

Population Issues in the 21st Century

The Role of the World Bank

April 2007



POPULATION ISSUES IN THE 21ST CENTURY

THE ROLE OF THE WORLD BANK

April 2007

Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

POPULATION ISSUES IN THE 21ST CENTURY: THE ROLE OF THE WORLD BANK

Paper prepared as background for the
2007 Health, Nutrition and Population (HNP) Sector Strategy.

Abstract: The objective of this paper is to discuss some obstacles and opportunities presented by population processes in order to prioritize areas for investment and analytical work as background information for the 2007 HNP Sector Strategy. **Within HNP, two areas fall within population: (1) reproductive, maternal, and sexual health issues, and the health services that address them; and (2) levels and trends in births, deaths, and migration that determine population growth and age structure. Many of the aspects of delivery of sexual and reproductive health services are addressed in the overall sector strategy. This paper, therefore, focuses on the determinants and consequences of demographic change, and on policies and interventions that pertain to fertility and family planning.**

Fertility has declined in most of the low- and middle-income countries, with TFRs converging toward replacement level, except in 35 countries, mainly in Sub-Saharan Africa, where a broad-based decline in fertility has not occurred. As the priorities of donors and development agencies have shifted toward other issues, and global funds and initiatives have largely bypassed funding of family planning, less attention is being focused on the consequences of high fertility. Reproductive health is conspicuously absent from the MDGs, and assistance to countries to meet the demand for family planning and related services is insufficient.

The need for Bank engagement in population issues pertains to economic growth and poverty reduction, as well as inequities in terms of the impact of high fertility on the poor and other vulnerable groups. Evidence indicates that large family size reduces household spending per child, possibly with adverse effects on girls, and the health of mothers and children are affected by parity and birth intervals. Equity considerations remain central to the Bank's work as poor people are less likely to have access to family planning and other reproductive health services. Other vulnerable groups that are less likely to be served by reproductive health services include adolescents and rural populations. Additionally, improved education for girls, equal opportunities for women in society, and a reduction of the proportion of households living below the poverty line are necessary elements of a strategy to achieve sustainable reductions in fertility. The Bank has a comparative advantage to address these issues at the highest levels of country policy setting, and its involvement in many sectors can produce synergies that will allow faster progress than a more narrow focus on family planning services.

Keywords: population, reproductive health, family planning, demography, fertility.

Disclaimer: The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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TABLE OF CONTENTS

Foreword.....	vii
Acronyms and Abbreviations	viii
Acknowledgements	ix
1. Overview	1
2. The Demographic Context: Reviewing Challenges and Emerging Issues.....	4
Global Population Trends	4
Population Issues in High-, Medium-, and Low-Fertility Countries	7
Multisectoral Determinants of Fertility Change	13
What is Different in Sub-Saharan Africa?	15
3. Rationale for Bank’s Action.....	17
Population and Economic Growth	17
Population and Poverty Reduction.....	18
Population and Equity	19
Unsafe Abortion.....	26
Conclusions.....	28
4. Global Policy Context	29
A Brief History	29
Current Environment	29
Trends in Population Assistance	30
The World Bank’s Support for Population and Reproductive Health Activities.....	32
5. Future Directions for the Bank in the Population Field.....	36
Comparative Advantages of the Bank in Achieving HNP Results.....	36
Translating Theory to Practice.....	38
References.....	41
Annex 1. The Bank’s and Client Countries’ Activities to Address Population Issues: Review of CASs and PRSPs	45
Annex 2a. Total Fertility Rate and Total Population in High-Fertility Countries	50
Annex 2b. Total Fertility Rate by Background Characteristics for Selected High-Fertility Countries	51
Annex 2c. Reproductive Health Indicators for 35 High-Fertility Countries.....	52
Annex 2d. Reproductive Health Indicators for 35 High-Fertility Countries	54
Annex 2e. Reasons Provided by Women for Not Using Contraception.....	56
Annex 3a. Population Health Indicators.....	57
Annex 3b. Population Health Indicators	63
Annex 4. HNP Results Framework: Population and Reproductive Health Component	69
Annex 5. Millennium Development Goals	70

List of Figures

Figure 2.1 World Population by Region, 1960-2005.....	4
Figure 2.2 Trends in Total Fertility Rate by Region, 1950 -2005	5
Figure 2.3 Trends in Life Expectancy by Region, 1960 -2005.....	6
Figure 2.4 High-fertility Countries: Trends in Fertility Decline, 1950 -2005	8
Figure 2.5 Total Population Estimates and Projections with and without Fertility Decline for Mali, Uganda, and Niger, 1950-2050	9
Figure 2.6 Medium-fertility Countries: Trends in Fertility Decline, 1950-2005.....	10
Figure 2.7 Age-Sex Structure of Population of Honduras and Egypt, 2005 and 2030.....	11
Figure 2.8 Low-fertility Countries, 1950-2005.....	11
Figure 2.9 Age-Sex Structure of Population of Thailand and Ukraine, 2005 and 2030.....	12
Figure 2.10 Old Age Dependency Ratio: Trends in Selected Countries with Low TFR.....	13
Figure 2.11 Relationship between the Total Fertility Rate and Contraception Prevalence (Modern Methods)	14
Figure 2.12 Trends in Fertility Rates in Malawi and Kenya for Available Years	16
Figure 3.1 Total Fertility Rate by Region and Wealth Quintile	20
Figure 3.2 Contraceptive Prevalence Rate by Region and Wealth Quintile.....	20
Figure 3.3 Use of Basic Maternal and Child Health Services in 56 Low- and.....	21
Figure 3.4 Proportion of Demand for Family Planning Satisfied by Region and Wealth Quintile (DHS 1996-2004).....	21
Figure 3.5 Husbands Say No to Contraception.....	23
Figure 3.6 Total Fertility Rate by Region and Geographic Distribution for Select Countries	25
Figure 3.7 Contraceptive Prevalence Rate by Region and Geographic Distribution	25
Figure 3.8 Contraceptive Prevalence Rate in Selected Countries by Geographic Distribution....	26
Figure 3.9 Number of Legal and Illegal Abortions Worldwide, 1995.....	27
Figure 4.1 Expenditures for Population Activities as a Proportion of Total Population Assistance, 1995-2004	31
Figure 4.2 Trends in Other Population/Reproductive Health and HIV/AIDS Lending, 1997-2006	32

List of Tables

Table 2.1 The Demographic Divide: Nigeria and France.....	7
Table 2.2 Characteristics of Countries According to Fertility Levels	8
Table 3.1 Sexual Activity among Youth.....	24

List of Boxes

Box 1 Multisectoral Interventions and Synergistic Effect on Fertility in Ethiopia	14
Box 2 Bangladesh's Success in Reducing Fertility: Lessons Learned	15
Box 3 Coverage of Population Issues in CAS: Good Practice Examples.....	34
Box 4 Population Issues and PRSPs: Ethiopia as a Country Example	35

FOREWORD

This *Discussion Paper* was prepared as a background note for the 2007 World Bank Strategy for Health, Nutrition, and Population Results (the HNP Strategy). It covers, in greater detail than the HNP Strategy itself, recent changes in population trends, the relationship between reproductive health and poverty, and donor assistance to reproductive health programs in low- and middle-income countries. It also proposes future directions for the Bank, making a case for expanding support to family planning and other reproductive health programs, to strengthen access to reproductive health services for the poor, for adolescents, and for other vulnerable groups.

Reproductive health is central to human development, sustained economic growth, and poverty reduction. Neglecting critical areas such as family planning, sexual health, and maternal & newborn health would have catastrophic implications for countries. The current escalating HIV/AIDS epidemic, as well as the limited progress on MDG 5 bears testimony to this.

The World Bank endorsed the 1994 Cairo Consensus coming out of the International Conference on Population and Development (ICPD). Since then, global attention and resources for population issues have been declining, and an urgent response is now required on the part of the Bank, as well as from other development partners, to reposition family planning within the ICPD agenda. Within this changing context, this discussion paper sets out approaches for the Bank to re-engage with countries and other partners to accomplish this.

Going forward, a priority for the Bank will be the 35 countries that have the highest fertility rates, often showing little change over time. Analytical work is urgently needed to determine the cause of sustained high fertility, addressing, among others, unfavorable socioeconomic factors influencing household behaviors, as well as reproductive health services that do not adequately address needs. Such analytical work will be the basis for policy dialogue, to be reflected in key strategic documents, such as Country Assistance Strategies, Country Economic Memoranda, Public Expenditure Reviews, and Poverty Reduction Strategy Papers.

This discussion paper is intended to stimulate the debate on the way forward for improving access to family planning and comprehensive reproductive health services in low- and middle-income countries. This debate will be an important input for upcoming sector work for developing a more strategic approach for the Bank in this area.



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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CAS	Country Assistance Strategy
CEM	Country Economic Memorandum
CPR	contraceptive prevalence rate
DAC	Development Assistance Committee
DFID	United Kingdom Department for International Development
DHS	Demographic and Health Survey
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
ESW	Economic and Sector Work
EU	European Union
GNI	Gross National Income
HD	Human Development
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition and Population
ICPD	International Conference on Population and Development
IDA	International Development Association
IEC	information, education, and communication
IOM	Institute of Medicine
KfW	Kreditanstalt für Wiederaufbau
MDGs	Millennium Development Goals
NGO	non-governmental organization
NIDI	The Netherlands Interdisciplinary Demographic Institute
NORAD	Norwegian Agency for Development Cooperation
NRC	National Research Council
OECD	Organisation of Economic Co-operation and Development
PDS	proportion of demand being satisfied by family planning
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PPP	purchasing power parity
PREM	Poverty Reduction and Economic Management
PRSC	Poverty Reduction Strategy Credit
PRSP	Poverty Reduction Strategy Paper
SIDA	Swedish International Development Agency
STD	sexually transmitted disease
TA	Technical Assistance
TFR	total fertility rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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1. OVERVIEW

As part of the preparation of the World Bank's sector strategy for Health, Nutrition, and Population (HNP), this discussion paper identifies and analyzes population issues that were not covered comprehensively in the *Background Strategy Note (World Bank 2006c)* for the preparation of the strategy. These issues were raised during the review process as significant issues that need to be addressed by development partners in order to achieve sustainable development results.

The objective of this discussion paper is to review the obstacles to scaled-up development efforts presented by population processes. Some of these findings are expected to be integrated in the overall sector strategy, to be discussed by the World Bank Board during fiscal year 2007. The main goal of this discussion paper is to identify the comparative advantage of the Bank's HNP sector in order to prioritize some areas for investments and analytical work, and to assess where other sectors in the Bank and other development organizations are expected to play more prominent roles in their collaboration with national programs. The discussion paper will also consider which areas often described as within the realm of "population" are actually part of the HNP sector's comparative advantage, and which ones need to be addressed by other sectors and agencies.

The paper consists of five sections. First, this section defines the scope of population as used in the HNP sector, and the areas that will be considered in this note are specified. This is followed by a description of recent trends in demographic indicators that have created the demographic backdrops for addressing development issues. The third section discusses the role the World Bank can play in population issues and places population within the context of economic growth, poverty reduction, and equity considerations. The fourth section deals with the global policy context since the 1994 Cairo International Conference on Population and Development (ICPD) which has guided the priorities of developing countries and donors in the past 13 years. The final section discusses collaboration between World Bank and partner development agencies in addressing different aspects of population.

The term "population" covers a variety of topics. Within the HNP sector, two broad areas are most commonly thought of as population:

- Reproductive, maternal, and sexual health issues, and the health services that are concerned with addressing them;
- Levels and trends in births, deaths, and migration that determine population growth and age structure, and frequently have an impact on economic growth and other sectors.

These areas are closely related. Reproductive health services help people maintain good health, and are an important factor in helping couples plan the number of children they want to have, and the timing of their births. In the aggregate, individual decisions on the number of births determine the overall birth rate; in turn, the level of fertility will be a factor in the demand for reproductive and other health services.

Improving health outcomes is a major component of development strategies to address poverty, and the HNP strategy currently under preparation will focus on strengthening health systems to achieve better outcomes. As many of the aspects of effective delivery of reproductive and sexual

health services are related to overall health system strengthening, including human resources, financing, regulation, and management, these are being included in the overall sector strategy. This discussion paper, therefore, will focus mostly on the determinants and consequences of demographic change, and, specifically, on policies and interventions that have an effect on fertility and family planning. Other trends resulting from demographic processes, such as changes in the age structure resulting in large youth populations and rapidly growing elderly cohorts, will also be presented.

HNP is not the only sector with a stake in the growth, size, structure, and spatial distribution of populations. Some examples of other sectors for which population processes matter are education (the size of school-age cohorts), urban and rural development (rural to urban migration), social protection (labor markets, pensions), gender (women's empowerment), environment, and economic management. Moreover, these sectors deal with factors that influence the desired number of children and the effective use of modern contraception. Especially since the 1994 ICPD, it has been emphasized that factors such as gender equality, educational attainment, female labor force participation, infrastructure development, and poverty are important determinants of the demand for family planning and fertility.

The previous strategy note for population work in the World Bank was developed in the late 1990s, following on the 1997 HNP strategy (World Bank 2001). Much has changed since then. As section 2 documents, fertility has continued to decline in most of the low- and middle-income countries, with total fertility rates (TFRs) converging in many countries toward the replacement level of two children per couple, and sometimes below this. But an important exception to this trend is seen in 35 countries, mainly in Sub-Saharan Africa, where a broad-based decline in fertility has not occurred. As the priorities of donor countries and development agencies have shifted toward other issues, and global funds and initiatives have largely bypassed funding of family planning, less attention is being focused on the consequences of high fertility, even in countries that are lagging in achieving sustainable population growth. Reproductive health was originally absent from the Millennium Development Goals (MDGs), after having been dropped from the earlier set of International Development Goals¹, but targets of achieving universal access to reproductive health have now been included as part of MDG 5 on improving maternal health (White, Merrick, and Yazbeck 2006). Less assistance is now available to these countries to meet the growing demand for family planning and related services than in previous decades, indicating an urgent need to refocus the attention of donors on completing what has been called a “development success story” (World Bank 1994b).

As a result of past success in helping couples in low- and middle-income countries plan for and achieve the number of children they desire, new demographic patterns are emerging for which countries need to be prepared. In many countries where primary education has become universal, declining birth cohorts are reducing the demand for primary education, but large cohorts born 10 to 25 years ago are resulting in record number of adolescents and young adults, boosting demand for secondary and tertiary education. These age groups are entering the labor force in large numbers, and have reproductive and sexual health needs that are often inadequately provided for by existing health services (World Bank 2006b, 2007b). In countries in which fertility decline

¹ Action is now underway in the UN system to attach indicators to the new target of universal access to reproductive health under the Improve Maternal Health goal.

started early, the proportion of the elderly relative to the working-age population is projected to rise rapidly, potentially creating stresses on public health and social security systems. In some countries, fertility has dropped to such low levels that population is expected to decline, which will exacerbate the impacts of age structure changes. This paper will discuss how these new demographic patterns call for different sectors to engage with countries to prepare for and address the issues.

The discussion paper examines the linkages between population and development, as well as the rationale for the Bank's involvement in this area. Key reasons for the Bank's engagement in population issues pertain to economic growth and poverty reduction considerations, as well as inequities in terms of the impact of high fertility on the poor and other vulnerable groups. Recent research indicates that rapid population growth in low socioeconomic setting countries can place constraints on their economic growth. Hence, there is now greater agreement than before on the linkages between population dynamics and economic growth. On the other hand, the "demographic dividend" offered by a changing age structure that results in a "youth bulge" can provide a window of opportunity for accelerated economic growth. Though a causal relationship between high fertility and poverty reduction is difficult to establish, there is evidence that large family size reduces household spending per child, possibly with adverse effects on girls. Moreover, the health of both mothers and children are affected by parity and birth intervals, respectively, while large family size is known to sometimes reduce investments in children's education. Equity considerations remain central to the Bank's work as poor people are less likely to have access to family planning and other reproductive health services than wealthier people, because of both less knowledge and more financial and other barriers to accessing services. Other vulnerable groups that are also less likely to be served by reproductive health services include adolescents, rural populations, and other marginalized groups. Increasing the demand for family planning through better information and more accessible and responsive services remains an important aspect of population and reproductive health programs, and can have a sizeable impact on fertility rates, as discussed in section 2. But fertility decline cannot be achieved through better health services alone. Improved education outcomes for girls, equal opportunities for women in society, and a reduction of the proportion of households living below the poverty line are necessary elements of a strategy to achieve sustainable reductions in fertility.

The Bank has a potential comparative advantage to address these issues at the highest levels of country policy setting, not only with ministry of health counterparts, but also with officials from finance and planning. This is important given the increasing recognition that political economy is a critical factor in the implementation of population and reproductive health programs, particularly in high-fertility countries. Its involvement in many sectors in countries can produce synergies that will allow faster progress than a more narrow focus on family planning services. The Bank will need its partners – United Nations Population Fund (UNFPA), World Health Organization (WHO), key bilaterals – to provide technical expertise and administrative knowledge in areas such as procurement of contraceptives, service delivery, and demand creation. The Bank will need to work with non-governmental organizations (NGOs) and community-based organizations to ensure that poor and other hard-to-reach women have access to reproductive health services, as well as help to work with communities to improve the demand for such services. It will also need to refocus internally, and build a consensus view in which unsustainably high fertility is once again included in discussions with governments.

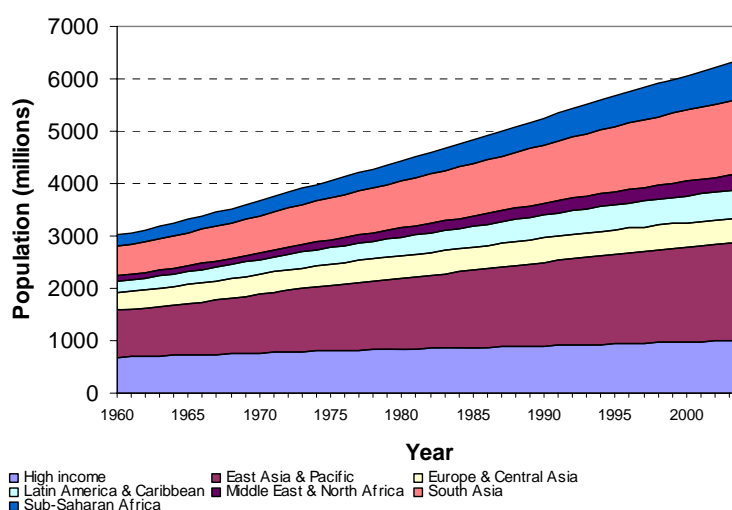
2. THE DEMOGRAPHIC CONTEXT: REVIEWING CHALLENGES AND EMERGING ISSUES

GLOBAL POPULATION TRENDS

The world is in the midst of major demographic changes. During recent decades, fertility levels have declined more rapidly—even in some of the poorest countries—than had been expected by most demographers (World Bank 2001). In 1970, Bangladesh had some of the worst social indicators and lowest income of all countries, with a TFR of about seven children per woman; now the TFR is about three. Similar declines in fertility can be found in countries in East Asia, Latin America, and the Middle East and North Africa. The widespread decline in fertility, coupled with reductions in mortality in most countries, have resulted in changes in the age structure and population growth rates that have far-reaching consequences for sectors such as health, education, labor markets, and social protection.

During the second half of the 20th century, world population more than doubled to reach 6 billion (Figure 2.1), an astonishing 3 billion increase in population in just 40 years. At midyear 2005, about 6.5 billion people shared this planet, and although the rate of increase has been reduced to 1.2 percent per year, an additional 75 million people are being added every year this decade. Population is projected to reach 9.1 billion by 2050, but another doubling of the population is now considered unlikely (UN 2004).

Figure 2.1 World Population by Region, 1960-2005



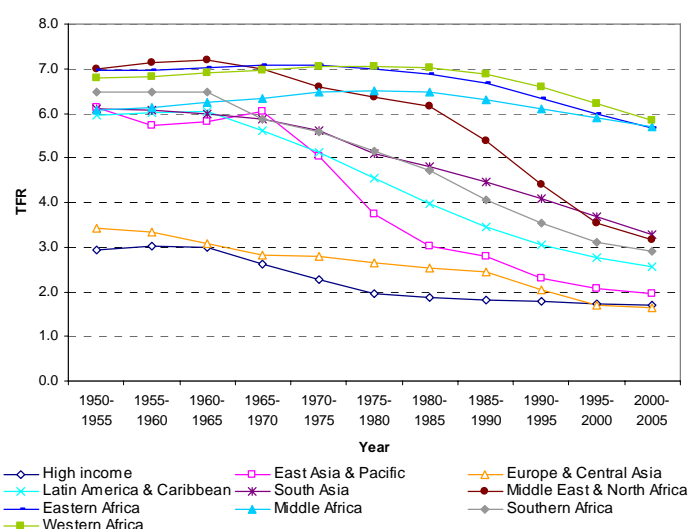
Source: World Bank 2006a.

As mentioned earlier, fertility declines have been recorded in most developing regions of the world (Figure 2.2). Fertility continues to decline in high-income countries as well, and TFRs are below the replacement level of about two children per woman in every member nation in the European Union (EU). The only region in which fertility has declined by only a small amount is Sub-Saharan Africa, where average fertility remains above five children per woman. Similarly, mortality has declined in all regions since 1960, with Sub-Saharan Africa lagging behind the other regions. Trends in fertility and mortality since the middle of the last century show at first a

divergence in demographic patterns among regions, followed by a gradual convergence toward low levels of fertility and high levels of life expectancy (Figure 2.2 and Figure 2.3). The exception to this convergence in demographic patterns is the Sub-Saharan Africa region.

As a result of rapid fertility decline and slowing population growth, the debate around the impact of population growth on development has abated due to the perception that current demographic rates make the issue less important for low- and middle-income countries (Sinding 2000). But increasingly, it is recognized that the decline in fertility has not reached all countries, with some continuing to experience population growth rates of over 3 percent per year—doubling in size in less than 25 years—and that in countries in which fertility has declined, new issues, such as large youth cohorts entering the labor force, or aging populations, are creating new challenges.

