

Contraception Availability and Population Growth in Cameroon and Zimbabwe

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Abstract

This article examines the relationship between access to contraceptives and population growth rates in Cameroon and Zimbabwe. Although these two countries share the same continent, their individual progress on offering contraceptives to their citizens varies greatly. In Cameroon, the national health care system is largely ineffective and less enthusiastic regarding the use of Western Medicine, failing to offer sexually active women the resources they need to control both rampant rates of sexually transmitted diseases and overwhelming birth rates. In Zimbabwe, the situation is very different as there are (a) much easier access to contraceptives, (b) well-defined birth control policies and (c) a government emphasizing the benefits of contraception use to improve the lives of its citizens. This article aims to highlight the ongoing relationship between contraceptive availability and birth rates.

I. Introduction

Cameroon and Zimbabwe are both developing countries in Sub-Saharan Africa. Cameroon is a lower-middle income country in West Africa, while Zimbabwe is a low-income country in Southern Africa. However, their stances and actions related to contraceptive use are very different. Furthermore, given that contraceptive use, when effectively promoted, can have significant effects on lowering population growth, these countries' attitudes related to contraceptive use have powerful implications. Today, Cameroon tends to adhere to long-standing pro-natalist population policies, while simultaneously providing few family planning and contraceptive services to its citizens, ultimately creating the perfect environment for large population growth to occur. Zimbabwe, on the other hand, has demonstrated almost the opposite, making family planning a large priority and adopting a community-based contraceptive distribution program.

Following this introduction, this article will provide a brief literature review, followed by some empirical background information on both countries. The subsequent discussion section will focus on four different aspects, drawing a link between contraceptive availability and population growth. The first sub-section of the discussion section looks into the historical context of contraceptive availability and population policies, and how those continue to influence policies and practices

today. The second sub-section discusses education, and how education levels correlate to contraceptive use. The third sub section looks at contraceptive availability in both countries; in addition to how often citizens take advantage of these contraceptive methods. The fourth sub-section discusses conventional family structures in sub-Saharan Africa, and how these tend to promote high birth rates. Finally, the last section of the article will provide some conclusions and suggestions for future measures that both countries can take.

II. Brief Literature Review

When looking at contraceptive use in correlation to population growth rates, a variety of factors must be considered to develop a thorough understanding of the relationship between the two. This brief literature review focuses on societal differences between Cameroon and Zimbabwe that influence contraceptive patterns, in addition to providing relevant historical context for related policies that are in place today.

- Akim Mturi and Kembo Joshua (2011) give a brief history of family planning efforts in Zimbabwe and how they have impacted fertility rates today. They discuss how shortly after gaining independence, in 1981, the new government took over the prior Family Planning Association of Rhodesia (FPAR) and changed it to become the Zimbabwe National Family Planning Council (ZNFPC) in 1984. The authors credit the success of ZNFPC to high governmental commitment, in addition to instituting different laws and policies to encourage the use of family planning, indiscriminate of economic status.
- A 1999 report by the Center for Reproductive Law and Policy (CRLP) and the Association of Women Jurists of Cameroon (ACAFEJ) provides information on Cameroon's past population policies that may have affected current fertility and contraceptive use rates. According to the report, Cameroon's population policies were pro-natalist at least until the 1980s. However, due to high, unwanted birth rates under this pro-natalist policy, the Cameroonian government switched its position in 1998 to lower the unwanted birth rates. To accomplish this the government stressed a limitation on resources to support large families, in addition to supporting educative measures surrounding family life, sexual education and educating citizens about birth control. However, as the report shows, there is a wide gap between the laws and policies affecting women's reproductive lives and the reality of women's reproductive lives in Cameroon.
- In looking at fertility rates and contraception usage between both countries, family planning measures must be taken into consideration as well. Ajong, et al (2016) discusses the current determinants of unmet need for family planning. On a more global level, these commonly include factors including age, marital status, religious statutes, education level, occupation and income. However, Ajong, et al found that the determinants most important when considering Cameroon include total number of pregnancies, number of children alive, approval of contraceptive use by the sexual partner, and discussing family planning within the couple.
- The study by Magure, Manene, Munjanja, Bradley and Mishra (2010) reviewed the trends in unmet need for family planning in Zimbabwe. Based on the further analysis of three consecutive Zimbabwe Demographic and Health Surveys (ZDHS) conducted in 1994, 1999, and 2005-06, they found that the groups within Zimbabwe that experience the highest unmet need include sexually-active women who have never been married, adolescents,

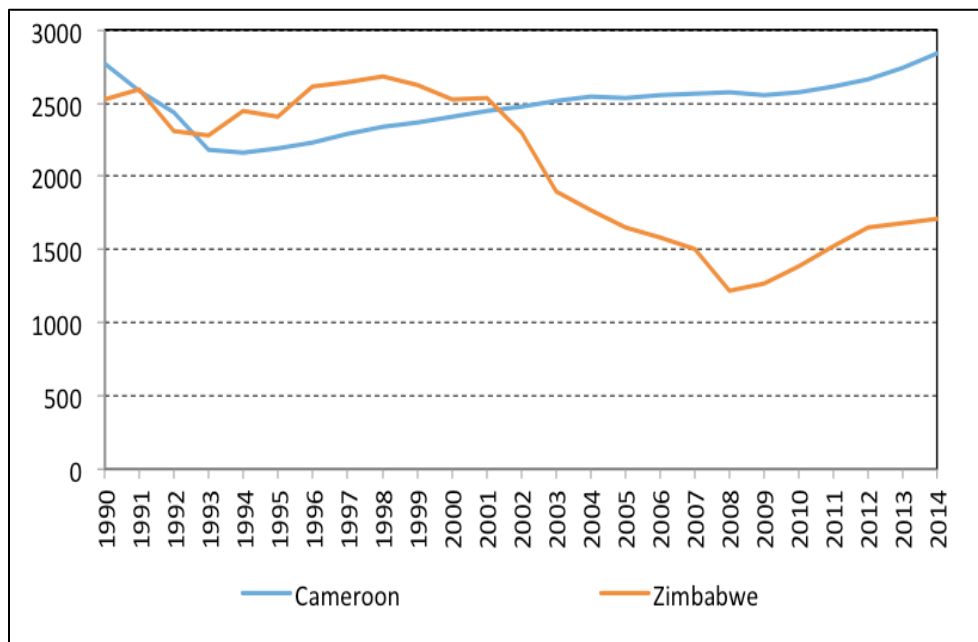
uneducated women, poor women, nulliparous women, and women in two Matebeleland regions. They came to the conclusion that “despite high contraceptive prevalence in Zimbabwe, subgroups of women with unmet need remain, particularly among marginalized women who may face barriers to family planning information and services.”¹

