

or failure of the transfer/ diffusion of policies. While policy diffusion privileges structure and concentrates on pattern-finding, the policy transfer framework put more attention on the role of agencies and stresses more on the tracing the policy transfer over time.

The literature also identifies several terms related to policy transfer, including lesson drawing (Rose, 1991), policy convergence (Bennett, 1991 b; Dolowitz, 1998), emulation (March and Dolowitz, 1996), which should not be confounded with the actual approach. For instance, policy learning was based on the same concept as policy transfer, but assumes that the drawing process was both rational and voluntary (Bulmer et al., 2007, p. 13) while Dolowitz and Marsh (2000) encompass both 'voluntary' and 'coercive' forms of practice in 'policy transfer'.

Policy transfer framework

Dolowitz and Marsh (1996) attempted to create a framework on policy transfer, revised in 2000 (Dolowitz, Marsh, 2000), which is organized around six main questions: who are the key actors involved in the transfer? What is transferred? From where are lessons drawn? What are the different degrees of transfer? Why do actors engage in the policy process? What restricts or facilitates the policy transfer process? After their revision of the framework, the authors included a new question: how is the process of policy transfer related to policy "success" or policy "failure"? in this sense, answering those previous questions are crucial to determine the cause of success or failure of FP in SSA since policy transfer is used to explain the FP policy outcomes. Table 1 summarizes the different determinants of the framework elaborated by Dolowitz and Marsh (2000).

Dolowitz and Marsh (2000) mentioned six main types of actors that are involved in contemporary policy transfer; elected officials, political parties, bureaucrats, pressure groups, policy entrepreneurs, and supranational institutions. Stone (2004) emphasizes the role of consultants and non-governmental institutions in offering advice based upon the “best practices” in other countries or regions. Policy goals, structure, and content are not the only objects of transfer according to Dolowitz and Marsh (2000). In fact, “softer” transfer of institutions, ideas, ideology, attitudes, and concepts as well as negative lessons can also be transferred from one country to another.

Transfer can take place across time, within countries and across countries and the degree of transfer as well as the reason why actors choose to transfer policy varies chronologically and depends on of where the policy originated from. Dolowitz and Marsh’s framework identifies endogenous and exogenous sources of learning, as in a national level, actors can draw lessons from political systems in their own country, from other countries, or again from a political system at an international level, which is the case from most countries in SSA. Knowing the different degree of transfer, whether it involves straightforward copying of policy, emulation which implies the transfer of ideas behind the policy, combinations or mixture of several policies or again inspiration, where other policies inspire the policy change but does expect the same outcomes than the original policy; is crucial to understand the failure or success of any transferred policy.

Placing policy transfer into a conceptual framework can advance the understanding of concepts such as what motivates policy-makers to engage in the policy transfer process? The policy transfer framework suggests four main reasons why actors get involved in policy transfer, and attempt to create a continuum that runs from lesson drawing, which is completely voluntary, to a coercive transfer, which involves the direct imposition of a program or institutions. Most of

the cases of transfer involved both coercive and voluntary elements. In this sense, the transfer can be the result of lesson drawing, where policy transfer is a rational decision taken by the actors to solve their issues. Transfer can also occur voluntarily, but driven by a perceived necessity, as the desire of international acceptance, or again, to remain competitive in a global market. Some countries also engage in policy transfer as a result of treaty obligations, or due to conditionality which mostly implies loans or political agreements with countries or institutions; since direct imposition, which happened for instance in the era of colonization, is less likely to occur now.

Studies show that success or failure of a particular policy transfer is not just contingent on the efficacy and (seeming) goodness of fit of the policy as such, but also of the human (f) actor and the socio-cultural values in which this policy is integrated. The policy transfer framework identified potential constraints that influence the "success" or "failure" of policy transfer which are: the lack of structural and institutional feasibility, the policy complexity and the cultural and ideological incompatibility between transferring countries. However, Marsh and Evans (2012) argue that it is difficult to assert whether a policy has been successful or not because of the subjectivity, and that it is important to acknowledge that a policy can 'succeed' on one dimension, or for one set of people, while 'failing' on another dimension, or for another set of people.Additionally, actors choose to transfer policy with the clear assumption that policy transfer will be successful, even though, studies show that importing policy often leads to failure because of different settings between the lender and borrowers. The policy transfer framework recognizes three categories of policy transfer failure: uniformed transfer, where the policy recipient has insufficient information on the policy transfer; incomplete transfer, which occurs when borrowing countries lack structural resources to achieve a successful policy; and finally, inappropriate

transfer, where insufficient attention are paid to the differences in culture, economy or political ideology in the borrowing country.

Table 1: Summary of the policy transfer framework by Dolowitz & Marsh (1996, 2000)

Want to	Why transfer? Continuum ………..	Have to	Who is involved in transfer?	What is transferred?	From where?			Degree of transfer	Constraint on transfer	How to demonstrate policy transfer	How transfer leads to policy failure
Voluntary	Mixtures	Coercive			Past	Within nation	Cross-national				
Lesson drawing (perfect rationality)	Lesson drawing (bounded rationality)	Direct imposition	Elected officials	Policies (Goals, content, instruments)	Internal	State governments	International organizations	copying	Policy complexity	Media	Uniformed transfer
	International pressures		Bureaucrats Civil servants	Programs	Global	City governments	Regional State Local governments	Emulation	Past policies	Reports	Incomplete transfer
	(image, consensus, perception) Externalities		Institutions			Local authorities		Mixtures	Structural institutional feasibility	Conferences	Inappropriate transfer
	Conditionalit y	Pressure groups Political parties	Ideologies					inspiration		Meeting visits	
	(loans, condition attached to business activity)		Attitudes/ Cultural values						Ideology cultural proximity, technology, economic bureaucratic language		
	obligations	Policy entrepreneurs, experts	Consultants think tanks, transnational corporations supranational institutions	Negative lessons			Past relations			Statements Written or verbal	