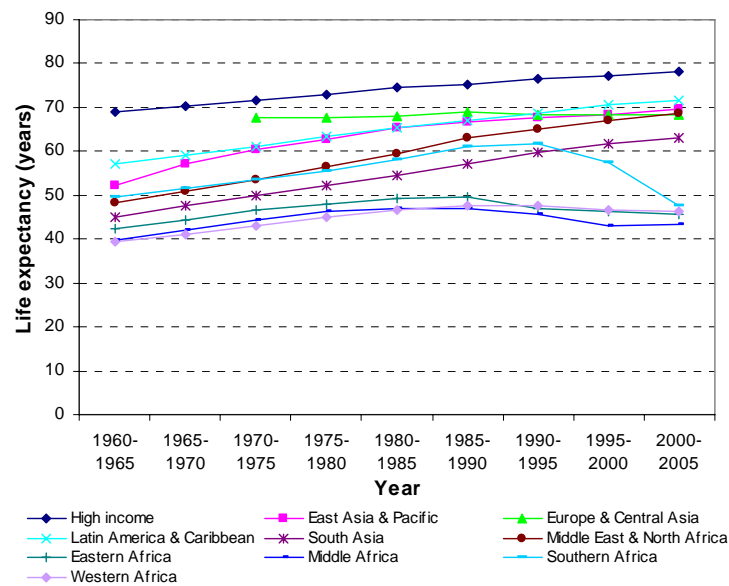
Figure 2.2 Trends in Total Fertility Rate by Region, 1950 -2005



Source: UN 2004.

Among the countries with declining fertility and mortality, substantial differences still remain. The pace of the decline in fertility varies greatly, and some countries have declined to well below replacement level, whereas others have bottomed out at levels above replacement. Other differences exist in the ages at which women are most likely to bear children, and in the mortality risks faced by people at different ages. As a result, the age-sex structures of populations will continue to differ for many decades.

Figure 2.3 Trends in Life Expectancy by Region, 1960 -2005



Sources: UN 2004; World Bank 2006a.

Despite the declines in fertility, the world population is expected to continue to grow over the next several decades, increasingly not because of high fertility, but due to population momentum² resulting from the young age structure of countries in which fertility has recently declined. In the coming decades, the world's population is projected to increase by 2.6 billion, with almost all of the growth taking place in the developing world. Even though Africa will be the fastest-growing region, due to the huge population size of Asia (60 percent of world's population lived in Asia in 2005), most of the people added to the world between 2005 and 2050 will be Asians.

Another significant shift is occurring worldwide in the age composition of the population. Nearly half the people of the world today are under 25 years old, and nine out of ten of these young people live in developing countries. At the same time, low fertility is accelerating the aging of populations, especially in countries with earlier fertility decline, including not only high-income countries, but also low- and middle-income countries in East Asia, Europe and Central Asia, and Latin America and the Caribbean.

While demographic patterns are converging in many regions, countries that are lagging in fertility decline and mortality reduction are increasingly different from the rest of the world. The longer it takes for countries to move to a low-fertility, low-mortality pattern, the greater the "demographic divide" will become. Table 2.1 illustrates this by comparing two countries (Nigeria and France) that had similar total populations in 1950, but have very different total

² Population momentum is the tendency for population growth to continue beyond the time that replacement-level fertility has been achieved because of a relatively high concentration of people in the childbearing years. This phenomenon is due to past high fertility rates, which results in a large number of young people. As these cohorts move through the reproductive ages, the number of births will exceed the number of deaths, even with low levels of fertility.

populations in 2005. The two countries illustrate the vast and growing differences in demographic patterns among countries on different sides of the divide.

Table 2.1 The Demographic Divide: Nigeria and France

Demographics	Nigeria		France	
	1950	2005	1950	2005
Population (millions)	32.8	131.5	41.8	60.5
Total fertility rate	6.9	5.9	2.7	1.9
Annual births (millions)	1.7	5.5	0.8	0.7
Annual deaths (millions)	1.0	2.4	0.5	0.6
Life expectancy at birth (years)	36	44	67	80
Infant mortality rate (per 1,000 births)	184	100	45	4
Adults with HIV/AIDS (2003), (%)	.	5.4	.	0.4
GNI PPP per capita ³ (\$)	.	1,040	.	30,540

Sources: UN 2004; World Bank 2006a, 2007a.

Another phenomenon of the past decades has been the rapid rise in the number of international migrants. In 1965, the number of people born in one country but resident in another was estimated at 75 million; this had increased to 191 million by 2005 (Bloom and Canning 2006; NRC and IOM 2005). While this is less than 3 percent of the global population, migration is unevenly distributed, with just 10 countries accounting for over half of the pool of international migrants (UN 2005). Future flows of international migration are difficult to anticipate, and depend on both individual preferences and countries' immigration laws that may enable or obstruct movements across borders.

POPULATION ISSUES IN HIGH-, MEDIUM-, AND LOW-FERTILITY COUNTRIES

In this note, countries have been grouped into three categories for the purpose of identifying broadly similar population issues. The first category consists of countries with high fertility rates (TFR over 5.0), often showing little change in fertility over time. The second group includes countries with intermediate fertility rates, with the TFR ranging from 2.5 to 5.0. The third group consists of countries with fertility rates near replacement level (TFR around 2.1), and, in an increasing number of countries, below replacement level. This broad categorization helps to describe general population issues facing countries; individual country-level analyses of population trends will be required to identify specific issues and how to address them. Table 2.2 summarizes some of the characteristics of countries, based on fertility levels.

³ GNI PPP per capita = gross national income in purchasing power parity divided by population.

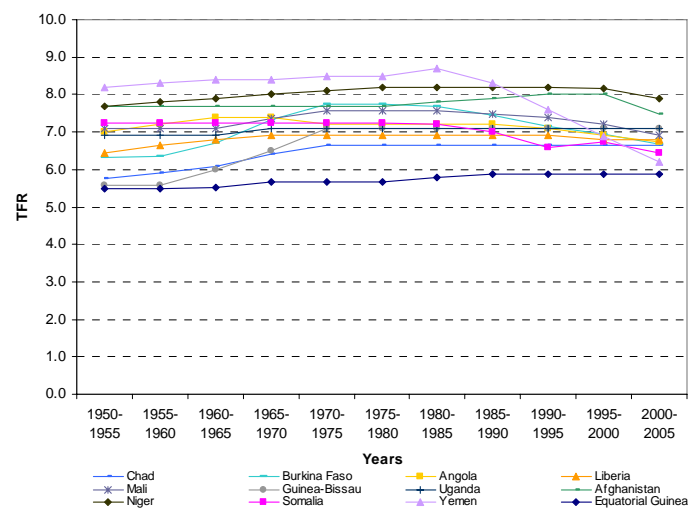
Table 2.2 Characteristics of Countries According to Fertility Levels

Indicator	Total Fertility Rate		
	Greater than 5 [range]	Between 5 and 2.5 [range]	Less than 2.5 [range]
Gross National Income (GNI) per capita (US\$)	344 [90-950]	1,110 [250-17,360]	10,502 [540-56,380]
Life expectancy at birth (years)	46 [38-61]	63 [36-79]	74 [61-82]
Under-5 mortality rate per 1,000	175 [59-283]	75 [6-156]	25 [3-106]
Primary completion rate, total (% of relevant age group)	52 [25-89]	93 [29-107]	98 [75-114]
Age 65 and over (%)	3 [2-3]	4 [2-10]	11 [1-20]

Sources: UN 2004; World Bank 2004.

High-fertility Countries

The first group consists of 35 countries, 31 of which are in the Eastern, Western, and Middle regions in Sub-Saharan Africa (as defined by the UN), and four in other regions (Timor-Leste, Afghanistan, Djibouti, and Yemen) (Annex Table 2a). In these countries, fertility has remained above five children per woman; in most, little change has been observed in past decades (Figure 2.4). Almost all of the high-fertility countries are low income (exceptions are Angola and Equatorial Guinea, which are middle income), and are characterized by having a high proportion of the population under age 15, and a low proportion of older people. Social indicators are generally poor, with low levels of educational attainment, high mortality, and high levels of poverty (Table 2.2).

Figure 2.4 High-fertility Countries: Trends in Fertility Decline, 1950 -2005

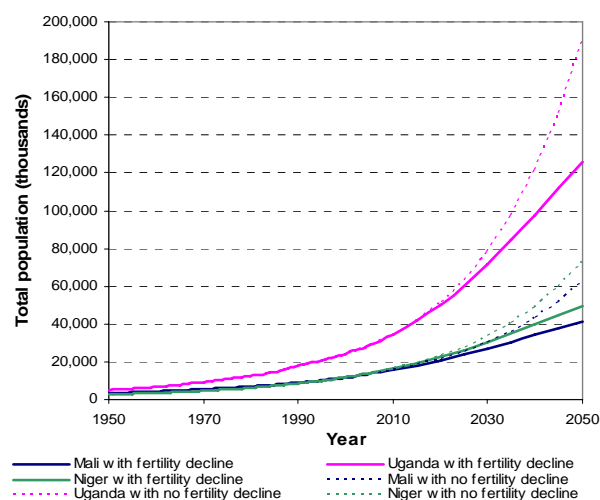
Source: UN 2004.

Population growth rates in countries with high fertility are generally high—an important exception consists of countries with very high levels of HIV prevalence, in which mortality has

increased in recent years and growth rates have fallen to below 1 percent per year. The future impact of AIDS mortality on population growth rates will depend on the unpredictable course of the epidemic and the effectiveness of ways to combat it, but is not expected to lead to population decline in Sub-Saharan Africa. Demographic projections show that in a few countries in Southern Africa in which fertility has declined simultaneously with a rapid increase in AIDS mortality, population growth may dip below zero, but recent reevaluations of the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates of HIV prevalence, as well as increased access to AIDS medicines, make this less likely than at the time the UN projections were published (UN 2005). For most countries in the high-fertility group, projections indicate doubling and tripling of population size, even with an assumed decline in fertility. Figure 2.5 shows the projected populations of Mali, Uganda, and Niger would still triple by 2050, even with optimistic scenarios of fertility decline. If fertility were to remain constant at current levels, the projections show fivefold increases in population. Whether such large populations in these countries would be possible, or whether mortality and migration would reduce the size of the increase, is difficult to predict at this time.

The age structures of the rapidly growing countries in this category are currently in the shape of a pyramid, indicating a large proportion in the younger ages, and they are projected to retain this shape. Aging is not expected to become an issue for the foreseeable future.

Figure 2.5 Total Population Estimates and Projections with and without Fertility Decline for Mali, Uganda, and Niger, 1950-2050



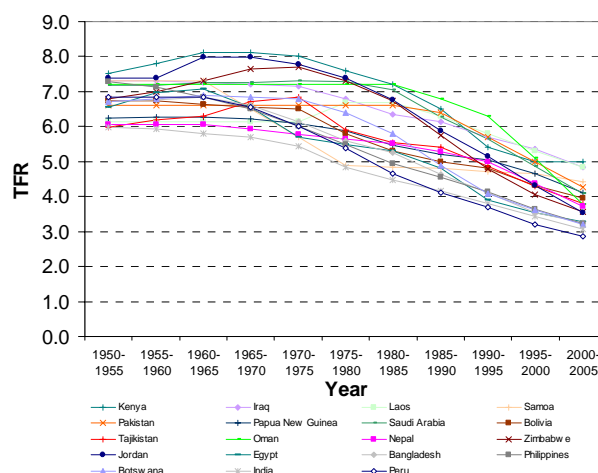
Source: World Bank 2007a.

Medium-fertility Countries

The second category consists of countries mostly in the Middle East and North Africa, East Asia and the Pacific, Southern Africa, Latin America and the Caribbean, and South Asia regions, in which fertility has declined rapidly from previously high levels to an average of around three children per woman, and can be expected, on the basis of recent trends, to continue to decline. This group of countries shows a great deal of variation in socioeconomic indicators: low- and middle-income countries are included, as well as a few high-income countries (Saudi Arabia, Israel, and Qatar). The levels of fertility of the countries in this group vary depending on when

the initial decline started, and on the pace of the decline (Figure 2.6). The decline in fertility in many of the countries reflects the successes of family planning programs that have expanded contraceptive use. But overall averages often hide large differences: poor households in many of these countries still have high levels of fertility and unmet needs for family planning.

Figure 2.6 Medium-fertility Countries: Trends in Fertility Decline, 1950-2005



Source: UN 2004.

Many of these countries have large cohorts of adolescents and young adults, reflecting previously high fertility rates (Figures 2.7a, 2.7b). Such trends create the demographic setting in which both young and old age dependency ratios are low, with many young workers entering the labor force. This “youth bulge” will require specific policies and actions on the part of government to ensure that educational and employment opportunities exist, so that a “demographic dividend” may be experienced (World Bank 2006b).

Countries in this group will generally continue to increase in population, due to population momentum created by the large cohorts of reproductive age. Over the next decades, an increasing number will likely face rapidly aging populations, as large, older cohorts move out of the labor force age groups.

Figure 2.7 Age-Sex Structure of Population of Honduras and Egypt, 2005 and 2030

Figure 2.7a: Age-Sex Structure of Honduras's Population, 2005 and 2030

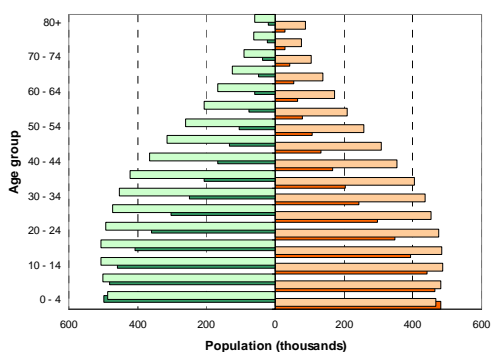
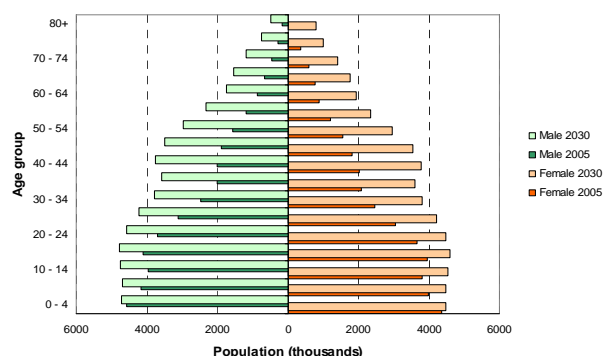


Figure 2.7b: Age-Sex Structure of Egypt's Population, 2005 and 2030

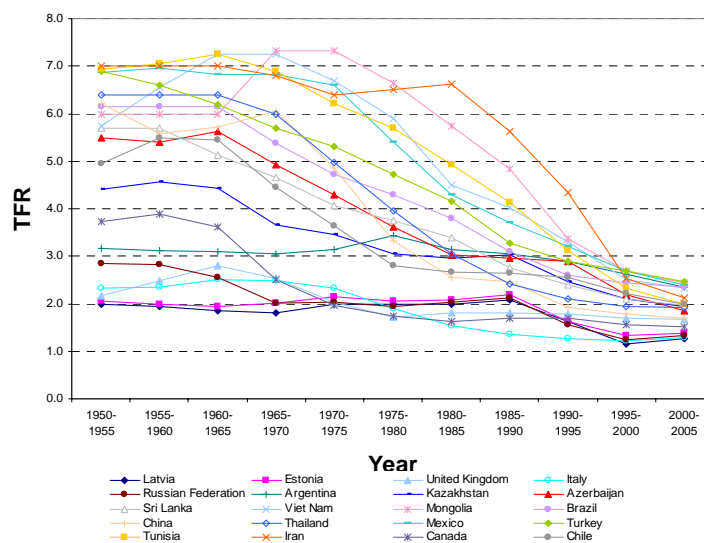


Source: UN 2004.

Low-fertility Countries

The third pattern consists of countries mostly in the high-income group and many countries in the Europe and Central Asia region, in which fertility has been low (below 2.5 children per woman) for some time (Figure 2.8). Some low- and middle-income countries in other regions (for example, Myanmar, Sri Lanka, Vietnam, Brazil, Tunisia) have also recently reached low levels of fertility.

Figure 2.8 Low-fertility Countries, 1950-2005



Source: UN 2004.

Figure 2.9 Age-Sex Structure of Population of Thailand and Ukraine, 2005 and 2030

Figure 2.9a: Age-Sex Structure of Thailand's Population, 2005 and 2030

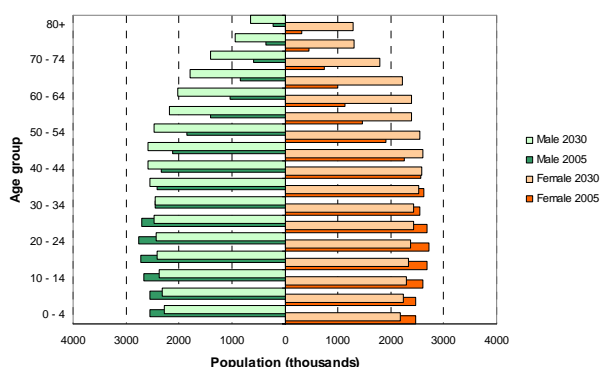
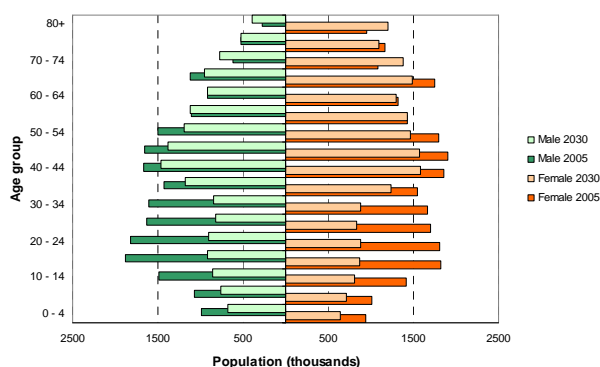


Figure 2.9b: Age Structure of Ukraine's Population, 2005 and 2030

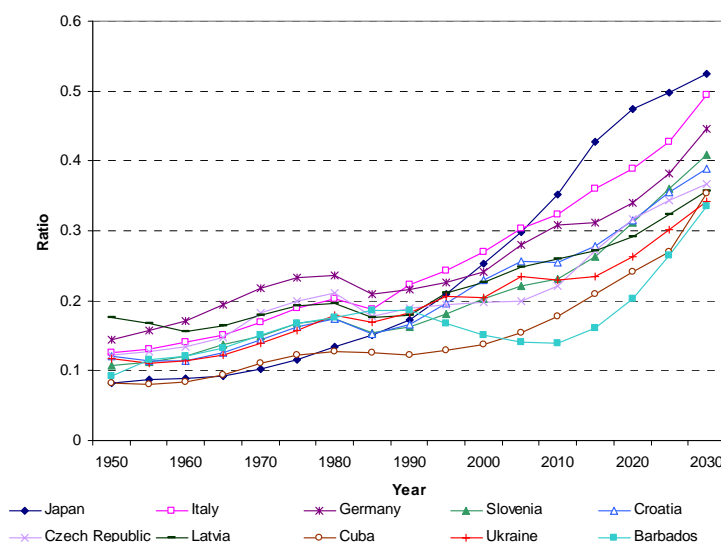


Source: UN 2004.

Except in countries that have just moved into this group (Figure 2.9a), most have relatively small cohorts of younger people, with rapidly growing populations at the older ages (Figure 2.9b, Figure 2.10). The degree to which aging is already an issue or is still two decades or more away depends on how long fertility has been low, and how low the TFR has dropped. Some countries in this group are still benefiting from the “demographic dividend” of having low dependency ratios at the younger and older ages, with large cohorts of working-age populations, but most will have moved beyond this stage.

In some countries, especially those in which fertility has dropped to very low levels for an extended period, population growth has become negative (as in Russia and Ukraine), and more countries in the low-fertility group will experience population declines in the coming decades. Some countries have adopted pronatalist policies intended to increase the fertility rate, and others have allowed higher levels of net migration to offset the decreasing rate of natural increase. Countries in the ECA region experienced very sharp drops in the number of births in the 1990s, and some show “inverted pyramid” population age structures (Figure 2.9b). This has created negative population momentum: even if fertility were to recover to above replacement level, population growth would not increase immediately, as the number of persons in the reproductive age groups will remain relatively small for some time.

Figure 2.10 Old Age Dependency Ratio: Trends in Selected Countries with Low TFR



Source: UN 2004.

MULTISECTORAL DETERMINANTS OF FERTILITY CHANGE

The reasons behind the decline in fertility (or the lack thereof) have been analyzed at length in social science research. Most commonly, two different types of determinants of fertility are distinguished: social, cultural, and economic variables, which influence decision making regarding the number of children a woman or couple decides to have; and biological and behavioral variables (often called “proximate determinants”) through which the socioeconomic variables operate (Bongaarts and Potter 1983). Both sets of factors are useful for understanding fertility change, as changes in socioeconomic variables can affect proximate determinants in unexpected ways. Increased female education, for example, is often associated with increased contraceptive use that lowers fertility, but is also associated with a reduced duration of breastfeeding, thus increasing fertility when contraception is not used⁴.

Among the most important socioeconomic factors shown in many analyses (Rutstein 2002) as correlated with the level of fertility are women's educational level (Ainsworth, Beegle, and Nyamete 1996; Cleland and Sindling 2005; Cochrane 1979; Tan and Haines 1984), employment status (Barkat-e-khuda, Roy, and Rahman 2000; Stakes and Hsieh 1983), urban-rural residence, household poverty (Gwatkin et al. 2004; Gwatkin, Wagstaff, and Yazbeck 2005), the cost of raising children, the cost of contraception, women's autonomy (Hogan, Berhanu, and Hailemariam 1999; Hindin 2000; ESCAP 1987), and husbands' occupation (Rutstein 2002). Cultural factors influence the desired family size that couples intend to achieve, as well as the acceptability of means to control fertility through contraception and abortion. Government policies regulate the availability of contraceptives, and can affect contraceptive use. Government and civil society organizations influence fertility through family planning programs that provide

⁴ The proximate determinants of fertility identified by Bongaarts and Potter are the proportion of women in sexual unions, the frequency of intercourse, the duration of postpartum abstinence and lactational amenorrhea, postpartum infecundability, use of contraception, sterility, and prevalence of induced abortion.

information and contraceptive commodities. In low-fertility countries, government pronatalist policies can mandate parental leave, and provide for subsidies that are intended to encourage increased fertility.

