Global Majority E-Journal, Vol. 16, No. 2 (December 2025), pp. 94–108

Curbing the Climb: Analyzing Population Growth in Relation to Contraceptive Access in Chad and Zimbabwe

Samantha Jaffe

Abstract

This article explores the impact of contraceptive access on population growth and socioeconomic development in Chad and Zimbabwe. Both countries experience high population growth rates that inversely affect the economic growth and development of each country. In Chad, efforts have been made to improve family planning, but contraceptive access remains limited. In contrast, Zimbabwe has made strides in integrating reproductive education into its health system and improving access to contraceptives through both public and private sectors. Zimbabwe's more structured approach to reproductive education and contraceptive access correlates with more significant improvements in health outcomes and a slower population growth rate compared to Chad. The article will delve into the critical role of contraceptive access in managing population growth and achieving sustainable development.

I. Introduction

Access to contraceptives and the ability to plan one's family are fundamental to improving the quality of life and achieving sustainable development. Yet, in developing countries, these rights are often constrained by political, cultural and economic barriers. As global population growth outpaces the capacity of many nations to provide essential resources, recognizing and providing for reproductive rights is increasingly critical. Approximately 218 million women in developing countries who want to avoid pregnancy are not using modern contraceptive methods, a staggering unmet need that perpetuates cycles of poverty, inequality, and poor health outcomes.[1]

This article focuses on Chad and Zimbabwe, exploring the connections among contraceptive access and key development indicators. These two sub-Saharan African countries exhibit vastly different trajectories in population trends and family planning outcomes, a disparity that highlights the critical role of policy frameworks, educational attainment, and cultural attitudes in shaping reproductive health.

[1] Sully (2020).

The article is structured into six sections. Following this introduction (Section I), a brief literature review provides a contextual overview of contraceptive access and population growth globally, as well as in Chad and Zimbabwe. Section III then outlines the socioeconomic backgrounds of Chad and Zimbabwe, examining purchasing power parity (PPP)-adjusted gross domestic product (GDP) per capita, life expectancy, and adult literacy to provide context for their respective stages of development. Section IV reviews key facts regarding the evolution of contraceptive access. Section V offers an ethical analysis of the implications of population control policies and access to family planning resources. Finally, the conclusion synthesizes the findings and suggests potential next steps for improving reproductive autonomy and sustainable development.

II. Brief Literature Review

A complex variety of factors converge relative to the globally acknowledged need to curb total fertility and population growth rates in developing countries. Socio-cultural, economic, and political forces within countries uniquely determine their success in achieving sustainable development trends. This brief literature review focuses on recent contributions analyzing relationships between contraceptive use, fertility rates, and unique social determinants in Chad and Zimbabwe. Tagang and Rwenge (2023) and Tilahun et al. (2019) discuss trends in Chad and three other countries while Gwatimba, Raselekoane and Nwafor (2020), Mturi and Joshua (2011), and Lasong, Bougangue, and Agyeman (2022) analyze the situation in Zimbabwe.

- In a recent analysis of fertility patterns in Chad, Tagang and Rwenge (2023) find a negative association between women's autonomy and fertility rate. While many countries in sub-Saharan Africa have falling fertility rates aiding sustainable economic growth, Chad's total fertility rate (TFR) is both higher than others and rising, recorded at 6.4 births per woman in 2014. Tagang and Rwenge used quantitative data from the Chad Multiple Indicator and Demographic and Health Survey (DHS/MICS) of 2014/2015 as well as qualitative data recorded in 2020 from a representative pool of Chadian interviewees to determine influential factors in fertility of Chadian women. Most notable was the fact that the vast majority of Chadian women have no education (68.4 percent) and little to no decision-making autonomy (44.9 percent and 37.7 percent, respectively). While the government of Chad is aware of the harmful consequences of high fertility and has just recently implemented family planning programs, gender inequality exists as a major social barrier to reducing Chadian fertility rates.
- With recognition of Chad as one of five countries most lagging in the demographic fertility transition, Tilahun et al. (2019) explore the key population indicators, policies, and trends that drive Chad's high fertility rates. After establishing Chad as having the lowest contraceptive prevalence rate (CPR) in the world, which Tilahun et al. consider the most valuable measure of the success of family planning programs, they identify ineffective policy implementation as a main source of lacking development. Chad's government recognized population growth and high fertility as issues in 1996 and accordingly implemented laws and policies to boost women's autonomy, access to health services, and educational attainment. Tilahun et al. (2019) criticize these policies for their failure to adequately deliver on any of their promises, citing the lack of funding and follow-through necessary to make substantial change.
- Gwatimba, Raselekoane and Nwafor (2020) discuss the obstacles that women in rural Zimbabwe face in accessing reproductive and sexual health rights. With the understanding

that culture is a significant determinant of health, relationships, and empowerment, the authors conducted a qualitative study to understand perspectives on the subject at both community and individual levels. They found that the prevalence of unequal gender relations and polygamy in Zimbabwe culture denies women their reproductive autonomy; many are denied decision-making power about whether to have sex, the bearing and spacing of children, and contraceptive use. This culturally determined gender inequality results in diminished quality of life and health for many women and their families.