Policy transfer in developing countries

It has been observed that most developing countries cannot function without external aid due to extreme levels of poverty (Burnside and Dollar, 2000; Easterly, 2003). As a result, they depend on financial and technical resources from external donors, finance organizations and developed countries. In studies related to policy transfer, supra-national organizations such as the WB and IMF are often identified as transfer agents between industrialized countries and developing countries (Holden, 2009) which use conditionality to influence the policy choice of government in developing countries, and make them adopt policies innovated in industrialized countries. According to Biersteker (1995: 186), ‘‘there was a pronounced interest in the willingness, especially on the part of the US government, to use the Fund [IMF] and the [World] Bank to force changes in developing country economic policy during the early 1980s.’’

Minogue (2002) focuses his paper on the conceptual and empirical problems that arise in the analysis of the administrative and political context of economic and social regulation in developing countries and argued that ‘Western’ models of regulation are not easily emulated or transferred because of the resistant political and administrative cultures that must receive them. He suggested that there was a need for reshaping the state-market relations in developing countries, as well as to encourage pro-poor strategies to achieve a successful policy transfer. It is obvious that countries are simply too different, economically, legally, politically, and culturally to make fruitful policy borrowing a serious possibility (Jong, Waaub, Kroesen 2007). Since countries in SSA strongly differs from one another and from other developing countries, even ambitious policy actors in the recipient country who actively attempt such an adoption will run into incompatibility and incongruence, which makes the transfer impossible or even deleterious. Studies argued that there is a higher chance of success if they do not copy, but creatively integrate the transfer in their

own context. However, it is still very difficult for developing countries to break their reliance on international aid, which prevents any programs including FP to be successful and sustainable. This paper examines this coercive influence that international organization have on the implementation of FP policies in SSA, and attempts to highlight the different reason why FP policies are not successful in this region.

METHODOLOGY

The main objective of this paper is to explain and understand why FP policy transfers in SSA are not successful? To answer this question, this paperuses a case study of sixlow-income countries in sub-Saharan Africa: Benin, Ethiopia, Madagascar, Malawi, Mali and Tanzania to highlight the differences in policy outcomes between the countries and to draw conclusions related to the reasons for failure or success of FP policies.Any of the 20 low-income countries in Sub-Saharan Africa could have been used for this case study, however, those countries were randomly selected after the exclusion of countries in conflict,the availability of data, as well as the existence of a family planning policy in the country.In the end, Benin, Ethiopia, Madagascar, Malawi, Mali, and Tanzania were selected among the 16 remaining eligible countries for this study. The six countries also have more or less similar patterns in terms of timing and FP policy adopted. The selection of the countries for this study ensures that countries are well distributed geographically (western Africa, eastern Africa) and also includes both Anglophone and Francophone countries. Benin, Madagascar, and Mali represent former French colonies while, Malawi and Tanzania represent Anglophone countries. Ethiopia can also be considered an Anglophone country even though the country has never been colonized in the past. Benin and Mali represent countries in western Africa while the remaining three are located in the eastern part of the continent.