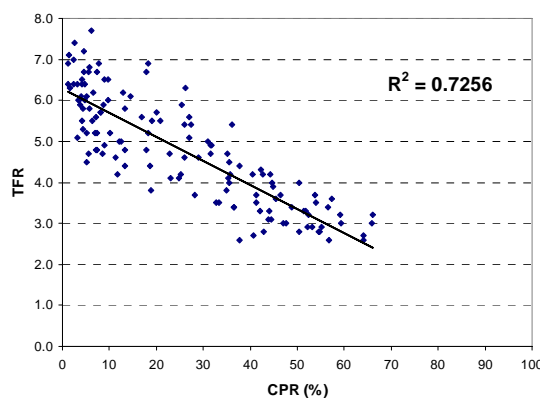
Box 1 Multisectoral Interventions and Synergistic Effect on Fertility in Ethiopia

Evaluation studies of the effect of family planning programs in developing countries have shown that exposure to family planning services throughout a woman's fertile period (15-49) would reduce her lifetime fertility by 0.5 to 1.5 children, with most estimates suggesting an effect at the lower end of this range. The findings of a recent comprehensive study of the onset of the fertility decline in Ethiopia, carried out through an analysis of the effect of intermediate determinants on fertility and using micro-econometric approaches, are consistent with these findings (World Bank 2006). The Ethiopia study underscored the importance of female education and female empowerment, household income, and urbanization, *combined* with access to family planning services in reducing fertility. In addition to its effect on a woman's own fertility, largely through delaying age at marriage, and thus the first birth, education is also found to have positive external effects, i.e. women residing in communities with more educated women tend to have fewer children *ceteris paribus*. In contrast with what is often found in the literature, educational attainment in Ethiopia starts to affect fertility from primary school onward, though the effects from post-primary education on fertility are stronger (which is in line with findings from other countries). Empowerment of women is also associated with fewer children born. The more cash women earn, the larger their decision power over their earned cash income, and the lower their fertility rate tends to be. A doubling of household income is, on average, associated with 1 to 1.5 fewer children born (rural women have, on average, 0.4 children more than urban women).

Source: World Bank 2006b.

Family planning programs have been the main intervention explicitly aimed at changing fertility in developing countries by encouraging the use of modern contraceptives. Such programs have been effective in many resource-poor settings, as well as in countries in which other determinants, such as education or female autonomy, are unfavorable for fertility decline (Bangladesh, Indonesia). Programs that have achieved a high level of contraceptive prevalence achieve lower fertility as well, as is illustrated in Figure 2.11.

Figure 2.11 Relationship between the Total Fertility Rate and Contraception Prevalence (Modern Methods)



Sources: Demographic and Health Surveys.

Box 2 Bangladesh's Success in Reducing Fertility: Lessons Learned

In Bangladesh, fertility dropped from nearly seven children per woman in 1975 to three in 2004. Political commitment to family planning, combined with a strategic program approach, resulted in a significant impact on reproductive behavior, in spite of considerable economic, social, and cultural obstacles, such as low levels of education and female status. The supply factor alone—a targeted family planning program—contributed substantially to the decline in fertility. The unexpectedly rapid fertility decline was possible because of the impact of effective family planning information and communication, affecting family size preferences of poor women and couples, combined with the delivery of health and family planning services by large numbers of “family welfare assistants” deployed in rural areas.

The main lessons learned from the Bangladesh success include first, that programs need to do more than merely supply contraceptives, and second, that when programs are made responsive to the actual needs and sensitivities of clients, contraceptive use can increase and fertility decline can accelerate. The Bangladesh experience also highlights the value of building on in-country capacity and a gradual development of family planning programs.

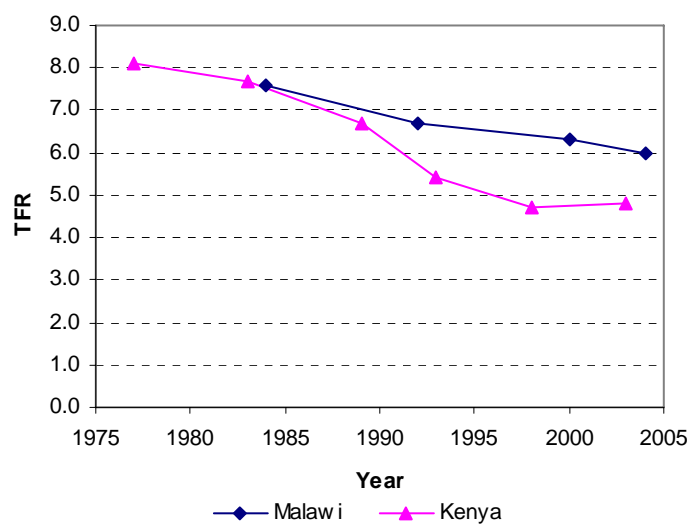
Sources: Merrick 1993; Cleland et al. 1994; Ginneken and Razzaque 2003; ORC Macro 2006.

Socioeconomic changes are important determinants of fertility change as well, and, in turn, a decline in fertility rates will have an impact on sectors other than population. Specifically, the two-way relationships between fertility and education, female labor force participation, childhood mortality, and gender equality, have been well documented. More recently, analyses of the association between demographic variables and the MDGs have been conducted, showing that lower fertility will facilitate reaching several of the targets (UN 2004). For example, fewer pregnancies would reduce the exposure of women to the lifetime risk of maternal mortality (MDG 5), and longer birth intervals would reduce infant mortality (MDG 4). Similarly, smaller family size is associated with higher levels of enrolment in school (MDG 2), higher labor force participation for women (MDG 3), and reductions in household poverty (MDG 1).

WHAT IS DIFFERENT IN SUB-SAHARAN AFRICA?

Of the 35 countries with high levels of fertility (defined in this note as a TFR of 5 or higher), 31 are in Sub-Saharan Africa. In some of the high-fertility countries in Sub-Saharan Africa, fertility has remained essentially constant over the past decades, but in others, slow declines have occurred, even though fertility remains high. In Malawi, for example, the Demographic and Health Survey (DHS) estimates of total fertility document a decline in the TFR from 7.6 in 1984 to 6.0 in 2004—a very slow decline in comparison with countries in other regions. Similarly slow declines are found in countries such as Burkina Faso, Nigeria, and Mozambique. Some other Sub-Saharan African countries (Tanzania, Kenya), experienced declines, but have recently shown an increase in the TFR—a rarely seen reversal of a downward fertility trend (Figure 2.12).

Figure 2.12 Trends in Fertility Rates in Malawi and Kenya for Available Years



Sources: Demographic and Health Surveys; 1984 Malawi Family Formation Survey; 1977-1978 Kenya Fertility Survey; 1983 Kenya National Demographic Survey.

Fertility has declined in countries across the globe, even in resource-poor countries (e.g. Vietnam, Bangladesh), in countries with low levels of female education (e.g. Haiti, Cambodia), in countries with low levels of female labor participation (e.g. Egypt, Turkey), and in countries with high levels of gender inequality (for example, Iran, India). Why, then, have so few countries in Sub-Saharan Africa experienced sustained fertility declines?

While several of the socioeconomic and cultural factors associated with high fertility are present in Sub-Saharan Africa (Acsadi and G.Johnson-Acsadi 1990), what is perhaps most important is that the demand for children has remained high. As a result, the use of modern contraceptive methods has remained low, and efforts to increase use have had limited success. The main reason for not using contraception in many high-fertility countries in Sub-Saharan Africa is a desire to have more children, rather than unawareness about fertility control or lack of access to contraception (See Annex Table 2e). Therefore, interventions that aim to lower fertility in Sub-Saharan African countries will need to address the high demand for children.

3. RATIONALE FOR BANK'S ACTION

Economic growth, poverty reduction, and equity are core rationales for Bank involvement in a particular sector or subsector. This section examines the relationship of these three areas and demographic variables to better understand why population issues are central to the Bank's agenda.

POPULATION AND ECONOMIC GROWTH

The relationship between population growth and development has been an area of much debate. Early views on the topic, articulated by Malthus, asserted that population growth has a negative impact on income growth because it overwhelms, at least in the short run, scarce natural resources as well as reproducible resources created by individuals, such as infrastructure and capital (Bloom and Canning 2006). In the mid-1950s, development economists started to pay attention to the work of economic demographers such as Coale and Hoover's 1958 analysis of India (Robinson and Ross, forthcoming). During the 1960s and 1970s, bilateral donors and multilateral development agencies, including the World Bank, started to invest in family planning programs as a way to control population growth, which was seen as an obstacle to economic development in poor countries. Following the publication of *The Population Bomb* (Ehrlich 1968), in which the rapidly growing global population was described as a “population explosion,” international support for family planning to control population grew strongly in popularity, and donor support for family planning expanded rapidly.

By the mid-1980s, as fertility decline was well under way in parts of the developing world, views on population and development became more nuanced. In 1986, “population neutralism” was highlighted in an influential review by the U.S. National Academy of Sciences. While generally supporting efforts to bring down very high rates of population growth in developing countries, this study placed considerably less importance on population as a cause of slow per-capita economic growth than earlier writings. The report concluded that “the connections between population growth and development are complex and difficult to measure quantitatively. Through adaptation and substitution, markets may reduce adverse effects.” The 1986 report had a significant influence on the thinking of development economists around the world and in general, many governments, donor agencies, and lending institutions started to look at population in more nuanced ways, placing less priority on curbing population growth than they had in the earlier period (Birdsall, Kelley, and Sinding 2001).

Notwithstanding these controversies, a consensus has emerged around the idea that *rapid* population growth may exert constraints on countries and regions at low levels of socioeconomic development (Birdsall, Kelley, and Sinding 2001; Kelley 1988). On the basis of empirical findings, the World Bank (World Bank 1994a) estimated that a population growth rate above 2 percent per year could slow the increase of incomes in poor countries. Rapid population growth is linked with expanding demand for public services, as well as a need for human capital investments. In a situation of rapid population growth, efforts made to meet these investments have to be constantly accelerated just to preserve the status quo (creating a “treadmill” effect). Rapid population growth can also threaten the macroeconomic stability of a country because considerable financial resources need to be mobilized for human capital investments, causing fiscal space problems.

Recently, the effects of changes in population age structure and dependency ratios on economic development have received much closer attention. In fact, this last phenomenon is the most important element that has been emphasized by recent economic research (Birdsall, Kelley, and Sinding 2001). The situation of East Asian countries has shed light on the impact of sharp fertility declines on economic performance before the 1997-98 crisis. By diminishing the relative proportion of youth, a rapid decline in fertility reduced the dependency ratios between generations and boosted the share of the potential labor force. This, in turn, enabled governments to raise investment levels for health and education, and also to increase their economic investments. However, changes in the age structure can only be exploited when they are accompanied by adequate investments and sound public policies (May 2005). Moreover, this demographic dividend is an opportunity that must be seized over a relatively short term before population aging sets in (Bloom, D.Canning, and J.Sevilla 2003).

Conversely, situations of prolonged declines in fertility, demographic aging, and shrinking population size can have negative consequences for the economy. Retirement schemes—particularly pay-as-you-go plans—become more difficult to finance when the proportion of workers diminishes compared to that of the retired population. Health expenditures also grow more rapidly in aging populations. However, it is important to keep in mind that age-specific behavior does not necessarily remain unchanged, and ignores the potentially significant effects of policy change. For example, in response to aging, people may adjust their behavior, resulting in increased labor force participation, immigration of workers from developing countries, and longer working lives (Bloom and Canning 2006).

A “second demographic dividend” that could mitigate the effects of aging is also being proposed in recent economic work (Lee and Mason 2006). According to this research, a population concentrated at older working ages and facing an extended period of retirement has a powerful incentive to accumulate assets. Some researchers suggest that the potential impact of the second dividend is even larger than the first demographic dividend due to the “youth bulge.” Moreover, given its indefinite nature, the second dividend can have a sustained impact on development. Like the first dividend, the second dividend depends heavily on the policy and institutional environment. Policy makers, especially in developing countries, will need to focus on establishing financial systems that are sound and accessible to encourage people making such investments.

POPULATION AND POVERTY REDUCTION

The impact of fertility decline on poverty reduction has been difficult to establish. While countries with more than 10 percent of their population living on less than a dollar per day have a total fertility of 4.6 children per woman, as compared with 2.3 children per woman in countries with poverty levels below 10 percent, such a correlation between demographic and poverty variables cannot be taken as evidence of a causal relationship. In other words, reducing total fertility does not necessarily cause a reduction of poverty. There are many other factors at play and high fertility may be, in part, an outcome of poverty. However, an important aspect to keep in mind is that implementing more effective reproductive health programs in high-fertility countries will target countries where poverty is greatest.

Even though there is consensus that more micro-analysis is needed since relationships tend to be context specific, recent research provides evidence that fertility rates have an important bearing on poverty. In particular, there is some evidence that large family size creates competition in household spending on children, with possible adverse effects on girls (Greene and Merrick 2005). Another way in which fertility decline can reduce poverty is through the demographic dividend: A recent analysis indicates that the demographic dividend could lead to a reduction in poverty in the developing world by about 14 percent between 2000 and 2015 (Mason and Lee 2004). A decline in the number of children per adult at the household level promotes income and asset accumulation, since such households are better able to make investments in education and finding good jobs.

POPULATION AND EQUITY

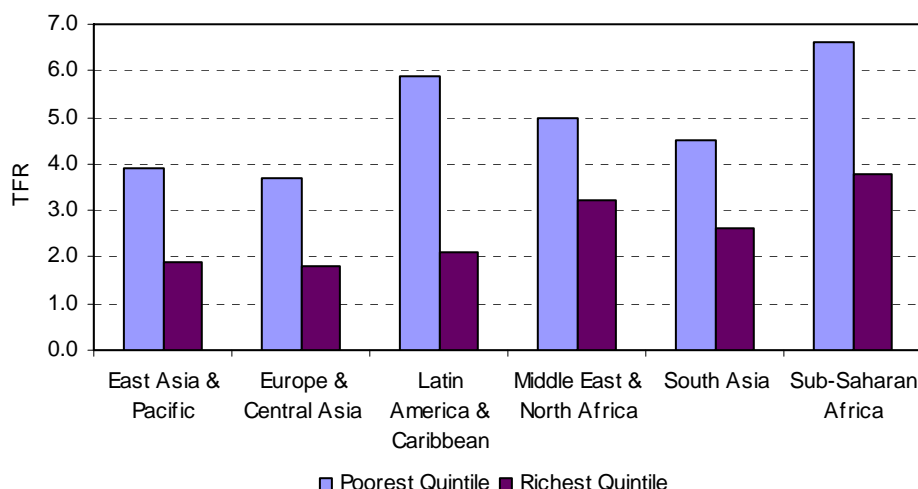
A key objective of the HNP strategy for the Bank is to improve HNP outcomes for the poor. Inequities in health are usually revealed by the following patterns: large disparities in health status, differential access to and use of health care services, and disproportionate exposure to health risks (Jamison 2006). This section discusses key dimensions of vulnerability, namely poverty, gender, youth, and rural/remote populations. These dimensions also interact with one another and can further worsen reproductive health outcomes (e.g. poor women are doubly disadvantaged by both poverty and gender).

Poverty

As discussed earlier, poverty and high fertility are often found to be closely related. Studies have shown that the poor are often not the primary beneficiaries of advancements in reproductive health services. This results in the phenomenon of “failing while succeeding”—namely that improvements in health, including reproductive health, are being achieved without significantly changing outcomes for the poor.

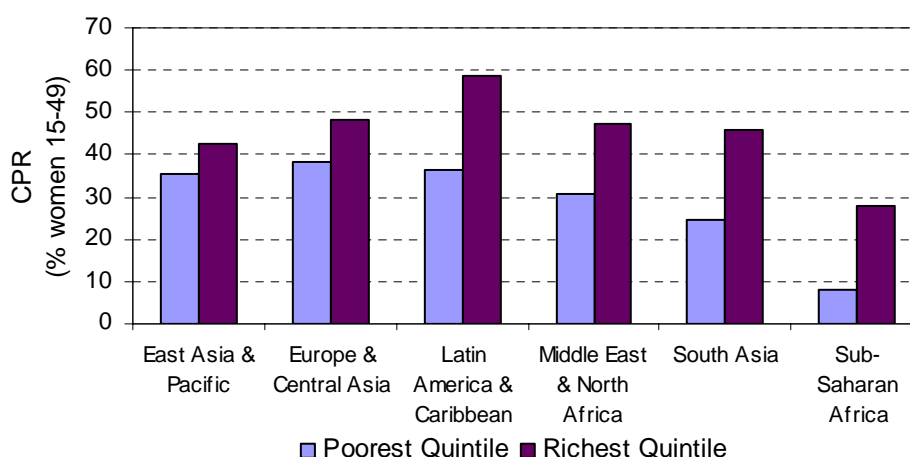
Quintile data from DHS indicate that the poor have higher TFRs than the rich across countries in all regions. This pattern of high fertility among the poor is present in countries of both high and medium fertility (Figure 3.1). Even in countries such as Bangladesh, where the national average TFR has fallen from seven in 1960 to three in 2004, the poor have substantially higher fertility than the rich. A similar pattern is seen in the utilization of family planning services. In all regions, particularly in Sub-Saharan Africa, South Asia, and Latin America and the Caribbean, the poor have lower contraceptive prevalence rates (CPRs) than the rich (Figure 3.2).

**Figure 3.1 Total Fertility Rate by Region and Wealth Quintile
(DHS 1995-2005, most recent country data)**



Note: Regional TFR averages are unweighted averages of select countries in each region.
Sources: Demographic and Health Surveys.

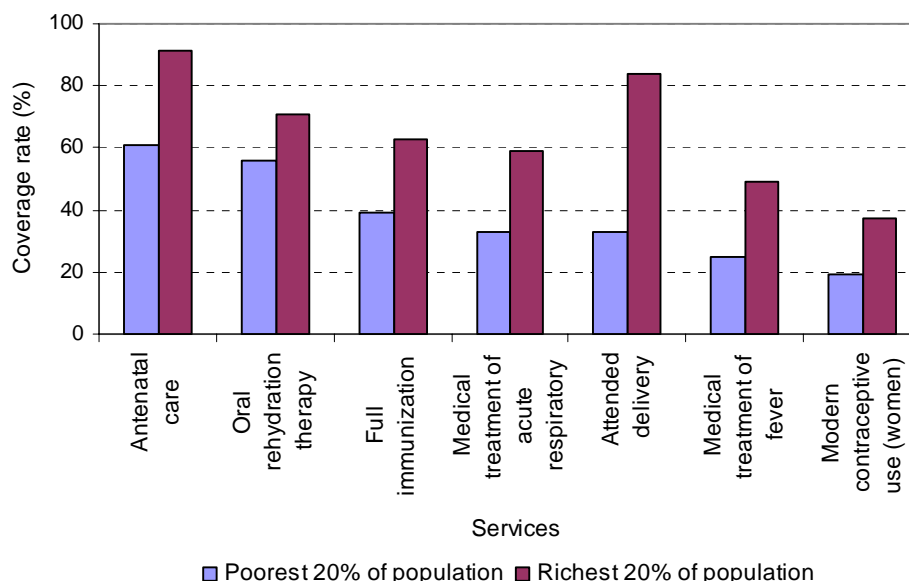
**Figure 3.2 Contraceptive Prevalence Rate by Region and Wealth Quintile
(DHS 1995-2005, most recent country data)**



Note: Regional CPR averages are unweighted.
Sources: Demographic and Health Surveys

The inequities in coverage rates of basic maternal and child health services for the poorest and richest quintiles for 56 low- and middle-income countries is evident in Figure 3.3 (White, Merrick, and Yazbeck 2006). As is evident in the figure, the largest relative differentials exist for reproductive health services—a woman in the richest quintile is twice as likely to use modern contraceptives as a poor woman, and the richest women are three times as likely to have an attended delivery (Gwatkin 2002). This pattern was particularly evident in South Asia, Central and South America, and Sub-Saharan Africa.

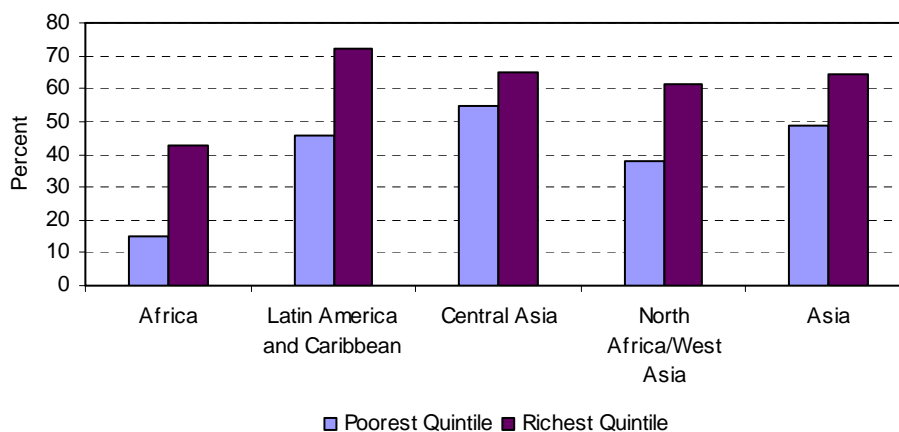
Figure 3.3 Use of Basic Maternal and Child Health Services in 56 Low- and Middle-Income Countries



Source: White, Merrick, and Yazbeck 2006.

Relatedly, a UN Millennium Project analysis of DHS indicates that a gap exists in the proportion of demand being satisfied by family planning use (PDS) (UN Millennium Project 2006) and that the PDS measure is strongly correlated to poverty⁵. Results of this analysis confirm that the poor are least likely to be able to act on their fertility preferences (Figure 3.4).

Figure 3.4 Proportion of Demand for Family Planning Satisfied by Region and Wealth Quintile (DHS 1996-2004)



Source: UN Millennium Project 2006

⁵ In general, PDS captures the ability of women to implement choices on family formation, particularly for demand of birth spacing longer than two years, and for limitation of further fertility. Specifically, PDS is the proportion of family planning users of modern methods to the sum of these users and individuals with unmet need. PDS takes into account not only the proportion of women of reproductive age using contraception, but also the degree to which individuals are able to translate their fertility preferences into action.