- Mturi and Joshua (2011) present an analysis of falling fertility rates in Zimbabwe based on data collected from several Zimbabwe Demographic and Health Surveys. Zimbabwe's total fertility rate is one of the lowest in the region, declining from 6.5 births per woman in 1984 to 3.8 births per woman in 2006. Mturi and Joshua attribute this decline to the successful Zimbabwe National Family Planning Council (ZNFPC), which replaced the prior Family Planning Association of Rhodesia (FPAR) under the Ministry of Health in 1984. The ZNFPC's strong-willed political efforts worked to establish laws and policies that removed key barriers to contraceptive access. Following these efforts, the CPR in Zimbabwe skyrocketed, becoming the most influential factor in fertility decline. Mturi and Joshua also discuss how Zimbabwe's government's post-independence efforts to change women's status gave women more opportunities, education, and autonomy, in turn contributing to falling fertility rates.
- Lasong, Bougangue and Agyeman (2022) provide an extension to Mturi and Joshua (2011) by analyzing data collected in the 2015 Zimbabwe Demographic and Health Survey, information that was not available for Mturi and Joshua (2011). Lasong, Bougangue and Agyeman assert that Zimbabwe is one of the most successful countries in Africa for contraceptive use, a status improved by factors such as exposure to mass media and education. In concordance with Mturi and Joshua (2011), Lasong, Bougangue and Agyeman recognize financial status, wealth, and geographic location as being determinants of contraceptive use. While Zimbabwe's CPR increased to 72.9 percent in 2015, the country still demonstrates moderate levels of unmet need for family planning.

III. Socioeconomic Background

Prior to examining the complex relationship between contraception and population growth in Chad and Zimbabwe, it is useful to review the evolution of three standard socioeconomic indicators: PPP-adjusted GDP per capita, life expectancy, and adult literacy. These indicators aid in understanding the context of development for both Chad and Zimbabwe.

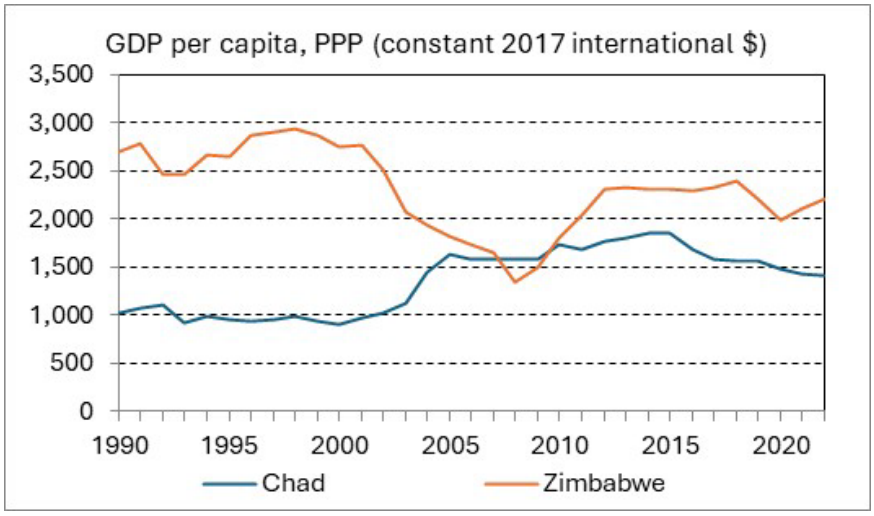
Figure 1 presents PPP-adjusted GDP per capita in constant 2017 international dollars from 1990 to 2022. In 1990, Chad had a GDP per capita of $1,027, which sharply declined to $917 in 1993 and then remained relatively stable until 2000. From 2000 to 2005, Chad experienced a sharp increase in its GDP per capita from $908 to $1,633. This increase catalyzed a stable period of growth until 2015, when the GDP per capita reached $1,853, at which point it began a steady decline to hit $1,413 in 2022.

Zimbabwe's GDP per capita was recorded at $2,705 in 1990 and fluctuated until reaching $2,932 in 1998. Zimbabwe's economy experienced a decade of sharp decline from 1998 to 2008, where its GDP per capita hit its lowest point at $1,353. From there, the GDP per capita sharply increased,

reaching $2334 in 2013 and remaining relatively stable since. In 2022, Zimbabwe's GDP per capita was $2,208, $497 below its recorded GDP per capita in 1990.

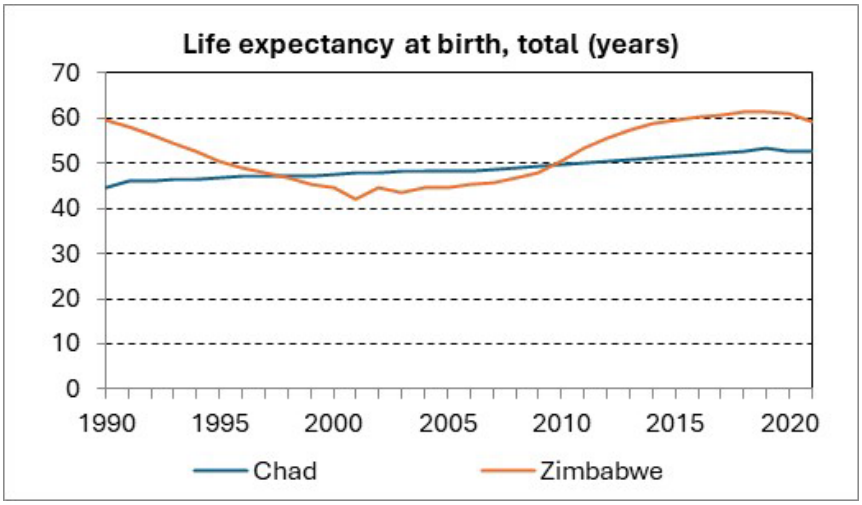
In 1990, Zimbabwe's GDP per capita was $1,678 greater than Chad's. Due to Zimbabwe's economic decline from 1998 to 2008, Zimbabwe's GDP per capita dipped in 2008 $224 below Chad's. As Chad's GDP per capita stabilized and Zimbabwe's increased, Zimbabwe's GDP per capita once again rose above Chad's. As of 2022, Zimbabwe's GDP per capita was $795 greater than Chad's, a difference that is over two times smaller than the difference recorded in 1990.

