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What Makes a Family Planning Program Successful in Sub-Saharan Africa?

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Abstract

Family planning programs are an important tool in slowing population growth but also for empowering the people, especially women. This article will focus on Nigeria and Rwanda, two similar countries in terms of location and development stage, but one major difference is their family planning programs. Rwanda's contraceptive prevalence was 58.4 percent in 2020; that is higher than the world average. Nigeria's contraceptive prevalence was stagnant at around 12 percent for the last decade. These differences in contraceptive prevalence rates are largely due to differences in their family planning programs. Rwanda is much further along in family planning than Nigeria. Some reasons for this include administrative attributes, but most importantly how Rwanda sees family planning from a social and culture standpoint. Approaching the program from the ethical lenses of efficiency, equity, and empowerment, leads to more successful family planning programs.

I. Introduction

Sub-Saharan Africa (SSA) has the highest population growth rate of any region in the world;[1] its population growth is not sustainable if SSA countries want to move forward in economic development and human development. As a result of this, many countries including Nigeria and Rwanda have implemented family planning programs that provide sexual education and give contraceptives to those who want them. Despite their geographic closeness and demographic similarities, Nigeria and Rwanda have very different family planning programs in terms of structure, effectiveness, attitudes towards women, among other things.

This article investigates the family planning programs of Nigeria and Rwanda. Following this introduction, a brief literature review will provide an overview of family planning programs in Nigeria and Rwanda. The third section comprises some socioeconomic background, comparing some key indicators of Nigeria, Rwanda and the world. The analysis of the family planning programs in each country and their effectiveness at reducing population growth and the unmet need for contraceptives will constitute the fourth section. The fifth section examines the family planning programs through a variety of ethical lenses provided by Mitchell (1994), including the

[1] World Bank (2025).

framework for if a development program is beneficial for women and the approach the country uses with the family planning programs before the last section provides the conclusion.

II. Brief Literature Review

The is a considerable number of publications related to family planning programs in Nigeria and Rwanda. Amiesimaka and Payam (2024) focuses on Nigeria, while Hutchinson et al. (2021) focus on three states in northwestern Nigeria. Ishaku et al. (2018) examine a new option for postpartum family planning in Nigeria, Senegal, and Kenya. Rugigana et al. (2019) and Schwandt et al. (2018) focus on Rwanda's family planning program. The following summaries are presented in chronological order of publication.

- Ishaku et al. (2018) examine the insights from engagements with stakeholders after introducing the Progesterone Vaginal Ring (PVR) as a new option for postpartum family planning in Nigeria, Senegal, and Kenya. The PVR has the advantage of suppressing ovulation and extending the period where women cannot have children because they are breastfeeding. Based on the results, all three countries were optimistic about its implementation, but Ishaku et al. (2018) also address socio-cultural factors that may limit the use of it, including stigma associated with women touching their private parts and taboo of male healthcare professionals with female patients.
- Schwandt et. al (2018) review the success of Rwanda's implementation programs that increase family planning and contraceptive use. They wanted to see why the program was so successful in Rwanda compared to other countries in the region. They discuss how Rwanda's government embraced family planning as a means of empowering their people and improving their livelihoods. They also acknowledged challenges of implementing the program in rural areas and backlash from religious communities, but ultimately built one of the most successful family planning programs of any individual nation.
- Rugigana et al. (2019) focused on examining the more recent barriers to family planning in Rwanda. They refer to the 2014-15 Rwanda demographic and health survey (RDHS), which showed that there has been a slow increase (of about three percent) in the use of modern family planning methods compared to the previous five years, and that the unmet need for contraception remains unchanged at 19 percent. The 2014-15 survey also revealed that the drop-out rate of family planning users is high despite that many strategies have been put in place to speed up the uptake in family planning in order to reap the demographic dividend. Their results showed that 74.6 percent of the women who had once used family planning methods had stopped using them at some point in their lives. Through focus group discussions and key informant interviews, they identified that the key barriers for family planning were side effects/health concerns, the need to have another child, rumors in the community about contraceptives, cultural beliefs such as considering many children a sign of wealth, and religious beliefs.
- Hutchinson et al. (2021) surveyed 3,000 women aged 15 to 49 years with a child under 2 years in the states of Kebbi, Sokoto and Zamfara in northwestern Nigeria in September 2019 to find out how to better tailor the efforts of programs that focus on social and behavior change (SBC). They assess the effects of intermediate determinants of contraceptive use/uptake and by demonstrating their potential impacts on contraceptive use, interpersonal communication with partners, and contraceptive approval. They