Given that in many developing countries the poor often have both the highest fertility rates and the lowest contraceptive use rates, ensuring financial and physical access to contraceptives for vulnerable groups should be an essential component of a comprehensive contraceptive security plan. However, studies have shown that those who can afford to pay for services often benefit from free goods provided by the public sector, while individuals who cannot afford to pay for services remain without essential reproductive health care (Waters, Hatt, and Aselsson 2002; Soucat and Rani 2003; Peters et al. 2002). This pattern is confirmed by studies such as the benefit incidence analysis of overall public spending on health in India, which showed that only 10 percent of government subsidies in health is captured by the poorest 20 percent, while the richest quintile captures more than 33 percent of health subsidies. However, what is particularly interesting is that policies and institutions can make a significant difference. Kerala's poor benefit 10 times as much as Bihar's in attaining health subsidies (Peters et al. 2002). This demonstrates the importance of targeting interventions and subsidies at specific vulnerable populations.

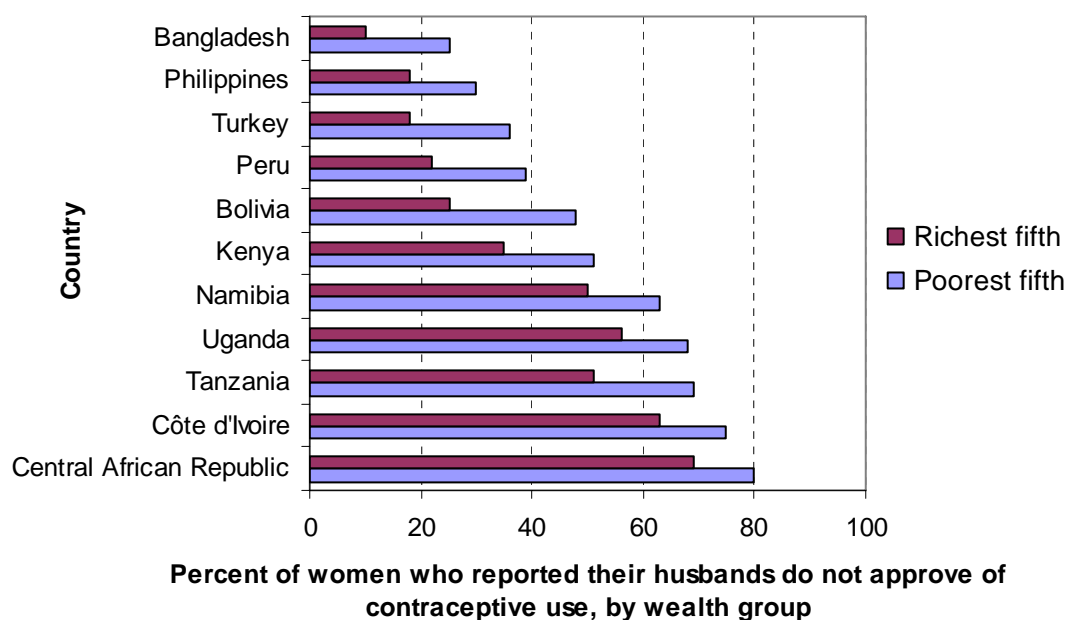
Gender

Lack of empowerment is a key factor in restricting women's access to family planning and other reproductive health services. Gender-based obstacles (Hausmann-Muela, Ribera, and Nyamongo 2003) to family planning include the following:

- Traditional gender norms of femininity may limit women's access to information, as well as their ability to control how and when they should engage in sexual relations.
- Traditional norms of masculinity may limit a man's or his partner's use of family planning services.
- Power inequalities in relationships between men and women, especially related to control of decision-making power, economic resources, time, and mobility, also affect women's access to services and their ability to use family planning.
- Many women may be afraid to raise the issue of contraception for fear that their partners may respond violently.
- Women's decisions about family planning may also reflect pressures from family members to use a particular method or not to use any method (USAID 2005).

An illustration of the negative combination of gender and poverty in making contraceptive choices is presented in Figure 3.5, which shows the percent of women by rich-poor quintile who report that their husbands do not approve of contraceptive use.

Figure 3.5 Husbands Say No to Contraception



Source: World Bank 2004.

Youth

Although mortality and morbidity among young people is low, awareness of the consequences of decisions for health, and of ways to avoid ill health, is very low among young people, especially girls, and only a small percentage of those who are aware actually adopt safe behaviors (World Bank 2007b). Early sex, unprotected sex, and having multiple partners can lead not only to HIV/AIDS and other sexually transmitted diseases (STDs), but also to high adolescent fertility rates and unplanned adolescent pregnancies. In surveys, adolescents indicate an unmet need for contraception that is more than twice as high as that of the general population. High levels of unwanted pregnancy and unsafe abortion are further evidence of the large unmet need for family planning for this group. Women aged 15 to 19 account for at least one-fourth of the estimated 20 million unsafe abortions performed each year (UNFPA). In Sub-Saharan Africa, almost 60 percent of women who have unsafe abortions are between the ages of 15 and 24. In Latin America and the Caribbean, young women make up about 40 percent of those who use unsafe abortions (Shah and Ahman 2004a, 2004b).

Moreover, adolescent pregnancies carry a higher risk of obstetric complications (e.g. fistulae) and maternal death. Worldwide, women 15 to 19 years old are twice as likely to die during childbirth than women in their 20s, and girls 14 years old and younger are more than five times as likely to die during childbirth than their counterparts in their 20s (Family Health International 1997).

In addition to a significant proportion of youth in developing countries—especially girls—who are sexually active within marriage or informal unions, many *unmarried* youth are also sexually active (Table 3.1) (Singh et al. 2005; World Bank 2007b). Unmarried adolescents lack access to

services in countries where premarital sex is legally or culturally proscribed. Even where young people are legally protected, reproductive health services may be out of reach. In South Africa, many reproductive health services are not easily accessible to youth, and young people feel that facility staff are judgmental and hostile (Dickison-Tetteh, Pettifor, and Moleko 2001).

Table 3.1 Sexual Activity among Youth*

	Males		Females	
	Married %	Unmarried and sexually active %	Married %	Unmarried and sexually active %
Benin	10.8	65.8	47.6	42.9
Bolivia	17.2	53.1	29.2	16.9
Burkina Faso	10.8	35.3	54.4	26.2
Cameroon	13.8	55.7	49.7	35.8
Dominican Republic	13.4	47.8	36.5	10.9
Ghana	7.3	25.2	31.3	29.0
Haiti	11.6	58.4	32.5	19.2
Kenya	8.8	59.3	36.1	21.6
Malawi	20.9	59.1	56.8	28.6
Mali	7.7	41.3	64.9	29.1
Mozambique	20.9	69.7	54.4	55.2
Uganda	22.6	26.0	52.6	27.5
Zambia	11.6	64.6	41.5	33.5
Zimbabwe	10.2	24.4	41.5	19.8

Sources: Demographic and Health Surveys.

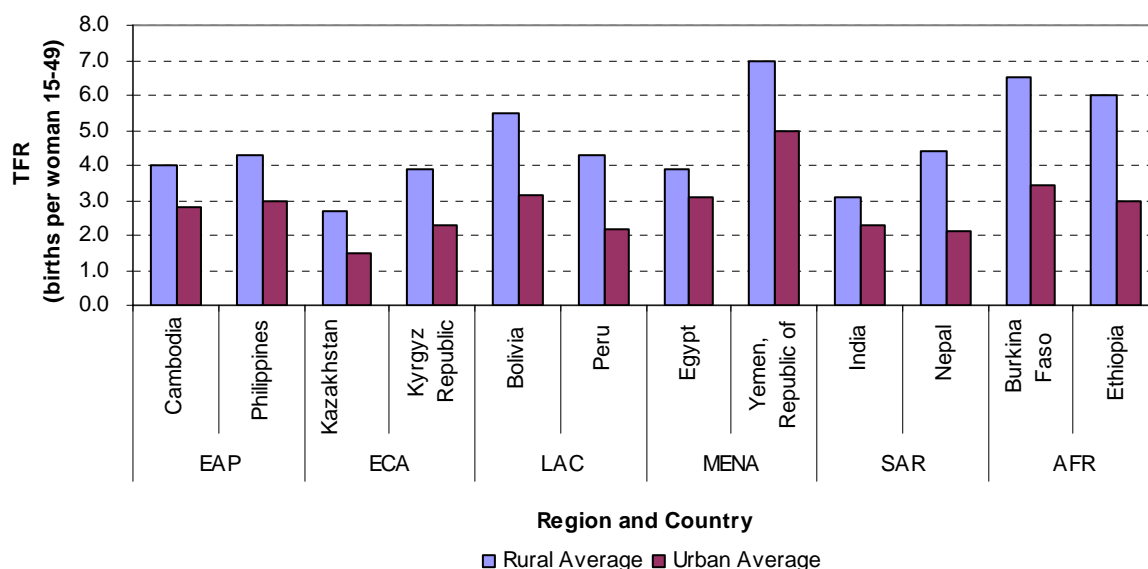
* Males and females aged 15-24 who report being in a union and those who report having had sex in the 12 months preceding the interview.

It is sometimes assumed that married adolescents are less likely to use contraceptives because they could be trying to get pregnant, but a DHS analysis of condom usage indicates that many adolescents who did not use contraceptive were actually trying to avoid pregnancy. In keeping with the interaction between dimensions of vulnerability, it is seen that risky sexual behavior is more likely to occur among poor youth due to their weaker position in negotiating safe sex, and youth are more likely to experience forced or transactional sex, increasing their risk of unwanted pregnancy (NRC and IOM 2005). For example, more than 20 percent of women attending antenatal clinics in Soweto, South Africa, reported having had sex with a “nonprimary” male partner in exchange for goods or money (Dunkle, Jewkes, and Brown 2004).

Rural Populations

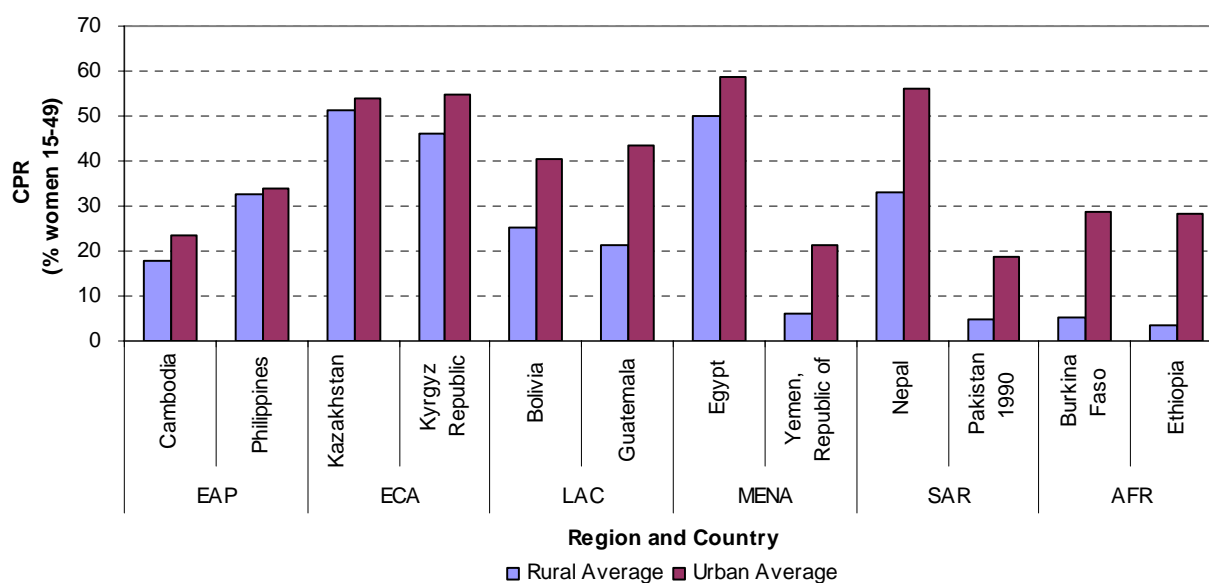
Significant urban-rural differences also exist with regard to fertility and contraceptive use. For example, changes in fertility rates and contraceptive use in most Sub-Saharan countries in the 1990s have been concentrated in the urban, richest population segments (World Bank 2004). Analysis of DHS data indicate that across the countries considered, TFRs are consistently higher in rural areas, while CPRs are consistently higher in urban areas. Figures 3.6 and 3.7 illustrate these patterns.

**Figure 3.6 Total Fertility Rate by Region and Geographic Distribution for Select Countries
(DHS 1994-2004, most recent country data)**



Source: Gwatkin et al. 2007.

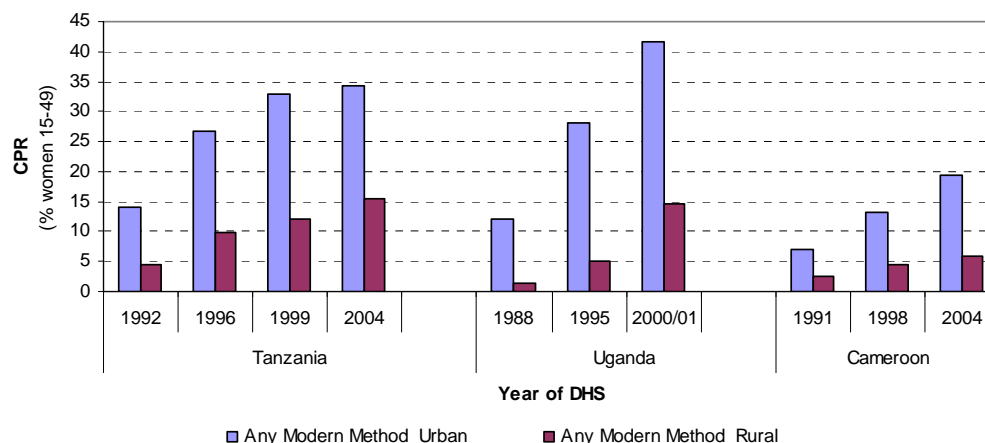
**Figure 3.7 Contraceptive Prevalence Rate by Region and Geographic Distribution
(DHS 1994-2004, most recent country data)**



Source: Gwatkin et al. 2007.

Even though analysis of DHS data shows some positive results in that CPRs have increased over the years in Sub-Saharan Africa, in many countries such as Tanzania, Uganda, and Cameroon, most of this success has taken place in urban areas (Figure 3.8).

Figure 3.8 Contraceptive Prevalence Rate in Selected Countries by Geographic Distribution and Year (DHS 1988-2004)



Sources: Demographic and Health Surveys 1991-2004.

High fertility contributing to inequities in other sectors

In addition to poverty, gender, youth, and geography contributing to inequities in fertility outcomes, there is an impact in the other direction as well, with fertility driving inequities in sectors such as education and employment. The long-standing quantity and quality of children argument illustrates how fertility can drive inequities in education and income levels. It has been shown that the more children a woman has, the less the investment is in each child (Becker and Lewis 1973). This means that in a poor, large family, each child will be less educated and will subsequently have lower income than each child in a smaller family. In other words, larger family size can adversely affect per-child investment in education, and can create inequities in education and perpetuate poverty.

Similarly, studies have shown that fertility has an impact on women's labor force participation and income. A cross-national study suggested that the percentage of women in the labor force is directly related to the TFR (McClamroch 1996). For example, in Bolivia, contraceptive use and women working for pay outside of the home were positively correlated. Similarly, in the Philippines, the average income growth for women with one to three pregnancies was twice that of women who had undergone more than seven pregnancies (UNFPA 2005; Barnett and Stein 1998). Thus, the number of children a woman has affects employment and income, and can therefore drive inequities in this sector as well.

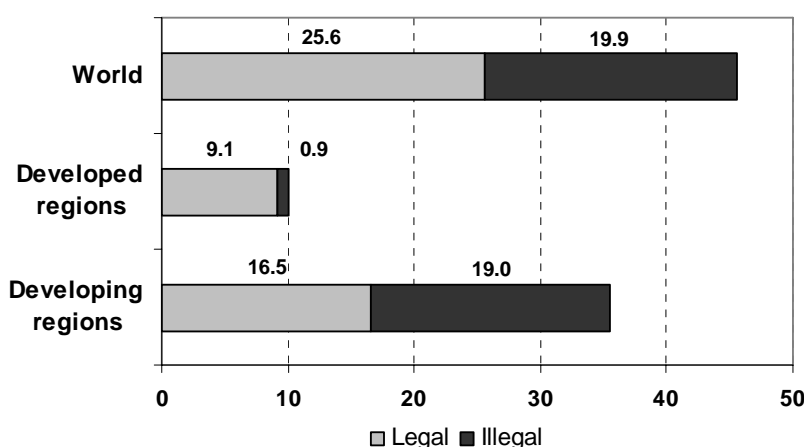
UNSAFE ABORTION

Each year, an estimated 210 million women throughout the world become pregnant and about one in five of them resort to abortion. Out of 46 million abortions performed annually, 20 million are estimated to be unsafe (Ahman and Shah 2002). Reducing unsafe abortion will directly contribute to the achievement of MDG-5 on maternal mortality. It has been estimated that some 68,000 women die each year as a consequence of unsafe abortion, and 5.3 million suffer temporary or permanent disability (Antman et al. 1992). Unsafe abortion may also increase the incidence of secondary sterility that jeopardizes the prospect for a woman to have the number of children she desires. In addition to the health consequences, unsafe abortions impose a

significant economic cost on both the individual as well as society through (a) the cost to the woman and her family in terms of lost income and the expenses incurred in seeking care for abortion complications; and (b) the use of scarce health resources for treating unsafe abortion complications that could have been prevented, so that these resources could be directed toward other health care needs.

All regions of the world appear to be affected by the practice of unsafe abortion. However, a disproportionate number of these unsafe abortions occur in developing countries, as is seen in Figure 3.9. In a country like Uganda, where family planning services are inadequate (TFR = 6.9, CPR = 18.2 percent, unmet need = 34.6 percent), about 1 million live births occur, and an estimated 300,000 induced abortions take place annually (Singh et al. 2005). Moreover, the cost of unsafe abortion is largely borne by the most vulnerable people and those who are least able to access safe services even where legal. For example, a number of studies report consistently high levels of unsafe abortion among adolescents in Africa (Mbonye 2000; Arowojolu et al. 2002; Hollander 2003).

Figure 3.9 Number of Legal and Illegal Abortions Worldwide, 1995



Source: Warriner and Shah 2006.

The main reason for a woman to seek an abortion is having an unintended pregnancy, often due to difficulties in obtaining access to an appropriate method of contraception, incorrect or inconsistent use of contraceptive methods, and contraceptive method failure. Other reasons for unwanted pregnancies include forced or unwanted sexual intercourse, and a lack of women's empowerment over sexual and reproductive matters. Societal norms, economic conditions, legal obstacles, and other systemic factors are likely to have a profound impact on women's recourse to abortion, and particularly unsafe abortion. Poverty, for example, is an important determinant in the decision to seek an abortion when women consider the financial consequences of an unintended pregnancy (Ahman and Shah 2002). Unsafe abortion figures illustrate how all four types of barriers—income, gender, geographic, and age—contribute to access to care.

Evidence from around the world points to three effective ways to mitigate the scourge of unsafe induced abortion, namely: (a) the expansion of quality family planning services in order to meet unmet needs; (b) the design of gender-sensitive programs that empower women, especially

young women, and facilitate their access to reproductive health services; and (c) the availability of information, education, and communication campaigns that highlight the dangers of unsafe abortion, but also address the stigmatization of women who undergo abortions.

CONCLUSIONS

The evidence provided shows the need for policy makers and development agencies, such as the World Bank, to address inequities in the area of reproductive health, including family planning services. Moreover, these vulnerability factors interact to exacerbate the situation—e.g. the dual factors of gender and poverty make poor women most at risk in the area of health, nutrition, and population. It is clear that without a targeted effort, both on the supply and the demand side, such inequities will persist and undermine overall progress in improving reproductive health outcomes. In this context, it is necessary to examine more closely the demand-side constraints to guide population and reproductive health programs. For example, an adequate analysis of whether the low use of contraceptives is an access issue or a motivation issue may benefit from a discussion of the multisectoral determinants of demand for birth spacing and birth limiting methods.

In addition to the health sector-related issues identified above, these vulnerable groups have less access to education, knowledge, and resources; have higher risk factors that contribute to poor overall health outcomes; are strongly influenced by cultural factors or strict religious beliefs; and are the hardest to reach in terms of behavior change communication strategies (White, Merrick, and Yazbeck 2006). Hence, based on country-level analysis, interventions that focus on some of these cross-sectoral issues, as well as stimulate demand for reproductive health services, will need to be supported.

4. GLOBAL POLICY CONTEXT

A BRIEF HISTORY

The significance of population growth, age composition, and spatial distribution in influencing development has been recognized for some time. Controversies and consensus around economic growth, population, and development have already been discussed in section 3 above.

During the 1990s, several global conferences, most notably the 1994 ICPD, called for achieving broader development goals through empowering women and meeting their needs for education and health, especially reproductive health. This new focus superseded top-down population interventions that were perceived to be narrowly focused on family planning and fertility control, and often adversely undermined individual rights⁶ and gender equity (May 2005). ICPD was successful in committing the world's nations to a comprehensive approach that included both high-quality reproductive health services, including family planning, and broad development efforts in raising educational levels, reducing infant and maternal mortality, and addressing gender inequities. However, the macroeconomic rationale for public concern with high population growth and the focus on the high fertility–household poverty relationship that has significant policy and development implications, were not dealt with in detail at ICPD. This may have unintentionally contributed to the dilution of the role of family planning in fertility decline, particularly in high-fertility countries.

In 2000, the MDGs, a new global contract between developed and developing countries to reduce extreme poverty and associated factors, was drawn up. While the MDGs do not explicitly include an overarching reproductive health goal, it is becoming increasingly obvious that many of the development goals cannot be achieved without directing attention and resources to reproductive health (Bernstein and Hansen 2006).

CURRENT ENVIRONMENT

Despite the centrality of reproductive health, including family planning, in the achievement of the MDGs, many challenges have emerged that reduce the likelihood of fulfilling the ICPD agenda.

- The devastation caused by HIV/AIDS, not fully anticipated in 1994, has affected every sector of society in many developing countries. This is not only reversing economic gains in the countries, but also requiring enormous resources to address the pandemic. There is also growing concern that AIDS is eclipsing other issues within reproductive health, sometimes resulting in donors and countries overemphasizing HIV/AIDS in their funding (Republic of Rwanda 2006).
- The reemergence of other communicable diseases such as malaria and tuberculosis, and the creation of new vertical funding initiatives adopted to address them, compete for

⁶ While ICPD did not create any new international human rights, it affirmed the application of universally recognized human rights standards to all aspects of population programs (ICPD Programme of Action)

resources with a number of health challenges, including the unmet need for family planning.

