



Opening Up the Demographic Dividend Window in Sub-Saharan Africa: How Did Low-Fertility Countries Do It?

By Eunice Mueni, Southern Voices Network Scholar
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In recent years, the demographic dividend has garnered enormous traction in policy circles as African policymakers, especially in ministries of finance and development planning, see it as central to achieving their economic growth targets. The demographic dividend is the economic benefit arising from a change in a society's age structure, from a structure dominated by child dependents to one with a greater proportion of working-age adults. It is estimated that a quarter to a third of the phenomenal socioeconomic development experienced by East Asian countries like Malaysia, South Korea, and Thailand between 1970 and 2000 can be attributed to this dividend.¹ Despite growing interest in the demographic dividend, the available evidence is inconclusive on the level of dividend that African countries can earn in the coming decades. Earlier demographers argued that Sub-Saharan African countries were not likely to earn the demographic dividend.² However, more recent evidence shows that countries in Sub-Saharan Africa (SSA) have the potential to reap the benefits of the demographic dividend if the right policies are in place.³ Although challenges including weak human capital, poor governance, political instability, and corruption can potentially derail SSA's chances of harnessing the demographic dividend, the first challenge that threatens the region's capacity to benefit from it is a high fertility rate.

SSA has the globe's highest fertility rate, and the pace of fertility decline has been sluggish. According to United Nations population projections, the total fertility rate for all of SSA was 5.1 births per woman in 2015, a decline

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of just 1.8 births per woman since 1960.⁴ By comparison, the average global fertility rate halved over the same period, from 5.1 to 2.5 births per woman. As such, SSA is forty years behind other regions in the world. This high fertility rate will constrain development in SSA countries through continued high child dependency burdens, which hamper investments in education, health, and the economy. It has also resulted in high population growth, with the continent's population projected to increase from 1.2 billion people in 2015 to 2.5 billion by 2050. This has implications for peace and security, if the prevailing challenges of unemployment and poverty are not addressed. However, it is important to note that within the sub-continent, there is enormous heterogeneity in fertility rates. A few countries, particularly in southern Africa, have experienced fertility rates close to the replacement level of 2.1 children per woman. These include Mauritius, South Africa, and Botswana. How did these countries achieve low fertility, and what can other countries learn from them about encouraging voluntary fertility decline?

Why Has Fertility Remained High in Sub-Saharan Africa?

First, understanding why fertility rates are not declining quickly despite improvements in family planning services and health and education systems will help indicate solutions to accelerate fertility decline. A recent report from the Demographic and Health Surveys (DHS) Program, funded by the United States Agency for International Development, identified three factors that drive high fertility rate in the sub-continent: high desired family size, low use of contraceptives, and high child mortality.⁵ Although age at first marriage has been shown to play only a minor role, if coupled with low contraceptive use, it becomes one of the drivers of high fertility. Lower educational attainment by women is an underlying factor in all these drivers of high fertility.

High Number of Desired Children

Because of the high value placed on children, African countries tend to see large family sizes, particularly in West and Central Africa where fertility remains the highest on the continent. Children are highly valued for a variety of cultural, religious, and socio-economic reasons. For example, in some societies children are seen as gifts from God and the number and timing of births may be seen as beyond one's control, while children may also be valued for their productivity in highly agricultural economies. Children bestow esteem, and large families command a great respect in some African communities. Indeed, in clan-based societies, children are seen as a continuation of the family or clan lineage; thus having a high number of children is seen as way of extending the clan's existence.

In addition, persistently high child mortality rates drive couples to have more children, in case some do not survive. The sub-continent has made substantial progress in improving child survival over the past 25 years. Overall under-five mortality rate declined from 180 to 83 deaths per 1000 live births. This is still, however, quite high by global standards, and SSA accounts for fifty percent of under-five deaths globally.⁶

Thus, lowering desired family size is a key step in encouraging fertility decline. Indeed, recently observed fertility declines in SSA are attributable to a decrease in the number of desired children rather than to a reduction of unwanted births.⁷ However, in most West African and Central African countries, fertility remains high, and desired family size is even higher than total fertility. In the absence of reduced demand for children, fertility will remain high because current fertility goals are not being achieved.

