A Symposium on
Fertility in Sub-Saharan Africa
Introduction: Fertility in Sub-Saharan Africa

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During the 1980s the population of Sub-Saharan Africa grew at a rate of 3.1 percent per year, the highest of any developing region (World Bank 1993). The population of South Asia, the developing region with the next highest rate, grew at 2.2 percent annually. Recent demographic surveys in Sub-Saharan Africa found that the average total fertility rate (TFR)—the number of children a woman would have in her lifetime at prevailing age-specific fertility rates—is generally between six and seven children per woman. Child mortality has declined steadily since World War II, but infant and child mortality remain relatively high (Hill 1990). In fifteen Sub-Saharan African countries, the infant mortality rate exceeds 100 per 1,000 live births, and in four countries the rate is greater than 140 per 1,000 (World Bank 1995). There are signs of fertility decline in a few countries (Botswana, Kenya, and Zimbabwe), but even in these cases total fertility is relatively high at five or more children per woman.

Economic growth in Sub-Saharan Africa has lagged behind population growth. Between 1965 and 1988, the gross national product (GDP) per capita grew by only 0.2 percent annually for the region; during the 1980s, average income per capita declined (World Bank 1990, 1993). Levels of human capital in the form of schooling and other training are low, and school enrollment rates have actually fallen in many countries. Although conditions vary a great deal, many countries, if not most, face the prospect of a rapidly growing labor force with low levels of human capital. Changing this scenario will require not only policies that help restore economic growth but that also enable families to have fewer children and to invest more in the quality of each child. To this end, most African countries have adopted or have endorsed public provision of subsidized family planning services, which provide families with not only the means to implement their fertility preferences but also to improve maternal and child health. However, levels of modern contraceptive use in all but a handful of Sub-Saharan African countries are still below 10 percent.

The persistent high levels of fertility and low levels of contraceptive use in most Sub-Saharan African countries have fostered a lively debate on two questions relevant to the design of population and human resource policies. First, is Africa different from other developing regions in terms of the factors influencing the demand for children? If it is sufficiently different, will the policies or factors that have affected the decline of fertility in other developing regions be

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effective in Sub-Saharan Africa? Second, are these outcomes due primarily to low levels of economic development that encourage large families or to insufficient provision of family planning information and methods? The articles in this symposium speak to both of these issues.

I. Is Africa Different?

Both the demographic and anthropological literatures point to important cultural institutions in Sub-Saharan Africa that encourage high fertility and spread the costs and benefits of children beyond the couple in question. Caldwell, Orubuloye, and Caldwell (1992), for example, mention the importance in traditional society of maintaining a lineage and leaving descendants, the separate budgets and decisionmaking between spouses, the spreading of child costs across the extended family through child fostering, and communal land tenure systems that favor large families. These institutions arose in an environment that favored high fertility. Are they impediments to demographic change?

The first two articles in the symposium (Ainsworth, Beegle, and Nyamete and Benefo and Schultz) show that despite these cultural influences, African fertility and contraceptive use are sensitive to policies associated with fertility decline elsewhere in the world. Perhaps one of the strongest associations worldwide is the negative relation between female schooling and fertility. Ainsworth, Beegle, and Nyamete confirm this relationship in a cross-national study of individual fertility determinants in fourteen Sub-Saharan African countries. Their study is important because it controls for other exogenous correlates of fertility and contraceptive use to isolate the relation with female education at the microlevel, and it does this in a comparable way across a large group of countries. Further, the authors distinguish between the effect of the early and late years of primary schooling, a point that has received a great deal of attention in bivariate analyses of female schooling and fertility. The most intriguing results are the important differences found across countries in the magnitude of the negative schooling-fertility relationship and in the relative impact of female and male schooling. What might explain these differences? The authors point to several possibilities—underlying differences in the quality of schooling, the labor market, child health, family planning programs, and the status of women. The data sets used did not permit an analysis of these factors, but the results suggest avenues for additional research, which could yield important policy insights. In the meantime the results of this article and others speak to an urgent need to raise the stunningly low levels of completed schooling among African women in order to lower fertility and improve child quality (see Montgomery, Kouamé, and Oliver 1995).

High levels of child mortality are also thought to be an impediment to fertility decline in Sub-Saharan Africa. Benefo and Schultz show that high levels of child mortality in Côte d'Ivoire and Ghana are resulting in higher fertility through a child "replacement effect." The estimated effect is relatively small, but it might
be expected in an environment where child mortality rates are very high and have not fallen below the critical threshold at which a response of lower fertility might be anticipated. Côte d'Ivoire and Ghana are adjacent countries with many cultural and geographic similarities, yet the determinants of fertility and child mortality are remarkably different in the two countries. This belies their different colonial experience and economic and social policies since independence. Ghana, for example, has equalized educational opportunities between men and women to a far greater extent than Côte d'Ivoire.

II. FAMILY PLANNING PROGRAMS AND THE DEMAND FOR CHILDREN

A recent study of the prospects for fertility decline in Sub-Saharan Africa concluded that there are small groups of women who want fewer children and who do not have easy access to family planning (van de Walle and Foster 1990). But, by and large, desired family size is still high—between six and nine children per woman. Thus, lowering fertility and raising contraceptive use will depend both on lowering the demand for children and increasing the availability of family planning services and information.

The last two articles (Feyisetan and Ainsworth and Thomas and Maluccio) assess the relative importance of family planning services and the factors affecting the demand for children in determining contraceptive use. The case studies analyze two countries at different stages in the demographic transition. Nigeria is the most populous country in Africa with limited female schooling and a nascent family planning program. Fewer than 5 percent of women are using modern contraception. At the other end of the spectrum is Zimbabwe, where extensive public investments in female schooling, family planning, and health infrastructure since independence in 1980 have already brought about a modest fertility decline. More than a third of Zimbabwean women are using modern contraceptive methods, one of the highest rates in Sub-Saharan Africa.

By linking women to the results from parallel service availability and "situation analysis" surveys, the authors attempt to control for the woman's characteristics as well as the quality, availability, and (in Nigeria) the price of family planning methods in their analyses of contraceptive use. This approach has recently been used to examine the impact of public health services on morbidity and child nutrition (Alderman and Lavy 1996) and the choice of medical provider (Mwabu, Ainsworth, and Nyamete 1993) in a number of African countries. Female schooling is a pervasive and very strong correlate of contraceptive use in both Nigeria and Zimbabwe despite their different stages in the demographic transition.

Feyisetan and Ainsworth find that the low availability of health and family planning services is constraining contraceptive use in Nigeria but that outpatient consultation fees are not. Broadly similar evidence emerges from Zimbabwe where, in addition, Thomas and Maluccio highlight differences in the impact of family planning programs on behaviors of poorer and better-off women.
They report that the system of community-based distributors is associated with higher adoption of contraceptives among better-educated women, whereas improved quality of distributors benefits the least educated more. The Nigerian and Zimbabwean studies are important reminders that different aspects of family planning services may be relatively more influential in raising contraceptive use at different phases of the demographic transition in Sub-Saharan Africa. They also make a strong case for strengthening the capacity to evaluate program interventions in Africa through random assignment and phased implementation of services to experimental and control communities.

Taken together, these four papers suggest that Sub-Saharan African fertility, although subject to unique cultural influences, can be expected to respond to many of the policies that have been found to lower fertility and raise investments in children in other parts of the world. They also point to fruitful avenues of research on the extent to which observed differences across countries can be attributed to differences in public policies.

REFERENCES