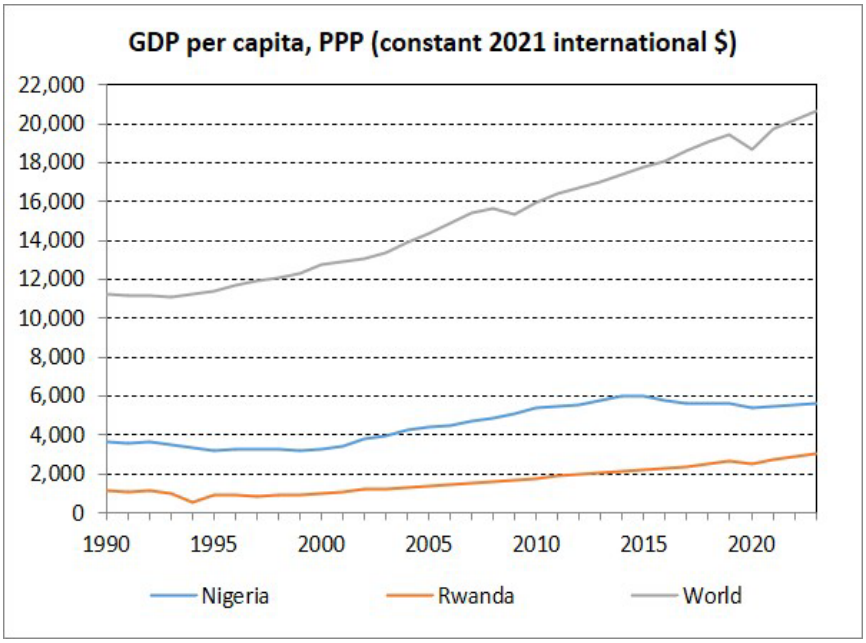
conclude that SBC programs interested in improving family planning outcomes could potentially achieve large gains in contraceptive use, even without large-scale changes in socioeconomic and health services factors, by designing and implementing effective SBC interventions that improve knowledge, encourage spousal/partner communication, and work towards increasing personal approval of family planning. Furthermore, they conclude that uncertainty about the time-order of influencers and outcomes precludes any inferences about the existence of causal relationships and the potential for impact from interventions.

- Amiesimaka and Payam (2024) examine why there is a gap in contraceptive usage despite the awareness of it. It explains that Nigeria's patriarchal society stages men as gatekeepers of women's reproductive health. They study the culture of family planning by analyzing documents from Nigeria's Minister of Health and conclude that family planning is seen as a right, but something women should shoulder. They recommend that Nigeria's policies address the gender imbalances that hamper women's access to family planning.

III. Socioeconomic Background

Figure 1 shows the GDP per capita adjusted for purchasing power parity in the constant international currency from 1990 to 2023. From 1990 to 2023, Nigeria's GDP per capita increased from $3,651 to $5,593 (which is a cumulative increase of 53.2 percent), Rwanda's increased from $1,122 to $3,060 (which is a cumulative increase of 172,7 percent), while the world average GDP per capita increased from $11,263 to $20,671 (which is a cumulative increase of 83.5 percent). Hence, even though Rwanda's GDP per capita is still far below that of Nigeria, Rwanda has made much more progress in relative terms. Both countries continue to be less than one third of the world average GDP per capita.

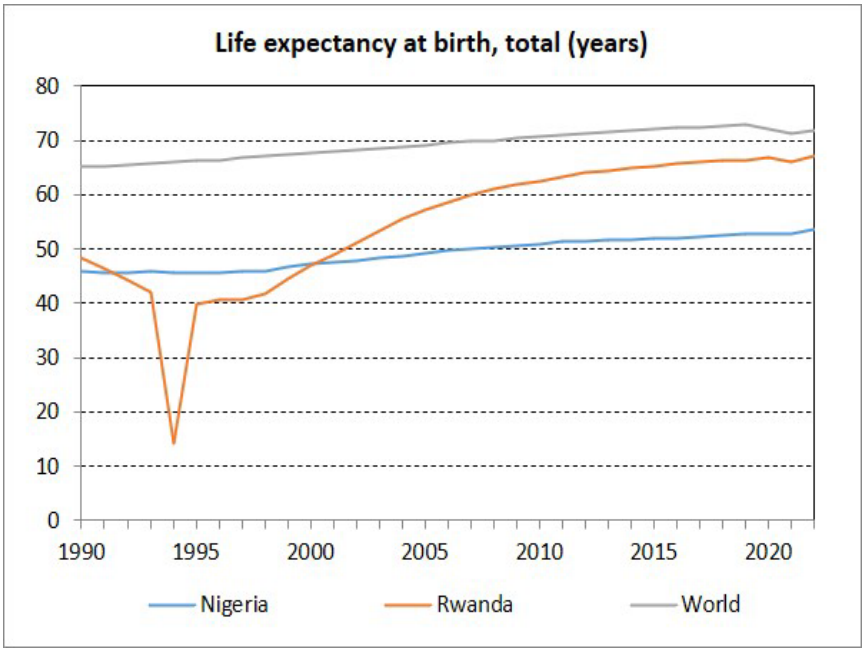
Figure 1: PPP-adjusted GDP per capita, 1990-2023



Source: Created by author based on World Bank (2025).