Figure 1: Country selection process

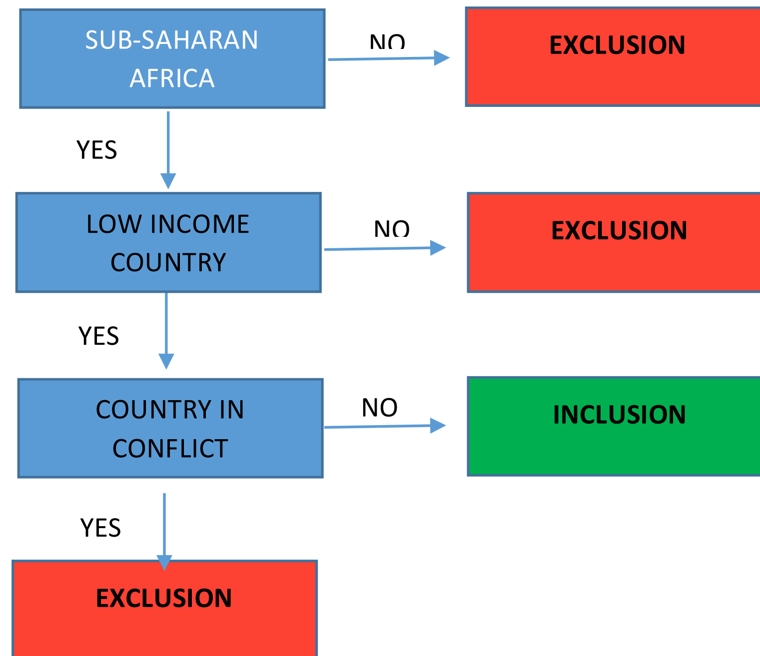
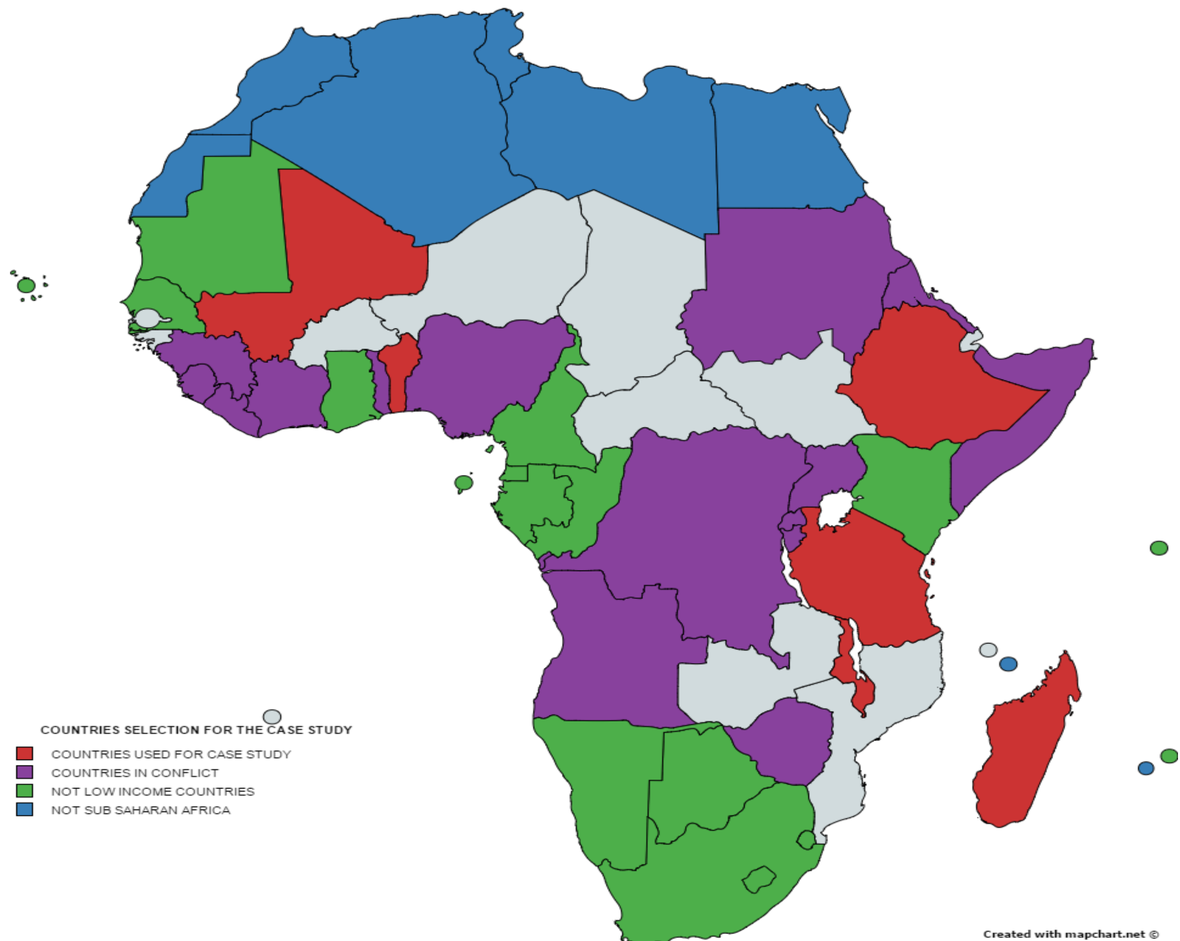


Figure 2: Map of country selection for the case study



To answer the research question, this research is using the policy transfer framework elaborated by Dolowitz and Marsh (2000) and answers six main questions to understand the policy transfer process, which is: (1) who is involved in the policy transfer process? (2) What is transferred? (3) From where are lessons drawn? (4) What are the different degrees of transfer? (5) Why do actors engage in policy transfer? (6) What restricts or facilitates the policy transfer process? Then, he explained how is the process of policy transfer related to policy "success" or policy "failure"?

This paper regroups evidence from the existing literature and uses qualitative data to answer our main research question and provides an analysis of FP policy in SSA in two phases consisting on:

1. Defining a successful FP based on population outcomes
2. Analyzing the transfer of FP policy in SSA

This research then uses two different approaches for each part of the analysis. The first part of the study focuses on identifying, and analyzing the main indicators of the success of the Family planning policy, using population outcomes, which reflect the success or failure of FP policies. Data issued by DHS 2011 Benin, DHS Ethiopia 2011, DHS Madagascar 2008, DHS Malawi 2010, DHS Mali 2012, DHS Tanzania 2011, are used to extract indicators of contraceptive prevalence, TFR, wanted fertility rate, and teenage pregnancy. As the previous literature has pointed out, unsatisfactory outcomes in FP are also due to the disparity between rural and urban areas. Therefore, a comparison between outcomes in rural and urban area is a crucial step of this research.

Second, the paper aims to understand the policy transfer and how is it related to Failure or Success, assuming that policy transfer is most of the time inappropriate, incomplete and uninformed. The analysis of policy transfer will focus first on a chronological examination of policy transfer process – which will focus on knowing the main actors and their roles in the policy transfer, understanding what part of the policy was transferred, and at what extent – during the main events which has led to the change in the measure taken by government to limit or space birth in Benin, Ethiopia, Madagascar, Malawi, Mali, Tanzania.To do so, this study compiled existing documents and policies related to FP in sub-Saharan Africa including reports and national population policy documents to analyze the policy transfer process. The study of family transfer process in SSA will help to situate the countries in the policy transfer continuum designed by

Dolowitz and Marsh (2000) by highlighting the main reasons behind the adoption of a certain policy for low-income countries in SSA. This research assumes that coercive or/and obligated transfer contributes to the failure of FP policies in SSA.