Figure 1: PPP-adjusted GDP per capita (constant 2017 international dollar), 1990–2022



Source: Created by author based on World Bank (2024).

Figure 2: Total Life Expectancy at Birth (years), 1990–2021

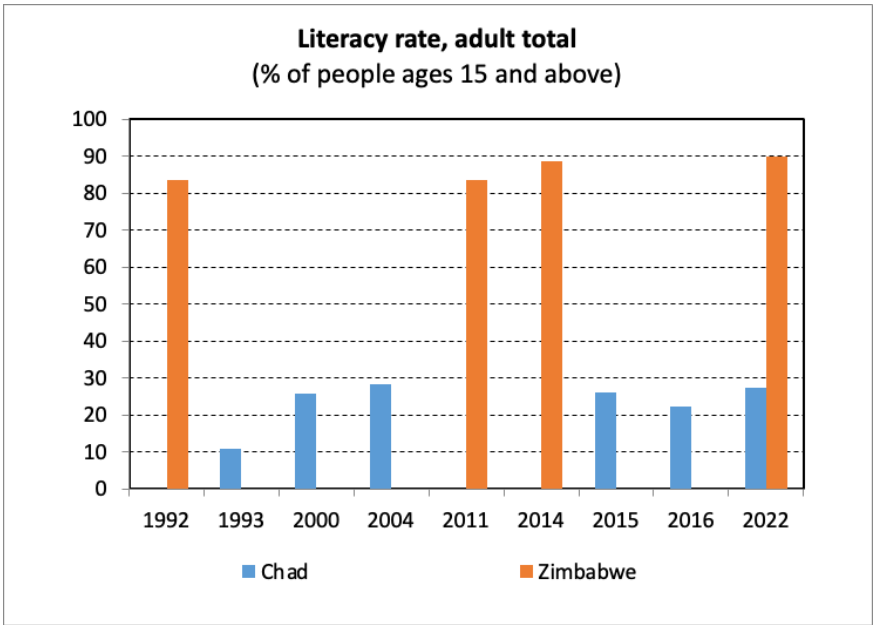


Source: Created by author based on World Bank (2024).

Figure 2 depicts the life expectancy at birth from 1990 to 2021. Apart from a miniscule decrease in 2006, Chad's life expectancy increased steadily from 44.7 years in 1990 to 53.3 years in 2019,

at which point it experienced slight decreases to 52.8 years and 52.5 years in 2020 and 2021, respectively. The trajectory of Zimbabwe's life expectancy at birth has been markedly less linear than that of Chad's. From 1990 to 2001, Zimbabwe's life expectancy sharply declined from 59.4 years to 41.9 years. Within a year it experienced a quick rise to 44.6 years in 2002, from which point it fluctuated slightly before rising steadily to 61.4 years in 2018. In a similar pattern as Chad and the rest of the world, Zimbabwe's life expectancy declined slightly from 2019 to 2021, dropping to 59.2 years. Zimbabwe's life expectancy was higher than Chad's in 1990 (by 14.7 years) and remained higher until 1998. However, from 1998 to 2009, Chad's life expectancy was higher than Zimbabwe's, after which point, in 2010, the positions reversed again. By 2021, Zimbabwe's life expectancy was 6.7 years above that of Chad.

Figure 3: Adult Literacy Rate (percent of people ages 15 and above), all available years



Source: Created by author based on World Bank (2024).

Figure 3 holds the available data on total adult literacy rate (percent of people ages 15 and above) from 1992 to 2022. Chad's lowest recorded adult literacy rate was 10.9 percent in 1993. By 2000, the percentage jumped to 25.7 percent and fluctuated slightly until being recorded at 27.3 percent in 2022. Zimbabwe's adult literacy rate was 83.5 percent in 1992, with insignificant change until reaching 88.7 percent in 2014. By 2022, Zimbabwe's adult literacy rate was 89.8 percent, over three times the value of Chad's adult literacy rate in the same year. Despite limited available data, it is evident that the total adult literacy rate in Zimbabwe far surpasses Chad's.

IV. Analysis of Facts

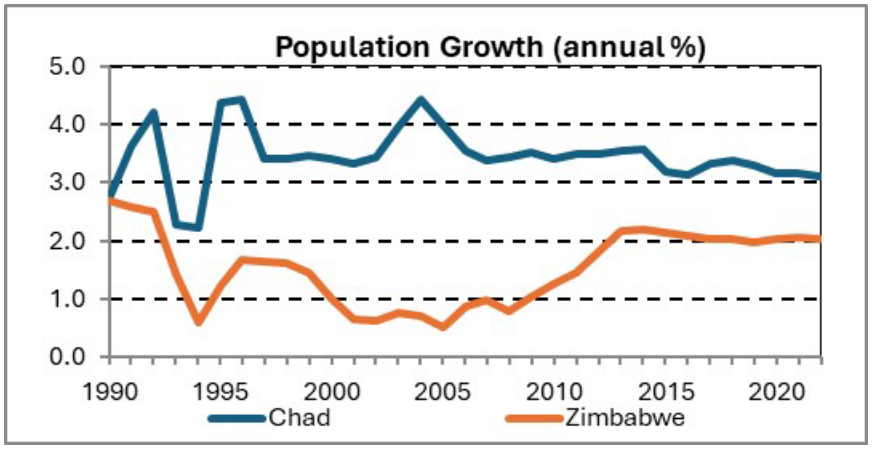
This section is divided into three subsections. The first subsection analyzes the key indicators of population size: population growth rates and total fertility rates in Chad and Zimbabwe. The second subsection reviews contraceptive prevalence and unmet need and the third subsection considers education and gender inequality.

