

**Профиль:**

«Население и развитие»/«Population and Development»

**КОД - 162**

**Время выполнения задания – 180 мин., язык – английский.**

**Максимальное количество баллов -100.**

**Read the article in English and analyze it critically answering the questions below.**

The US National Academy of Sciences Panel on the Population Dynamics of Sub-Saharan Africa met for the first time in February 1990 in Washington, DC to launch a major initiative aimed at deepening understanding of demographic change in the subcontinent. The initiative produced a total seven volumes, including a set of reports providing an in-depth analysis of various aspects of African socioeconomic and demographic trends and two country-specific reports. These showed that, outside of South Africa where the transition was well established, fertility remained very high (generally above 6 children per woman) in much of the continent but that unquestionable signs of country-level decline were visible in a few countries such as Kenya and Zimbabwe.

My review of the papers included in the main report, Demographic Change in Sub-Saharan Africa (Foote, Hill, and Martin 1993), argued that high fertility in sub-Saharan Africa was not a peculiar expression of African cultures but a rational response to the continent's specific circumstances and that changes in those circumstances could usher in a new era (Mbacke 1994).

Twenty-five years later, in July 2015 and at the same location, the Workshop on Recent Trends in Fertility in sub-Saharan Africa was held to take stock of the same topic, at a time when the continent's leaders have started paying serious attention to fertility as a key factor in economic development.

Armed with richer and better-quality data than was available in the early 1990s, when Africa's fertility transition was just starting, the papers presented at the workshop—many of which appear in revised form in this volume—provide a rich picture of the changes that occurred over the quarter-century and of the factors behind them. The papers also discuss the policy implications and the potential for harnessing a demographic dividend in support of the continent's development.

This commentary will focus on the “African exceptionalism” that is a thread throughout a number of the chapters in this volume. As John Bongaarts puts it, “the pronatalist nature of African societies implies a resistance to fertility decline that is absent or weaker in non-African countries.” And according to John Casterline and Samuel Agyei-Mensah, “gaining a deeper understanding of the continued high demand for children in Middle and West Africa... is a high priority in African demography.” The questions we are grappling with include the following: Why should African societies be more pronatalist than other societies? And is it possible to accelerate the African fertility transition?

Bongaarts's chapter provides an overview of the state of the fertility transition in sub-Saharan Africa as compared to other developing regions.

It shows that, even if by 2014 the fertility transition had started in all countries except Niger, its pace was slower and that, at any given level of development, fertility and desired family size were higher in Africa. He refers to the fact that African countries have higher fertility than countries in other regions after controlling for socioeconomic development as the “Africa effect.”

As shown in a number of chapters in this volume, the Africa effect is sustained by a higher demand for children and lower use of modern contraception. A look back at history helps

us understand this distinctiveness of sub-Saharan Africa. The demographic trajectory described by available data is the result of long-term processes that unfolded during a century of colonial rule and by reproductive systems shaped by that rule. In the face of extreme and prolonged high-mortality conditions, African populations developed an efficient system for maximizing fertility and child survival. Colonial rule exerted additional pressure for high fertility by maintaining very high mortality levels and boosting the demand for labor. There is ample evidence that colonial rule significantly increased already exceptional mortality levels in its initial phase (Caldwell 1985; Dawson 1987; Turshen 1987; Coquery-Vidrovitch 1988), explaining the deep-rooted fear of family extinction identified by Caldwell (1982). Fertility also had to meet the huge demand for labor by a production system that had to satisfy the needs of the European countries while continuing the production of staple foods (Cordell, Gregory, and Piche 1987).

Hertrich's chapter describes one component of this system: a nuptiality regime that maximizes the time women spend in reproduction and weakens the couple's agency about its own fertility by making marriage a contract between families, not between individuals, and shaping gender relations in a way that impedes autonomous decision making.

A significantly larger age gap between spouses than elsewhere reinforced gender norms and made men's voices far more dominant than women's in decisions relating to reproduction. The other component of the system includes traditional practices that ensured prolonged birth spacing for improved child survival and the spreading of the costs and benefits of child bearing and rearing through child fostering. The Africa effect is due to the fact that the unraveling of this highly effective reproductive system is taking time.

But why this slow change in fertility given the recent rapid and significant declines in child mortality? Why would a system that is no longer needed to ensure survival and demographic growth persist to the detriment of economic development? Is it that Africans are just different or could the persistence of high fertility be a rational response to current socioeconomic conditions and the weakness of the support typically provided by well-functioning states in terms of security and other basic services? I would argue that, just as in the past, the current reproductive behavior of African societies is highly rational and that it could change rapidly if the required environment is created and the right efforts invested.

One reason for persistent high fertility can be found in the prevailing high levels of poverty and insecurity. As Bongaarts shows, while economic growth was occurring in the rest of the world, living conditions deteriorated significantly for two decades (known as Africa's lost decades) from 1980 to 2000. Per capita GDP peaked at \$700 in 1980, fluctuated under \$600, and reached the low level of \$599 in 2001 (World Development Indicators). The 1980 level was reached again only in 2004, which means that living conditions have deteriorated for a quarter-century in sub-Saharan Africa. Despite the economic recovery that has been observed in the last decade, the majority of African populations still face economic insecurity and uncertainty, which tends to reinforce the hold of traditional norms.