Relevant factors are identified in the literature using content analysis of existing literature made on FP policies and programs in sub-Saharan Africa. The literature consists of 45 articles issued from 1985 to 2015 and related to FP in SSA, in francophone countries and also in the six respective countries. Several keywords were used to search relevant articles; "Family planning in sub-Saharan Africa" "family planning policy" "barriers in Family Planning". Articles were included when they: 1) focused on FP in SSA, Benin, Ethiopia, Madagascar, Malawi, Mali and Tanzania, 2) included barriers in contraceptive use 3) highlighted weakness or strength of FP policies or programs. A total of 45 articles in English and French are included in this review. "Google Scholar" "Guttmacher" "Popline" "MEDLINE" "Jstor" represents a non-exhaustive list of the database used for this study. Data are compiled using Zotero and then are coded via "Microsoft Excel" before analysis.

FAMILY PLANNING AND POLICY TRANSFER IN SSA

The objective of this research is to understand why FP policy and its transfer in SSA are not successful. This section discusses the results found in the literature about what the definition of successful FP, while looking at population outcomes among the six countries. Next, this section focuses on the analysis of FP policies in those countries and attempts to identify who transferred FP policies in SSA, what is transferred, what is the degree of transfer, why transfer occurs, from where the lessons were drawn (Dolowitz, Marsh, 1996, 2000)?

Effect and impact of FPpolicies: what is a successful FP?

Because outcomes on population reflect the success of the FP policy, it is necessary to identify the indicators and to measure the impact of FP policy in this paper. This study assumes that, the primary goal of any FP policies is to promote and encourage the use of contraception among the population, by ensuring that the latter recognizes the health and economic benefits of using contraception, as well as to provide a suitable environment, so that any women who desire to control their fertility, will have access to any method they choose, without any restriction, in order to meet their fertility preferences. This research also shows that, after almost 55 years of implementing FP policies, FP outcomes are still unacceptably low mostly because of a high number of desired children, a high prevalence of unmet needs in FP, a high teenage pregnancy, as well as a vast disparity between rural and urban outcomes. This study categorizes the countries in two groups according to the goal of their FP policies. First, the spacers (Benin and Mali) whose policies are focusing on spacing birth, and then, the limiters (Ethiopia, Madagascar, Malawi, Tanzania) where policies in FP are designed to reduce the family size.

According to the data provided by the DHS, Malawi has the highest prevalence rate (46.1%) while Mali has the lowest percentage of women using any kind of contraception (10.30%). It is not surprising that the limiters have higher outcomes on CPR and TFR compared to the spacers. Western countries both have a very low contraception rate, however, even though Benin CPR is lower (7.9%) compared to Mali (9.9%), women in Benin have more incentive to use Contraceptive and more particularly traditional methods of contraception. It is also true for limiters like Ethiopia, Madagascar, and Tanzania as well, where a similar level of CPR (respectively, 27.3%, 29.9%, and 27.4%) is observed and higher CPR is found in Madagascar (39.9%). The data collected from the DHS of the six countries also shows that there is a lot of disparity between the

CPR in the rural and urban area. Extreme cases were the outcomes in Mali where CPR in a rural area is almost three times lower than in urban area, and Ethiopia where rural CPR is half of the CPR in an urban area.

Trends in fertility rates are also comparable to the contraceptive use. Total fertility rates in both countries are extremely high, because of the high desired number of children, but also because of the differences in fertility rates between urban and rural areas. Countries like Benin promote the use of contraceptives but with the motivation of spacing births and not reducing Family size, and its population outcomes highly reflect this intention. In Benin, Madagascar, and Mali, women overall have almost as many children as they want, while in Ethiopia only 62% of their fertility goal is fulfilled. In Madagascar, Malawi, and Tanzania, the Total fertility rate remains very high because of a high number of children that women in the rural area have during their reproductive life. It is evident that women in a rural area also want more children than the ones in the cities.

The success of any FP policy also depends on how governments contribute in making FP accessible, and in promoting wider acceptance in FP use. The demand satisfied by FP reflects this government effort as it represents the percentage of women who do not want any more children and are using contraceptives. Since Benin and Mali had low CPR, it may seem that women in both countries do not want to use contraceptives. However, the fact that their demand satisfied by FP is low implies that there are still a lot of unmet needs in FP and also that CPR can get higher in the next few years if governments implement effective policies. In Madagascar, Malawi and Tanzania, there are still around 40% of women who want to stop having children but who are not using any contraceptive method. In terms of rural and urban comparison, demands on FP are more satisfied in an urban area than in rural parts of SSA. Table 2 shows the outcomes in FP in the six SSA countries.

Table 2: Summary of FP outcomes in Benin, Ethiopia, Madagascar, Malawi, Mali, and Tanzania[5]

	SPACERS		LIMITERS			
	BENIN	MALI	ETHIOPIA	MADAGASCAR	MALAWI	TANZANIA
MODERN CONTRACEPTIVE PREVALENCE[6]	7.90%	9.90%	27.30%	29.20%	42.20%	27.40%
CONTRACEPTIVE PREVALENCE (ALL METHODS)[7]	**12.90%**	**10.30%**	**28.60%**	**39.90%**	**46.10%**	**34.40%**
MODERN CONTRACEPTIVE PREVALENCE (URBAN)	9.50%	21.80%	49.50%	35.60%	49.60%	34.10%
MODERN CONTRACEPTIVE PREVALENCE (RURAL)	6.80%	6.80%	22.50%	28.00%	40.70%	27.20%
DEMAND SATISFIED BY FP[8]	**28.40%**	**28.50%**	**53.10%**	**67.90%**	**63.80%**	**61.10%**
DEMAND SATISFIED BY FP (URBAN)	31.10%	48.80%	77.80%	77.60%	69.50%	70.20%
DEMAND SATISFIED BY FP (RURAL)	26.30%	21.10%	46.00%	66.10%	62.50%	52.70%
FERTILITY RATE[9]	4.90	6.10	4.80	4.80	5.70	5.4
WANTED FERTILITY RATE[10]	4.60	5.90	3.00	4.70	4.50	4.7
SCORE WFR/TFR	**93.88%**	**96.72%**	**62.50%**	**97.92%**	**78.95%**	**87.04%**
FERTILITY RATE (URBAN)	4.3	5	2.6	2.9	4	3.70
FERTILITY RATE (RURAL)	5.4	6.5	5.5	5.2	6.1	6.10
WANTED FERTILITY RATE (URBAN)	4	5.2	1.8	3.4	3.3	3.3
WANTED FERTILITY RATE (RURAL)	5	6.1	3.4	4.9	4.8	5.3