IV.1. Evolution of Population Growth and Fertility

To understand the development status of a country it is necessary to review its population indicators, the premier of which is population growth. While population growth can be a beneficial driver of economic and social changes, excess growth can significantly impede progress. As depicted in Figure 4, both Chad and Zimbabwe have experienced significant fluctuations in their population growth rates since 1990. Between 1989 and 1990, both countries underwent a population increase of approximately 2.7 percent. Following that year, in a pattern that continues to the present day, Chad maintained a population growth rate that far higher than Zimbabwe's. After undergoing a series of spikes and pitfalls, Chad's annual population growth rate evened to approximately 3.4 percent each year from 1997 to 2003 before increasing by a full percentage point to its maximum height of 4.4 percent in 2004. Since then, the rate has dropped slightly over the years, reaching 3.1 percent in 2022.

In comparison, Zimbabwe's population growth rate peaked prior to 1990, after which it declined to hit its second lowest point of 0.59 percent in 1994. Population growth proceeded to rise again slightly, reaching 1.7 percent in 1996. From 2001 to 2008, population growth remained below 1 percent, before rising a full percentage point to a stable approximate 2 percent rate in 2012 that continues today. The growth rates for both countries remain far above the average world growth rate, which has steadily been declining to hit 0.79 percent in 2022.[2]

Figure 4: Population Growth (annual percent), 1990–2022

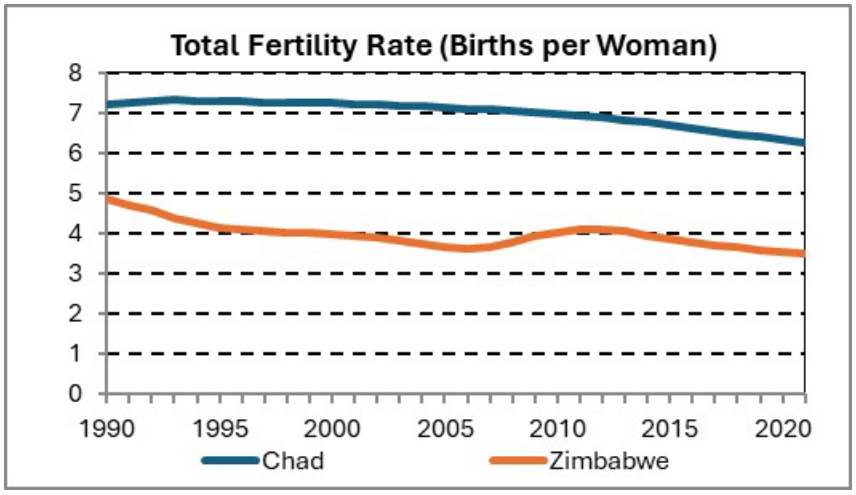


Source: Created by author based on World Bank (2024).

While population growth rates are useful to examine to understand the overall changes in a country's population over time, reflecting changes in birth rates, death rates, and migration, reviewing trends in the total fertility rates (TFR) of each country can more accurately portray the evolution related to a country's reproduction. Further, TFR can be applied as an indicator for development status and outcomes within a country. Countries with high TFR are forced to make greater investments (e.g., in healthcare and education), stretching scarce resources to a point of ineffectiveness and thus impeding development.[3]

[2] World Bank (2024).
[3] Yaya et al. (2020).

Figure 5: Total Fertility Rate (births per woman), 1990–2022



Source: Created by author based on World Bank (2024).

The trends in both Chad and Zimbabwe's TFRs are much less volatile than their respective population growth trends. Figure 5 displays a staggering difference between the rates of the two countries though both demonstrate an overall decline in births per woman over time. Chad recorded an average of over 7 births per woman from 1990 to 2009 and since has remained at over 6. The most recent data indicates a TFR of 6.2 births per woman, the second highest in the world and far above its neighbors, who report TFRs no greater than 5.5 births per woman.[4] In fact, Zimbabwe's TFR has not been over 7 births per woman since 1973 and was last equal to Chad's current rate of 6.2 births per woman in 1983. It has since steadily declined (excluding a miniscule increase from 2009 to 2013) to reach 3.4 births per woman in 2021, representing a 45 percent decrease in births per woman.[5]

Chad's high fertility and rapid population growth exacerbate existing challenges related to poverty, health, and education, making it difficult for the country to break the cycle of underdevelopment. By contrast, Zimbabwe's ability to reduce fertility rates and manage population growth is a tremendous success relative to other countries in sub-Saharan Africa and has positive long-term implications for its development.