Figure 2 shows the average life expectancy of a person at birth in both countries from 1990 to 2022. In 2022, Rwanda had a life expectancy of 67.1 years, while Nigeria had a life expectancy of 53.6 years in the same year. That is, Nigeria's life expectancy was 13.5 years below that of Rwanda, even though they had about the same life expectancy in 1990. There was a huge dip in Rwanda's life expectancy in 1994 due to the Rwandan genocide. However, Rwanda's life expectancy recovered within one year, and then grew strongly from 1997 to 2008, followed by more moderate growth during the subsequent 14 years. On the other hand, Nigeria's life expectancy grew very moderately during the last three decades, increasing by only 7.6 years. Despite Rwanda's progress, both countries continue to have life expectancies considerably below the world average, which in 2022 was roughly 72 years.

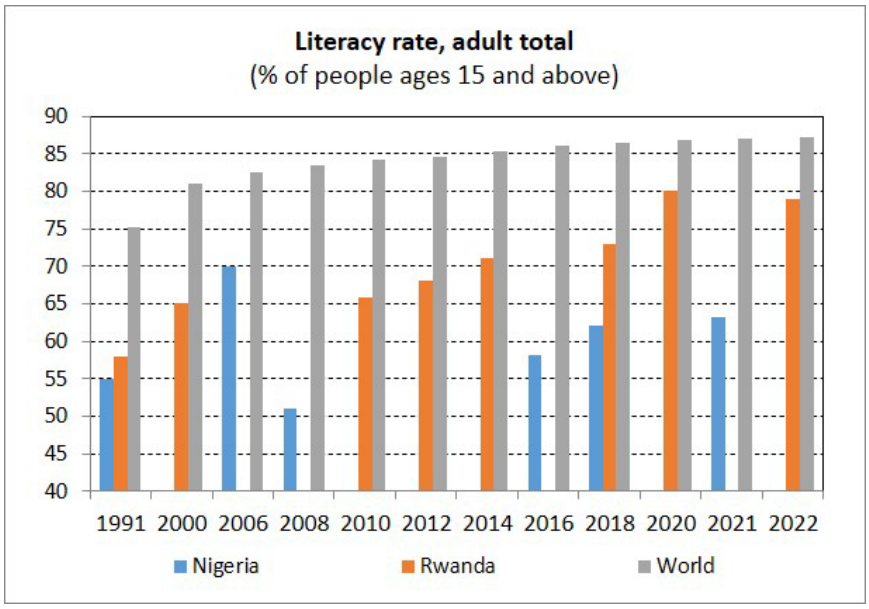
Figure 2: Life Expectancy in Years, 1990-2022



Source: Created by author based on World Bank (2025).

Figure 3 shows the percentage of people who are at least 15 years old and literate. A first main observation is that both Nigeria and Rwanda have literacy rates below the world average, which increased from 75.3 percent in 1991 to 87.2 percent in 2022. With exception of a marginal decrease from 2020 to 2022, Rwanda's literacy rate also increased during the last three decades, and more strongly than the world average. On the other hand, Nigeria's literacy rates have been highly volatile during the 1990s and 2000s, increasing relatively sharply from 55 percent in 1991 to 70 percent in 2006, to only drop to 51.1 percent two years later in 2008. Though Nigeria's literacy rate then improves continuously, the improvements have been relatively small, and hence, Nigeria's literacy rate are currently far below that of Rwanda.

Figure 3: Literacy Rates Ages 15 and Above (percent), All Years with Data for at Least Nigeria or Rwanda



Source: Created by author based on World Bank (2025).

Comparing the two countries across the three indicators shown in Figures 1 to 3, it is interesting to point out that Rwanda has a far lower GDP per capita than Nigeria, however, Rwanda overtook Nigeria in terms of life expectancy in 2001, and with exception of 2006, Rwanda is also more literate than Nigeria. Hence, in terms of human development, Rwanda is slightly more advanced than Nigeria, which can also be seen by the difference in the United Nations Human Development Index (HDI): Nigeria currently has an HDI of 0.560, Rwanda has an HDI of 0.578.[2]

IV. Analysis of Facts

There are two subsections included in this analysis. The first subsection reviews the most recent population pyramids of Nigeria and Rwanda. While the different shapes of Nigeria's and Rwanda's population pyramid implicitly reflect recent demographic trends, which are influenced by family planning programs, the second subsection focuses on some key indicators directly related to family planning in Nigeria and Rwanda.

IV.1. Analysis of Population Pyramids

As shown in the right bottom corner of Figure 4, Nigeria has a total population of around 233 million people in 2024. This is more than 16 times the population of Rwanda (14.3 million). However, what is more important for this article is the difference in the shape of the population pyramids, even though they might appear to be relatively marginal.