This study considers how governments and other actors, via FP policies implemented; aim to provide a suitable environment so that any women who desire to control their fertility will have access to any method they choose, without any restrictions. According to the literature, women do not always want to use birth control to reduce their number of children; instead FP is used to reach

[5]Data issued from DHS 2011 Benin, DHS Ethiopia 2011, DHS Madagascar 2008, DHS Malawi 2010, DHS Mali 2012, DHS Tanzania 2011

[6]Percentage of women who are practicing, or whose sexual partners are practicing, at least one modern method of contraception.

[7]Percentage of married or in-union women aged 15 to 49 who are currently using any method of contraception.

[8]The percentage of fecund women of reproductive age who want no more children or want to postpone having a child, and who are currently using a modern

[9]Number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with age-specific fertility rates of the specified year.

[10]Estimate of what the total fertility rate would be if all unwanted births were avoided.

their desired number of children. In this case, FP policies are considered successful when the demand of FP is satisfied and when women reach their fertility goal – ideally when TFR=WFR. This second categorization was also made to avoid undermining countries who did notintend to lower their fertility rate or the spacers. As a result, Madagascar is the most successful country where population reached their highest fertility goal (97.92%), combined with a highest satisfied needs in FP (67.9%). Malawi and Tanzania are next with a relatively high demand satisfied even though there is still room for improvement in terms of reaching the fertility preference. Despite the fact that spacers (Benin and Mali) are situated in upper level due to their high score in reaching their fertility goals, they are still unsuccessful in implementing FP policies since they did not satisfy the needs of women in terms of contraceptives.

Figure 3: Countries categorization according to their goal in fertility preferences and the demand satisfied by FP

Wanted fertility/ Total fertility rate	Less than 15%	15-30%	30%-45%	45%-60%	60-75%	More than 75%
More than 90%		Benin Mali			Madagascar	
80%-90%						
70%-80%					Malawi Tanzania	
60%-70%				Ethiopia		
50%-60%						
40%-50%						
30%-40%						
20-30%						
10%-20%						
Less than 10%						

Demand satisfied by FP

Transfer of family planning policy insub-saharan africa

Family planning policy, as well as national population policy on birth limitation, or birth spacing evolved in Sub-Saharan Africa over time, from the colonization period until today where after the Millennium Development Goals, countries are moving toward the achievement of the Sustainable Development Goals by 2030. Regardless of the status of their population policies, almost all African countries now provide either direct or indirect support for family planning programs (United Nations, 1989b; Population Reference Bureau, 1990).In order to understand the factors contributing to the failure or success of FP in sub-Saharan Africa, the study will be elaborated in three parts consisting of a chronological overview of FP policy in SSA, and an analysis of the FP policy transfer according to Dolowitz and Marsh's Framework.

Chronological analysis of FP policy transfer in Sub-Saharan Africa

The compilation of documents related to Family planning policy in sub-Saharan Africa shows that five (5) chronological main events has influenced to the change in FP policy: the colonization from 1886-1960, the post-colonial period and the introduction of family planning (1967), the World population conference in Mexico (1984) coupled with the African Population Conference in Arusha, Tanzania the same year, the International Conference on Population and Development in Cairo Egypt (1994) and finally the Millennium Development Goals implemented by the UN (2000). The Sustainable Development Goals is, with certainty, the next global policy which is going to shape and change global policies and particularly policies in developing countries.

TABLE: Summary of FP policies in Benin, Ethiopia, Madagascar, Malawi, Mali and Tanzania from 1960 to 2010

	Before 1960	1960	1970	1980	1990	2000
BENIN	French law 1920	National institution (CNBPF)		Bamako initiativeCommunity based development 1983, family planning services were Integrated into government MCH	Population policy focused on population wellbeing and not on promotion of FP	Youth policy (2001) Contraceptive Security Participation of men in FP Introduction of implants Healthy timing and spacing of pregnancies Promoting reproductive health among youth to reduce adolescence pregnancy
ETHIOPIA		1966: Establishment of the Family Guidance Association of Ethiopia (FGAE)		1980 the Federal Ministry of Health (FMOH) add family planning to its maternal and child health program	The 1996 Guidelines for Family Planning Services (updated in 2011), Health Sector Development Program from 1996 to 2010 Creation of the national Population Policy (1993)	The 2002 Health Sector Development Program II 2006 HSDP III The Plan for Accelerated and Sustained Development to End Poverty of 2005–06, (MOFED 2006) The National Reproductive Health Strategy for 2006–15 2008 Ethiopian IHP roadmap
MADAGASCAR	French law 1920	National institution (FISA)			Population policy	Creation of the strategic document for poverty reduction (2000) Elaboration of the MAP (2007) Health sector development plan (2007-2011) Creation of the national policy on reproductive health (2000)
MALI	French law 1920	AMPPF	June 1972, decree on "practices of voluntary birth	Bamako initiative: Community based development	Adoption of a population policy (1990s)	Adoption of the “loilahoutoure” in 2002