- A National Research Council (1993) Working Group on Factors Affecting Contraceptive Use examined the literature on the socioeconomic, social organizational, and family planning program factors that are related to contraceptive use in Sub-Saharan Africa. The report used a multivariate analysis to assess the relative importance of those factors that could be measured and for which data were available from surveys. Chapter 7 of the report assesses the relative importance of contraceptive use versus postpartum practices in inhibiting fertility in Africa. The report also explains that the HIV/AIDS epidemic can affect contraceptive use in two ways: In areas with high HIV/AIDS prevalence, families may reduce contraceptive use in order to have more children to increase the chances of having some surviving. On the other hand, efforts to slow the spread of HIV/AIDS may encourage increased contraceptive use.

III. Empirical Background

Prior to specifically focusing on contraception usage and its relationship to fertility and population growth in Cameroon and Zimbabwe, it is helpful to look first at the evolution of three basic socioeconomic indicators: purchasing power parity (PPP) adjusted gross domestic product (GDP) per capita, life expectancy, and poverty.

Figure 1: GDP per capita, PPP (constant 2011 international dollar), 1990-2014



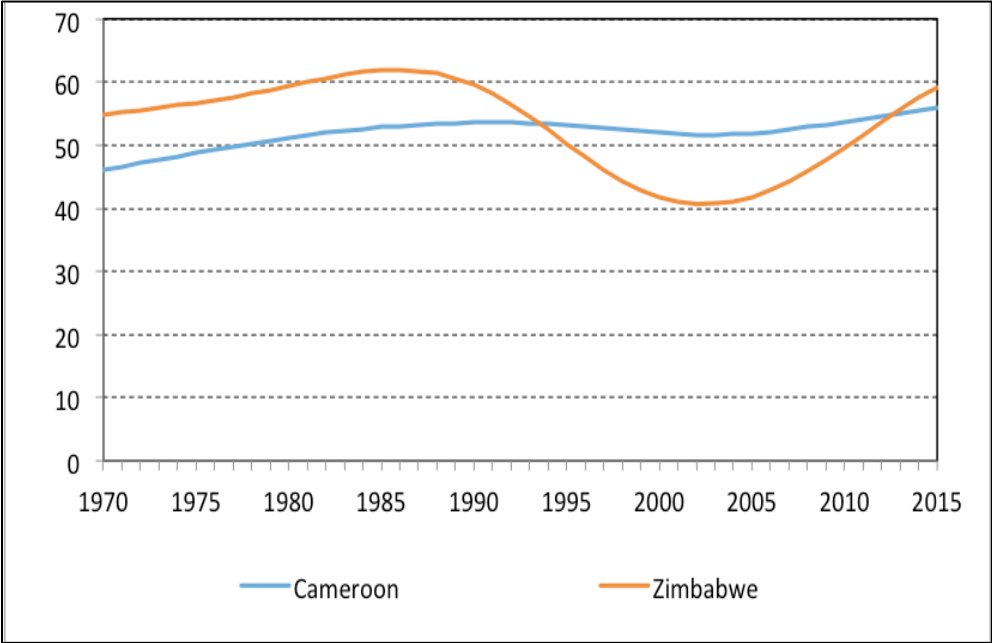
Source: Created by author based on World Bank (2016).

¹ Magure, Manene, Munjanja, Bradley and Mishra (2010), p. vi.

Figure 1 shows the disparities between Cameroon and Zimbabwe in terms of PPP-adjusted GDP per capita from 1990 to 2014. Cameroon started at a GDP per capita of \$2,768 in 1990, experiencing a decline in growth until 1994 when it reached a low of \$2,160. However, since then it has progressively grown, recently reaching \$2,835 in 2014. Zimbabwe started at a GDP per capita of \$2,526 in 1990, witnessing a significant decline until 2008 when it was \$1,218. Although it has begun to rise again, reaching \$1,709 in 2014, we can see that Cameroon is outperforming Zimbabwe by slightly over \$1,000 when looking at the most recent data available.

Figure 2 shows the life expectancy at birth for both Cameroon and Zimbabwe from 1970 to 2015. Cameroon’s average life expectancy started off at 46 years in 1970, and has since witnessed a long-term period of slow growth, reaching 55 years in 2015. Zimbabwe, however, exhibits a much different pattern. It started off at 54 years in 1970, peaking at 61 in 1986 and then experiencing a period of decline until 2002 when it bottomed out at 40 years. While there are a variety of factors that have contributed to Zimbabwe’s decline in life expectancy during the 1990s, the HIV/AIDS epidemic has been a major factor. In the 2000s, Zimbabwe’s average life expectancy has grown significantly, surpassing Cameroon in 2015 with an average of 59 years.

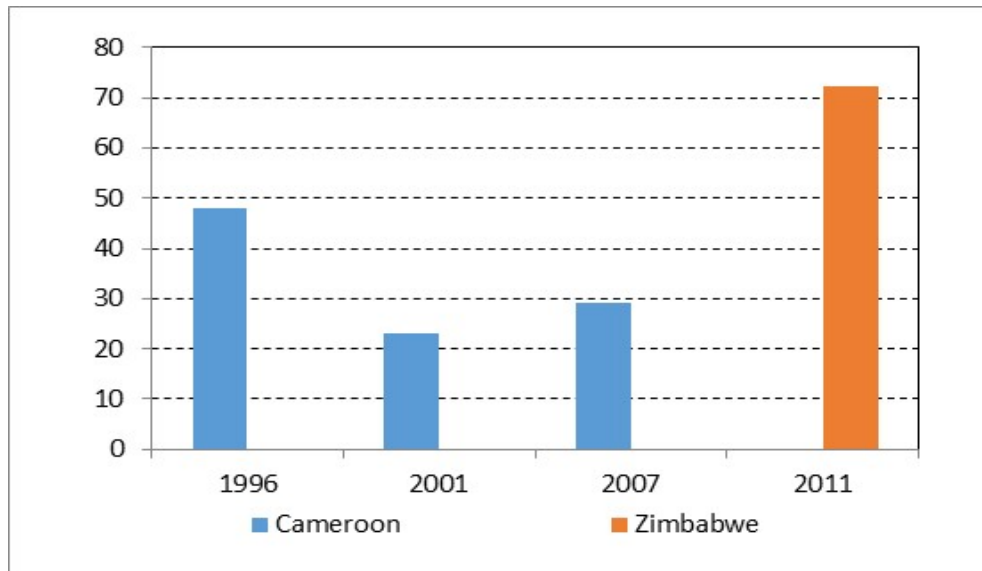
Figure 2: Life Expectancy at Birth, Total (years)



Source: Created by author based on World Bank (2016).