- The broad ICPD Programme of Action itself poses a dilemma for reproductive health advocates at two levels.
 - The macroeconomic rationale that was a critical underpinning of the strong political and budgetary support for international cooperation in the field of population is missing in today's population debate.
 - Securing resources may need programs to adopt a phased approach consistent with national financial and capacity constraints, which could be conceived as running counter to the inclusiveness of the ICPD agenda.
- In a number of countries, health reform, poverty reduction strategies, and new donor support mechanisms emphasizing sectorwide approaches, though not inherently unsupportive of reproductive health, may not be giving the necessary attention to reproductive health issues due to the many competing priorities.

TRENDS IN POPULATION ASSISTANCE

The ICPD Programme of Action estimated that the implementation of programs in the area of population and reproductive health – defined by Organization of Economic Cooperation and Development (OECD) and Development Assistance Committee (DAC) as family planning, maternal health, and the prevention of STDs, including HIV/AIDS, as well as programs that address the collection, analysis, and dissemination of population data – would cost US\$18.5 billion by the year 2005. Approximately two-thirds of the projected costs were expected to come from developing countries, and a third (about US\$6.1 billion) from the international donor community.

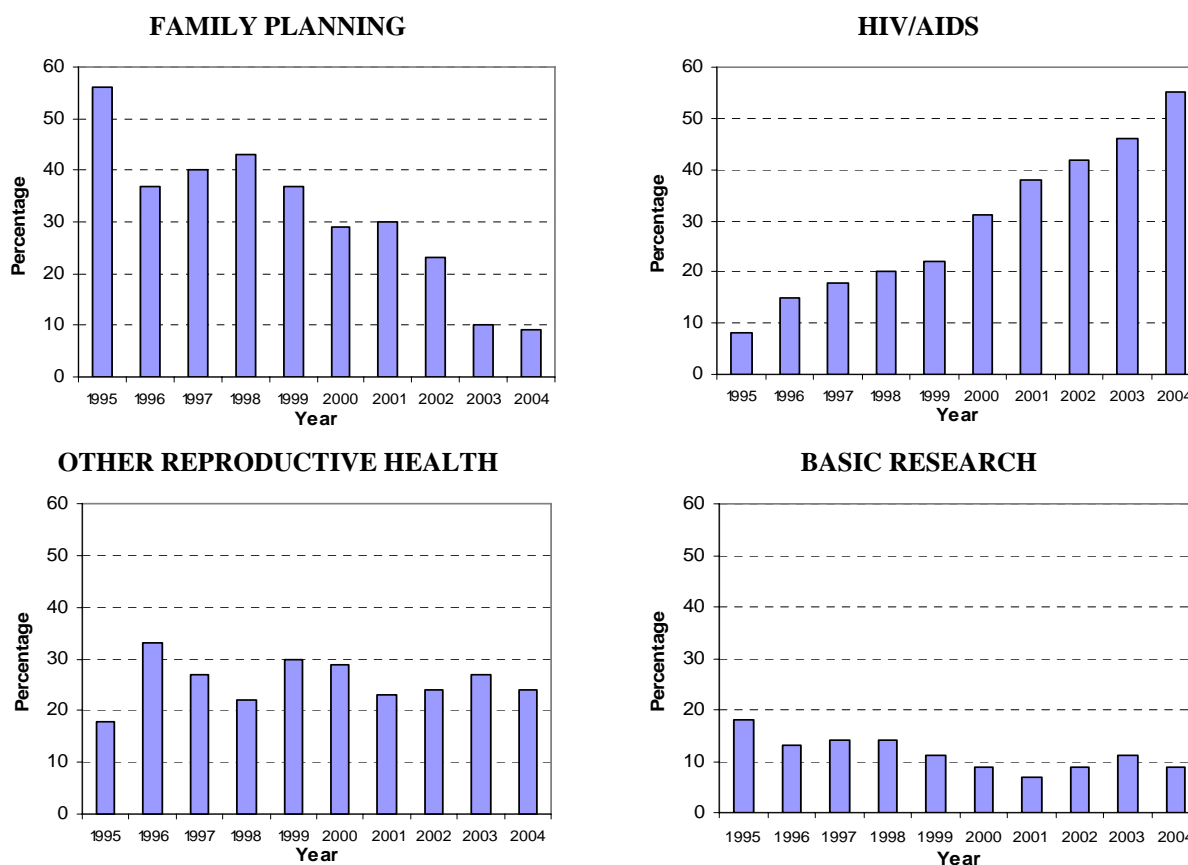
At first glance, overall trends in funding appear adequate. In constant dollars adjusted for inflation using 1993 prices (the year in which ICPD cost estimates were made), international population assistance (using the ICPD definition above), excluding development bank loans, grew at 13 percent annually until 2003 (the last year for which data is available) (UNFPA 2003). Bilateral assistance is the largest share of population assistance. Multilateral assistance through the UN system has actually declined since 1994, while private assistance has increased considerably from 1994 (UNFPA 2003). Loans from development banks fluctuate every year, depending on the project approval cycles (see section 4.2 below for World Bank support). However, even though the gap between the level of resources required and that actually made available is narrowing, there are two areas for serious concern:

The resources being allocated to population assistance fall far short of required amounts. Both donors and domestic organizations are lagging behind their promises. In real terms, estimates for 2005 show that donors would reach a funding level of approximately 70 percent of their ICPD goal, and the developing world (i.e. governments, NGOs, and consumers) would reach a funding level at about 44 percent of the ICPD goal (Dalen and Reuser 2005a). Moreover, the attainment of goals is driven to a large extent by the funding behavior of “big players”—the United States on the donor side and China on the developing side. The United States contributes far more than half of the total donor contributions, a significant part of which is committed

through the President's Emergency Plan for AIDS Relief (PEPFAR), the program for HIV/AIDS. On the developing country side, China contributes a third of all domestic government spending in the developing world. Thus, many developed and developing countries are not close to achieving the goals set at the time of ICPD. Of particular concern is that many countries, especially in Sub-Saharan Africa, do not generate domestic resources to support their population programs, and instead rely almost entirely on donor assistance.

There has been a substantial shift in spending among the various categories of the so-called “costed population package” toward STD/HIV/AIDS expenditures. Currently, almost 50 percent of the resources being provided for population are allocated to AIDS-related activities (UNFPA 2003). This shift towards STD/HIV/AIDS expenditures is likely to continue in donor assistance: in 2005, more than two-thirds of donor assistance was expected to fund such programs (Dalen and Reuser 2005b). Given this major shift in assistance toward HIV/AIDS/STD programs, it is not surprising that other elements of the ICPD package (family planning and basic research, data and population and development policy analysis) have received much less funding, as seen in Figure 4.1 below.

Figure 4.1 Expenditures for Population Activities as a Proportion of Total Population Assistance, 1995-2004



Source: UNFPA 2006.

THE WORLD BANK'S SUPPORT FOR POPULATION AND REPRODUCTIVE HEALTH ACTIVITIES

Lending

The World Bank has been lending for population and reproductive health issues since the early 1970s. Lending for population and reproductive health projects shows a general upward trend for the past decade, with some decline during FY05-FY06. In countries with high fertility (TFR > 5), however, lending for population and reproductive health has remained relatively constant for the last 10 years. This is clearly an issue that needs further analysis at the country level to determine whether the Bank can do more to assist reproductive health programs in these countries.

It is important to note that these lending figures may not be providing the full picture, as it is difficult to isolate the population component from other activities in increasingly more frequent integrated projects. This is because Bank loans are increasingly used for broader health/social sector programs that have ICPD components embedded in them, but these may go unrecorded since they are not disaggregated by the four ICPD categories. It is important that the Bank undertakes a systematic review to document both successes and failures in its work in the area of population and reproductive health so that the lessons learned can be applied to future Bank operations.

Figure 4.2 Trends in Other Population/Reproductive Health and HIV/AIDS Lending, 1997-2006

Figure 4.2a Other Population and Reproductive Health and HIV/AIDS Lending: 3-Year Rolling Averages FY97-FY06

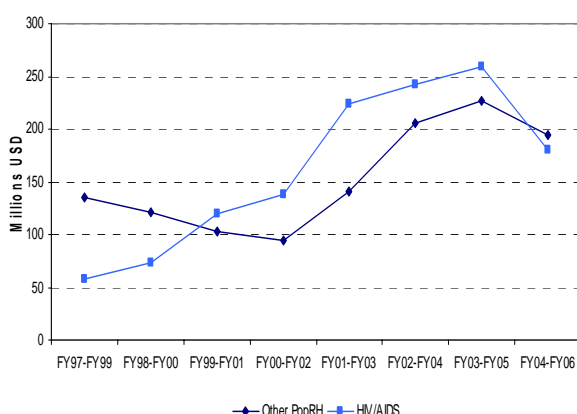
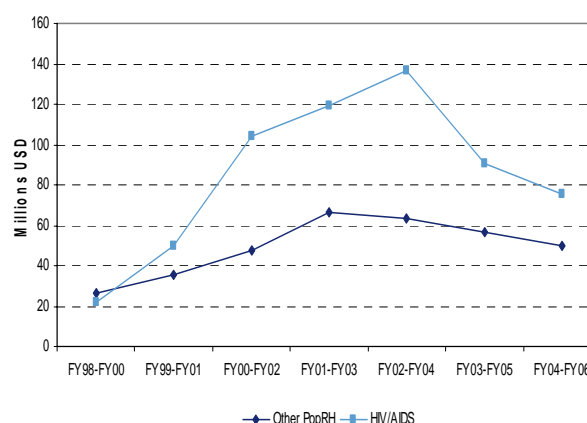


Figure 4.2b Other Population and Reproductive Health and HIV/AIDS Lending in Countries with TFR > 5: 3-Year Rolling Averages FY98-FY06



Source: Business Warehouse database of the World Bank

Non-lending

An analysis of non-lending activities in high-fertility countries show that for the period from fiscal year 2001 to fiscal year 2006, about 50 percent of the high-fertility countries had population and reproductive Analytical and Advisory Activities (AAA) (53 ESW⁷ and 7 TA⁸).

⁷ Economic and Sector Work

⁸ Technical Assistance

Most of the ESW and TA with a population and reproductive health component have health system performance as the primary theme (less than 10 percent of ESW and 30 percent of TA have population and reproductive health as a primary theme). Country-level analysis is needed to determine where additional analytical work is required to better guide Bank population support to these countries.

Country Assistance Strategy (CAS) Review

An analysis of the most recent CASs of the 35 high-fertility countries, 11 selected mid-fertility countries with high population momentum, and two low-fertility countries revealed the following:

- Of the 35 high-fertility countries, 29 had CASs available for analysis, of which 21 percent addressed high or excessive fertility, 59 percent addressed population and family planning, and 41 percent addressed reproductive health in general.
- Of the 11 mid-fertility countries selected, 10 had CASs available for analysis, which showed that while 44 percent recognized population as an issue, only 11 percent addressed fertility specifically. Meanwhile, 22 percent included family planning in the discussion, while 11 percent included reproductive health.
- The analysis of the two low-fertility country CASs revealed that one of them, the Russian Federation, addressed declining fertility as an emerging issue. (Annex 1).

The above picture clearly indicates the need to work more intensively on mainstreaming population and reproductive health issues within the development agenda of countries in which fertility issues still need to be addressed. Niger, Yemen, Burundi, and Timor-Leste are examples of CASs that address population and fertility issues substantively, while some CASs did not mention population-related issues. The other high-fertility country CASs mention population-related issues at least contextually, and a few have some significant coverage of the issues (i.e. a lending/non-lending activity or CAS indicator).

Box 3 Coverage of Population Issues in CAS: Good Practice Examples

Niger: High fertility and rapid population growth were not only acknowledged as major problems, but fertility was also used as one of the CAS performance benchmarks. Moreover, a population ESW was planned and subsequently delivered. That ESW has been most instrumental in enhancing the in-country policy dialogue on population issues, and has led to a free-standing International Development Association (IDA) population operation, currently in preparation, which is the first population-specific operation in many years in the World Bank Africa Region. The preparation of a National Population and Reproductive Health Strategy was also a CAS benchmark as well as a lending trigger, while reproductive health was included in one of the CAS pillars. Other Bank partners such as the EU have joined the effort. Finally, population issues have also been given a high priority in the new Rural and Social Policy Reform (Development Policy Lending) Credit.

Yemen: The 2006 CAS recognizes that a 2002 Population Policy Note informed the current CAS on fertility issues and has designated high fertility as one of five key CAS areas for this CAS period. Population growth rate is included in the list of indicators, and is linked to economic growth and water supply. A significant youth population is acknowledged, and high fertility rates are documented. A National Population Strategy to address these issues is in place. In the lending portfolio, restructuring of the Health Sector Reform Project (which includes family planning) is proposed and is expected to lead to a Population II Project to specifically address high fertility and family planning issues. Pillars two and three address population and reproductive health. Contraception is addressed effectively, and CPR is included as a CAS indicator. Furthermore, earlier in 2006, the Bank produced a study on “Promoting the Demand for FP in Yemen.”

Sources: World Bank CASs

Poverty Reduction Strategy Paper (PRSP) Review

Overall:

- The most recent PRSPs of the high-fertility countries (TFR ≥ 5) were analyzed for content related to population and family planning. This rapid desk analysis was done to determine if population and family planning issues were substantively addressed in the PRSPs. The methodology used is described in Annex 1. Of the 35 high-fertility countries, 27 had PRSPs available for analysis.
- Most of the PRSPs recognized population growth as an issue for poverty reduction, and had objectives or strategies to address the issue. However, many PRSPs failed to translate these objectives or strategies into specific policies or indicators to measure progress over time.
- Of the 27 PRSPs, 13 (48 percent) had at least one indicator, five (19 percent) had at least one policy, five (19 percent) had both a policy and an indicator, and 13 had neither a policy nor an indicator related to population and family planning. Most PRSPs had an indicator on condom use, but it was included with respect to STD/HIV/AIDS and was unrelated to family planning. None of the PRSPs mentioned population momentum.

Box 4 Population Issues and PRSPs: Ethiopia as a Country Example

Ethiopia, a country with high fertility, had a PRSP which addressed population issues substantially. High fertility and rapid population growth were not only acknowledged as major impediments to economic growth and poverty reduction, but were included as one of the specific goals and translated into action. Ethiopia's National Population Policy has targets of reducing TFR to 4 and increasing CPR to 44 percent by 2015. Specific activities to achieve these goals include improvements in the quality and scope of reproductive health service delivery; population research, data collection and dissemination; expansion and strengthening of domestic capacity for training in population; female education policies, and expansion of information, education, and communication (IEC) activities and social mobilization.

Source: World Bank PRSP

5. FUTURE DIRECTIONS FOR THE BANK IN THE POPULATION FIELD

This section will first discuss the comparative advantages of the Bank in achieving HNP results focusing in more detail on the population, or “P,” subsector. The second part will discuss practical steps for the Bank to employ in strengthening the population agenda at the country level.

COMPARATIVE ADVANTAGES OF THE BANK IN ACHIEVING HNP RESULTS

The following actual and potential comparative advantages for HNP results identified by the Health Sector Strategy Update Briefing Note are particularly relevant for achieving the population agenda:

- multisectoral approach to country assistance
- health systems approach to country assistance
- capacity for large-scale implementation of programs
- core economic and fiscal analysis capacity across sectors
- substantial country focus and presence
- engaging private health actors

Using these comparative advantages to their full potential in order to achieve results in strengthening population policy and programs are discussed below.

Multisectoral approach. As discussed earlier, fertility is influenced by trends in many sectors. In particular, female education, gender empowerment, female labor participation, and income growth can all have a major impact on increasing demand for family planning and in reducing fertility. However, population and reproductive health issues have traditionally been harbored within the HNP sector, even though population and reproductive health issues are impacted, positively or negatively, by many other sectors, such as education, gender, social protection, and poverty reduction and economic management (PREM). A more systematic approach to mainstream population within the core agenda of both the Human Development (HD) and PREM networks would greatly enhance the adoption of a truly multisectoral approach. In this context, there are a number of population specialists within the Bank who are employed in other sectors or networks, and are currently not used sufficiently for population-related work.

Health systems approach to country assistance. Family planning is an integral part of reproductive health services, and it is now increasingly acknowledged that provision of comprehensive reproductive health services serves as a proxy indicator of a functioning health system. Moreover, an effective health system also reduces child mortality, which in turn has been linked to declines in fertility levels. In addition, addressing “dual protection” (protection against STIs and HIV/AIDS, as well as unintended pregnancies), as well as offering family planning services and HIV counseling in a synchronized manner is more likely through a well-functioning health system.

The Bank’s comparative advantages in strengthening health systems are mainly in the areas of health financing, system governance, accountability for health service delivery, and demand-side interventions, all of which are important to further the population agenda.

Family planning services have been particularly susceptible to underfunding. As discussed earlier, both governments and donors have not lived up to their financial commitments to support family planning and, as a result, shortfalls of contraceptive supplies pose a growing problem. The Bank, with its sector and fiscal analysis capacity, as well as engagement in policy dialogue with senior stakeholders, can help address this critical issue through donor harmonization and aid alignment, and mainstreaming family planning financing needs within a country's national health plan.

Another factor limiting contraceptive supplies is the inadequate logistics capacity in many developing countries. At the country level, a sound logistics system ensures the smooth distribution of contraceptive commodities and other supplies so that each service delivery point has sufficient stock to meet clients' needs.

Influencing household behaviors is also recognized as critical for the use of family planning services. Socio-cultural factors such as disapproval by family and the community discourages some potential clients, while in some countries, providers and even programs may deny services to vulnerable groups such as unmarried adolescents. The low status of women often poses a barrier: although more than two-thirds of family planning users worldwide are women, in many societies, women lack the power to make independent decisions about using contraceptives or seeking services. Educating girls, improving female economic opportunities, and giving women voice and choice in the design, management, and oversight of reproductive health programs, are some ways to encourage access to health services. Moreover, effective behavior change and communication is central to family planning services, and can lead to higher rates of contraceptive adoption, effective use, and continuation.

Capacity for large-scale implementation of programs. It is important to note that Bank support is shifting toward supporting broader country health sector strategies rather than financing individual programs. Such support is directed toward building country capacity in the health sector, including strengthening logistics and financial management, providing a continuum of care from community to facility level, strengthening human resource management, and monitoring for results—all of which are critical for successful family planning programs. By supporting large-scale implementation of an integrated health sector plan that includes family planning, the Bank can play an important role in keeping family planning as a priority in high-fertility and high-population-momentum countries. Even though historically some successful family planning programs were based on a vertical approach, such an approach is now considered less attractive, both from a sustainability standpoint as well as from a comprehensive reproductive health approach.

Core economic, fiscal, and cross-sectoral analysis capacity across sectors. The Bank is well positioned to systematically include population and reproductive health dimensions in key strategic documents, such as the CAS, the Country Economic Memorandum (CEM), and the Public Expenditure Review (PER). The Bank is particularly well placed to provide the fiscal and economic analysis to ensure that funding of population issues is placed within the overall development financing agenda of the country. Population dimensions must also be taken into account in key documents prepared by the World Bank's clients, or with them, such as the PRSP and the Poverty Reduction Strategy Credit (PRSC). Emphasis should also be put on a number of critical linkages, such as the synergies between reproductive health and HIV/AIDS programs,

and fertility and educational attainment. It should be noted that, once done, the analysis of population and reproductive health issues are available for use in key strategic documents prepared either by the World Bank or by the client countries.

Substantial country focus and presence. The bulk of the work on population and reproductive health issues is to be done at the country level. The decentralization of Bank programs and staff to the field level in recent years has further strengthened country-level policy dialogue. Addressing institutional changes that are needed in-country in order to integrate population issues across key sectors requires sustained engagement at the country level. In this context, a clear strategy and strong political commitment are needed. This strategy can be best achieved by a coordinated strategy implemented by a visible, strong, and high-level in-country unit with the mandate to design, monitor, and evaluate the effectiveness of the program. The Bank can help strengthen such institutional mechanisms, and foster collaboration with external national or international partners.

Engaging private sector health actors. It is important to engage private sector actors—the commercial sector, NGO sector, and social marketing—in order to achieve contraceptive security. Countries should consider information about the market for family planning commodities and services in order to define and promote complementary roles for the public and private sectors, as well as to better identify which segments of the population each of those sectors should serve. The public sector can create conditions that support and promote a greater role for the private sector in meeting the growing needs of family planning users. Taking steps to actively involve and expand the private sector's market share is a critical strategy for achieving a more equitable distribution of available resources, addressing unmet need, and ensuring family planning services and commodities security. The Bank can play a crucial role in influencing the public policy dialogue to promote such participation by the various private actors.

TRANSLATING THEORY TO PRACTICE

The above section identifies a number of entry points for the Bank to engage on population issues from both within and outside the health sector. In practice, the World Bank assists its client countries through analytical work, policy dialogue, technical assistance, and a lending or grant program. The role of political economy in the implementation of population and reproductive health programs and policies is critical. The Bank, by providing the necessary analytical basis for policy discussion, can play a constructive role in prompting policy makers to take action *now* for future changes in population structure and size. Given the different demographic contexts, the Bank's engagement with countries will need to be tailored to the specific needs of countries.

In the *high-fertility countries*, the Bank, in collaboration with country counterparts, will need to carry out analytical work first, to identify the most important barriers to bringing about a reduction in fertility. As mentioned earlier, such analytical work should be reflected consistently in key strategic documents that inform the policy dialogue, such as CASSs, CEMs, PERs, PRSPs. This analytical work should also form the basis for the generation of advocacy products that target high-level policy makers and other stakeholders who can shape the population policy dialogue. It is important to note that in a number of these high-fertility countries, HIV/AIDS is also a major public health and development issue, and the analytical work and training materials

would need to be developed within this context. The analytical work should begin immediately as part of the fiscal year 2008 work program, and should cover several countries per year, with priority given to countries that are developing new CASs or PRSPs. The analytical basis may lead to either specific population and reproductive health lending (as in the case of Niger in 2005), or to greater emphasis on population and reproductive health in other operations. In this context, there is a need to jointly develop training materials with WBI to help staff target policy makers and implementers in high-fertility settings.