IV.2. Contributing Factors: Contraceptive Prevalence and Unmet Need

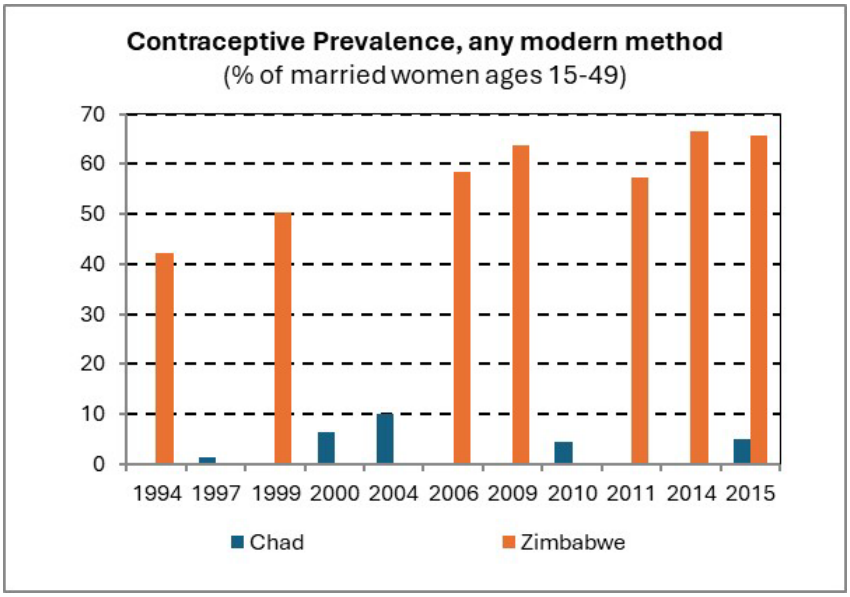
Among the most influential factors to determining fertility rates and population growth are levels of access to modern contraception. As limited data is available on contraceptive access and use, it is helpful to consider multiple indicators to develop a comprehensive understanding of the reproductive landscapes in Chad and Zimbabwe. The CPR, defined as the percentage of married women ages 15–49 who are practicing, or whose sexual partners are practicing, at least one modern method of contraception (e.g. sterilization, oral hormonal pills, the intrauterine device, condoms, and the implant), is one of the most predictive measures of trends in fertility rates.

Figure 6 contains all the available data on CPR in Chad and Zimbabwe, showcasing a stark

[4] Tagang and Rwenge (2023).
[5] Mturi and Joshua (2011).

difference in use between the two countries. According to the World Bank (2024), Chad reported a low point of 1.2 percent in 1997, which briefly rose to 9.9 percent in 2004 before declining by almost 50 percent to reach 5.5 percent in 2015. Though other data sources report slightly different CPRs in 2015, ranging from 6.7 percent[6] to 7.7 percent[7], all similarly conclude Chad to have the lowest CPR in both the sub-Saharan region and the world. In striking contrast to Chad, Zimbabwe's CPR has continued to increase even during years of political and economic crises. Zimbabwe's success in implementing family planning programs and contraceptive uptake (which will be further elaborated on in subsequent sections) is cited as the most significant factor in their falling fertility rates. Earliest available data places the country's CPR at 14 percent in 1982, a rate that is double that of Chad today.[8] As indicated in Figure 6, the CPR has since increased by over 70 percent, reaching a peak rate of 66.5 percent in 2014.

Figure 6: Contraceptive Prevalence Rate (percent of married women ages 15–49), all available data from 1990–2022

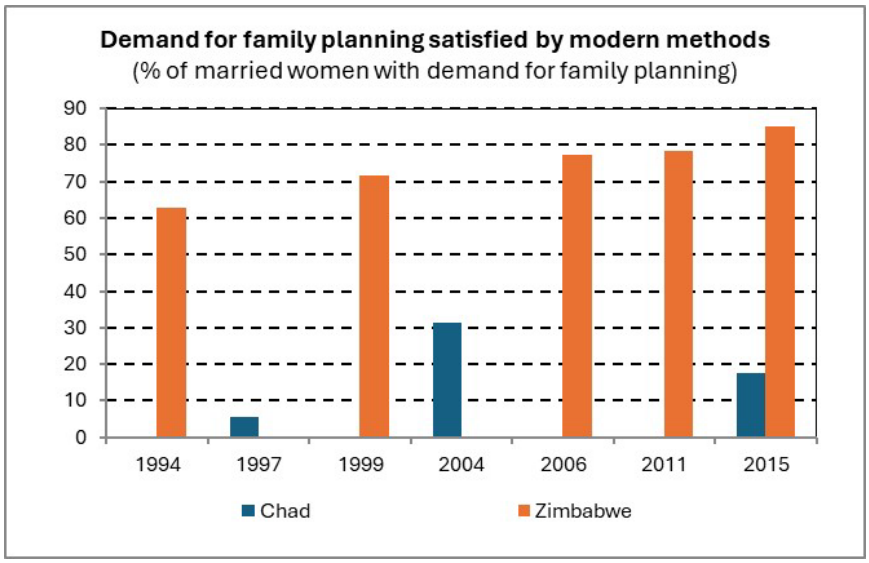


Source: Created by author based on World Bank (2024).

Partnered with data on CPRs, which provides information on the use of contraception, data on the demand for family planning satisfied by modern methods reports on the other half of the contraceptive issue: access. Figure 7 contains the limited available data recorded in Chad and Zimbabwe on this subject and demonstrates familiar trends. The percentage of demand satisfied in Chad is far below that of Zimbabwe, experiencing a peak at 31.4 percent in 2004 before once again dropping by almost 50 percent to 17.6 percent satisfied demand in 2015. Conversely, Zimbabwe's rates of satisfied demand steadily increased over time to reach 85.2 percent in 2015, almost 5 times higher than Chad's rate in the same year. Meeting the demand for family planning is a crucial element in developmental progress as it provides women the tangible resources to enact their reproductive autonomy.