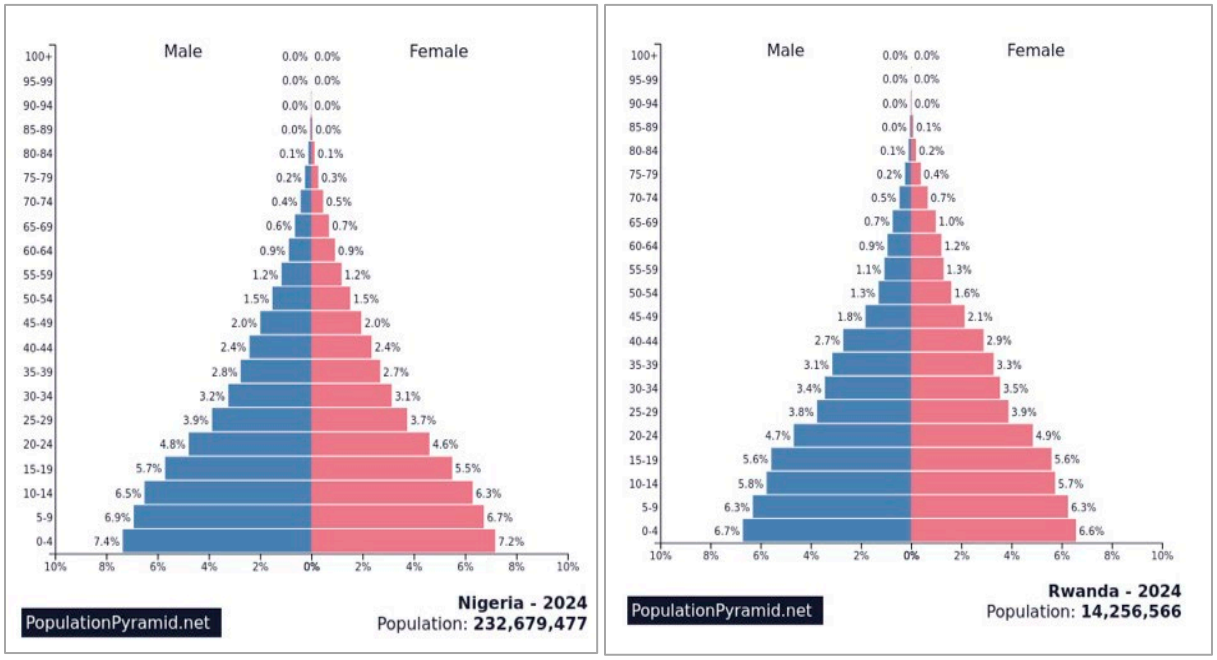
Both, Nigeria's and Rwanda's pyramids are the classic pyramid shape, with the youngest age group (the 0-4 year old) constituting the highest percentage of the population, followed by the subsequent age groups. However, the 0 to 4 year old constitute 14.6 percent of Nigeria's total

[2] United Nations Development Programme (2023).

population, while the same age group constitute 13.3 percent of Rwanda's population. Nigeria also has a higher percentage of its population for the next two age groups (the 5-9 year old, and the 10 to 14 year old). Hence, 41.0 percent of Nigeria's population are below 15 years old, while 37.4 percent of Rwanda's population are below 15 years old.

The 15 to 19 year old age group represents the same percentage (11.2 percent) of the total population in Nigeria and Rwanda, with all the subsequent age groups (including the very old) having a higher percentage in Rwanda than in Nigeria. Clearly, Rwanda has a higher percentage of its population at the working age (15 to 64 years) than Nigeria. As we will see more clearly in the next subsection, all these differences are due to Rwanda's lower fertility rates and higher contraceptive prevalence.

Figure 4: Population Pyramids of Nigeria (left chart) and Rwanda (right chart) in 2024



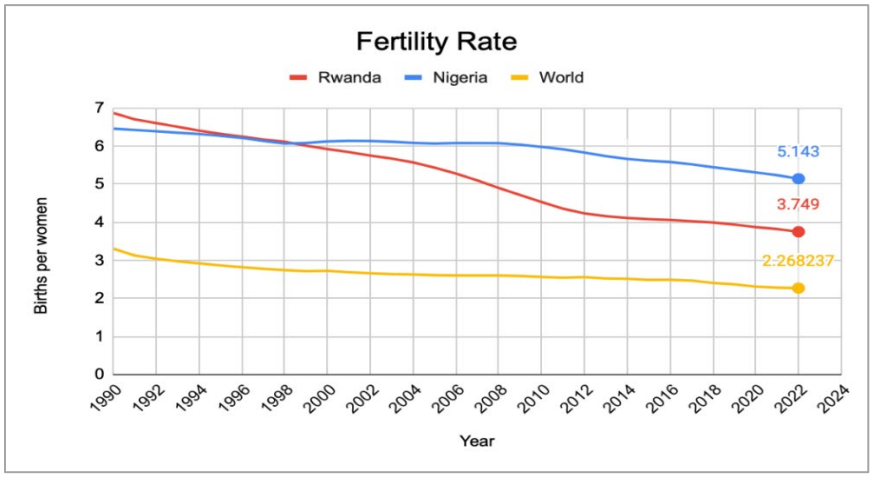
Source: PopulationPyramid.net (based on United Nations data).