A key change to signal in our “business model” of working in these high-fertility countries is to incorporate population work within the core agendas of both PREM and HD. Unless population issues are approached in a multipronged fashion, it is unlikely to accelerate a demographic transition in these countries. The focus of Bank operations dealing with population and reproductive health in these countries should include an emphasis on generating the demand for reproductive health services through strengthening female education, improving women's economic opportunities, and reducing gender disparities, as well as strengthening services that provide contraception and other reproductive health services.

In the *mid-fertility countries*, where fertility has started to decline, a more focused approach will be needed. In many of these countries, women in poor households and rural areas still have very high fertility, and strengthening services to reach these populations would be a priority. Depending on when fertility decline started, these countries may have large youth populations, and the Bank should stand ready to provide analytical support for how to respond to the large numbers of adolescents in need of education, health services, and skills needed to enter the labor market. Country-specific needs for Bank financing to address population and reproductive health issues will vary among the countries in this group.

In *low-fertility* client countries, the Bank should build on existing analytical work (World Bank 2005; Chawla et al. Forthcoming) and provide support as needed on issues related to aging, such as reforming health services, social security schemes, and the impact of long-term low fertility on the labor force and economic growth.

A key aspect of the Bank's HNP work is to assist countries in measuring progress in addressing priority HNP outcomes. Indicators to measure results in population issues are included within the overall HNP results framework (See Annex 5) and effort should be made to mainstream these indicators within a country's monitoring and evaluation system.

The Bank works on population and reproductive health issues along with a wide array of development partners and global partnerships, such as the Partnership for Maternal, Newborn and Child Health and Reproductive Health Supplies Coalition. As was noted in the section on the global policy context, it is impossible for the Bank to work on reproductive health issues without the support and collaboration of the broader international community. The UNFPA is the lead technical agency in the population field, with a large network of field offices. The Bank already uses UNFPA's contraceptive procurement know-how and has intensified its collaboration in other areas (e.g., training and country program management). The WHO, as the normative agency, is a critical partner at both the global and country levels. As population issues are linked to reproductive health, HIV/AIDS, and child survival, the Bank works also with WHO, UNAIDS, and the United Nations Children's Fund (UNICEF), respectively. Bilateral donors are playing an

important role (e.g., DFID, NORAD, SIDA, Netherlands, KfW), both in determining priority investments and developing the financing framework for such investments. The Bank is also increasingly partnering with the numerous NGOs active in population and reproductive health to reach vulnerable populations and to increase the demand for reproductive health services.

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ANNEX 1. THE BANK'S AND CLIENT COUNTRIES' ACTIVITIES TO ADDRESS POPULATION ISSUES: REVIEW OF CASS AND PRSPS

A review of most recent CASS and PRSPs of countries with high fertility rates ($TFR \geq 5$); medium fertility rates ($2.5 < TFR < 5$) and high population momentum; and low fertility rates ($TFR < 2.5$) was conducted to determine the extent to which the World Bank and its client countries address population issues at the country level. Of the 35 high-fertility countries, 29 CASS and 27 PRSPs were available for review, as listed in Table A1. Of the medium-fertility countries with high population momentum, 10 CASS were reviewed (Table A2). Finally, two CASS of countries with low fertility were reviewed. The most recently available CASS and PRSPs were downloaded from the World Bank's Image Bank. A desk review was done by searching for selected population terms to check the contents of the documents for involvement in population issues.

Table A1. High-Fertility Countries: $TFR > 5$

CAS	PRSPs
Benin	Afghanistan
Burkina Faso	Burkina Faso
Burundi	Burundi
Chad	Chad
Congo, Rep. of	Congo, Dem. Rep.
Côte d'Ivoire	Congo, Rep. of
Djibouti	Côte d'Ivoire
Equatorial Guinea	Djibouti
Eritrea	Ethiopia
Ethiopia	Guinea
Guinea	Guinea-Bissau
Guinea-Bissau	Kenya
Kenya	Madagascar
Madagascar	Malawi
Malawi	Mali
Mali	Mauritania
Mauritania	Mozambique
Mozambique	Niger
Niger	Nigeria
Nigeria	Rwanda
Rwanda	Senegal
Senegal	Sierra Leone
Sierra Leone	Tanzania
Tanzania	Timor-Leste
Timor-Leste	Uganda
Togo	Yemen, Republic of
Uganda	Zambia
Yemen, Republic of	
Zambia	

Table A2. Countries with $2.5 < \text{TFR} < 5$ and High Population Momentum

Country	Population Momentum	TFR
Bangladesh	1.5	3.2
Bolivia	1.6	4
Ghana	1.6	4.4
Guatemala	1.7	4.6
India	1.4	3.1
Jordan	1.7	3.5
Morocco	1.5	2.8
Pakistan	1.7	4.3
Philippines	1.5	3.2
Uzbekistan	1.6	2.7

Table A3. Countries with $\text{TFR} < 2.5$

Country	TFR
Russian Federation	1.3
Ukraine	1.1

Methodology for CAS Review

The CASs were reviewed using the following terms:

- Fertility (e.g. “high fertility” or “excessive fertility”)
- Population (not just documentation of what the population is, but rather within the context of population issues)
- Family planning
- Contraceptive
- Contraception
- Reproductive health

The CASs were reviewed to identify the presence of the above terms in a substantive capacity, particularly in the notional projects. If the terms existed for statistical purposes only, they were not included in the datasheet. If, however, the terms existed for more substantial purposes—indicators, lending triggers, proposed lending or non-lending activities—then they were included in the resulting datasheet. Thus, context was particularly important in the analysis.

Methodology for PRSP Review

The search terms used were:

- population momentum
- fertility
- population or population growth rate
- family planning
- contraceptives or contraception
- condom use
- reproductive health (family planning within reproductive health)

Once the terms were identified, the paragraph/sentence in which the term appeared was read to check if the term substantially addressed any of the population issues. The terms were considered to be substantive if they appeared in policy statements or in an indicator. A count was done for each substantive term addressing population issues. The terms were, however, considered insignificant if they appeared only in the background description or for statistical purposes, or if they appeared in goals, objectives, or strategies, but were not subsequently translated into policy or indicators. The counts and the context of the use of the terms were entered into a spreadsheet.

The following were considered while searching and reading the context for the defined terms:

A. Population momentum

- Is it recognized as an issue?
- Are there objectives/indicators that explicitly address population momentum issues?

B. Population Issues

- Are there any objectives to address population issues?
- Are indicators identified to measure progress?
- Is it included in pillars, intervention, or for data collection?

C. High Fertility

- Are there any objectives to address high fertility?
- Are indicators identified to measure TFR over time?
- Is it included in pillars, intervention, or for data collection?

D. Population growth rare

- Are there any objectives to address high growth rate?
- Are indicators identified to measure growth rate over time?
- Is population growth included in pillars, intervention, or for data collection?

E. Family planning (FP)

- Are there any objectives to address family planning programs?
- Are indicators identified to measure FP progress?
- Is it included in pillars, intervention, or for data collection?

F. Contraceptives or contraception

- Are there any objectives to promote contraceptive utilization rates in the country?
- Are indicators identified to measure progress?
- Is it included in pillars, intervention, or for data collection?

G. Condom use

- Is any information provided on condom use in the country?
- Does the term condom used in context to contraception?
- Is it included in pillars, intervention, or for data collection?

H. Reproductive Health (RH)

- Is family planning explicitly mentioned within RH context?
- Are indicators identified to measure RH/FP progress?

Results of CAS Review

Overall:

The most recent CASs of the 36 high-fertility countries, 11 selected mid-fertility countries with high population momentum, and two low-fertility countries were analyzed for content related to population and fertility issues. Of the 36 high-fertility countries, 29 had CASs available for analysis, of which 21 percent addressed high or excessive fertility, 59 percent addressed population and family planning, and 41 percent addressed reproductive health in general.

Of the 11 mid-fertility countries selected, 10 had CASs available for the analysis, which indicated that while 44 percent recognized population as an issue, only 11 percent addressed fertility specifically. Meanwhile, 22 percent included family planning in the discussion, while 11 percent included reproductive health.

The analysis of the two low-fertility country CASs revealed that one of them, the Russian Federation, addressed fertility and population as emerging issues.

High-fertility country examples:

Niger, Yemen, Burundi, and Timor-Leste are examples of CASs that address population and fertility issues substantively. Mali, Sierra Leone, Mozambique, Madagascar, and Djibouti had no mention of these issues in their most recent CASs (as of July 2006). The other high-fertility country CASs mention them at least contextually, and a few have some significant coverage of the issues (i.e. a lending/non-lending activity or CAS indicator).

Niger is one of the high-fertility countries doing rather well on the population front with regard to its CAS. High fertility is not only acknowledged as a problem, but it is also one of the CAS performance benchmarks. Population growth is documented and a population ESW planned. A national Population and Reproductive Health Strategy is not only a CAS benchmark, but also a lending trigger, while reproductive health is included in one of the CAS pillars.

Yemen's 2006 CAS recognizes that a 2002 Population Policy Note informed the current CAS on fertility issues and has designated high fertility as one of five key CAS areas for this CAS period. Population growth rate is included in the list of indicators, and is linked to economic growth and water supply. A significant youth population is acknowledged. High fertility rates are documented despite a National Population Strategy. In the lending portfolio, restructuring of the Health Sector Reform Project (which includes family planning) is proposed, which is expected to lead to a Population II Project to specifically address high-fertility and family planning issues. Pillars two and three address population and reproductive health. Contraception is addressed effectively, and CPR is included as a CAS indicator. Furthermore, earlier in 2006, the Bank produced a study on "Promoting the Demand for FP in Yemen."

Burundi's CAS links population growth with food production and the environment. The government agenda includes generation of a National Population Policy to reduce demographic growth. A "Health and Population" lending project is proposed.

Timor-Leste's CAS mentions population growth rate several times, and links population growth with per-capita income, poverty, food security, and land use. The growing youth population is mentioned with regard to the need for job creation. A Population AAA is proposed, and family planning is included in the service delivery pillar.

Results of PRSP Review

Overall:

The most recent PRSPs of the high fertility countries ($TFR \geq 5$) were analyzed for content related to population and family planning. This rapid desk analysis was done to determine if population and family planning issues were substantively addressed in the PRSPs. Of the 35 high-fertility countries, 27 had PRSPs available for analysis.

Most of the PRSPs recognized population growth as an issue, and had objectives or strategies to address the issue. However, many PRSPs failed to translate these objectives/strategies into specific policies or indicators to measure progress over time.

Of the 27 PRSPs, 13 (48 percent) had at least one indicator, five (19 percent) had at least one policy, five (19 percent) had both policy and an indicator, and 13 PRSPs had neither a policy nor an indicator related to population and family planning. Most PRSPs had an indicator on condom use, but it was included with respect to STI/HIV/AIDS and was unrelated to family planning. None of the PRSPs mentioned population momentum.

High-fertility country examples:

Yemen is one of the high-fertility countries where population issues were addressed substantially in the PRSP. High fertility and rapid population growth were not only acknowledged as major impediments to economic growth and poverty reduction, but was included as one of the specific goals that was subsequently translated into policies, programs, and an indicator (reduce population growth rate by 3 percent per annum). Moreover, budget was allocated specifically for each of the four population policies that were outlined.

Ethiopia, a country with high fertility, had a PRSP which addressed population issues substantially. High fertility and rapid population growth were not only acknowledged as major impediments to economic growth and poverty reduction, but were included as one of the specific goals and translated into action. Ethiopia's National Population Policy has targets of reducing TFR to 4 and increasing CPR to 44 percent by 2015. Specific activities to achieve these goals include improvements in the quality and scope of reproductive health service delivery; population research, data collection and dissemination; expansion and strengthening of domestic capacity for training in population; and expansion of IEC activities and social mobilization.

ANNEX 2A. TOTAL FERTILITY RATE AND TOTAL POPULATION IN HIGH-FERTILITY COUNTRIES

Country	Population (in million)		Country	Population (in million)	
	TFR 2000-2005	2005		TFR 2000-2005	2005
Niger	7.9	14.0	Equatorial Guinea	5.9	0.5
Timor-Leste	7.8	1.0	Ethiopia	5.9	71.3
Afghanistan	7.5	..	Guinea	5.9	9.4
Guinea-Bissau	7.1	1.6	Mauritania	5.8	3.1
Uganda	7.1	28.8	Nigeria	5.8	131.5
Mali	6.9	13.5	Rwanda	5.7	9.0
Angola	6.8	15.9	Zambia	5.7	11.7
Burundi	6.8	7.5	Eritrea	5.5	4.4
Liberia	6.8	3.3	Mozambique	5.5	19.8
Burkina Faso	6.7	13.2	Madagascar	5.4	18.6
Chad	6.7	9.7	Togo	5.4	6.1
Congo, Dem. Rep.	6.7	57.5	Côte d'Ivoire	5.1	18.2
Sierra Leone	6.5	5.5	Djibouti	5.1	0.8
Somalia	6.4	8.2	Kenya	5.0	34.3
Congo, Rep.	6.3	4.0	Senegal	5.0	11.7
Yemen, Rep. of	6.2	21.0	Tanzania	5.0	38.3
Malawi	6.1	12.9	Central African Rep.	5.0	4.0
Benin	5.9	8.4			

Sources: United Nations World Population Prospects: The 2004 Revision. World Development Indicators 2006

ANNEX 2B. TOTAL FERTILITY RATE BY BACKGROUND CHARACTERISTICS FOR SELECTED HIGH-FERTILITY COUNTRIES

Total fertility rate by background characteristics								
Country and year of survey	TFR	Residence		Highest educational level			Wealth Quintiles	
		Urban	Rural	No education	Primary	Secondary or higher	Lowest	Highest
Benin 2001	5.6	4.4	6.4	6.3	4.9	3.6	7.2	3.5
Burkina Faso 2003	5.9	3.4	6.5	6.3	4.5	2.5	6.6	3.6
Chad 2004	6.3	5.7	6.5	6.3	7.4	4.2	5.1	6.0
Eritrea 2002	4.8	3.5	5.7	5.5	4.2	3.1	-	-
Ethiopia 2000	5.5	3.0	6.0	5.9	4.7	3.2	6.3	3.6
Kenya 2003	4.9	3.3	5.4	6.7	5.5	3.2	7.6	3.1
Madagascar 2003/2004	5.2	3.7	5.7	6.5	5.7	3.4	-	-
Malawi 2000	6.3	4.5	6.7	7.3	6.4	3.0	7.1	4.8
Mali 2001	6.8	5.5	7.3	7.1	6.6	4.1	7.3	5.3
Mauritania 2000/01	4.5	4.1	4.8	4.8	4.7	3.2	5.4	3.5
Mozambique 2003	5.5	4.4	6.1	6.3	5.3	2.9	6.3	3.8
Nigeria 2003	5.7	4.9	6.1	6.7	6.3	4.2	6.5	4.2
Rwanda 2000	5.8	5.2	5.9	6.2	5.8	4.9	6.0	5.4
Tanzania 2004	5.7	3.6	6.5	6.9	5.6	3.3	7.3	3.3
Uganda 2000/01	6.9	4.0	7.4	7.8	7.3	3.9	8.5	4.1
Zambia 2001/02	5.9	4.3	6.9	7.4	6.5	3.9	7.3	3.6

Sources: Demographic and Health Surveys

ANNEX 2C. REPRODUCTIVE HEALTH INDICATORS FOR 35 HIGH-FERTILITY COUNTRIES

Selected fertility and family planning indicators for high-fertility countries					
		Teenage pregnancy (%)	Current use of contraception, currently married women (%)		Knowledge of contraceptive methods, currently married women (%)
Country and year of survey	Total fertility rate 15-49	Percentage who has had at least one pregnancy	Any method	Any modern method	Any modern method
Benin 1996	6.0	26.0	16.4	3.4	76.2
Benin 2001	5.6	21.5	18.6	7.2	90.7
Burkina Faso 1992/93	6.5	-	24.9	4.2	-
Burkina Faso 1998/99	6.4	25.4	11.9	4.8	77.2
Burkina Faso 2003	5.9	23.2	13.8	8.8	90.4
Burundi 1987	6.9	5.9	8.7	1.2	63.8
Central African Republic 1994/95	5.1	36.1	14.8	3.2	68.6
Chad 1996/97	6.4	38.5	4.1	1.2	42.8
Chad 2004	6.3	36.6	2.8	1.6	48.6
Côte d'Ivoire 1994	5.3	35.0	11.4	4.3	71.5
Côte d'Ivoire 1998/99	5.2	31.0	15.0	7.3	86.9
Eritrea 1995	6.1	23.0	8.0	4.0	62.0
Eritrea 2002	4.8	14.0	8.0	7.3	87.2
Ethiopia 2000	5.5	16.3	8.1	6.3	85.3
Guinea 1999	5.5	37.2	6.2	4.2	69.1
Kenya 1989	6.7	25.4	26.9	17.9	91.3
Kenya 1993	5.4	20.5	32.7	27.3	96.9
Kenya 1998	4.7	20.9	39.0	31.5	97.7
Kenya 2003	4.9	23.0	39.3	31.5	95.3
Liberia 1986	6.7	45.4	6.4	5.5	68.0
Madagascar 1992	6.1	29.0	16.7	5.1	61.7
Madagascar 1997	6.0	35.7	19.4	9.7	69.3
Madagascar 2003/2004	5.2	34.0	27.1	18.3	84.2
Malawi 1992	6.7	34.7	13.0	7.4	91.8
Malawi 2000	6.3	33.0	30.6	26.1	98.4
Mali 1987	7.1	50.6	4.7	1.3	28.6
Mali 1995/96	6.7	41.5	6.7	4.5	64.6
Mali 2001	6.8	40.4	8.1	5.7	76.2
Mauritania 2000/01	4.5	15.8	8.0	5.1	68.2
Mozambique 1997	5.2	40.0	5.6	5.1	60.4
Mozambique 2003	5.5	41.0	25.5	20.8	90.4

		Teenage pregnancy (%)	Current use of contraception, currently married women (%)		Knowledge of contraceptive methods, currently married women (%)
Country and year of survey	Total fertility rate 15-49	Percentage who has had at least one pregnancy	Any method	Any modern method	Any modern method
Niger 1992	7.0	36.2	4.4	2.3	58.0
Niger 1998	7.2	43.1	8.2	4.6	75.1
Nigeria 1990	6.0	28.3	6.0	3.5	41.2
Nigeria 1999	4.7	21.9	15.3	8.6	61.9
Nigeria 2003	5.7	25.2	12.6	8.2	76.2
Rwanda 1992	6.2	10.5	21.2	12.9	98.8
Rwanda 2000	5.8	6.8	13.2	5.7	96.8
Senegal 1986	6.4	30.5	11.3	2.4	67.8
Senegal 1992/93	6.0	23.8	7.5	4.8	70.4
Senegal 1997	5.7	22.3	12.9	8.1	82.5
Tanzania 1992	6.2	29.0	10.4	6.6	77.6
Tanzania 1996	5.8	26.1	18.4	13.3	87.7
Tanzania 1999	5.6	24.5	25.4	16.9	94.9
Tanzania 2004	5.7	26.0	26.4	20.0	97.4
Togo 1988	6.4	26.5	33.9	3.1	81.4
Togo 1998	5.2	19.4	23.5	7.0	93.4
Uganda 1988	7.4	37.2	4.9	2.5	77.9
Uganda 1995	6.9	42.9	14.8	7.8	91.6
Uganda 2000/01	6.9	31.4	22.8	18.2	97.5
Zambia 1992	6.5	33.8	15.2	8.9	90.7
Zambia 1996	6.1	30.7	25.9	14.4	97.7
Zambia 2001/02	5.9	31.6	34.2	25.3	99.1
Yemen, Republic of 1991/92	7.7	14.1	9.7	6.1	53.2
Yemen, Republic of 1997	6.5	15.5	20.8	9.8	79.2

Sources: Demographic and Health Surveys

ANNEX 2D. REPRODUCTIVE HEALTH INDICATORS FOR 35 HIGH-FERTILITY COUNTRIES

	Need for family planning services (%)			Source of supply for current modern contraceptive methods		
	Unmet need - space	Unmet need - limit	Unmet need - total	Public	Private medical or other private	Other, don't know or missing
Benin 1996	17.2	8.6	25.7	43.5	46.8	9.6
Benin 2001	17.5	9.7	27.2	45.5	50.1	4.4
Burkina Faso 1992/93	18.2	6.3	24.5	-	-	-
Burkina Faso 1998/99	19.0	6.8	25.8	53.0	43.1	3.9
Burkina Faso 2003	21.8	7.0	28.8	53.9	43.8	2.3
Burundi 1987	-	-	-	86.7	10.5	2.8
Central African Republic 1994/95	11.6	4.6	16.2	49.3	44.9	5.7
Chad 1996/97	6.6	3.1	9.7	59.3	15.7	25.0
Chad 2004	18.4	2.3	20.7	60.0	36.9	3.1
Côte d'Ivoire 1994	20.0	7.1	27.1	25.5	66.9	7.6
Côte d'Ivoire 1998/99	20.0	7.6	27.7	30.8	64.4	4.9
Eritrea 1995	21.4	6.1	27.5	78.4	19.9	1.7
Eritrea 2002	21.0	6.0	27.0	74.0	23.0	3.0
Ethiopia 2000	21.3	13.8	35.2	77.5	19.7	2.8
Guinea 1999	16.0	8.2	24.2	49.9	42.1	8.0
Kenya 1989	-	-	-	70.5	28.5	1.0
Kenya 1993	21.4	14.1	35.5	69.2	29.2	1.7
Kenya 1998	14.0	9.9	23.9	58.0	41.7	0.4
Kenya 2003	14.4	10.1	24.5	53.4	46.5	0.1
Liberia 1986	-	-	-	31.1	67.0	2.0
Madagascar 1992	16.5	16.0	32.4	38.8	59.9	1.3
Madagascar 1997	14.1	11.4	25.6	52.1	46.8	1.1
Madagascar 2003/2004	11.3	12.3	23.6	57.5	41.2	1.3
Malawi 1992	23.6	12.1	35.7	69.9	28.7	1.5
Malawi 2000	17.2	12.5	29.7	68.0	19.3	12.8
Mali 1987	-	-	-	76.9	8.8	14.3
Mali 1995/96	20.1	5.7	25.7	52.0	31.1	17.0
Mali 2001	20.9	7.6	28.5	51.8	44.7	3.6
Mauritania 2000/01	22.9	8.6	31.6	69.2	22.5	8.2
Mozambique 1997	16.9	5.6	22.5	82.7	13.1	4.1
Mozambique 2003	10.8	7.5	18.4	69.0	28.9	2.1
Niger 1992	15.7	3.0	18.7	93.3	6.3	0.4
Niger 1998	14.0	2.7	16.6	83.6	16.0	0.3

