sired family size. The very limited literature on this subject has yielded two hypotheses about the underlying mechanism for such a link.

* The costs of contraception affect preferences. According to Easterlin’s widely used framework for the determinants of fertility, the demand for children and the costs of contraception both affect fertility, albeit independently. The former is determined by social and economic factors as well as child mortality; the latter is affected by a range of factors (e.g., lack of knowledge, costs of travel, contraceptive commodities and providers, objections from husbands or family, fear of side effects). Robinson and Cleland have examined this issue and concluded that the assumption of independence is questionable. They argue that when the overall costs (including social, economic and health) of regulating fertility are high, the demand for fertility limitation is weak, because there is little point in aiming for a goal that cannot be implemented without great difficulty (e.g., by abstinence). In contrast, reduced costs allow couples to reassess, reaffirm and more readily attain their fertility preferences. Although this conclusion seems reasonable and plausible, Robinson and Cleland have not provided direct empirical evidence to support their claim.

* Information education and communication programs. Family planning programs generally use education and communication programs to provide women with information about birth control methods and where and how to obtain them. This information increases the social acceptability of birth control and counters unfounded rumors and negative perceptions of methods. Information, education and communication programs also explain the advantages of small families. Their messages, especially on radio and television, appear to have had a substantial impact on fertility preferences. This impact seems to have been increased by strong and visible government support, as the previous case studies have illustrated.

Unfortunately, available survey data do not allow the accurate estimation of the contribution these mechanisms have made to declines in family size preferences in many countries.

**Conclusion**

In the past 50 years, a reproductive revolution has swept through much of the developing world, leading to large fertility declines in Asia, Latin America and North Africa. In contrast, fertility declines in Sub-Saharan Africa have been small on average, and the continent’s total fertility has remained higher than five births per woman. Hence, its population has more than quadrupled between 1950 and 2010 and is expected to double again by 2050. These demographic trends in Sub-Saharan Africa have raised concerns about their potential adverse impact on health, social and economic development and the environment.

Such concerns have led to investments in family planning programs, especially in Asia, Latin America and North Africa, where levels of unwanted and unplanned childbearing, and an unsatisfied demand for contraceptives have been well documented. Family planning programs allow women and men to control their reproductive lives, thus improving their family’s welfare and benefiting their country’s economy and environment. International consensus on this issue is reflected in the UN Millennium Development Goals, specifically Target 5B—to provide universal access to reproductive health by 2015 and to reduce the unmet need for family planning.

Despite the well-recognized benefits of family planning programs, policymakers in Sub-Saharan Africa have made limited investments in them; one key reason is the AIDS epidemic, which has caused many deaths. However, early predictions of the decline of Africa’s population have not been realized; the epidemic has peaked and its demographic impact has been limited, partly because of widely available antiretroviral treatment.

A second reason for limited investments in family planning is the belief that it cannot succeed given Africa’s cul-