IV.2. Fertility, Contraceptive Prevalence, and Unmeet Need for Contraception

Fertility rates are defined as the number of children for each woman in each country. Typically, in countries with lower fertility rates women are more educated, have more political and social rights, and have jobs where they contribute to the economy.

Figure 5 illustrates that both Rwanda and Nigeria are above the world average in terms of fertility rates. Nigeria has a higher fertility rate than Rwanda by a significant amount. Nigeria's fertility rate remained relatively stable for nearly two decades, and only started to decrease moderately since 2010. Rwanda's fertility rate has been decreasing since 1990, especially from 2006 to 2013, before leveling off from 2014 to 2019, and then starting to decrease again in 2020. Rwanda's fertility rate has decreased from 6.9 children per woman in 1990 to 3.7 children per woman in 2022. While Rwanda's fertility rate was higher than that on Nigeria in 1990, it is now substantially below Nigeria's fertility rate.

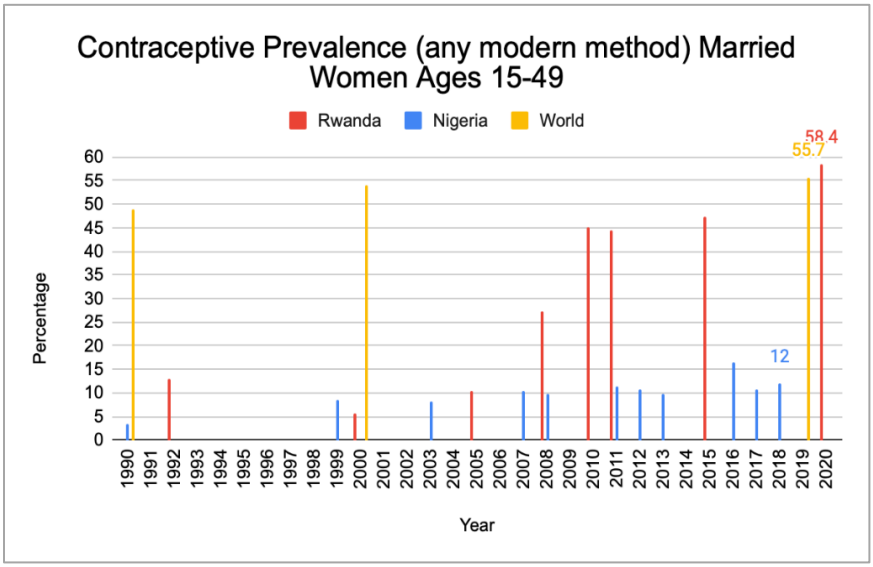
Figure 5: Fertility Rate (births per women), 1990–2023



Source: Created by author based on World Bank (2025).

Figure 6 shows the contraceptive prevalence of any modern method of married women ages 15 to 49 years. Nigeria did not reach their goal of reaching a contraceptive prevalence rate of 36 percent by 2018. In 2018, they actually had a contraceptive prevalence of 12 percent according to the World Bank (2025). Their contraceptive prevalence rose by roughly 7 percent since 1990. So, we can conclude that their goal of building the systems for family planning to be implemented was not as successful. On the other hand, Figure 6 shows that Rwanda had a contraceptive prevalence of 58.4 percent in 2020, which is almost 2 percent above the world average. The contraceptive prevalence rose steeply since 2005.

Figure 6: Contraceptive Prevalence (any modern method) in Married Women Ages 15–49, all available years

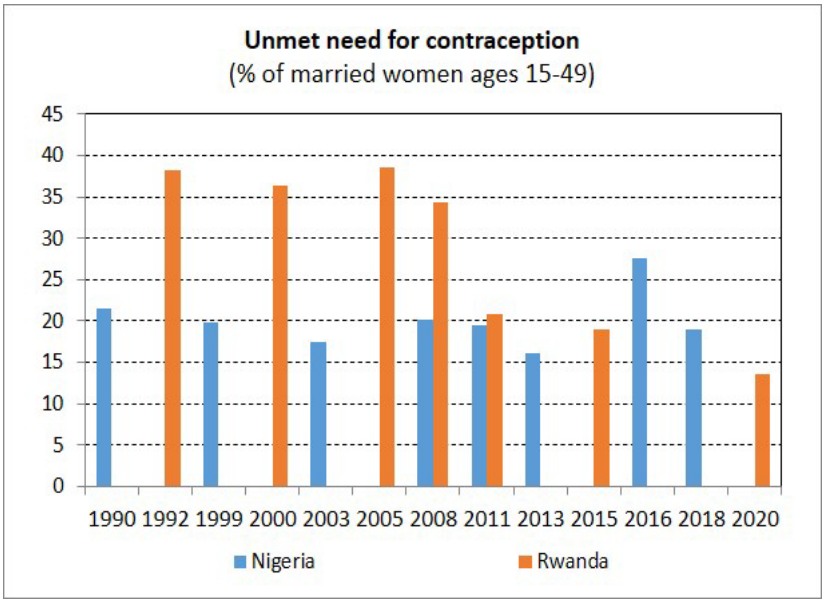


Source: Created by author based on World Bank (2025).