[6] Yaya et al. (2018).
[7] Adde et al. (2022).
[8] Zinanga (1992).

Figure 7: Demand for Family Planning Satisfied by Modern Methods (percent of married women with demand for family planning), all available years



Source: Created by author based on World Bank (2024).

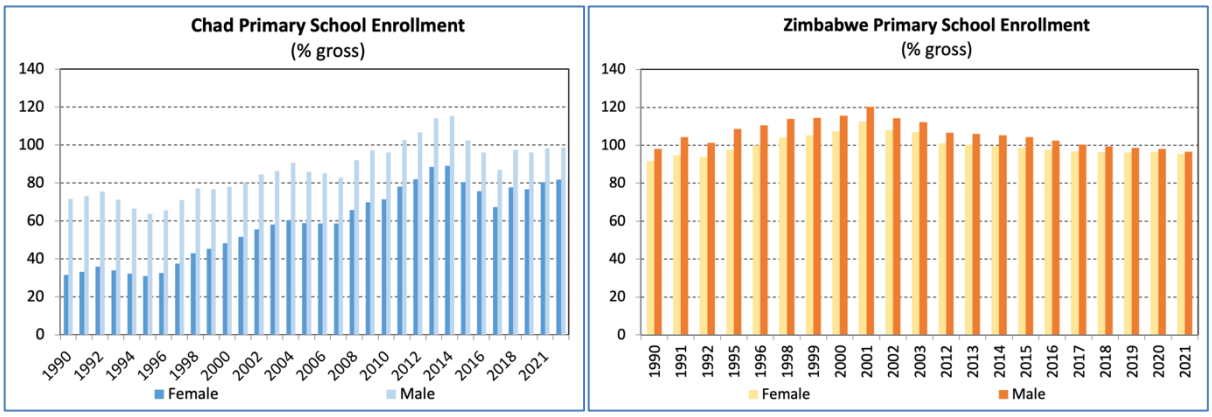
IV.3. Contributing Factors: Gender Roles and Inequality

While contraceptive access is undoubtedly a key factor in prevalence rates and in turn, fertility and population growth rates, contraceptive use is also influenced by several cultural factors. Gender roles and inequality are pervasive factors affecting fertility rates and female autonomy in both countries. Chad remains entrenched in gender norms that restrict women's freedoms, negatively impacting their ability to access education, health care, and decision-making.[9] In Zimbabwe, post-independence efforts greatly improved women's status and education, though many Zimbabwean women continue to report unequal power relations that prevent them from making decisions on sexual activity, protection, and contraception.[10]

Women's educational attainment is considered a consistent predictor of contraceptive use because it improves knowledge, empowerment, autonomy and access.[11] Figures 8–13 display female and male gross primary, secondary, and tertiary school enrollment in Chad and Zimbabwe, which present clear trends for each country. In Chad, female enrollment has steadily increased over time at all three levels of education. The gender gap in primary school enrollment in Chad has significantly decreased but remains gaping for both secondary and tertiary school enrollment. Comparatively, total enrollment rates in Zimbabwe have been relatively stable across all three types and the gender gap is significantly smaller. For the more recent years, the gender gap is practically non-existent in both primary and tertiary school enrollment of Zimbabwe as both have a difference of less than one percentage point between female and male enrollment.

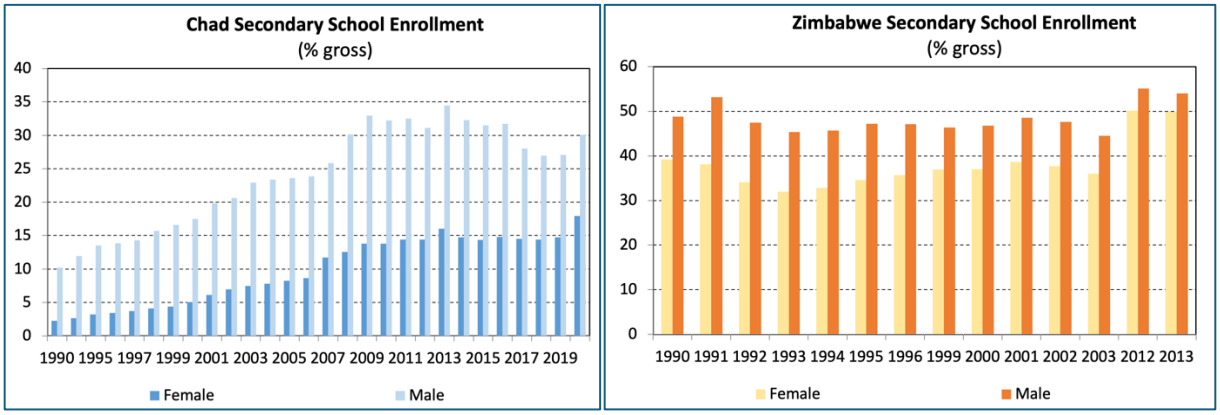
[9] Tagang and Rwenge (2023).
[10] Gwatimba et al. (2020).
[11] Tilahun et al. (2019).