			spacing in the Republic of Mali," Abrogation of the French law 1920			Revisiting population policy in 2003
MALAWI	Malawi Penal Code of 1930 (Sections 149-151)	President Kamuzu Banda banned family planning in Malawi in 1964		1982 National Child Spacing Program 1986-1995 National Health Plan 1987, resolution calling for birth spacing as a national policy	1990 National Population Planning Unit (PPU) 1992 first DHS National Family Planning Council of Malawi in 1997/8 Local Government Act in 1999 begins decentralizing health service Family Planning Association of Malawi (FPAM) is launched	2000: Essential Health Package (EHP) for health services Malawi Growth And Development Strategy (MGDS) 2006 – 2011 National reproductive health strategy 2006-2010- Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi (2007) Guidelines for community initiatives for reproductive health (2007) Community Based Injectable Contraceptive Services Guidelines (2008)
TANZANIA	1959 creation of the Family Planning Association of Tanzania (UMATI)	1969 UMATI became an IPPF member	1973 recognition of UMATI and support of government	1984 Start of 'National Child Spacing Program' 1987 National Population Committee was set up 1988 first Community Based Distribution programs in Tanzania 1989 The 5-year National Family Planning Programme (NFPP) And the FP unit (FPU)	1992 National Population Policy was launched by the Planning Commission. 1997 Decentralization for the delivery of basic health services (including family planning) 1998 FPU became the Reproductive and Child Health Section (RCHS).	2001 National Adolescent Health and Development Strategy 2003 USAID direct funding on FP stopped 2007 Comprehensive Council Health Planning Guidelines 2008 National Road Map To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008 – 2015) 2010 National Family Planning Cost Implementation Plan (2010-2015)

Who are involved in policy transfer? The role of government and supranational organizations in policy transfer

The success of FP policies in SSA is mainly determined by the role that actors play in the policy transfer process. Governments in the countries studied change their positions and their commitment to FP overtime. The role of international organizations in influencing policy change, but also in supporting FP programs in SSA, is also crucial.

Government commitment in the promotion of FP policy

Governments in SSA did not show their interest in promoting birth control policy from the beginning. The compilation of FP policy documents among Benin, Ethiopia, Madagascar, Malawi, Mali and Tanzania shows that elected official in SSA expressed enormous resistance to implementing population policy after the 1960's and did not perceive that they need to reduce their growth rate by any means particularly countries in Western Africa. As a result, Benin and Mali's government have been less concerned about the promotion of FP policies compared to the remaining four countries.

Role of international organizations:

Supranational organizations like the World Bank, WHO, IMF etc., have an important role to play in the promotion of contraceptive use in SSA countries. International aid from those organizations for reproductive health, including FP, is estimated to be around $17 billion for the year 2000 (Stewart, Stecklov, Adewuyi, 1999). Organizations like UNFPA or USAID also have promoted FP and have agreements with the government in Benin, Ethiopia, Madagascar, Mali, Malawi and Tanzania to implement birth control policy (Bertrand et al., 1993; Richey, 1999).

International Planned Parenthood Federation (IPPF) via local associations FISA in Madagascar, CNBPF in Benin, AMPPF in Mali, FGAE in Ethiopia, are also considered as the main actors in promoting FP policies in SSA

In Tanzania, the role of those organizations is less. In 2003, USAID stopped funding FP programs and, since then, the Tanzanian government provides its own FP program. The table shows the degree of involvement of the actors in the transfer of FP policy.

Table 3: main actors and their degree of involvement in FP policy transfer

	GOVERNMNENT INVOLVEMENT	ROLE OF SUPRANATIONAL ORGANIZATIONS
BENIN	Moderate	Strong
MALI	Moderate	Strong
ETHIOPIA	Strong	Strong
MADAGASCAR	Strong	Strong
MALAWI	Strong	Strong
TANZANIA	Strong	Moderate

What is transferred?

According to Dolowitz and marsh's framework, when policy transfer occurs, not only policies and programs are transferred. Instead "soft" transfer involves also the transfer of ideology or institutions. Transfer of FP policy in SSA begins since the colonization period especially for former French colonies

Gallagher et al. (2015) found differences in modern contraceptive rate and TFR between former British and French colonies, indicating that more coercive policies surrounding abortion and reproductive health generally may play an important role in access to safe abortion and contraception, as well as overall family size. The colonization certainly affected the francophone countries more than the Anglophones, since all the three French-speaking countries had past

French colonial law (Boye et al., 1991; Gallagher et al., 2015; Heckel, 1986). During the colonization period, the French Law of 1920 was the only valid policy in former French colonies, and no study or legal documents showed the need, from the government or the population, to limit or space birth before that period. That is why our analysis of FP policy transfer in sub-Saharan Africa starts with the colonization. The French colonizers enforced the 1920 law which forbids "the sale, preparation for sale, public offering or exhibition, display or distribution, public or not, of all forms of advertising in whatever form they may be: ads, displays, and drawings of contraceptive promotional material, etc. Offenders are liable to receive criminal sanctions." (Aplogan et al, 1995; Locoh & Makdessi, 1996; Pryor, 1990).

In Benin, the government folded family planning into a broader focus on family well-being in 1987 (Aplogan et al., 1995) while policies in Tanzania and Malawi clearly stipulates their "birth-spacing" policies to improve maternal and child health. The government of Benin showed resistance in the change of their view of FP after the colonization, although the government adopted the ICPD definition of reproductive health which promotes FP as a human reproductive right and prepared to adopt a population policy in this accordance after 1994 (Aplogan et al., 1995).