Low Educational Achievement

Although educational achievement has improved in most African countries due to the global *Education for All* initiative led by UNESCO, there exists much variation across the continent. West and Central Africa have

the highest fertility rates and also show the lowest rates of secondary school enrollment among women. In countries such as Chad, Niger, and Central African Republic, only about 10 percent of women have more than a secondary education.⁸ Most girls drop out of school to get married or drop out due to teenage pregnancy. Low educational attainment is highly correlated with high fertility and high desired family size, so educating girls beyond primary school level will not only delay their child bearing, but also give them autonomy on reproductive decisions.⁹

Child Marriage

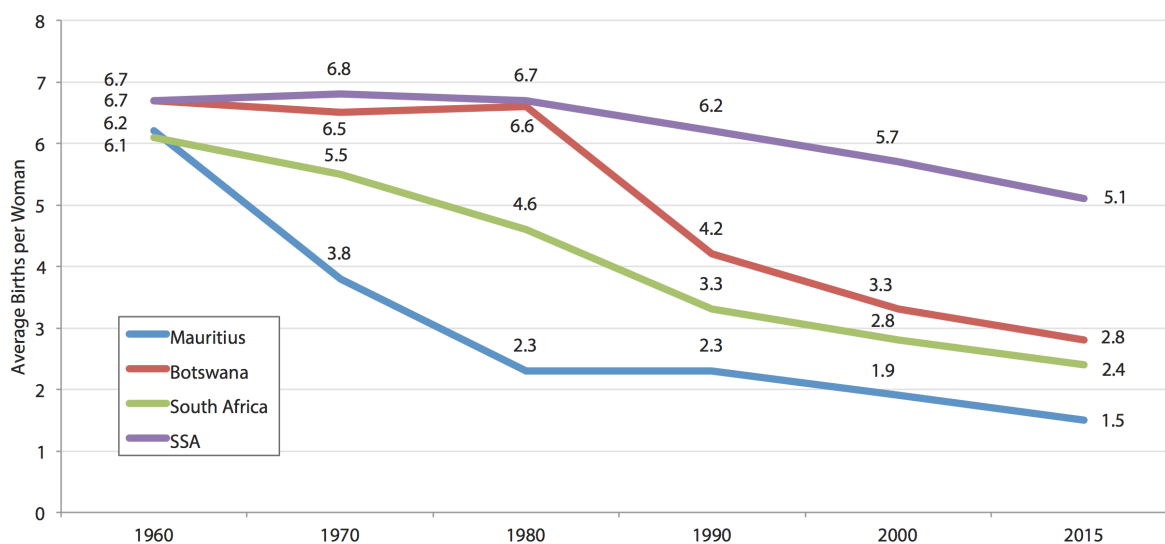
Child marriage is a very common practice in many African countries. The median age at first marriage ranges from a low of 15.9 years in Niger and Chad to a high of 27 years in Botswana.¹⁰ The legal minimum age of marriage is as low as 15 years in several countries, mostly in Central and West Africa.¹¹ Moreover, although most countries have a legal minimum age of marriage of 18 years, many of these laws are not enforced. Early marriage not only curtails educational achievement among girls who drop out of school to get married, but also increases the exposure time to child bearing, resulting in higher fertility. Girls who marry younger also have less control over their reproductive decisions.¹²

Low Use of Contraceptives

According to Guttmacher, SSA has the globe's highest proportion of women with an unmet need for contraceptives.¹³ Nonetheless, the level of unmet need is lower than might be expected because fertility preferences are high. Low use of contraceptives results in unplanned pregnancies. Although low contraceptive uptake could be a function of lack of adequate family planning services, it also reflects low demand. Encouraging small family sizes will increase demand for contraceptives; with lower fertility if demand is met.