Figures 8 and 9: Gross Primary School Enrollment (percent), all available years



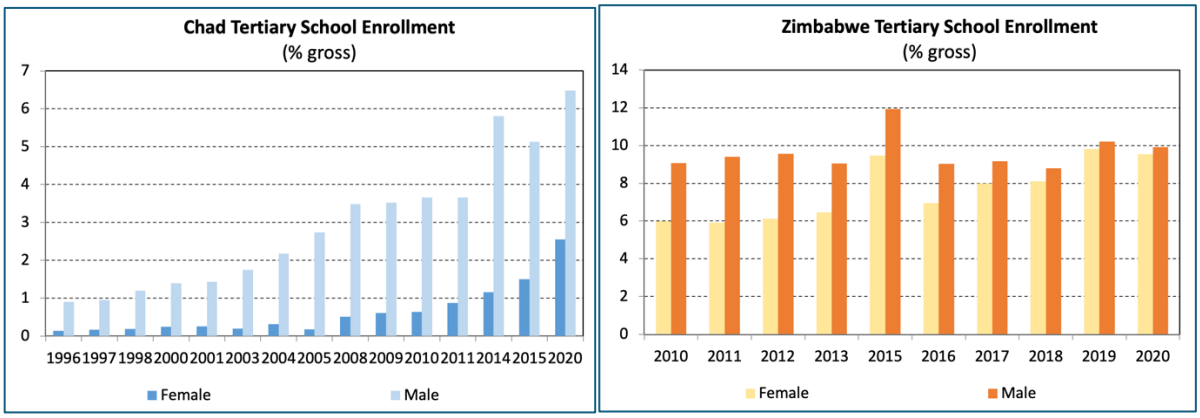
Source: Created by author based on World Bank (2024).

Figures 10 and 11: Gross Secondary School Enrollment (percent), all available years



Source: Created by author based on World Bank (2024).

Figures 12 and 13: Gross Tertiary School Enrollment (percent), all available years



Source: Created by author based on World Bank (2024).

This data is corroborated by the 2023 Global Gender Gap Report, which gave Chad and Zimbabwe scores of 0.637 and 0.991, respectively, regarding the gender gap in educational attainment.[12] Both countries are moving in the right direction to achieve gender equality, but considerations must continue to be made for gender empowerment and autonomy. The same report declared both Chadian and Zimbabwean women to have uneven and restricted rights regarding reproductive autonomy, political empowerment, access to financial services, and justice. While education is instrumental in providing women knowledge to inform their desires and decisions, it is ineffective if they are unable to wield it.

V. Ethical Analysis

This section analyzes ethical perspectives on contraceptive access and population growth in Chad and Zimbabwe. The first subsection examines efforts made to implement family planning programs and population policies. The second subsection reviews the ethical implications of contraceptive access.

V.1. Population Control Policies and Programs

Similar to much of sub-Saharan Africa, both Chad and Zimbabwe existed historically as pronatalist countries. The preference for large families was typically informed by a desire for social prestige, cheap, inter-family labor, and to compensate for high infant mortality and child mortality rates. The inability for these countries to sustainably develop has, however, led to shifting perspectives on reproductive measures and fertility. As such, the governments of both Chad and Zimbabwe have implemented programs and policies to curb their climbing population sizes.

In 1986, Chad began to receive assistance from the United Nations Population Fund (UNFPA), a partnership that persists today. In accordance with the UN Sustainable Development Goals, UNFPA aims to aid Chad in improving infrastructure for women's health care and outcomes, providing medical training, and eliminating harmful traditional practices. With their help, Chad's government adopted the Population Policy Declaration in 1994, which formally recognized the detrimental impacts of rapid population growth and high fertility rates on integrated and sustainable development. The policy's overall goals were to improve key development indicators, including maternal, infant, and child mortality, total fertility rate, and population growth. More specifically, the policy outlined intentions to strengthen women's rights, social status, and specific health care services, including contraceptive access.[13]

In practice, however, the declaration has done little to improve cultural norms or health outcomes for Chadian women, exemplified by the prevailing high fertility and population growth rates. In fact, the Country Programme Document for Chad of the United Nations Population Fund (UNFPA) (2016, p. 2) explicitly refers to "the lack of application of the decree enforcing law (…) on the promotion of reproductive health, which would allow freedom of choice to access family planning services." Similarly, seven years later, the United Nations Population Fund (UNFPA) (2023, p. 2) states that "[t]he low modern contraceptive prevalence rate is due to the poor availability of high-quality sexual and reproductive health and rights (SRHR) services alongside the prevailing social norms and the low status of women and girls." The consistency of these

[12] World Economic Forum (2023). Scores range from 0 to 1, with 1 representing complete parity.
[13] Diakité (2003).

findings clearly indicates a stagnation of progress in reproductive freedom and thus in development goals as well.

Zimbabwe, in contrast, provides a much more structured, effective, and successful approach to family planning. In the 1950s, family planning was initiated as a voluntary movement; the Family Planning Association (FPA) was a coalition of volunteers that introduced modern methods to the open-minded urban few in Zimbabwe. Following the 1961 national census, which exposed the country's high fertility rates and population growth, the Zimbabwean government took interest in the FPA. They were provided an annual grant to continue existing services and supported by the Ministry of Health, which began to distribute contraceptives. After Zimbabwe gained independence in 1980, the newly established government fully adopted the FPA, restructuring and expanding the organization, helping to bring the CPR from 14 percent in 1982 to 43 percent in 1988.[14]

The post-independence government passed several measures in quick succession to improve the health of women and the development of the country. The 1980 Free Health Care Act provided free services, including contraceptive access, to those earning less than $150 per month. The 1975 Drugs and Allied Substances Act was amended to give special standing to oral contraceptives; patients are only required to obtain one initial prescription, after which it can be refilled indefinitely. In addition, designated lay personnel working under the Ministry of Health (as opposed to solely medical professionals) were given permission to distribute contraceptives, increasing access and availability for the rural majority (76 percent of the total population living in rural areas). Further, with the age of consent at 16 and age of legal majority at 18, individuals can obtain contraception without spousal or guardian consent.[15]