Similarly, despite the restrictive law that Mali inherited from their former French colonizers, the government of Mali developed an early population program in June 1972 with its decree on "practices of voluntary birth spacing in the Republic of Mali." It was the first country in Francophone Africa to accept and legalize family planning as an integral part of its effort to protect the health of mothers and children. Only recently, few years after the implementation MDG, Mali started to promote FP as a mean of reducing family size. On the other hand, Tanzania first supported FP in 1974, because of maternal and child health rationales. At this point of time, the government clearly expressed that "development, not population growth, was the major problem

for Tanzania" (Rukonge, 1987, pp. 4). Though, in the 1990's Tanzania started to implement policy that aims to encourage the population to have fewer children.

	BIRTH SPACING	BIRTH LIMITATION	PAST RESTRICTIVE POLICIES
BENIN	YES	NO	YES
MALI	YES	YES	YES
ETHIOPIA	YES	YES	NO
MADAGASCAR	YES	YES	YES
MALAWI	YES	YES	YES
TANZANIA	YES	YES	NO

All countries now have similar health systems based on decentralization and community-based distribution of FP services to increase the access of contraceptives in remote areas, after the Bamako Initiative in 1987.

"Member States are encouraged to strengthen their national health information systems, to facilitate a regular update of required information but also to develop common strategies to overcome the major health problems that appear in the African region" (WHO, 2004)

The decentralization within healthcare provision in SSA was supported by donors like World Banks or IMF, as a key strategy for good governance and to encourage international healthcare reform since the 1980s (Willis & Khan, 2009).

The government of Benin chose to maintain its birth spacing policy without promoting birth reduction. Instead, the government focused on contraceptive security, participation of men in FP, introduction of implants, healthy timing and spacing of pregnancies as well as the promotion of reproductive health among youth to reduce adolescent pregnancy.

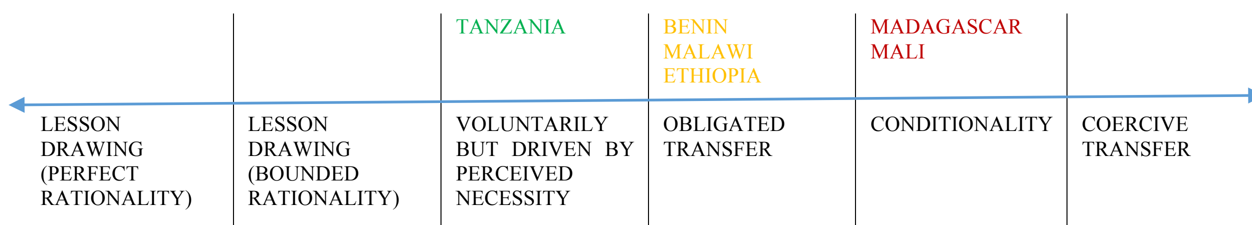
	BENIN	MALI	ETHIOPIA	MADAGASCAR	MALAWI	TANZANIA
Youth integration	X		X		X	X
Contraceptive Security	X	X	X	X	X	X
gender programs	X	X				
Reproductive health	X	X	X	X	X	X
Decentralization	X	X	X	X	X	X
community based development	X	X	X	X	X	X
HIV/AIDS Programs			X		X	X

From where the lessons are drawn?

	BENIN	MALI	ETHIOPIA	MADAGASCAR	MALAWI	TANZANIA
PAST GLOBAL POLICY	X	X	X	X	X	X
PAST INTERNAL POLICY					X	X
INTERNATIONAL ORGANIZATION	X	X	X	X	X	X

Why did actors transfer policy?

According to Ethiopia's national population policy, for instance, the interest in controlling birth was in most part due to the worsening food scarcity in the country around 1985.



Barriers in FP policy in SSA

The review of the literature on FP policies in SSA identified several constraints which influence the success or failure of the policy in the region and also in the six countries in this case study. Studies shows that structural and institution feasibility, challenges such as access to FP, funding of programs or the collaboration with the private sector and NGOs are major constraints that prevent the success of FP in SSA (Ashford, 2003; Bertrand et al.,1993;Campbell, Prata, & Potts, 2013) especially in Malawi, Madagascar and Ethiopia. Policy complexity, which concerns the method promoted, the integration of different programs, like gender, youth, HIV/AIDS, or again the gap in policy between rural and urban areas, are also factors which contribute to the failure of FP in SSA (Ashford, 2003; Bertrand et al., 1993). Tanzania and Malawi are the countries that are most concerned about overcoming the constraint of policy complexity in order to improve their FP policy. The failure of FP policy in SSA is also due to cultural and ideological barriers. Religion, the lack of decision power among women, beliefs regarding FP, child marriage is reasons why women do not use contraceptives (Ashford, 2003; Bertrand et al., 1993; Campbell, Prata, & Potts, 2013). Studies claim that this reticence in using FP due to cultural and ideological values is more resistant in rural areas than in cities. Countries like Mali, Malawi, and Benin, are the most concerned with this issue even though studies have demonstrated that culture, the perception of FP and religion – especially for countries with a large Muslim community – are the main determinants of FP policies success. Countries with lower cultural and religious barriers are more likely to increase their modern contraceptive prevalence and decrease their fertility rate. The existence of past policies also undermines the success of FP policies in SSA especially in francophone countries due to colonial French Law restricting the use and importation of contraceptives in 1920 (Bertrand et al.,1993). The inefficacy and the need for improvement of past FP policies are contributing to

the failure of contemporary programs. The figure shows the summary of the main constraint in FP policy transfer in SSA.