Our final indicator to review the effectiveness of the two countries' family planning programs is the unmet need for contraception. Given that societal norms may lower the need for contraceptives, a lower unmet need may not necessarily imply that family planning programs are effective. However, the trends still provide some useful information. As Figure 7 shows, Nigeria has not made any progress with reducing the unmet need for contraception during the last three decades. While Nigeria's unmet need was about 20 percent in the 1990s and 2000s, it decreased to 16.1 percent in 2013, but then increased relatively sharply to 27.6 percent in 2016. It then decreased again in 2018 to 18.9 percent, which is the last year such data is available for Nigeria.

Rwanda had a far higher unmet need for contraception than Nigeria during the 1990s and 2000s, with the unmet need being about 35 percent (nearly twice that of Nigeria). However, by 2011, Rwanda had reduced its unmet need to 20.8 percent, nearly catching up with Nigeria's 19.4 percent for that year. But unlike Nigeria, Rwanda then continued to decrease its unmet need for contraception, reaching 18.9 percent in 2015 and 13.6 percent in 2000. Even though the World Bank (2025) has data for the world average unmet need for only one year (2000), in which it stood at 12.5 percent, comparing this with the data provided in Figure 7, it is reasonable to conclude the both Nigeria and Rwanda had and continue to have higher unmet need for contraception than the world average.

Figure 7: Unmet Need for Contraception in Nigeria and Rwanda, all available years



Source: Created by author based on World Bank (2025).

V. Ethical Analysis

The ethical analysis is divided into three subsections. The first subsection summarizes the key elements of the family planning programs in Nigeria and Rwanda. The second subsection discusses how family planning programs can be linked to Mitchell (1994)' five approaches for women in development. The third subsection looks into applying these approaches to family planning programs of Nigeria and Rwanda.

V.1. Key Elements of Nigeria's and Rwanda's Family Planning Programs

According to the website of the United Nations Population Fund Nigeria,[3] the Nigerian government committed to providing free access to family planning commodities with the goal towards achieving a contraceptive prevalence rate of 36 percent by 2018. However, as was shown above (Figure 6), the Nigerian government did not achieve this goal as the contraceptive prevalence rate was still 12 percent (one third of the goal) in 2018. The website of the United Nations Population Fund Nigeria also outlines how the Nigerian government plans to accomplish this:

- Build effective supply chain management for the supplies.
- Procure and distribute family planning supplies including commodities needed for Intrauterine devices (IUDs) and other equipment.
- Build capacity of health providers on family planning technology and client-friendly clinics.
- Support local NGOs and other organizations that demand the creation of family planning services and how to execute culturally acceptable interventions.
- Promote country engagement and promote integrated service delivery approach for Maternal Newborn and Child Health.

Nigeria's program has to do with building the foundational structures of family planning programs. However, the supply chain, obtaining the contraceptives, and building family planning facilities are both at early stages and so far, Nigeria's family planning program has not been effective. Ishaku et al. (2018) state that one key factor for Nigeria's failure with family planning is social norms and stigmas surrounding contraception and reproductive health. Ishaku et al. (2018) studied Nigeria along with Senegal and Kenya and found that while all the countries were optimistic about the implementation of their programs, there were many taboos around male healthcare providers with female patients and women touching their private parts to insert devices themselves. Both of these taboos provide barriers to communities implementing family planning programs and receiving the care they need.[4] Furthermore, Amiesimaka and Payam (2024) state that culture around family planning is another barrier. They find that family planning is seen as something women have to take care of themselves instead of something that should be addressed on a larger scale. These attitudes create imbalances that hamper women's access to family planning efforts.[5]

On the other hand, Rwanda's family planning program is considered to have been effective, as was confirmed by the analysis provided in the previous section of this article. According to the website of the United Nation Population Fund Rwanda,[6] Rwanda's goals for the future of its family planning program are to:

- Reduce the unmet need for family planning among all women, not just married women.
- Increase the usage of family planning among married women to 65 percent.
- Increase the percentage of women accepting family planning after delivery.
- Decrease the teenage pregnancy rate.

[3] https://nigeria.unfpa.org/en/topics/family-planning-26.
[4] Ishaku et al. (2018).
[5] Amiesimaka and Payam (2024).
[6] https://rwanda.unfpa.org/en/topics/family-planning.