Finally, Figure 3 shows all available data on the percentage on people living in poverty in Cameroon and Zimbabwe. Using the international poverty line of \$1.90-a-day, it shows that nearly half of Cameroon’s population lived in poverty in 1996. The poverty headcount ratio then declined to 23.1 percent in 2001, but increased to 29.3 percent in 2007, which is the last year such data is available. In the case of Zimbabwe, the only available data on poverty is for 2011, when 72.3 percent of the population lived below the national poverty line.

Figure 3: Percentage of Population Living in Poverty (all available data)



Source: Created by author based on World Bank (2016).

IV. Discussion

Although many different factors contribute to contraception availability, which then influences fertility rates and population growth rates in Cameroon and Zimbabwe, this discussion session will focus on four issues: first, the historical context and influences on contraceptive availability; second, the role of education; third, the current contraceptive access and use; and fourth, the traditional family structure within these two sub-Saharan African countries.

IV.1. Historical Context and Influences on Contraceptive Availability

Looking into the history of contraceptive usage on a worldwide scale, a revolution took place from the 1960s onwards, with contraceptive prevalence rising from less than 10 percent in the early 1960s to approximately 55 percent in the late 1980s.² However, the situation was much different in Sub-Saharan Africa, a region that has typically been characterized by high birth rates and limited access to modern contraception, in addition to large rural populations, low socioeconomic development levels, high infant mortality rates, and deeply ingrained cultural values that encourage large family sizes.³ Therefore, as this contraceptive revolution took place, many African governments questioned the concept of limiting population growth and were skeptical of funding these programs given other problem areas throughout their countries that needed funding. Furthermore, in order to gain a better understanding of contraceptive availability and population growth in Cameroon and Zimbabwe today, it is crucial to look into their historical stances on these topics.

Looking at Zimbabwe, it is one of the few sub-Saharan countries that have demonstrated a long-term commitment to family planning and population control. Before gaining its independence from the British in 1980, the government did not have any formal population policies; instead

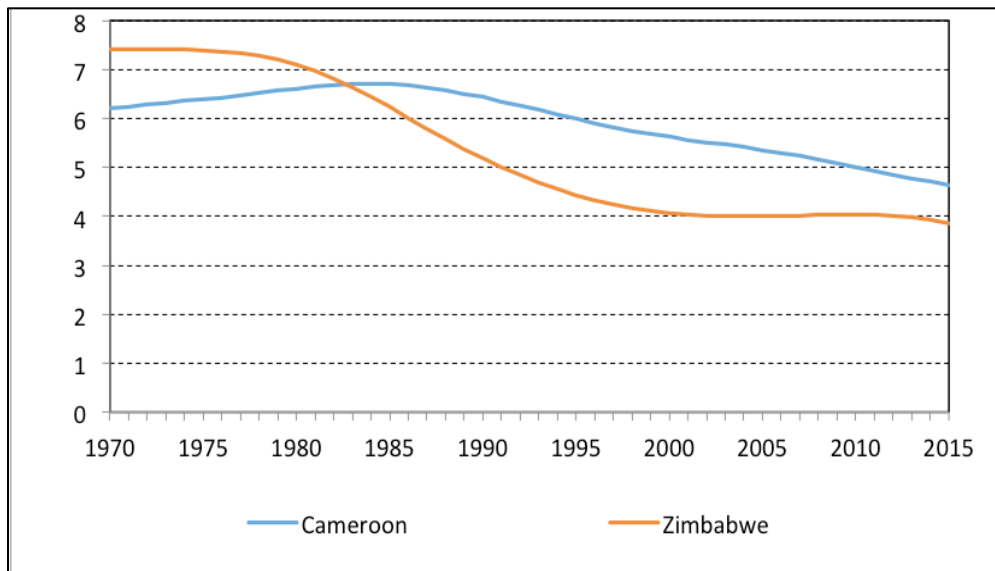
² National Research Council (1993).

³ National Research Council (1993).

encouraging the creation of family planning services. Beginning in the 1970s, mostly private and mission health facilities dispensed family planning information, while the government subsidized the private family planning association. However, after gaining its independence, actions taken by the country significantly shifted. In 1981, the Ministry of Health took on family planning activities as part of its child spacing program, and the Zimbabwe National Family Planning Council was formed, both making contraceptives more readily available and at fairly low prices. This early prioritization of making contraception available to citizens is expected to continue over the next years, making Zimbabwe a leader within the continent in this realm.⁴

According to the Report by the Center for Reproductive Law and Policy (CRLP) and the Association of Women Jurists of Cameroon (ACAFEJ) (1999), Cameroon’s history has adhered more to upholding the tradition of encouraging population growth and large family size. As the report states, Cameroon adopted a pro-natalist policy until the 1980s. However, after extremely high birth rates and large numbers of unwanted children, the government switched its position in 1998, attempting to decrease birth rates within the country. To succeed in this goal, government officials began emphasizing family life education, sex education and contraceptive education for community members. Additionally, in 1992 Cameroon instituted a National Population policy to improve the lives of its citizens, incorporating a specific measure to increase access to family planning services in rural and suburban areas. Overall, while Cameroon did eventually begin to focus on population control and contraceptive education, their efforts began much later than Zimbabwe’s, one of the potential reasons why contraceptive availability in the country, which will be discussed more in depth later on, is still lacking.

Figure 4: Total Fertility Rate (births per woman)



Source: Created by author based on World Bank (2016).

