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

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

Study Objectives

This study18(ne)23(x)28(a)4(m)4(i)4(ne)3(s)6(f)30(a)4(c)8(t)10(o)21(r)24(s)6(that)24((ha)24(v)17
different contexts, and explores how political will affects the polic and program environments for famil planning.

Table 1. Key Informant Interviews by Group

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

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

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

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

Results

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

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

Ethiopia has the second largest population size in Sub-Saharan Africa after Nigeria. Its

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

In Rwanda, Dr. Jean Damascene Ntawukuriryayo, former Minister of Health and current president of the Senate, emerged as an early key local advocate at the center of domestic advocacy efforts. He is well educate TJ [ewe, drsd513 Tw 5rs(y)4(e)-1(r-4(y.001 Twu-4(s)2(uF)6

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

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

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

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

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The African Institute for Development Policy (AFIDEP)

AFIDEP is a non-profit policy think tank whose purpose is to translate research evidence and use it to advocate for improved policies and program effectiveness in Africa. The Institute seeks to ensure that policy makers and program managers at national, regional, and international levels have consistent and sustained availability of timely, relevant, trusted, and accessible evidence to enable them to set proper priorities, increase investment, and enhance effectiveness of intervention programs in these areas. The ultimate goals are to contribute to the improvement of the wellbeing of Africans by reducing unplanned pregnancies, reducing maternal and child deaths, slowing population growth, and improving sexual and reproductive health outcomes of young people. AFIDEP's work currently focuses on three issues: 1) Population change and development; 2) Maternal and child health; and 3) Adolescent Reproductive Health and Development. AFIDEP works various partners to advocate for investment and action in addressing population and health issues in Africa in selected countries (currently Kenya, Malawi, Ethiopia, Uganda, and Rwanda) and at a global level. It

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