How Did Mauritius, Botswana, and South Africa Achieve Low Fertility?

Figure 1: Trends in total fertility rates between 1960 and 2015



Source: UN Population Division, 2015 Population Prospects; Statistics Botswana, 2014

As the previous chart shows, Mauritius, Botswana, and South Africa have achieved fertility rates close to the replacement level of 2.1 children per woman. Understanding how these countries addressed the issue of high fertility preferences offers some learning opportunities for other African countries.

Mauritius

Fertility transition in Mauritius started in the 1960s. With the decline in mortality rates due to a malaria elimination campaign that began in 1947, desired family size dropped, and fertility rate declined drastically.¹⁴ By 2014, the infant mortality rate had declined to 14.5 deaths per 1000 live births, while the under-five mortality rate was 16 deaths per 1000 live births.¹⁵ This reduction in child mortality assured parents that the few children they had would survive to adulthood. In addition, there were marked improvements in women's education. By 1962, 80 percent of young women could read and write. Today, primary net enrollment rates are 98 percent, while net enrollment rates for secondary school are 78 percent.¹⁶ The gross enrollment rate at tertiary level was 47 percent. Increased educational attainment resulted in increased labor force participation (in particular, women are credited for the successful textile and tourism industries in the country), which translated to lower fertility rates. Increased education and employment for women raised the age at first marriage from 22 to 27 years. A voluntary national family planning program was started and funded by the government to meet the increased demand for modern contraceptives created by a reduction in fertility preferences. This was coupled with a strong information, education, and communication campaign that saw women accept the concept of a small family. Fertility has thus declined significantly, with women having 1.5 children on average in 2015, down from 6.2 in 1960.

Botswana

Botswana experienced its steepest fertility decline between 1980 and 2006. The fertility rate decreased from 6.6 in 1981 to 2.8 in 2011. The government of Botswana showed a strong commitment to address high population growth with a campaign to reduce desired family size. This campaign went hand in hand with the empowerment of women through better provision of education, the inclusion of women in employment activities, and the adoption of legislation that granted unmarried women the same legal rights to property, credit, and businesses as men. According to the government of Botswana's 2014 Literacy Survey, the female literacy rate between ages 10 and 70 increased from 36.0 percent in 1981 to 87.3 percent in 2014 and has been consistently higher than male literacy rates.¹⁷ These factors provided women with a wider range of choices beyond just child bearing, thus leading to a decline in fertility preferences.

This increased demand for contraceptives, which was met with a strong voluntary national family planning program that has provided free services since 1973. In 1991, the country's family planning program was rated as the strongest in Africa. Family planning services were also integrated into the primary health care system, which were well-structured and distributed throughout the country. Thus women have been able to access the contraceptives needed to meet their reproductive goals, and contraceptive use increased to 51 percent by 2007. Nonetheless, teenage pregnancy is still a major challenge to fertility reduction. In 2007, about 12 percent of teenage girls had had children or were pregnant.

South Africa

The fertility rate started to decline in South Africa in the 1960s and has continued through the 2000s, from 6.1 children in 1960 to 2.4 children per woman today. The South African government strongly supported family planning in the 1960s, driven by the fear that high population growth would undermine the country's prosperity and economic development. However, the uptake was poor, particularly among the black

population. This was mainly because of the prevailing political climate under apartheid in which the program was seen as a strategy to reduce the black population so that it would not overwhelm the white population.

Fertility decline was thus driven by the precarious political, social, and financial situation prevailing among the black population in the 1960s, including the increasing landlessness and joblessness created by the homeland system.¹⁸ With many men relocating to the mining cities to work, women were often left alone as heads of households. The economic hardship drove women to limit their family sizes, thus driving contraceptive adoption. Notably, women were able to access the contraceptives needed to achieve their reproductive goals, thanks to family planning services that were freely available since 1963. Contraceptive use thus increased to 64.6 percent by 2003, and fertility declined markedly among both the rural and urban African population, which had lagged behind other population groups. An improved health care system and increasing education access among the black population also contributed to the observed fertility decline. These factors, coupled with a gradual broadening of the space for female employment through the lifting of formal restrictions and the combating of prejudice and discrimination and the escalation of pension payments to African senior citizens that could have muted intergenerational reliance on children for old-age security, have continued to play a major role in the continued fertility decline to date. The high prevalence of HIV and AIDS has also been associated with fertility decline.¹⁹