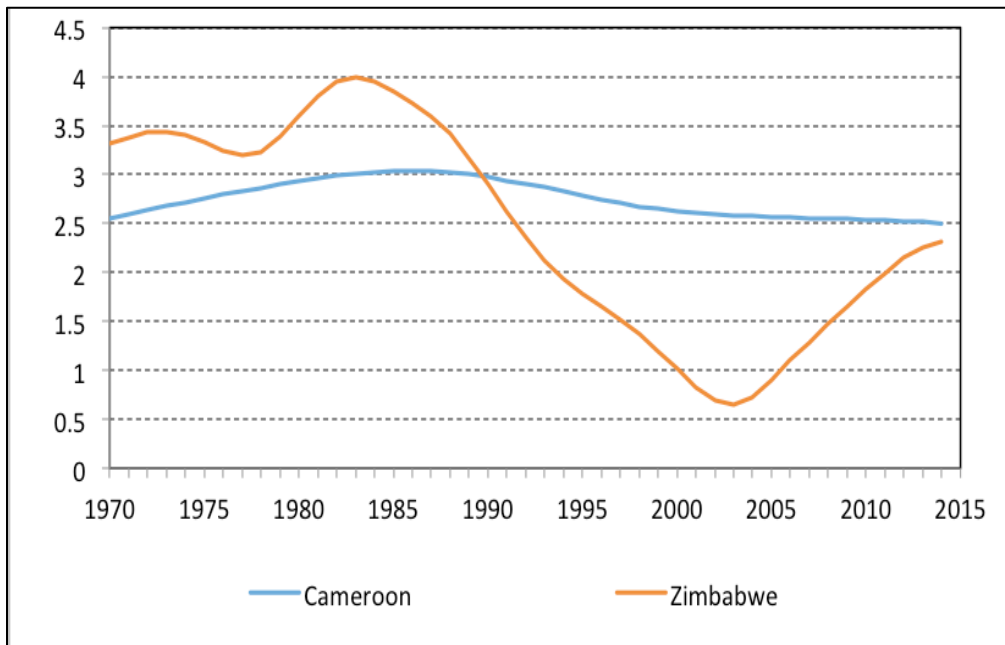
The effects of these historical policies and practices are reflected in the evolution of total fertility rates per woman shown in Figure 4. In Cameroon, fertility rates have decreased very moderately from 6.2 births per woman in 1970 to 4.6 births per woman in 2015. In contrast, Zimbabwe’s total

⁴ This paragraph is based on National Research Council (1993).

fertility rate has decreased much more drastically. As shown in Figure 4, starting at a very high rate of 7.2 births per woman in 1970, the country’s total fertility rate began to decline especially during the 1980s, which correlates to the country gaining independence in 1981 and the government taking over the Family Planning Association (as was already referred to in the literature review above). Though Zimbabwe’s fertility rates stabilized during most of the 2000s, they finally started to decrease once again in 2011, reaching 3.8 births per woman in 2015.

Another way to visualize the impact of family planning policies is by looking at population growth rates, though the HIV/AIDS epidemic is distorting the population growth rates especially in Zimbabwe. As shown in Figure 5, Cameroon’s population growth rates have been increasing from 2.55 percent in 1970 to 3.04 percent in 1986, after which they have been declining, reaching 2.50 percent in 2015. On the other hand, Zimbabwe’s population growth rates have been more volatile, and experiencing largely due to the HIV/AIDS epidemic a very drastic decline from 1983 until 2003.⁵ Due to the decline in HIV/AIDS prevalence rates, Zimbabwe’s population growth rates have started to increase since 2003, but remained at 2.3 percent in 2014 below those of Cameroon.

Figure 5: Population Growth (Annual Percentage)



Source: Created by author based on World Bank (2016).

IV.2. Role of Education

Education is critical in empowering women around the world, and consequently, leading to lower fertility rates and lower family sizes overall.⁶ Additionally, as the National Research Council

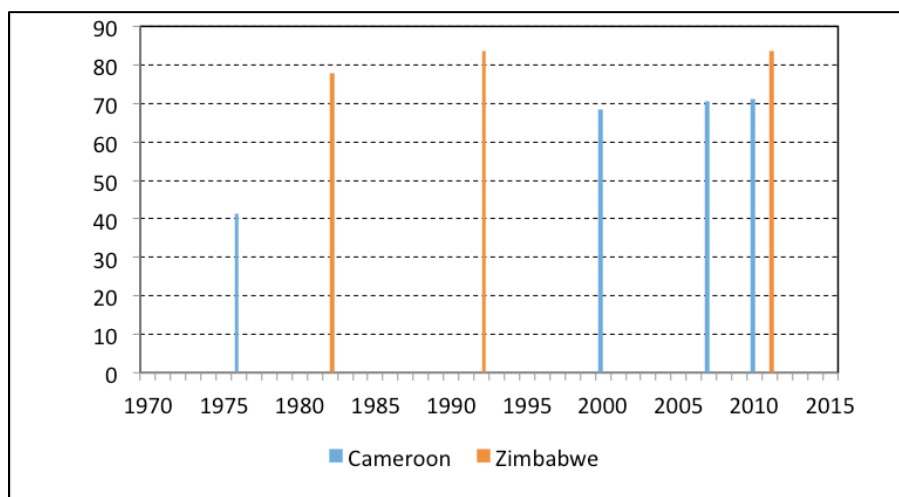
⁵ Zimbabwe’s HIV prevalence rates increased from the emergence of HIV/AIDS to a maximum of 29.6 percent in 1998, after which they gradually declined to 16.7 percent in 2014. Hence, HIV/AIDS is still a very serious issue in Zimbabwe.

⁶ See Nierenberg (2002) for further details.

(1993) points out, the use of modern contraceptives increases with education, and the use of modern contraceptives becomes even more likely if women attend post-secondary educational institutions. Therefore, providing citizens and specifically females with even a baseline education can be highly influential in determining birth rates and contraceptive usage.

Figure 6 shows the overall adult literacy rates between both countries. While the data is somewhat restricted, given that actual literacy rates are only available for 3-4 years each within both countries, an overall trend can ultimately be deciphered. From 1976 to 2010, Cameroon’s adult literacy rate rose from 41 percent to 71 percent, a 30 percent increase overall. Zimbabwe’s adult literacy rate began at 77 percent in 1982, rising to 83 percent in 2011, approximately a 6 percent overall increase. Although Zimbabwe’s rate increase is much smaller, its starting point of 77 percent already tops Cameroon at its end point in 2011 at 71 percent. This exemplifies that from early on, Zimbabwe’s population has been much more educated overall than that of Cameroon.