	Need for family planning services (%)			Source of supply for current modern contraceptive methods		
	Unmet need - space	Unmet need - limit	Unmet need - total	Public	Private medical or other private	Other, don't know or missing
Nigeria 1990	15.5	4.9	20.5	37.1	59.8	3.1
Nigeria 1999	12.9	4.5	17.4	42.9	49.8	7.3
Nigeria 2003	11.8	5.1	16.9	22.8	72.0	5.2
Rwanda 1992	20.8	18.0	38.8	96.3	0.7	3.1
Rwanda 2000	24.0	11.6	35.6	69.0	29.8	1.3
Senegal 1986	-	-	-	46.7	43.0	10.3
Senegal 1992/93	22.3	7.0	29.3	59.1	36.3	4.5
Senegal 1997	25.5	9.4	34.8	68.3	30.2	1.4
Tanzania 1992	18.8	9.0	27.9	72.9	21.9	5.2
Tanzania 1996	15.4	8.5	23.9	74.2	21.8	4.0
Tanzania 1999	13.8	8.0	21.8	67.2	32.2	0.6
Tanzania 2004	15.1	6.7	21.8	68.4	23.4	8.2
Togo 1988	-	-	-	41.7	45.2	13.1
Togo 1998	21.4	10.9	32.3	48.0	50.6	1.3
Uganda 1988	-	-	-	82.7	15.7	1.5
Uganda 1995	18.3	10.7	29.0	47.4	49.6	3.0
Uganda 2000/01	20.7	13.9	34.6	36.0	61.8	2.2
Zambia 1992	21.6	9.1	30.7	56.1	43.2	0.7
Zambia 1996	18.7	7.8	26.5	59.9	35.8	4.3
Zambia 2001/02	16.8	10.6	27.4	60.9	37.5	1.6
Yemen, Republic of 1991/92	-	-	-	47.4	44.6	8.0
Yemen, Republic of 1997	17.2	21.4	38.6	49.4	47.5	3.1

Sources: Demographic and Health Surveys

ANNEX 2E. REASONS PROVIDED BY WOMEN FOR NOT USING CONTRACEPTION

DHS	Reason for not using contraception					
	Wants more children	Opposition to use	Knows no method	Knows no source	Health concerns	Access or cost
Benin 2001	17.6	17.6	5.2	2.9	14.3	1.4
Burkina Faso 2003	17.5	13.7	3.9	5.8	10.0	3.2
Cameroon 2004	37.4	11.8	4.7	1.2	7.2	0.8
Chad 2004	19.0	18.0	19.3	7.5	4.0	0.8
Côte d'Ivoire 1998/99	39.8	17.4	8.3	4.2	4.1	0.2
Eritrea 2002	60.3	7.4	4.4	3.9	4.8	0.2
Ethiopia 2000	41.8	10.4	7.9	1.8	10.4	0.3
Ghana 2003	13.8	8.8	4.4	1.3	33.2	1.8
Guinea 1999	55.6	12.6	5.6	0.8	4.4	0.5
Kenya 2003	13.9	15.8	2.0	0.3	22.0	0.2
Madagascar 2003/2004	19.8	12.5	4.5	3.5	28.6	0.9
Malawi 2000	7.9	20.9	2.8	0.9	20.8	0.9
Mali 2001	16.3	32.9	8.2	3.2	8.8	1.2
Mauritania 2000/01	15.9	15.2	4.2	2.9	7.2	0.3
Mozambique 2003	49.4	9.1	2.9	1.2	4.3	1.0
Namibia 2000	21.0	16.1	4.1	0.3	11.0	0.9
Niger 1998	33.2	9.2	7.4	7.8	2.9	2.6
Nigeria 2003	36.1	17.7	7.3	1.2	8.6	0.3
Rwanda 2000	19.8	8.1	2.3	4.1	19.7	1.8
Senegal 1997	31.1	6.6	13.1	-	4.7	0.7
South Africa 1998	23.8	13.3	1.6	0.7	19.5	-
Tanzania 2004	15.6	22.9	1.8	1.1	28.4	0.3
Togo 1998	28.0	10.6	2.6	4.9	9.9	1.5
Uganda 2000/01	10.6	10.9	3.1	1.8	23.4	2.0
Zimbabwe 1999	9.3	8.9	0.5	-	10.2	2.7

Sources: Demographic and Health Surveys

ANNEX 3A. POPULATION HEALTH INDICATORS

	Total population (in thousand)	GNI per capita (current US\$)	Life expectancy at birth (years)	Population growth rate (annual %)		Population ages 0-14	Population ages 15-64	Population ages 65 and above	Dependency ratio	
				% of total			Young	Old		
	2005	2005	2004	1990-2005	2005-2020	2005	2005	2005	2005	2005
Afghanistan	-	-	-	-	-	-	-	-	-	-
Albania	3,130	2,580	74	-0.3	0.6	27	65	8	0.4	0.1
Algeria	32,854	2,730	71	1.7	1.4	30	66	5	0.5	0.1
American Samoa	58	-	-	-	-	-	-	-	-	-
Andorra	66	-	-	-	-	-	-	-	-	-
Angola	15,941	1,350	41	2.8	2.7	46	51	2	0.9	0.0
Antigua & Barbuda	81	10,920	-	1.7	-	-	-	-	-	-
Argentina	38,747	4,470	75	1.2	0.9	26	63	10	0.4	0.2
Armenia	3,016	1,470	71	-1.1	-0.1	21	67	12	0.3	0.2
Aruba	101	-	-	-	-	-	-	-	-	-
Australia	20,321	32,220	80	1.2	0.9	20	68	13	0.3	0.2
Austria	8,211	36,980	79	0.4	0.1	16	68	17	0.2	0.2
Azerbaijan	8,388	1,240	72	1.1	0.7	26	67	7	0.4	0.1
Bahamas, The	323	-	70	1.6	1.2	28	65	6	0.4	0.1
Bahrain	727	-	75	2.6	1.5	27	70	3	0.4	0.0
Bangladesh	141,822	470	63	2.1	1.6	35	61	4	0.6	0.1
Barbados	270	-	75	0.3	0.2	19	71	10	0.3	0.1
Belarus	9,776	2,760	68	-0.3	-0.6	15	70	15	0.2	0.2
Belgium	10,471	35,700	79	0.3	0.1	17	66	18	0.3	0.3
Belize	292	3,500	72	2.9	1.1	37	59	4	0.6	0.1
Benin	8,439	510	55	3.3	2.7	44	53	3	0.8	0.1
Bermuda	65	-	-	0.4	-	-	-	-	-	-
Bhutan	918	870	64	2.8	7.8	38	57	5	0.7	0.1
Bolivia	9,182	1,010	65	2.1	1.6	38	57	5	0.7	0.1
Bosnia & Herz.	3,907	2,440	74	-0.7	-0.1	17	69	14	0.2	0.2
Botswana	1,765	5,180	35	1.4	-0.4	38	59	3	0.6	0.1
Brazil	186,405	3,460	71	1.5	1.1	28	66	6	0.4	0.1
Brunei Darussalam	374	-	77	2.5	1.8	30	67	3	0.4	0.0
Bulgaria	7,741	3,450	72	-0.8	-0.8	14	69	17	0.2	0.2
Burkina Faso	13,228	400	48	2.9	2.9	47	50	3	0.9	0.1
Burundi	7,548	100	44	1.9	3.2	45	52	3	0.9	0.1
Cambodia	14,071	380	57	2.5	1.9	37	60	3	0.6	0.1
Cameroon	16,322	1,010	46	2.2	1.5	41	55	4	0.7	0.1
Canada	32,271	32,600	80	1.0	0.8	18	69	13	0.3	0.2
Cape Verde	507	1,870	70	2.4	2.1	40	56	4	0.7	0.1
Cayman Islands	45	-	-	-	-	-	-	-	-	-
Central Afr. Rep.	4,038	350	39	2.0	1.4	43	53	4	0.8	0.1
Chad	9,749	400	44	3.2	2.8	47	50	3	1.0	0.1
Channel Islands	149	-	79	0.3	0.4	16	69	15	0.2	0.2
Chile	16,295	5,870	78	1.4	0.9	25	67	8	0.4	0.1

	Total population (in thousand)	GNI per capita (current US\$)	Life expectancy at birth (years)	Population growth rate (annual %)		Population ages 0-14	Population ages 15-64	Population ages 65 and above	Dependency ratio	
									Young	Old
	2005	2005	2004	1990-2005	2005-2020	2005	2005	2005	2005	2005
China	1,304,500	1,740	71	0.9	0.6	21	71	8	0.3	0.1
Colombia	45,600	2,290	73	1.8	1.3	31	64	5	0.5	0.1
Comoros	600	640	63	2.1	4.2	42	55	3	0.8	0.0
Congo, Dem. Rep.	57,549	120	44	2.8	3.0	47	50	3	0.9	0.1
Congo, Rep.	3,999	950	52	3.2	3.1	47	50	3	0.9	0.1
Costa Rica	4,327	4,590	79	2.3	1.3	28	66	6	0.4	0.1
Côte d'Ivoire	18,154	840	46	2.4	1.7	42	55	3	0.8	0.1
Croatia	4,444	8,060	75	-0.5	-0.1	16	67	17	0.2	0.3
Cuba	11,269	-	77	0.4	0.1	19	70	11	0.3	0.2
Cyprus	835	-	79	1.4	1.0	20	68	12	0.3	0.2
Czech Republic	10,196	10,710	76	-0.1	-0.2	15	71	14	0.2	0.2
Denmark	5,418	47,390	77	0.4	0.2	19	66	15	0.3	0.2
Djibouti	793	1,020	53	2.3	1.6	41	56	3	0.7	0.1
Dominica	72	3,790	-	0.0	-	-	-	-	-	-
Dominican Rep.	8,895	2,370	68	1.5	1.2	33	63	4	0.5	0.1
Ecuador	13,228	2,630	75	1.7	1.3	32	62	6	0.5	0.1
Egypt, Arab Rep.	74,033	1,250	70	1.9	1.7	34	62	5	0.5	0.1
El Salvador	6,881	2,450	71	2.0	1.4	34	61	5	0.6	0.1
Equatorial Guinea	504	-	43	2.4	2.1	44	52	4	0.9	0.1
Eritrea	4,401	220	54	2.5	2.7	45	53	2	0.8	0.0
Estonia	1,345	9,100	72	-1.0	-0.4	15	68	17	0.2	0.2
Ethiopia	71,256	160	42	2.2	2.8	45	53	3	0.8	0.1
Faeroe Islands	48	-	-	-	-	-	-	-	-	-
Fiji	848	3,280	68	1.1	0.5	32	64	4	0.5	0.1
Finland	5,245	37,460	79	0.3	0.2	17	67	16	0.3	0.2
France	60,743	34,810	80	0.5	0.2	18	65	17	0.3	0.3
French Polynesia	257	-	74	1.8	1.2	28	67	5	0.4	0.1
Gabon	1,384	5,010	54	2.5	1.4	40	56	4	0.7	0.1
Gambia, The	1,517	290	56	3.2	2.1	40	56	4	0.7	0.1
Georgia	4,474	1,350	71	-1.3	-0.7	19	67	14	0.3	0.2
Germany	82,485	34,580	78	0.3	0.0	14	67	19	0.2	0.3
Ghana	22,113	450	57	2.4	1.8	39	57	4	0.7	0.1
Greece	11,089	19,670	79	0.6	0.1	14	68	18	0.2	0.3
Greenland	57	-	-	0.2	-	-	-	-	-	-
Grenada	107	3,920	-	0.9	-	-	-	-	-	-
Guam	170	-	75	1.6	1.3	30	64	6	0.5	0.1
Guatemala	12,599	2,400	68	2.3	2.2	43	52	4	0.8	0.1
Guinea	9,402	370	54	2.8	2.3	44	53	4	0.8	0.1
Guinea-Bissau	1,586	180	45	3.0	3.0	48	49	3	1.0	0.1
Guyana	751	1,010	64	0.2	-0.2	29	65	5	0.4	0.1

	Total population (in thousand)	GNI per capita (current US\$)	Life expectancy at birth (years)	Population growth rate (annual %)		Population ages 0-14	Population ages 15-64	Population ages 65 and above	Dependency ratio	
									Young	Old
	2005	2005	2004	1990-2005	2005-2020	2005	2005	2005	2005	2005
Haiti	8,528	450	52	1.4	1.3	37	59	4	0.6	0.1
Honduras	7,205	1,190	68	2.6	1.9	39	57	4	0.7	0.1
Hong Kong, China	6,944	27,670	82	1.3	1.0	14	74	12	0.2	0.2
Hungary	10,088	10,030	73	-0.2	-0.3	16	69	15	0.2	0.2
Iceland	295	46,320	80	1.0	0.7	22	66	12	0.3	0.2
India	1,094,583	720	63	1.7	1.3	32	63	5	0.5	0.1
Indonesia	220,558	1,280	67	1.4	1.0	28	66	6	0.4	0.1
Iran, Islamic Rep.	67,700	2,770	71	1.5	1.5	29	67	5	0.4	0.1
Iraq	-	-	-	-	-	-	-	-	-	-
Ireland	4,151	40,150	78	1.1	1.1	20	69	11	0.3	0.2
Isle of Man	77	-	-	0.7	-	-	-	-	-	-
Israel	6,909	18,620	79	2.6	1.2	28	62	10	0.4	0.2
Italy	57,471	30,010	80	0.1	0.0	14	66	20	0.2	0.3
Jamaica	2,657	3,400	71	0.7	0.3	31	61	8	0.5	0.1
Japan	127,956	38,980	82	0.2	-0.1	14	66	20	0.2	0.3
Jordan	5,411	2,500	72	3.6	2.2	37	60	3	0.6	0.1
Kazakhstan	15,146	2,930	65	-0.5	-0.1	23	68	9	0.3	0.1
Kenya	34,256	530	48	2.5	2.5	43	54	3	0.8	0.1
Kiribati	99	1,390	-	2.1	-	-	-	-	-	-
Korea, DPR of	22,488	-	64	0.9	0.4	25	68	7	0.4	0.1
Korea, Rep. of	48,294	15,830	77	0.8	0.1	19	72	9	0.3	0.1
Kuwait	2,535	-	77	1.2	2.5	24	74	2	0.3	0.0
Kyrgyz Republic	5,156	440	68	1.0	1.1	31	62	6	0.5	0.1
Lao PDR	5,924	440	55	2.4	2.0	41	55	4	0.7	0.1
Latvia	2,300	6,760	71	-1.0	-0.5	15	68	17	0.2	0.2
Lebanon	3,577	6,180	72	1.8	1.0	29	64	7	0.4	0.1
Lesotho	1,795	960	36	0.8	-0.3	39	56	5	0.7	0.1
Liberia	3,283	130	42	2.9	2.9	47	51	2	0.9	0.0
Libya	5,853	5,530	74	2.0	1.7	30	66	4	0.5	0.1
Liechtenstein	34	-	-	-	-	-	-	-	-	-
Lithuania	3,415	7,050	72	-0.5	-0.4	17	68	15	0.2	0.2
Luxembourg	457	65,630	78	1.2	1.3	19	67	14	0.3	0.2
Macao, China	460	-	80	1.4	0.7	16	76	8	0.2	0.1
Macedonia, FYR	2,034	2,830	74	0.4	0.1	20	69	11	0.3	0.2
Madagascar	18,606	290	56	2.9	2.4	44	53	3	0.8	0.1
Malawi	12,884	160	40	2.1	2.2	47	50	3	1.0	0.1
Malaysia	25,347	4,960	73	2.3	1.4	32	63	5	0.5	0.1
Maldives	329	2,390	67	2.8	2.3	41	56	3	0.7	0.1
Mali	13,518	380	48	2.8	2.9	48	49	3	1.0	0.1
Malta	404	13,590	79	0.8	0.4	18	69	14	0.3	0.2

	Total population (in thousand)	GNI per capita (current US\$)	Life expectancy at birth (years)	Population growth rate (annual %)		Population ages 0-14	Population ages 15-64	Population ages 65 and above	Dependency ratio	
						% of total			Young	Old
				1990-2005	2005-2020	2005	2005	2005	2005	2005
Marshall Islands	63	2,930	-	2.1	-	-	-	-	-	-
Mauritania	3,069	560	53	2.8	2.5	43	54	3	0.8	0.1
Mauritius	1,248	5,260	73	1.1	0.7	25	69	7	0.4	0.1
Mayotte	180	-	-	-	-	-	-	-	-	-
Mexico	103,089	7,310	75	1.4	1.3	31	64	5	0.5	0.1
Micronesia, Fed. States of	110	2,300	68	0.9	0.4	39	58	3	0.7	0.1
Moldova	4,206	880	68	-0.2	-0.2	18	72	10	0.3	0.1
Monaco	33	-	-	-	-	-	-	-	-	-
Mongolia	2,554	690	65	1.3	1.4	30	66	4	0.5	0.1
Morocco	30,168	1,730	70	1.5	1.6	31	64	5	0.5	0.1
Mozambique	19,792	310	42	2.6	1.7	44	53	3	0.8	0.1
Myanmar	50,519	-	61	1.4	0.8	29	66	5	0.4	0.1
Namibia	2,031	2,990	47	2.5	1.1	42	55	3	0.8	0.1
Nepal	27,133	270	62	2.3	1.8	39	57	4	0.7	0.1
Netherlands	16,329	36,620	79	0.6	0.3	18	68	14	0.3	0.2
Neth. Antilles	183	-	76	-0.3	0.5	23	68	9	0.3	0.1
New Caledonia	234	-	75	2.2	1.6	28	66	6	0.4	0.1
New Zealand	4,110	25,960	79	1.2	0.5	21	66	12	0.3	0.2
Nicaragua	5,487	910	70	2.2	1.8	39	58	3	0.7	0.1
Niger	13,957	240	45	3.3	3.2	49	49	2	1.0	0.0
Nigeria	131,530	560	44	2.5	1.9	44	53	3	0.8	0.1
Northern Mariana Islands.	79	-	-	-	-	-	-	-	-	-
Norway	4,618	59,590	80	0.6	0.5	20	65	15	0.3	0.2
Oman	2,567	-	75	2.2	2.0	34	63	3	0.5	0.0
Pakistan	155,772	690	65	2.4	2.0	38	58	4	0.7	0.1
Palau	20	7,630	-	-	-	-	-	-	-	-
Panama	3,232	4,630	75	2.0	1.5	30	64	6	0.5	0.1
Papua New Guinea	5,887	660	56	2.4	1.7	40	57	2	0.7	0.0
Paraguay	6,158	1,280	71	2.5	2.0	38	59	4	0.6	0.1
Peru	27,968	2,610	70	1.7	1.4	32	63	5	0.5	0.1
Philippines	83,054	1,300	71	2.0	1.5	35	61	4	0.6	0.1
Poland	38,165	7,110	74	0.0	-0.1	16	71	13	0.2	0.2
Portugal	10,557	16,170	77	0.4	0.2	16	67	17	0.2	0.3
Puerto Rico	3,911	-	77	0.7	0.5	22	66	12	0.3	0.2
Qatar	813	-	74	3.7	1.6	22	77	1	0.3	0.0
Romania	21,632	3,830	71	-0.5	-0.4	15	70	15	0.2	0.2
Russian Federation	143,151	4,460	65	-0.2	-0.5	15	71	14	0.2	0.2
Rwanda	9,038	230	44	1.6	2.1	43	54	2	0.8	0.0
Samoa	185	2,090	70	0.9	0.2	41	55	5	0.7	0.1
San Marino	28	-	-	-	-	-	-	-	-	-

	Total population (in thousand)	GNI per capita (current US\$)	Life expectancy at birth (years)	Population growth rate (annual %)		Population ages 0-14	Population ages 15-64	Population ages 65 and above	Dependency ratio	
									Young	Old
	2005	2005	2004	1990-2005	2005-2020	2005	2005	2005	2005	2005
São Tomé & Príncipe	157	390	63	2.0	1.9	39	56	4	0.7	0.1
Saudi Arabia	24,573	11,770	72	2.7	2.2	37	60	3	0.6	0.0
Senegal	11,658	710	56	2.5	2.1	43	54	3	0.8	0.1
Serbia and Montenegro	8,168	3,280	73	-1.7	1.6	18	68	14	0.3	0.2
Seychelles	84	8,290	-	1.3	-	-	-	-	-	-
Sierra Leone	5,525	220	41	2.0	2.2	43	54	3	0.8	0.1
Singapore	4,351	27,490	79	2.4	0.9	20	72	8	0.3	0.1
Slovak Republic	5,387	7,950	74	0.1	0.0	17	71	12	0.2	0.2
Slovenia	1,998	17,350	77	0.0	-0.3	14	70	16	0.2	0.2
Solomon Islands	478	590	63	2.7	2.1	41	57	2	0.7	0.0
Somalia	8,228	-	47	1.4	2.7	44	53	3	0.8	0.0
South Africa	45,192	4,960	45	1.7	0.4	33	63	4	0.5	0.1
Spain	43,389	25,360	80	0.7	0.2	14	69	16	0.2	0.2
Sri Lanka	19,582	1,160	74	0.9	1.0	24	69	7	0.4	0.1
St. Kitts and Nevis	48	8,210	-	0.9	-	-	-	-	-	-
St. Lucia	166	4,800	73	1.4	0.5	29	64	7	0.5	0.1
St. Vincent & the Grenadines	119	3,590	71	0.6	0.3	29	64	7	0.5	0.1
Sudan	36,233	640	57	2.2	1.8	39	57	4	0.7	0.1
Suriname	449	2,540	69	0.7	0.4	30	64	6	0.5	0.1
Swaziland	1,131	2,280	42	2.6	-0.9	41	55	4	0.7	0.1
Sweden	9,024	41,060	80	0.4	0.3	17	65	17	0.3	0.3
Switzerland	7,441	54,930	81	0.7	-0.1	16	68	16	0.2	0.2
Syrian Arab Rep.	19,043	1,380	74	2.6	2.1	37	60	3	0.6	0.1
Taiwan, China	22,858	16,170	76	0.8	-	-	-	-	-	-
Tajikistan	6,507	330	64	1.4	1.6	39	57	4	0.7	0.1
Tanzania	38,329	340	46	2.5	1.7	43	54	3	0.8	0.1
Thailand	64,233	2,750	71	1.1	0.7	24	69	7	0.3	0.1
Timor-Leste	976	750	-	1.8	3.8	41	56	3	0.7	0.1
Togo	6,145	350	55	2.9	2.3	43	53	3	0.8	0.1
Tonga	102	2,190	72	0.5	0.0	36	58	6	0.6	0.1
Trinidad & Tobago	1,305	10,440	70	0.5	0.2	22	71	7	0.3	0.1
Tunisia	10,022	2,890	73	1.4	1.0	26	68	6	0.4	0.1
Turkey	72,636	4,710	70	1.7	1.2	29	65	5	0.4	0.1
Turkmenistan	4,833	-	63	1.8	1.2	32	64	5	0.5	0.1
Uganda	28,816	280	49	3.2	3.7	50	47	2	1.1	0.1
Ukraine	47,111	1,520	68	-0.6	-1.2	15	69	16	0.2	0.2
UAE	4,533	-	79	6.3	2.0	22	77	1	0.3	0.0
United Kingdom	60,203	37,600	79	0.3	0.2	18	66	16	0.3	0.2
United States	296,497	43,740	77	1.1	0.9	21	67	12	0.3	0.2
Uruguay	3,463	4,360	75	0.7	0.6	24	63	13	0.4	0.2