The Zimbabwe National Family Planning Council (ZNFPC) Act of 1985 was most influential in the rapid improvements to family planning and outcomes. This act of parliament established the ZNFPC as a parastatal in the Ministry of Health with six key units: Community Based Distribution; Youth Advisory Services; Medical and Clinical; Information, Education and Communication; Training; and Evaluation and Research. This extensive framework ensures that contraceptives are available to even the most hard-to-reach populations within Zimbabwe, with 24 percent of contraceptive users receiving supplies from ZNFPC community distributors and 13 percent receiving supplies from ZNFPC static and mobile clinics.[16] Further, the ZNFPC accounts for the critical role of education in health outcomes, providing early education services for youth, support groups for parents, and appropriate, empirical information for the general public.

In both countries, existing structures reflect ethical commitments to addressing issues of sustainable development and health and gender equity. While Chad's policies demonstrate an awareness of the need for improvements in family planning services their implementation remains insufficient. Conversely, by anticipating the needs of and potential burdens on its citizens, Zimbabwe has successfully designed and implemented a framework that has produced remarkable tangible outcomes.

V.2. Ethical Perspectives on Contraceptive Access

As contraceptive access and reproductive rights are undoubtedly public health concerns with

[14] Zinanga (1992).
[15] Zinanga (1992).
[16] Zinanga (1992).

significant correlations to development, it is prudent to analyze the subject with a dual lens of bioethics and development ethics. The following application utilizes common core elements of both fields. The bioethical framework of principlism, introduced by Tom Beauchamp and James Childress in 1979, focuses on universally applicable rules which includes autonomy, justice, and utility. In parallel, many development ethicists agree upon a set of ethical lenses, including but not limited to the rights, justice, and utilitarian approach.

Arguably most central to the subject of contraceptive access and usage are the perspectives of autonomy and the rights approach. Autonomy underscores the necessity of allowing individuals to exercise their capacity for self-determination and make informed, voluntary decisions about their own lives. Autonomy is encapsulated in the rights approach, which similarly decrees that humans have intrinsic rights and abilities to freely decide over their lives. By providing access to contraceptives, countries affirm a commitment to protecting the innate rights of humans, especially women to make autonomous decisions about their reproductive health. Policies that restrict access to contraceptives (such as Chad's stipulation of spousal consent) undermine autonomy by eliminating freedom of choice for the primary stakeholder.

Justice exists as a shared value in both frameworks and highlights the need for equitable treatment of all human beings. This value applies to both fair distribution and societal treatment, which are essential to the ongoing issue of contraceptive access. Distributive justice demands equitable access to contraceptives for all to ensure that they equally have the resources necessary to prosper and make decisions about their individual health. The Zimbabwean government exemplified an implementation of justice via the Free Health Care Act and the ZNFPC mobile and community-based units, measures which anticipated and addressed barriers for low-income and rural populations. Justice is particularly relevant in a sociological context as well, especially as Chad and Zimbabwe (currently and historically, respectively) often consider women to be below men in terms of social status. This disparity leads to an unequal distribution of power in decision-making and finance, which may in turn be reflected in a woman's ability to obtain contraceptives. The stark disparity in the valuation and rights afforded to different genders is a clear violation of justice that raises serious ethical concerns.

Finally, both bioethics and development ethics consider utility, which calculates the most favorable balance of benefit over harm. Applying utility to contraceptive access reveals that implementing reproductive rights both improves individual outcomes and generates societal benefits, without causing significant, if any harm. Increasing access to contraceptives has repeatedly proven to hold a positive relationship with economic development as it allows women to plan their futures, complete higher levels of education, and participate in the workforce, all ventures which promote economic productivity. Further, increased contraceptive access reduces maternal and infant mortality rates, unsafe abortions, and sexually transmitted infections, which consequently reduces health care costs and improves overall quality of life. From a utility perspective, investing in contraceptive access yields significant benefits by fostering healthier, more productive societies.

VI. Conclusion

Zimbabwe's robust family planning framework has significantly reduced its fertility rates and enhanced reproductive autonomy, serving as a model for successful policy implementation. In contrast, Chad's persistently high fertility rates and limited access to contraceptives reveal gaps in policy enforcement and entrenched gender inequalities that undermine development efforts.

Improving reproductive health outcomes requires multifaceted solutions that address both systemic barriers and cultural norms. For Chad, stronger enforcement of existing policies, investment in healthcare infrastructure, and community-based education and distribution initiatives could help bridge the gap between demand and access. Meanwhile, Zimbabwe's success underscores the importance of government commitment and comprehensive family planning programs, which can serve as a blueprint for other nations facing similar challenges. Sustainable solutions must also incorporate broader efforts to promote gender equality, as empowered women are more likely to seek and benefit from reproductive health services.

Looking ahead, initiatives that prioritize education, especially for young girls, play a crucial role in fostering informed, autonomous, and empowered decision-making about reproductive health. When coupled with robust policies that promote and enforce gender equality, these efforts can pave the way for healthier futures—not only for women and their children but for entire communities and nations. With the support of international cooperation and organizational funding, developing countries can commit to these priorities and advance toward sustainable development goals while affirming reproductive rights as an integral part of fundamental human rights.

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