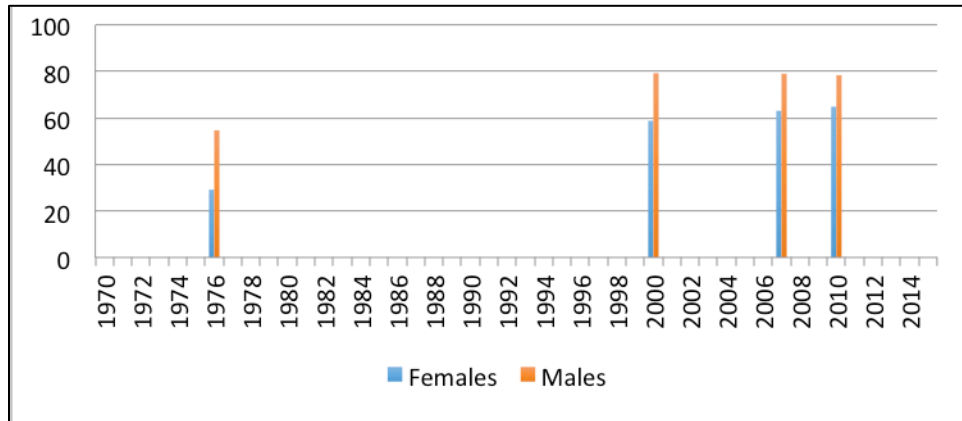
Figure 6: Adult Literacy Rate (percentage of both sexes ages 15+), all available data



Source: Created by author based on World Bank (2016).

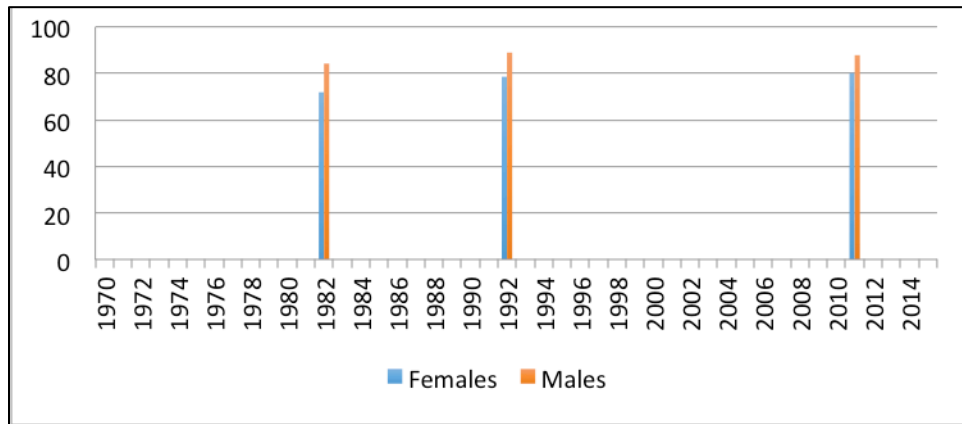
In addition to overall adult literacy rates, it is also important to understand how female literacy rates differ from those of males in both countries. Although education for both genders is important as they both factor into the family planning process, educating women is more crucial as they are the ones who will physically bear children if they choose to do so. Figure 7 highlights the disparities between male and female literacy rates in Cameroon. Although data is only available for four years, each one of these instances shows male literacy to be higher than female literacy. In 1976, the male literacy rate was 54 percent, while the female rate was only 29 percent. By 2010, these rates rose to 78 percent and 64 percent, respectively. Figure 8 shows the same data for Zimbabwe for all years available from 1970 to 2014. While the literacy rates are still higher for males at each of the three dates, the differences between the two genders are much smaller, ranging from 7 to 13 percent. Therefore, when comparing these two graphs, we can see that literacy rates and education are much more equal in Zimbabwe than Cameroon, likely contributing to lower population growth and fertility rates in Zimbabwe.

Figure 7: Cameroon’s Literacy Rate by Gender, Ages 15 and Above (percent)



Source: Created by author based on World Bank (2016).

Figure 8: Zimbabwe’s Literacy Rate by Gender, Ages 15 and Above (percent)



Source: Created by author based on World Bank (2016).

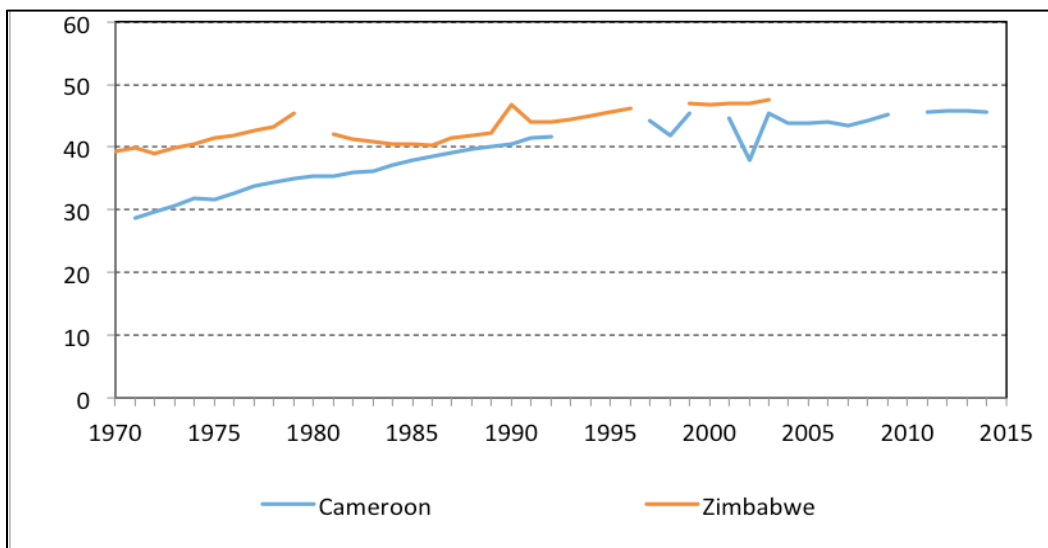
In addition to looking at literacy rates, it can also be revealing to examine the level of education that women in both Cameroon and Zimbabwe are obtaining. According to Demographic and Health Surveys and to the World Fertility Survey reports (two different methods of statistical analysis that have been carried out throughout different regions of sub-Saharan Africa), knowledge of modern contraceptive methods is strongly related to average female schooling levels.⁷ Therefore, even a slightly shorter duration in education could account for a much less comprehensive knowledge of possible and available contraceptive methods.