Policy Options and Recommendations

Despite increasing contraceptive uptake, declining child mortality rates, and improving educational access for women, fertility rates and desired family size in Sub-Saharan Africa remain persistently high. To further reduce fertility, desired family size has to decline markedly. Due to the cultural, religious, and ethnic drivers of high fertility, an integrated approach will be required to reduce fertility preferences. Governments, international donors, and policymakers all have a key role to play.

African Governments and Policymakers

1. Political leaders should take the lead by addressing the pros and cons of high fertility rates, while stressing the micro- and macro socio-economic benefits of reduced family size, as has been done in Rwanda. Key actions could include changing social attitudes with national campaigns, increasing support to family planning and educational programs, and pushing for the implementation of regional protocols that support inclusive development and women and girls' empowerment.
2. Empower girls and women by promoting women's education, labor force participation, and land ownership. Deliberate and systemic efforts should be made to economically empower women particularly in contexts that devalue women. This requires a multidimensional and integrated approach including interventions that target women, their communities, and society at large. Mere quotas for public positions or economic empowerment trainings are not sufficient. Additionally, the legal minimum marriage age should be set at 18 years in countries where it is below that. These laws must be enforced in all countries, with severe punishments for those who marry under-age girls.
3. Increase budgetary allocations to the health sector to 15 percent of national budget as recommended in the Abuja Declaration. Increased investments will translate to strengthening public health interventions like better management of malaria, prevention of mother-to-child transmission (PMTCT) of HIV, immunization against childhood illnesses, and food supplementation programs, resulting in lower child mortality. Improved child survival encourages lower fertility rates as couples realize that fewer births are needed to reach their targets for surviving children.

4. Increase efforts to address all barriers to the access and use of contraceptives in order to meet the demand created by increasing preferences for small families. This can be achieved through voluntary family planning programs supported by strong national-level leadership and full integration into all health facilities. Community-based outreach services should be promoted to ensure universal access to family planning.

International Policymakers and Donors

1. Mobilize governments, the private sector, and the community to support initiatives on slowing population growth. Encouraging buy-in at the national level and including governments and civil society in the project development stage ensures sustainability and the scale-up of successful projects after donor exit.
2. Take advantage of the avenues created by intergovernmental organizations to advance progress on women's empowerment and reproductive health issues. For example, the African Union identified 2010 to 2020 as the decade of the African women, which all stakeholders should leverage as an opportunity to spotlight progress on women's empowerment.
3. Expand efforts to promote and support African endeavors toward the empowerment of women and girls. Although much is being done to empower women, most initiatives focus on economic and entrepreneurship trainings for women. Education and outreach toward men to support women's empowerment cannot be neglected. A holistic approach should instead be adopted, aimed at understanding the societal view of the role of women and engaging the whole community to suggest and implement viable solutions.
4. Fund and conduct rigorous monitoring and evaluation of programs, and actively incorporate lessons learned into programming. The sharing of lessons learned should be encouraged to avoid redundancy and support efficient resource utilization.

For a set of policy recommendations related to demographic dividends and fertility rates in Africa, see the accompanying Africa Program Policy Brief No. 11 by Eunice Mueni.

Eunice Mueni served as a Southern Voices Network Scholar at the Wilson Center from April to June 2015. She is a Knowledge Translation Officer at the African Institute for Development Policy (AFIDEP) in Nairobi, Kenya, which is a member of the Southern Voices Network.

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1300 Pennsylvania Avenue, N.W.
Washington, DC 20004-3027

 www.wilsoncenter.org/africa
 africa@wilsoncenter.org
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 202.691.4118