	Total population (in thousand)	GNI per capita (current US\$)	Life expectancy at birth (years)	Population growth rate (annual %)		Population ages 0-14	Population ages 15-64	Population ages 65 and above	Dependency ratio	
						% of total			Young	Old
	2005	2005	2004	1990-2005	2005-2020	2005	2005	2005	2005	2005
Uzbekistan	26,593	510	67	1.7	1.3	33	62	5	0.5	0.1
Vanuatu	211	1,600	69	2.3	1.7	40	57	3	0.7	0.1
Venezuela, RB de	26,577	4,810	74	2.0	1.5	31	64	5	0.5	0.1
Vietnam	82,966	620	70	1.5	1.2	30	65	5	0.5	0.1
Virgin Islands U.S.	115	-	79	0.7	-0.3	24	65	11	0.4	0.2
West Bank & Gaza	3,626	-	73	4.1	3.0	45	51	3	0.9	0.1
Yemen, Rep. of	20,975	600	61	3.7	3.0	46	51	2	0.9	0.0
Zambia	11,668	490	38	2.2	1.7	46	51	3	0.9	0.1
Zimbabwe	13,010	340	37	1.4	0.6	40	56	4	0.7	0.1
World	6,437,784	6,987	67	1.4	1.1	28	64	7	0.4	0.1
East Asia & Pacific	1,885,332	1,627	70	1.1	0.7	24	69	7	0.3	0.1
Europe & Central Asia	472,948	4,113	69	0.1	0.1	20	68	12	0.3	0.2
Latin America & Caribbean	551,371	4,008	72	1.5	1.2	30	64	6	0.5	0.1
Middle East & North Africa	305,429	2,241	69	2.0	1.8	33	62	4	0.5	0.1
South Asia	1,470,002	684	63	1.9	1.5	33	62	5	0.5	0.1
Sub-Saharan Africa	741,364	745	46	2.4	2.2	44	53	3	0.8	0.1
High income	1,011,337	35,131	79	0.8	0.3	18	67	15	0.3	0.2

Source: World Development Indicators 2006

ANNEX 3B. POPULATION HEALTH INDICATORS

	Total fertility rate (births per woman)		Adolescent fertility rate (births per 1,000 women ages 15-19)	Contraceptive prevalence (% of women ages 15-49)	Unmet need for contraception (% of married women ages 15-49)	Total fertility rate by wealth quintiles	
						1994-2005	
	1985-1990	2000-2005	2004	1996-2004	1995-2004	Lowest	Highest
Afghanistan	7.9	7.5	-	10	-	-	-
Albania	3.1	2.3	16	75	-	-	-
Algeria	5.3	2.5	8	57	-	-	-
American Samoa	-	-	-	-	-	-	-
Andorra	-	-	-	-	-	-	-
Angola	7.2	6.8	141	6	-	-	-
Antigua and Barbuda	-	-	-	53	-	-	-
Argentina	3.1	2.4	59	-	-	-	-
Armenia	2.6	1.3	30	61	12	2.5	1.6
Aruba	-	-	-	-	-	-	-
Australia	1.9	1.7	15	-	-	-	-
Austria	1.5	1.4	13	51	-	-	-
Azerbaijan	3.0	1.9	31	55	-	-	-
Bahamas, The	2.6	2.3	59	-	-	-	-
Bahrain	4.1	2.5	18	-	-	-	-
Bangladesh	4.6	3.2	123	59	11	4.1	2.2
Barbados	1.8	1.5	42	55	-	-	-
Belarus	2.0	1.2	26	-	-	-	-
Belgium	1.6	1.7	8	-	-	-	-
Belize	4.7	3.2	82	56	-	-	-
Benin	6.9	5.9	130	19	27	7.2	3.5
Bermuda	-	-	-	-	-	-	-
Bhutan	5.8	4.4	33	31	-	-	-
Bolivia	5.0	4.0	82	58	23	6.7	2.0
Bosnia and Herzegovina	1.9	1.3	23	48	-	-	-
Botswana	4.9	3.2	76	48	-	-	-
Brazil	3.1	2.3	89	77	7	4.8	1.7
Brunei Darussalam	3.4	2.5	29	-	-	-	-
Bulgaria	1.9	1.2	44	42	-	-	-
Burkina Faso	7.4	6.7	159	14	29	6.6	3.6
Burundi	6.8	6.8	50	16	-	-	-
Cambodia	5.8	4.1	48	24	30	4.7	2.2
Cameroon	6.1	4.6	114	26	20	6.5	3.2
Canada	1.7	1.5	14	-	-	-	-
Cape Verde	5.9	3.8	90	53	-	-	-
Cayman Islands	-	-	-	-	-	-	-
Central African Republic	5.7	5.0	126	28	16	5.1	4.9
Chad	6.7	6.7	192	3	10	5.1	6.0
Channel Islands	1.5	1.4	13	-	-	-	-
Chile	2.7	2.0	61	-	-	-	-

	Total fertility rate (births per woman)		Adolescent fertility rate (births per 1,000 women ages 15-19)	Contraceptive prevalence (% of women ages 15-49)	Unmet need for contraception (% of married women ages 15-49)	Total fertility rate by wealth quintiles	
	1985-1990	2000-2005	2004	1996-2004	1995-2004	1994-2005	
						Lowest	Highest
China	2.5	1.7	5	87	-	-	-
Colombia	3.2	2.6	77	78	6	4.1	1.4
Comoros	6.5	4.9	55	26	35	6.4	3.0
Congo, Dem. Rep.	6.7	6.7	227	31	-	-	-
Congo, Rep.	6.3	6.3	145	-	-	-	-
Costa Rica	3.4	2.3	75	80	-	-	-
Côte d'Ivoire	6.9	5.1	123	15	28	6.4	3.7
Croatia	1.8	1.3	15	-	-	-	-
Cuba	1.8	1.6	50	73	-	-	-
Cyprus	2.4	1.6	8	-	-	-	-
Czech Republic	1.9	1.2	12	72	-	-	-
Denmark	1.5	1.8	7	-	-	-	-
Djibouti	6.4	5.1	54	-	-	-	-
Dominica	-	-	-	50	-	-	-
Dominican Republic	3.6	2.7	91	70	11	4.5	2.1
Ecuador	4.0	2.8	84	66	-	-	-
Egypt, Arab Rep. of	4.8	3.3	43	60	11	4.0	2.9
El Salvador	3.9	2.9	85	67	-	-	-
Equatorial Guinea	5.9	5.9	188	-	-	-	-
Eritrea	6.3	5.5	93	8	27	8.0	3.7
Estonia	2.2	1.4	23	-	-	-	-
Ethiopia	6.8	5.9	90	8	35	6.3	3.6
Faeroe Islands	-	-	-	-	-	-	-
Fiji	3.5	2.9	37	44	-	-	-
Finland	1.7	1.7	10	-	-	-	-
France	1.8	1.9	9	-	-	-	-
French Polynesia	3.6	2.4	40	-	-	-	-
Gabon	5.5	4.0	106	33	28	6.3	3.0
Gambia, The	6.2	4.7	119	18	-	-	-
Georgia	2.3	1.5	33	41	-	-	-
Germany	1.4	1.3	10	-	-	-	-
Ghana	6.1	4.4	64	25	34	6.4	2.8
Greece	1.5	1.3	9	-	-	-	-
Greenland	-	-	-	-	-	-	-
Grenada	-	-	-	54	-	-	-
Guam	3.1	2.9	68	-	-	-	-
Guatemala	5.7	4.6	112	43	23	7.6	2.9
Guinea	6.6	5.9	191	7	24	5.8	4.0
Guinea-Bissau	7.1	7.1	194	8	-	-	-
Guyana	2.7	2.3	63	37	-	-	-

	Total fertility rate (births per woman)		Adolescent fertility rate (births per 1,000 women ages 15-19)	Contraceptive prevalence (% of women ages 15-49)	Unmet need for contraception (% of married women ages 15-49)	Total fertility rate by wealth quintiles	
	1985-1990	2000-2005	2004	1996-2004	1995-2004	1994-2005	
						Lowest	Highest
Haiti	5.9	4.0	62	27	40	6.8	2.7
Honduras	5.4	3.7	99	62	-	-	-
Hong Kong, China	1.3	0.9	5	-	-	-	-
Hungary	1.8	1.3	21	-	-	-	-
Iceland	2.1	2.0	18	-	-	-	-
India	4.2	3.1	73	47	16	3.4	1.8
Indonesia	3.4	2.4	54	57	9	3.0	2.2
Iran, Islamic Rep. of	5.6	2.1	20	74	-	-	-
Iraq	6.2	4.8	-	44	-	-	-
Ireland	2.3	1.9	14	-	-	-	-
Isle of Man	-	-	-	-	-	-	-
Israel	3.1	2.9	15	-	-	-	-
Italy	1.3	1.3	7	60	-	-	-
Jamaica	3.1	2.4	79	65	-	-	-
Japan	1.7	1.3	4	-	-	-	-
Jordan	5.9	3.5	26	56	11	5.2	3.1
Kazakhstan	3.0	2.0	29	66	9	3.4	1.2
Kenya	6.5	5.0	96	39	25	7.6	3.1
Kiribati	-	-	-	21	-	-	-
Korea, Democratic People's Republic of	2.5	2.0	2	-	-	-	-
Korea, Rep. of	1.6	1.2	3	81	-	-	-
Kuwait	3.9	2.4	24	50	-	-	-
Kyrgyz Republic	4.0	2.7	33	60	12	4.6	2.0
Lao PDR	6.3	4.8	89	32	-	-	-
Latvia	2.1	1.3	17	-	-	-	-
Lebanon	3.3	2.3	26	63	-	-	-
Lesotho	5.1	3.6	37	30	-	-	-
Liberia	6.9	6.8	224	10	-	-	-
Libya	5.7	3.0	7	-	-	-	-
Liechtenstein	-	-	-	-	-	-	-
Lithuania	2.1	1.3	21	-	-	-	-
Luxembourg	1.5	1.7	9	-	-	-	-
Macao, China	2.1	0.8	-	-	-	-	-
Macedonia, FYR	2.0	1.5	23	-	-	-	-
Madagascar	6.3	5.4	124	27	24	8.1	3.4
Malawi	7.2	6.1	158	31	30	7.1	4.8
Malaysia	4.0	2.9	18	-	-	-	-
Maldives	6.6	4.3	64	39	-	-	-
Mali	7.5	6.9	201	8	26	7.3	5.3
Malta	2.0	1.5	15	-	-	-	-

	Total fertility rate (births per woman)		Adolescent fertility rate (births per 1,000 women ages 15-19)	Contraceptive prevalence (% of women ages 15-49)	Unmet need for contraception (% of married women ages 15-49)	Total fertility rate by wealth quintiles	
	1985-1990	2000-2005	2004	1996-2004	1995-2004	1994-2005	
						Lowest	Highest
Marshall Islands	-	-	-	34	-	-	-
Mauritania	6.2	5.8	99	8	32	5.4	3.5
Mauritius	2.2	2.0	32	76	-	-	-
Mayotte	-	-	-	-	-	-	-
Mexico	3.7	2.4	67	73	-	-	-
Micronesia, Federated States of.	5.2	4.4	34	45	-	-	-
Moldova	2.6	1.2	31	62	-	-	-
Monaco	-	-	-	-	-	-	-
Mongolia	4.8	2.4	53	69	-	-	-
Morocco	4.4	2.8	-	63	10	3.3	1.9
Mozambique	6.3	5.5	102	17	18	6.3	3.8
Myanmar	4.2	2.5	19	34	-	-	-
Namibia	6.2	4.0	53	44	22	6.0	2.7
Nepal	5.3	3.7	114	38	28	5.3	2.3
Netherlands	1.6	1.7	5	75	-	-	-
Netherlands Antilles	2.3	2.1	26	-	-	-	-
New Caledonia	3.1	2.4	30	-	-	-	-
New Zealand	2.1	2.0	24	-	-	-	-
Nicaragua	5.2	3.3	120	69	15	5.6	2.1
Niger	8.2	7.9	260	14	17	8.4	5.7
Nigeria	6.8	5.8	142	13	17	6.5	4.2
Northern Mariana Islands	-	-	-	-	-	-	-
Norway	1.8	1.8	10	-	-	-	-
Oman	6.8	3.8	46	32	-	-	-
Pakistan	6.4	4.3	69	28	-	-	-
Palau	-	-	-	17	-	-	-
Panama	3.2	2.7	86	-	-	-	-
Papua New Guinea	5.2	4.1	60	26	-	-	-
Paraguay	4.9	3.9	65	57	-	-	-
Peru	4.1	2.9	53	69	10	5.5	1.6
Philippines	4.6	3.2	36	49	17	5.9	2.0
Poland	2.2	1.3	15	-	-	-	-
Portugal	1.6	1.5	19	-	-	-	-
Puerto Rico	2.3	1.9	56	-	-	-	-
Qatar	4.7	3.0	19	43	-	-	-
Romania	2.3	1.3	35	64	-	-	-
Russian Federation	2.1	1.3	29	-	-	-	-
Rwanda	8.3	5.7	47	13	36	6.0	5.4
Samoa	4.8	4.4	33	-	-	-	-
San Marino	-	-	-	-	-	-	-

	Total fertility rate (births per woman)		Adolescent fertility rate (births per 1,000 women ages 15-19)	Contraceptive prevalence (% of women ages 15-49)	Unmet need for contraception (% of married women ages 15-49)	Total fertility rate by wealth quintiles	
	1985-1990	2000-2005	2004	1996-2004	1995-2004	1994-2005	
						Lowest	Highest
São Tomé and Príncipe	5.6	4.1	65	29	-	-	-
Saudi Arabia	6.3	4.1	33	21	-	-	-
Senegal	6.8	5.0	82	11	35	7.4	3.6
Serbia and Montenegro	2.2	1.7	23	58	-	-	-
Seychelles	-	-	-	-	-	-	-
Sierra Leone	6.5	6.5	179	4	-	-	-
Singapore	1.7	1.4	5	-	-	-	-
Slovak Republic	2.2	1.2	21	-	-	-	-
Slovenia	1.7	1.2	6	-	-	-	-
Solomon Islands	6.0	4.3	47	11	-	-	-
Somalia	7.0	6.4	69	-	-	-	-
South Africa	3.9	2.8	67	56	15	4.8	1.9
Spain	1.5	1.3	9	-	-	-	-
Sri Lanka	2.8	2.0	19	70	-	-	-
St. Kitts and Nevis	-	-	-	-	-	-	-
St. Lucia	3.7	2.2	62	-	-	-	-
St. Vincent and the Grenadines	3.2	2.3	66	58	-	-	-
Sudan	5.8	4.4	52	7	-	-	-
Suriname	3.0	2.6	43	42	-	-	-
Swaziland	6.1	4.0	37	48	-	-	-
Sweden	1.9	1.6	7	-	-	-	-
Switzerland	1.5	1.4	5	-	-	-	-
Syrian Arab Rep.	6.2	3.5	34	48	-	-	-
Taiwan, China	-	-	-	-	-	-	-
Tajikistan	5.4	3.8	30	34	-	-	-
Tanzania	6.4	5.0	110	26	22	7.3	3.3
Thailand	2.4	1.9	48	72	-	-	-
Timor-Leste	5.2	7.8	177	10	-	-	-
Togo	6.6	5.4	98	26	32	7.3	2.9
Tonga	4.8	3.5	12	33	-	-	-
Trinidad and Tobago	2.8	1.6	36	38	-	-	-
Tunisia	4.1	2.0	7	66	-	-	-
Turkey	3.3	2.5	41	71	10	3.9	1.7
Turkmenistan	4.6	2.8	16	62	10	3.4	2.1
Uganda	7.1	7.1	208	23	35	8.5	4.1
Ukraine	2.0	1.1	29	89	-	-	-
United Arab Emirates	4.8	2.5	20	-	-	-	-
United Kingdom	1.8	1.7	26	-	-	-	-
United States	1.9	2.0	50	64	-	-	-
Uruguay	2.5	2.3	69	-	-	-	-

	Total fertility rate (births per woman)		Adolescent fertility rate (births per 1,000 women ages 15-19)	Contraceptive prevalence (% of women ages 15-49)	Unmet need for contraception (% of married women ages 15-49)	Total fertility rate by wealth quintiles	
	1985-1990	2000-2005	2004	1996-2004	1995-2004	1994-2005	
						Lowest	Highest
Uzbekistan	4.4	2.7	36	68	-	4.4	2.2
Vanuatu	5.0	4.2	49	28	-	-	-
Venezuela, R. B. de	3.6	2.7	91	-	-	-	-
Vietnam	4.0	2.3	20	79	5	2.2	1.4
Virgin Islands (U.S.)	3.1	2.2	35	-	-	-	-
West Bank and Gaza	-	-	-	42	-	-	-
Yemen, Rep. of	8.3	6.2	93	23	-	7.3	4.7
Zambia	6.7	5.7	128	34	27	7.3	3.6
Zimbabwe	5.8	3.6	92	54	13	4.9	2.6
World	3.4	2.6	58	-	-	-	-
East Asia & Pacific	2.9	2.1	16	78	-	-	-
Europe & Central Asia	2.5	1.6	30	69	-	-	-
Latin America & Caribbean	3.5	2.5	78	72	-	-	-
Middle East & North Africa	5.3	3.1	33	59	-	-	-
South Asia	4.5	3.2	80	46	16	-	-
Sub-Saharan Africa	6.4	5.4	135	22	-	-	-
High income	1.8	1.7	25	-	-	-	-

Sources: World Development Indicators 2006, United Nations World Population Prospects: The 2004 Revision, Demographic and Health Surveys.

ANNEX 4. HNP RESULTS FRAMEWORK: POPULATION AND REPRODUCTIVE HEALTH COMPONENT

Strategic Policy Objective	Final outcomes	How do we measure these results? Final Indicators	Multisectoral Contributions to Intermediate Outcomes/Outputs	How do we measure these results? Intermediate Indicators (Reporting Accountability of Sectors)
Improve the level and distribution of key HNP outcomes, outputs, and system performance at country and global levels in order to improve living conditions, particularly for the poor and vulnerable	Improved maternal, reproductive, and sexual health (MDG 5, Target 6)	Maternal mortality ratio Total fertility rate Adolescent fertility rate Increased birth spacing	<i>HNP, Education, Infrastructure:</i> Improved coverage with effective maternal and perinatal interventions	<i>HNP reporting accountability:</i> % women with deliveries attended by skilled health personnel % women with at least one antenatal care visit during pregnancy <i>Infrastructure reporting accountability:</i> % of rural population with access to an all-season road
			<i>HNP, Gender, Education:</i> Improve family planning and sexual health	<i>HNP reporting accountability:</i> Contraceptive prevalence rate among women of reproductive age Unmet need for contraception Prevalence rate of STIs among adults and young people (15-24 years)
			<i>HNP:</i> Reduced incidence of cervical cancer	<i>HNP reporting accountability:</i> HPV immunization coverage

ANNEX 5. MILLENNIUM DEVELOPMENT GOALS

1. Eradicate extreme poverty and hunger
<p><i>Target 1:</i> Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.</p> <p><i>Target 2:</i> Halve, between 1990 and 2015, the proportion of people who suffer from hunger.</p>
2. Achieve universal primary education
<p><i>Target 3:</i> Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.</p>
3. Promote gender equality and empower women
<p><i>Target 4:</i> Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.</p>
4. Reduce child mortality
<p><i>Target 5:</i> Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</p>
5. Improve maternal health
<p><i>Target 6:</i> Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.</p>
6. Combat HIV/AIDS, malaria, and other diseases
<p><i>Target 7:</i> Have halted by 2015 and begun to reverse the spread of HIV/AIDS</p> <p><i>Target 8:</i> Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases</p>
7. Ensure environmental sustainability
<p><i>Target 9:</i> Integrate the principles of sustainable development into country policies and programs and reverse the losses of environmental resources.</p> <p><i>Target 10:</i> Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation.</p> <p><i>Target 11:</i> Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers.</p>
8. Build a global partnership for development
<p><i>Target 12:</i> Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. This includes a commitment to good governance, development, and poverty reduction - both nationally and internationally</p> <p><i>Target 13:</i> Address the special needs of the least developed countries. Includes: tariff and quota-free access for least-developed countries' exports; enhanced program of debt relief for HIPC's and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</p> <p><i>Target 14:</i> Address the special needs of landlocked countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and the outcome of the 22nd special session of the General Assembly)</p> <p><i>Target 15:</i> Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term</p> <p><i>Target 16:</i> In cooperation with developing countries, develop and implement strategies for decent and productive work for youth</p> <p><i>Target 17:</i> In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries</p> <p><i>Target 18:</i> In cooperation with the private sector, make available the benefits of new technologies, especially information and communications</p>

Note: A target for universal access to reproductive health is being added to MDG 5.



HEALTH, NUTRITION,
AND POPULATION



HUMAN DEVELOPMENT NETWORK

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