Figure 9 shows the percentage of students enrolled in secondary education institutions who are female between both countries. Beginning in 1971, Cameroon’s secondary education enrollment was 28 percent female. By 2012, this percentage had increased to 45, signifying a large-scale shift in educational gender representation throughout the country. Unfortunately, the data for Zimbabwe is slightly more limited. While they started off with a secondary education enrollment of 39 percent

⁷ See National Research Council (1993).

in 1970, the most recent available data indicates that this number has increased to 49 percent in 2012 (not pictured on the line graph). Based on this data, overall, women in Zimbabwe make up a higher share of enrollment in secondary education institutions by approximately 4 percentage points, giving them a small upper-hand in having more educated females, who are more likely to learn about and use contraception throughout their lives.

Figure 9: Percentage of Students in Secondary Education who are Female



Source: Created by author based on World Bank (2016).

IV.3. Current Contraceptive Availability and Usage

In addition to historical context and education, contraceptive access is obviously a key factor to consider in regards to population. Obviously, citizens in Cameroon and Zimbabwe cannot be expected to use of modern contraceptive methods if they are not able to get their hands on them, and therefore would continue contributing to higher population sizes without access. To provide a better idea of what the term “contraceptive” means, this article will first briefly explain what services and contraceptive methods are currently available in both countries.

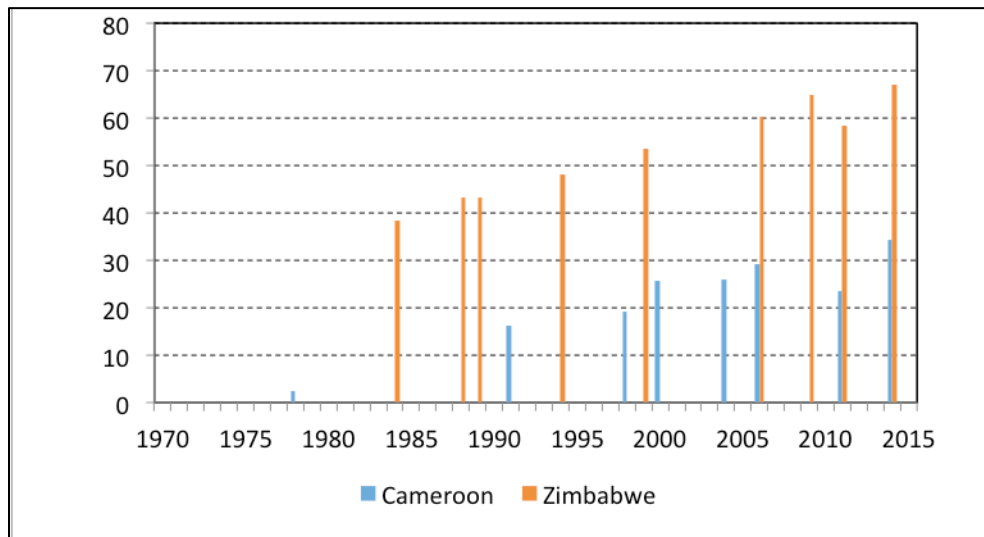
Since 1981 when the Zimbabwe National Family Planning Council (ZNFPC) was established, they have provided a wide range of services throughout the country. As of 1993, there were 37 operating Family Planning Clinics, which distributed oral contraceptives, condoms, intrauterine devices (IUDs) and injectables. Additionally, the country had two institutions in Harare and Bulawayo where citizens could receive tubal ligations, vasectomies and infertility counseling resources. Zimbabwe has also adopted a community-based distribution system, appointing 700 trained distributors to travel around different regions of the country and educate, motivate and provide citizens with oral contraceptives to use. Today, these resources have likely only grown, now leading researchers among the country to look into ways to best target specific population groups and adapt their system to be even more efficient, given that overall contraceptive accessibility has been accomplished within the country.⁸

⁸ This paragraph is mostly based on Manjanja (1993).

Unfortunately, specific information regarding which contraceptive methods are currently available in Cameroon is fairly scarce. In addition to weak political support for family planning programs, additional limitations including a lack of qualified personnel, limited information and publicity, poor management among existing family planning programs and low socioeconomic status provide some explanation and context for this lack of data.⁹ Therefore, while contraceptive prevalence and unmet needs will be discussed in the context of Cameroon shortly, specific methods remain vague.

Figure 10 contrasts contraceptive prevalence of any kind, as opposed to modern contraceptive methods (which will be further explained shortly) between the two countries. Looking at the earliest data available for Cameroon, we can see that in 1978 their contraceptive prevalence was only 2.4 percent. Growing to 34.4 percent in 2014, usage has skyrocketed over this 36-year period, signifying a small victory within the country itself. However, upon comparing Cameroon’s contraceptive prevalence to Zimbabwe’s, it becomes evident that Cameroon still has a long way to go in providing contraceptives for its female citizens. In Zimbabwe, the prevalence started at 38.4 percent in 1984, increasing to 66.9 percent in 2014. Therefore, Zimbabwe’s contraceptive prevalence is practically twice that of Cameroon, likely a large contributing factor to Zimbabwe’s slower population growth.

Figure 10: Contraceptive Prevalence, Any Methods (Percentage of Women ages 15-49)



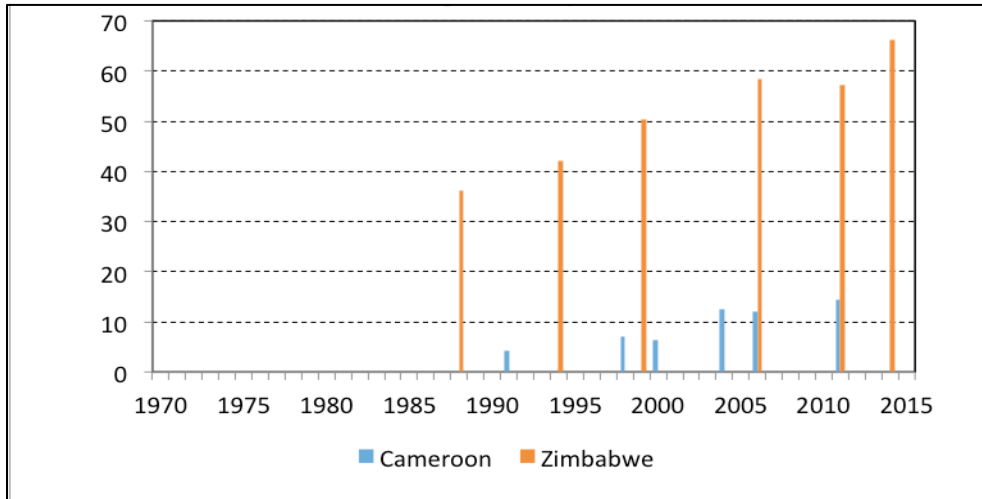
Source: Created by author based on World Bank (2016).