The conditions are ripe for change and are indeed changing. In the last decades, the continent has witnessed significant declines in child mortality and unprecedented increases in school enrollment for both sexes. And we know that positive trends in education and reductions in child mortality are drivers of demand for contraception. Further, improved data availability has made it clear that, contrary to a long-held belief, "there is ample evidence of conscious desires to limit family size. This conclusion applies even to most of the countries that show little or no fertility decline to date" (Casterline and Agyei-Mensah). But in the absence of adequate programs, this demand remains unsatisfied, unmet need remains high, and fertility decline is slow.

An acceleration of the fertility transition requires supportive political leadership. But most African leaders do not support family planning. As noted in the chapter by John May, "Even African leaders who are convinced of the validity of the rationale to curb high fertility levels might decide not to intervene because they do not want to antagonize their constituencies

and create unwanted political problems.” However, when they do decide to act, they can bring about change quickly—as demonstrated by the experience of Rwanda, where the modern contraceptive prevalence rate (CPR) among married women of reproductive age rose from 10 percent to 45 percent between 2005 and 2010. Rwanda’s 2003 reproductive health policy gave an important priority to family planning but obviously underestimated what could be achieved in the short term. Use of modern methods among currently married women had collapsed from 13 percent in 1992 to 4 percent genocide and the destruction of much of the country’s infrastructure.

What happened in Rwanda is that the highest levels of leadership, starting with the President himself, changed their outlook about the threats of rapid population growth for a country that exhibited one of the highest fertility levels on record (8.7 in 1978) (Cohen 1993) and is today one of the most densely populated in Africa. By legitimizing family planning and making it a national priority, the country’s leaders challenged traditional norms and practices and made it legitimate for all Rwandans to do the same. Rwanda’s success arose from a strong national conviction that family planning was key to the country’s development, the ability of the political leadership to move the topic from a taboo to a national priority, and the development of an effective family planning program with a broad reach. Solo (2008) provides an excellent account of how this happened. As shown below, the decisive shift in men’s views about reproduction and family planning that occurred between 2005 and 2010 should be added to the factors of success identified by Solo.

One key objective of Rwanda’s reproductive health policy of 2003 was to strengthen men’s participation in the family planning (FP) program, and awareness-raising among men during administrative and political meetings was a key strategy to achieve that goal. According to May and Kamurase (2009), the climate became conducive for a rapid expansion of FP services, with politicians at all levels routinely mentioning the need to use FP to reduce family size. Rwanda’s program was able to eliminate or at least weaken a major barrier to the development of FP programs in Africa: men’s opposition to FP. The FP strategy for 2012–16 still identified as a persistent challenge the “lack of decision-making power of women about use of FP and insufficient support, participation and sometimes violence from their male partners” (Rwanda, Ministry of Health, 2012, p. 14). Data from the DHS surveys (conducted between 1986 and 2015) that asked the relevant question show that Rwanda is the only sub-Saharan country in which the proportion of men wanting no more children is higher than that of women at all parity levels. This relationship holds for the two most recent surveys (2010 and 2014–15) but not for any of the earlier surveys, demonstrating the impact of the national effort to convince men of the benefits of FP.

Ethiopia and Malawi achieved impressive progress too. DHS data show that the modern CPR among married women of reproductive age increased from 9 percent to 27 percent in Ethiopia between 2000 and 2011, and from 26 percent to 42 percent in Malawi between 2000 and 2010. The preliminary report of Malawi’s 2015 survey estimates the modern CPR among married women at 58 percent (the highest level recorded outside of Southern Africa). The fact that the two previous surveys show higher proportions of men than women wanting no more children<sup>2</sup> (albeit not at all parity levels as in Rwanda) confirms that FP adoption can be rapidly accelerated when the fertility preferences of men change.

These three success stories are all in East Africa and might not be good models for Middle and Western Africa, which are the last frontier of the demographic transition. This part of the continent lags behind Eastern and Southern Africa because the institutions that support high fertility are stronger there and family planning programs are weaker (Caldwell, Orubuloye, and Caldwell 1992; Caldwell and Caldwell 1995). There is indeed no enthusiastic support for family planning among top-level political leadership outside of a few ministers of health and, consequently, family planning programs are mainly funded by external donors.

Two regional initiatives have been launched recently to strengthen family planning and reproductive health programs in Middle and Western Africa. The Sahel Women’s Empowerment

and Demographic Dividend (SWEDD) is a World Bank initiative targeting six Sahelian countries with IDA funding of up to \$207 million for five years (UNFPA 2016). Officially launched in November 2015, its components are still being put in place in participating countries with UNFPA support. The Ouagadougou Partnership, launched in February 2011, involves nine francophone countries where family planning programs are among the weakest in the region (Ouagadougou Partnership 2016a). The Partnership has supported all participating countries in developing FP implementation plans. Annual funding from the Partnership's core donors (USAID, Government of France, Gates Foundation, and Hewlett Foundation) increased from \$80 million in 2012 to \$109 million in 2014. Government contributions are still very modest and focused on buying commodities (Ouagadougou Partnership 2016a, p. 7).