	BENIN	ETHIOPIA	MADAGASCAR	MALAWI	MALI	TANZANIA
CULTURAL	Strong	Moderate	Moderate	Strong	Strong	Strong
STRUCTURAL	Strong	Very strong	Very strong	Very strong	Strong	Strong
PAST POLICY	Moderate	Moderate	Moderate	Low	Low	Low
POLICY COMPLEXITY	Low	Low	Low	Strong	Very strong	Very strong

DISCUSSION

After the analysis of the existing FP policy in Benin, Ethiopia, Madagascar, Malawi, Mali and Tanzania, the six countries can be distinguished in two categories.

- The spacers (Benin, Mali) or the countries that promote FP to space birth. Despite its recent initiative to limit the number of children, Mali is categorized here as a spacer because of the long period where the country only implemented FP for birth spacing.
- The limiters (Ethiopia, Madagascar, Malawi and Tanzania) or the countries that promote the use of contraceptive method to reduce family size

However, all the countries in SSA share commonalities in the reason why the FP policies are not successful enough.

Common reasons that leads to unsuccessful FP in SSA

Strong structural barriers like the accessibility of FP or the lack of infrastructure is the main reason why family planning has not satisfactory met the demand for the programs among the six countries.

The primary goal of any FP policy- to promote and encourage the use of contraception among the population by ensuring that the health and economic benefits of using contraception are recognized -as well as to provide a suitable environment, so that any women who desire to control their fertility, will have access to any method they choose- is not fulfilled in this case.

Unsuccessful FP policy among spacers

The results of this research show that spacers are not successful in implementing FP policies in their countries. Despite their high score in reaching their fertility preference, FP in Benin and Mali have considerable unmet demand. FP policies are not successful among the spacers, for several reasons.

- The lack of commitment from the governments of Benin and Mali in promoting the FP policy has resulted in a large unsatisfied demand. Despite the transfer of several programs in Benin and Mali, FP policies are still unsuccessful among the spacers due to the lack of involvement of the government. The relatively early introduction of FP policies in Mali did not lead to the success of Family planning in the long run because of the incomplete transfer and the late initiative of the government to implement policies to reduce birth.

- Moreover, Benin and Mali both have vertical programs in FP where the role of international organizations are very strong but do not align with the core concept of the national policy. The synergy between government and the existing organization supporting FP in those countries is deficient.

- Even though women in those countries reached their fertility preferences, they still desire a high number of children. The preference in high number of children is linked with strong cultural and ideological barriers for FP use among women of reproductive age.

The limiters: Ethiopia, Madagascar, Malawi, Tanzania

Madagascar has the most successful outcomes in FP policies because FP is culturally and ideologically more acceptable in Madagascar than in some other countries where husband approval, mistaken beliefs about FP as well as religious barriers are still persistent.

However, the demand satisfied by FP in rural area is higher in Madagascar when compared to the other countries because, even though Madagascar still suffers from strong structural barriers (health facilities, human resources, funding…), these barriers are lower on the island than in Ethiopia, Malawi and Tanzania. Malawi and Tanzania for instance have relatively high demand satisfied in FP even though women still have difficulty in meeting their fertility preferences because of the very strong structural barriers in FP, particularly in rural areas.

FP policies in Madagascar are also more successful than the others because the country does not have to implement parallel policies like AIDS and STD, so they can entirely focus on the promotion of contraceptive use. It is clear that in countries like Malawi the FP policies are not successful enough because of the HIV/AIDS pandemic in the country which undermines the funding and the programs in FP.

The results of the research show that a "voluntary" transfer, or obligated transfer but driven by a perceived necessity like in Ethiopia or Tanzania does not necessarily guarantee the success of FP policies. For instance, Madagascar transferred FP policies because of conditionality; however, the

FP in the country is still relatively successful compared to Benin, Mali, Tanzania, Ethiopia and Malawi.

Financial independence for FP provision can contribute to the success of FP policies. However, without a suitable environment in the implementation of FP policy, the success of the FP is questionable. For instance, in Tanzania the need for authorization from the husband leads to less successful family planning despite its financial independence. In addition, Tanzania does not have enough infrastructures and human resources to satisfy the demand for FP from women of reproductive age.

RECOMMENDATIONS AND CONCLUSION

This study attempts to understand why FP policies are not successful in SSA by taking into account that FP policies in those countries have been based on global population policies. This study assumes that the primary goal of any FP policy is to promote and encourage the use of contraception among the population by ensuring that the latter recognizes the health and economic benefits of using contraception. An additional goal of FP policy is to provide for women who desire to control their fertility by granting access to any method they choose. The results of the study show that actors involved in FP policy transfer should be equally involved in the process and a weaker commitment from one side increase the likelihood of the failure of the policy.

The policy environment is also crucial for the successful implementation of FP policy. If a country has strong cultural and ideological barriers to the use of FP, the government and other actors should reinforce their communication programs to educate the population on the importance of FP and also to promote behavioral change. Insuring that a country has the appropriate infrastructure, such as health centers and human resources, is also necessary before and during the implementation of

the policy. Actors should then find alternatives to improve the distribution of FP and to ensure its accessibility especially in rural areas.

Governments in SSA should focus more on promoting education to increase acceptance of FP. Studies show that FP policies are more successful when the population, especially the women and girls, are more educated. In addition, other issues in reproductive health such as HIV/AIDS and STI should be taken into account while implementing a successful FP policy. Finally, coercive transfer undermines not only the ability of the country to implement a successful FP policy. Financial independence of the country is also of paramount importance in FP success as it allows them to implement their own policies in the future.

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