While Figure 11 is fairly similar to Figure 10 in terms of content, it differs in terms of one key aspect. Instead of looking at any contraceptive method, it looks at modern contraceptive methods (defined by the World Bank as including female and male sterilization, oral hormonal pills, the intra-uterine device (IUD), the male condom, injectables, the implant, vaginal barrier methods, the female condom and emergency contraception). The contrast between the two countries is even more extreme in this sense. By 2014, modern contraceptive prevalence was 14.4 percent in

⁹ Pillai and Teboh (2010).

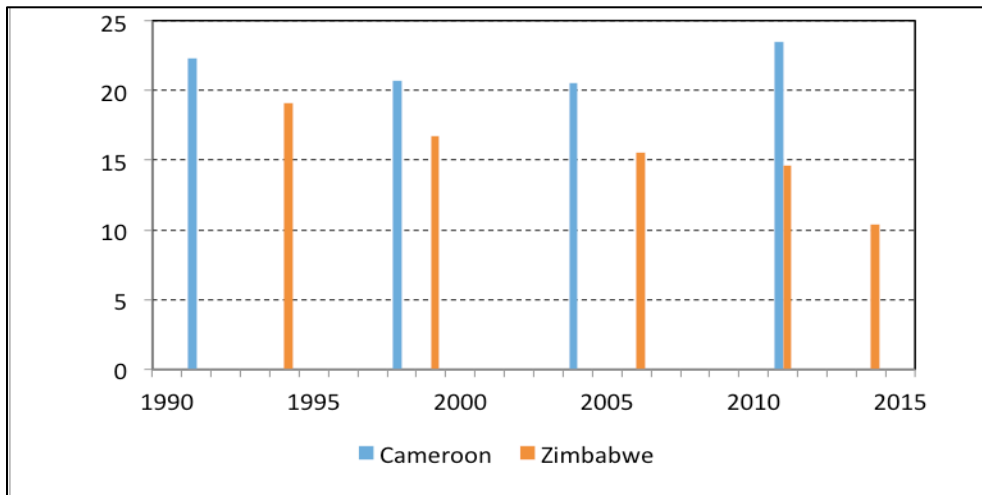
Cameroon and 57.3 percent in Zimbabwe, again demonstrating that Zimbabwe surpasses Cameroon by almost four times its rate. Additionally, it should be taken into consideration that these more modern methods of birth control are more likely to be tested, and therefore more likely to be effective in terms of preventing pregnancy as opposed to older, more traditional forms.

Figure 11: Contraceptive Prevalence, Modern Methods (Percentage of Women ages 15-49)



Source: Created by author based on World Bank (2016).

Figure 12: Unmet Need for Contraception (Percentage of Married Women ages 15-49)



Source: Created by author based on World Bank (2016).

As shown in Figure 12 above, Zimbabwe also has a lower unmet need for contraception among married women than Cameroon does. In 1991, Cameroon's unmet need for contraception was 22.3 percent. By 2011, it had increased to 23.5 percent, signifying a real problem within the country and providing an explanation for their ongoing population growth. Zimbabwe started with an unmet need for contraception of 19.1 percent in 1994, decreasing to 10.4 percent in 2014.

Therefore, while Zimbabwe has shown consistent progress over time in providing contraceptive measures to its constituents, Cameroon has continued to struggle.

IV.4 Traditional Family Structures

Dating back hundreds of years, African countries have commonly exhibited pronatalist policies, relating to kinship and in favor of keeping lineages and systems of descent intact (National Research Council, 1993). It is also evident by looking at many of these countries today, that these policies and ideals remain valued among citizens, simultaneously supporting high fertility rates (National Research Council, 1993). Given that these values are still highly visible, we must consider their influence in Cameroon and Zimbabwe to see if they can explain both countries' population growth.

Today, socio-cultural factors such as traditional beliefs, gender roles and religion greatly contribute to unmet contraceptive needs in Zimbabwe. Large families are seen as a source of strength and wealth, leading couples to have more children to raise their own social ranking within their respective communities. Additionally, there is great importance placed on giving birth to a male child, as they will eventually become the successors to any empires or lines of lineage that many elders in Zimbabwe value highly. Therefore, when considering these two factors, they clearly perpetuate and promote high fertility rates among women to secure a comfortable social status in comparison to others.¹⁰

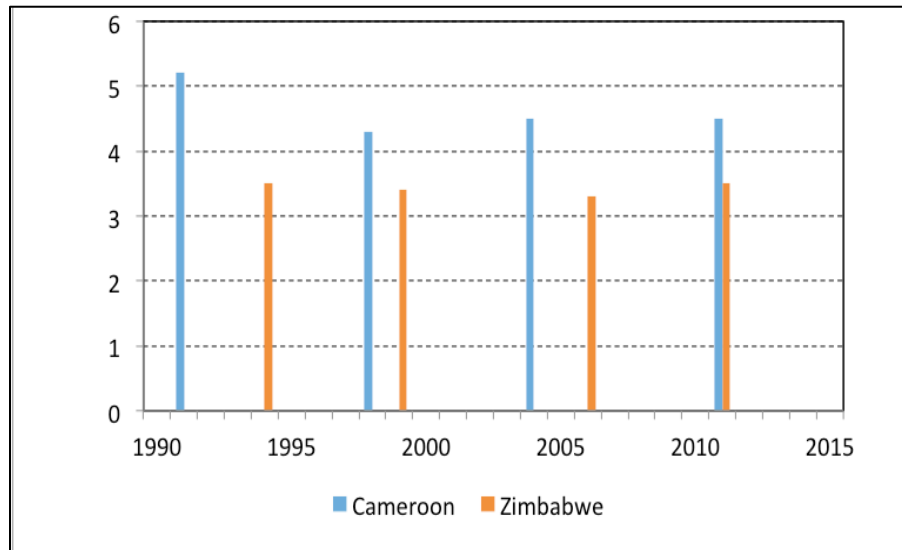
In Cameroon, similar beliefs and traditions prevail throughout the country today. Except for one ethnic group in Cameroon who is matrilineal -- the Kom people -- Cameroonian society overall is mainly patriarchal. Because there is a strong preference to give birth to sons, many women continue getting pregnant until have a boy, creating bigger families and higher population rates in the process. Additionally, this desire to have a son often influences contraceptive use, making women more unlikely to take advantages of contraceptives available to them due to these cultural pressures of having male children.¹¹