The health ministers who are supportive of FP have been able to achieve results by putting donor funding to good use. The progress report presented at the last annual meeting of the Ouagadougou Partnership estimates that the nine countries have recruited 1.7 million additional users of modern methods in the five years since 2011 (Ouagadougou Partnership 2016b). These results are visible in the two countries with the richest data in francophone Africa: Burkina Faso and Senegal. Senegal launched a continuous DHS in 2012, and PMA2020 has been collecting DHS-like data twice a year in Burkina Faso since 2014; these data make it possible to look at trends since the launch of the Partnership. The proportion of married women using modern contraception rose from 12 percent to 21 percent in Senegal and from 15 percent to 24 percent in Burkina Faso. PMA2020 data suggest that the annual rate of increase in the modern CPR in Burkina Faso rose from 0.7 percent in the period 2010–14 to 4.7 percent in 2015–16, indicating an acceleration of the pace of contraceptive uptake.

These changes are not yet showing up in the TFR, which barely budged from 5.0 to 4.9 births per woman in Senegal and from 6.0 to 5.7 in Burkina Faso. This may be simply due to the fact that the fertility rates pertain to the three years preceding the survey and that adoption of contraception necessarily has a lagged effect on fertility rates. Another explanation could be that, as is the case for most countries in the region, these changes in contraceptive use are still too modest to overcome the effect of shortened postpartum non-susceptibility (Lesthaeghe 2014). Ultimately, this minimal effect on fertility can be explained by the fact that the demand for children remains high. For example, in Senegal, the nearly universal pattern of increasing desire to stop childbearing documented in the chapter by Casterline and Agyei-Mensah seems to have reversed in the last five years. The proportion of married women wanting no more children declined from 21 percent to 18 percent between 2010–11 and 2015, and the decline was observed at all parity levels. The proportion of women of reproductive age who reported wanting no more children in 2015 is slightly lower than it was in 1986 (18 percent vs 19 percent). It is therefore no surprise that the total fertility rate has scarcely budged in the last decade.

The sharp divide between Eastern and Southern Africa, on the one hand, and Middle and Western Africa, on the other, is also partly due to the fact that contraceptive use in the latter region is still concentrated in urban areas, leading Lesthaeghe (2014) to conclude that “On the whole, in much of Sub-Saharan Africa a decisive fertility transition at the national level will not occur for as long as the rural areas fail to get their share of attention” (p. 19).

The future course of the sub-Saharan fertility transition is uncertain. It is clear, however, that it will depend heavily on what happens in Middle and Western Africa. While the situation is changing almost everywhere, in the absence of supportive leadership the transition is likely to continue at the current slow pace for some time, with increases in contraceptive use barely sufficient to counterbalance the decline of postpartum insusceptibility.

There are many reasons to be doubtful about African leaders' readiness to encourage widespread voluntary use of FP. One of those can be found in the continent's roadmap for the next half century, Agenda 2063 (Africa Union 2015), which aims to use the demographic dividend as an additional lever in support of development efforts. While the potential demographic dividend is touted throughout the 200-page document, nowhere are actions aimed

at addressing high fertility considered. On the contrary, the dividend seems to be seen as an unavoidable consequence of the extreme youthfulness of the African populations: “the anticipated decline in fertility rates and dependency ratios, in addition to the expected emergence of a middle class, will translate to a demographic transition” (pp. 4–5) and a demographic dividend, as long as serious investments are made in human capital and job creation. But, while investments in human capital are critical, the pace of fertility decline will also need to accelerate in order for African countries to reap a meaningful dividend.

**SOURCE:**

Based on the paper (с сокращениями) Mbacké, C. (2017). The persistence of high fertility in sub-Saharan Africa: a comment. *Population and Development Review*, 43, 330-337.

**QUESTIONS:**

1. The author mentions here the “African exceptionalism” definition. What does it mean? How could you interpret it from the demographic point of view? Are you agree with the author’s interpretation?
2. What was the influence of colonial legacy on the reproductive regime in Africa? Please describe the mechanisms and give the examples.
3. What were the reasons for the colonial legacy in the reproductive regime to survive after the independency?
4. What is the role of the political will (of the local governors and of the countries-donors) for the anti-natalist policy implementation? Are you agree with author? Please provide 1-2 your own examples.
5. Why does the author uses examples from Rwanda? What other examples does he use?
6. What could be the reasons for the discrepancies between Eastern and Southern and Western and Central Africa in anti-natalist policy and fertility patterns? What are the reasons for it (according to the author and in your opinion)?
7. What could be the social and economic consequences of the stalled fertility decline in Africa? Please provide at least 3 examples and describe the mechanisms.