These goals show that Rwanda has a family planning program that has been succeeding for many years, at least partly due to the overall positive attitude of the Rwandan government and people towards family planning.

May (2017) states that one of the major contributors to the success of family planning programs is the structure, leadership, funding, and attitudes or culture surrounding family planning. Schwandt et. al (2018) found that when asked why Rwanda's family planning program was so successful experts credited the strong leadership of the government to implement and run the program effectively, funding from outside sources, and collaboration with local leaders. Schwandt et al. also state that the Rwandan government views family planning as an essential step to becoming more economically developed. They call Rwanda a model for family planning programs especially in SSA. Although Rwanda still has goals to further improve, many other countries could learn from Rwanda what to do for their own family planning programs.

V.2. Ethical Frameworks for Family Planning

In order to properly examine the family planning programs, an ethical lens is needed. Before examining family planning related to ethical approaches to women in development outlined in Mitchell (1994), it needs to be recognized first of all that based on the Program of Action adopted by 179 governments attending the International Conference on Population and Development in 1994, family planning and reproductive rights are human rights.[7]

Mitchell (1994) outlined an ethical approach to studying development as it applies to women. Her three criteria for an ethical approach to development for women include the empowerment of women, the need to address strategic concerns (poverty, industrialization etc.), and a gender analysis within the design of development projects. This gives insight into whether the programs are helpful to women and whether the program is addressing women's issues in an ethical manner. She also advocated against the idealization of traditional lifestyles as being women-centered, saying that are not helping women and are not ethical.

Mitchell (1994) also refers to five approaches to women in development as attitudes programs take by attempting to enhance the development of women, which are the welfare approach, the efficiency approach, the anti-poverty approach, the equity approach, and the empowerment approach. Mitchell (1994) provides some valuable tools for evaluating the approach any program may use. The approaches could be reflective of the society's attitudes towards women and towards women's influence in the economy and development.

- The welfare approach considers women recipients of aid or charity rather than active participants in the process of development. An example of this would be directly giving cash to women. To the degree that family planning benefits women, family planning programs could be considered within the welfare approach.
- The efficiency approach is based on the economic rationalist line that investments are made in women so they will be more productive in the economy. An example of this would be introducing an employment program for women. To the degree that family planning programs allow women to contribute to the economy by working instead of taking care of children, family planning programs could be considered within the efficiency approach.

[7] United Nations Population Fund (n.d.).

- The anti-poverty approach states women are the poorest of the poor and links women's poverty to unequal ownership of land and resources. An example of this would be small-scale credit programs or other economic programs for women. Though there is some agreement among development economists that high population growth and poverty constitute a vicious cycle, there is limited way to consider family planning programs within the anti-poverty approach.
- The equity approach is similar to the anti-poverty approach but goes beyond economic to political, social, and cultural changes. An example of this would be literacy training or voting registrations programs for women. While family planning programs can have broader benefits for women, social and cultural changes are typically seen as barriers to family planning.
- The empowerment approach recognizes that women need to gain power over their lives through rooting out oppressive systems. An example of this would be expanding women's lobbying groups and addressing their concerns in the government.[8] There is little doubt that family planning programs typically empower women, and hence, the two go hand in hand.

V.3. Application to Nigeria's and Rwanda's Family Planning Programs

This subsection applies Mitchell's (1994) ethical framework for assessing gender related development programs to Nigeria's and Rwanda's family planning programs. The programs will be compared to the criteria for the ethical implications.

Nigeria's family planning program reflects the welfare approach. Nigeria's goals are to build the facilities to distribute contraceptives, not women getting involved in the economy, fighting for equality, or feeling empowered. There are no other economic or social aspects to the program at this point, they are trying to build the foundations to get the contraceptives to people who want them. Nigeria also does not meet Mitchell's criteria for an ethical family planning program. The program goals outlined by the United Nation Population Fund (see the previous subsection) did not include anything about empowering women or addressing issues that overlap with women's issues like poverty, urbanization, etc. Also, the program does not gear towards women's needs.

On the other hand, Rwanda's family planning program can be considered to be in line with Mitchell's efficiency approach. According to Schwandt et. al (2018), Rwanda views family planning through a social lens as a way to improve overall health, and through an economic lens. They write (p. 2):

> The Rwandan Government maintains an aggressive approach to the stated goal of reaching middle-income country status, and views family planning as an integral part of the strategy to grow the nation's economy.

Since they are implementing the family planning program with the intention of women contributing to the economy and overall economic advancement of the country, the program can be considered to follow an efficiency lens. However, according to an undated United Nation Population Fund outline of Rwanda's family planning program, Rwanda is shifting in the direction of the equity or empowerment approaches. Some of their goals include to integrate sexual

[8] Mitchell (1994).

education into schools, integrative sexual health and reproductive rights into economic initiatives to empower people to make informed decisions, and delivering reproductive health services into humanitarian settings. These initiatives go past the initial steps of distributing contraceptives and teaching people how to use them. This is integrating family planning and reproductive health as an integral part of society and culture. This provides women more equality socially and empowers them to take control of their futures by planning when they want to be mothers.