Figure 13 helps understand the desired family sizes that are common in Cameroon and Zimbabwe by looking at wanted fertility rates in each country. According to the World Bank (2016), wanted fertility rate "is an estimate of what the total fertility rate would be if all unwanted births were avoided." In Cameroon, the wanted fertility rate was 5.2 percent in 1991, decreasing slightly to 4.5 percent in 2004 and leveling off from there. In Zimbabwe, the wanted fertility rate was 3.5 percent in 1994 and despite some slight wavering in 1999 and 2006; it remained at 3.5 percent in 2011. Therefore, we can see that Cameroon continues to demonstrate a higher preference to have more children in comparison to Zimbabwe by one percent overall.

¹⁰ This paragraph is based on Chitereka and Nduna (2010).

¹¹ This paragraph is based on Pillai and Teboh (2010).

Figure 13: Wanted Fertility Rate (Births per Woman)



Source: Created by author based on World Bank (2016).

V. Conclusion

For many people and policy makers today, dramatic population growth is seen as a threat, contributing to environmental degradation worldwide and to unsustainable development patterns in developing countries. Given the still low-income per capita levels and missing social security systems, it is unrealistic to expect zero population growth for both Cameroon and Zimbabwe. However, by comparing the patterns and strategies used by both countries, it is possible to identify realistic ways to curb high population growth rates further and to work towards a more sustainable global population size within the upcoming decades and centuries.

Based on the data presented in this article, we can assume that contraceptive availability and sufficient family planning procedures are correlated to lower population growth rates. Therefore, by providing political support and education regarding contraceptives, in addition to making sure that they are physically accessible, developing countries can reach their constituents and impact their contraceptive choices at a variety of different levels. Zimbabwe currently engages in all three of these previously mentioned practices, while Cameroon is essentially lacking in all of them. This explains why Zimbabwe's fertility rates have been declining considerably more over the past few decades than in Cameroon.

In terms of further steps to be taken in the future, different strategies should be used in each country. Since Zimbabwe's contraceptive presence and distribution system is fairly advanced today after decades of development, they can focus on reevaluating their system to see which members of their population, if any, are still being excluded or facing any remaining barriers that would deter them from taking advantage of these contraceptive measures. When looking at Cameroon, they could learn from Zimbabwe's success, taking measures such as subsidizing more contraceptive education programs and developing concrete, structured population policies to ensure that their population growth does not get out of control in the coming years.

Finally, something that both countries can work on is reevaluating the long-standing traditions of having large family sizes, and favoring male children, which perpetuates gender inequality and gender discrimination on a national level.

References

- Ajong, Atem Bethel; Phillip Nana Njotang; Martin Ndinakie Yakum; Marie José Essi; Felix Essiben; Filbert Eko Eko; Bruno Kenfack and Enow Robinson Mbu (2016). Determinants of Unmet Need for Family Planning among Women in Urban Cameroon: A Cross Sectional Survey in the Biyem-Assi Health District, Yaounde. *BioMed Central (BMC) Women's Health*, Vol. 16, No. 4, pp. 1-8; available at: <https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-016-0283-9>.
- Center for Reproductive Law and Policy (CRLP) and the Association of Women Jurists of Cameroon (ACAFEJ) (1999). *Women's Reproductive Rights in Cameroon: A Shadow Report* (1999). New York: The Center for Reproductive Law and Policy (CRLP); available at: www.reproductiverights.org/sites/default/files/documents/sr_cam_1199_eng.pdf.
- Chitereka, Jekoniya and Busiku Nduna, (2010). Determinants of Unmet Need for Family Planning in Zimbabwe. Liverpool, UK: Liverpool Associates in Tropical Health; available at: www.znfpc.org.zw/images/pdfs/unmetneed_for_family_planning_2010.pdf.
- Magure, Tsitsi M.; Tov Manene; Stephen P. Munjanja; Sarah E. K. Bradley and Vinod Mishra (2010). Trends in Unmet Need and the Demand for Family Planning in Zimbabwe. *Zimbabwe Working Papers*, No. 6. Calverton, Maryland, USA: ICF Macro; available at: <https://dhsprogram.com/pubs/pdf/WPZ6/WPZ6.pdf>.
- Manjanja, S. (1993). Zimbabwe: A Family Planning Profile. *Malawi Medical Journal*, Vol. 9, No. 1 (March), p. 37; available at: <http://www.ajol.info/index.php/mmj/article/viewFile/111016/100783>.
- Mturi, Akim and Kembo Joshua (2011). Falling Fertility and Increase in Use of Contraception in Zimbabwe. *African Journal of Reproductive Health*, Vol. 15, No. 2 (June), pp. 31-44.
- National Research Council; Division of Behavioral and Social Sciences and Education; Commission on Behavioral and Social Sciences and Education; Working Group on Factors Affecting Contraceptive Use (1993). *Factors Affecting Contraceptive Use in Sub-Saharan Africa*. Washington, DC: National Academy Press; available at: <https://www.nap.edu/catalog/2209/factors-affecting-contraceptive-use-in-sub-saharan-africa>.
- Nierenberg, Danielle (2002). *Correcting Gender Myopia* (Washington, DC: Worldwatch Institute); available at: <http://www.worldwatch.org/system/files/EWP161.pdf>
- Pillai, Vijayan K. and Consoler Teboh (2010). A Decade of Contraceptive Use in Cameroon: Influences of Structural Changes. *Open Access Journal of Contraception*, Vol. 2 (December), pp. 5-11; available at: <https://doi.org/10.2147/OAJC.S12621>.
- World Bank (2016). *World Development Indicators / Global Development Finance Database* (Washington, DC: The World Bank); as posted on the World Bank website: <http://data.worldbank.org/data-catalog/> (downloaded on June 28, 2016).