Rwanda's family planning program can also be considered to be in line with the Mitchell's empowerment approach.[9] The attitude and investment in family planning led to a very successful program that effectively increased their contraceptive prevalence, decreased their fertility rate, and contributed to increase in overall human development, all which empowered women. It also empowers vulnerable populations like teenagers and women in rural areas. Rwanda's family planning program is also aware on gender issues and includes women's needs in the program. They use current research for how to structure and run their program and receive significant funding from outside international organizations and NGOs to continue expanding their program.[10]

VI. Conclusion

Rwanda and Nigeria are similar in being lower-middle income countries in SSA. Both are below world average in terms of human development. Despite this, one of their major differences is their family planning programs. Nigeria is in the early stages of implementing a national family planning program and has not met the ethical standards set up by Mitchell (1994). Rwanda, on the other hand, is much more advanced in their family planning, with major improvements to their contraception use and lower fertility rates over the past 20 years.

Looking forward, countries that want to implement successful family planning programs should take notes from Rwanda. They have strong networks of funding to bring the supplies in, structure to make sure people who need it receive it, and leadership to navigate the challenges of running the program. Another important aspect is the integration of family planning to the culture. If family planning is viewed as a way to improve health for everyone and a way to empower women, then it will be more successful. SSA, including Nigeria, needs to embrace family planning as a way to not only slow population growth but grow their economy, improve health standards, and empower women to make choices about their own lives and futures.

References

Amiesimaka, Obreniokibo Ibifubara and Shahin Payam (2024). Family planning policy and gender in Nigeria: A thematic analysis of the government's Health Policy Perspective. *Sociology of Health & Illness*, Vol. 47, No. 2 (February), e13853; available at: https://onlinelibrary.wiley.com/doi/full/10.1111/1467-9566.13853.

Hutchinson, Paul L; Udochisom Anaba; Dele Abegunde; Mathew Okoh; Paul C. Hewett; and Emily White Johansson (2021). Understanding family planning outcomes in northwestern Nigeria: analysis and modeling of social and behavior change factors. *BMC Public Health*,

[9] Schwandt et al. (2018).
[10] Schwandt et. al (2018).

Vol. 21, No. 1168; available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC8212536/pdf/12889_2021_Article_11211.pdf.

Ishaku, Salisu M.; Nafissatou Diop; Babacar Mané; Wilson Liambila; Saumya Rama-Rao; Heather Clark; Harriet Birungi; Godwin Unumeri; and Francis Obare (2018). Introducing the Progesterone Vaginal Ring (PVR) as a New Option for Postpartum Family Planning in Sub-Saharan Africa: Insights from Engagements with Stakeholders. *African Journal of Reproductive Health*, Vol. 22, No. 2, pp. 68–75.

May, John F. (2017). The Politics of Family Planning Policies and Programs in Sub-Saharan Africa. *Population and Development Review,* Vol. 43, No. S1, pp. 308–329.

Mitchell, Suzette (1994). The Ethics of Development for Women. *Development Bulletin* (of the Australian Development Studies Network), Vol. 30, April Issue, pp. 40–42.

Rugigana, Etienne; Jeanine Condo; Robert Banamwana; and Daphrose Nyirasafari (2019). National Study in Rwanda Family Planning Barriers. *Rwanda Public Health Bulletin*, Vol. 1, No. 1 (March), pp. 31–32; available at: https://rbc.gov.rw/publichealthbulletin/img/rphb_issues/6c778cda88bf24a024e6b56f4d3945f41564438202.pdf.

Schwandt, Hilary M.; Seth Feinberg; Akrofi Akotiah; Tong Yuan Douville; Elliot V. Gardner; Claudette Imbabazi; Erin McQuin; Maha Mohamed; Alexis Rugoyera; Diuedonné Musemakweli; Cliff Wes Nichols; Nelly Uwajeneza Nyangezi; Joshua Serrano Arizmendi; Doopashika Welikala; Benjamin Yamuragiye; and Liliana Zigo (2018). Family Planning in Rwanda is Not seen as Population Control, but rather as a Way to Empower the People: Examining Rwanda's Success in Family Planning from the Perspective of Public and Private Stakeholders. *Contraception and Reproductive Medicine*, Vol. 3, Article No. 18; available at: https://link.springer.com/article/10.1186/s40834-018-0072-y.

United Nations Population Fund (n.d.). International Conference on Population and Development. United Nations Population Fund, website resource; available at: https://www.unfpa.org/icpd.

World Bank (2025). *World Development Indicators database* (Washington, DC: The World Bank); as posted on the World Bank website: https://datacatalog.worldbank.org/home (downloaded on January 4, 2025).