

**Experiences with
Fertility Reduction in
Five High-Fertility Countries**
Synthesis of Case Studies

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Why this Study?

Countries with high levels of fertility lag behind others in development indicators and in progress toward the Millennium Development Goals. While several developing countries have lowered fertility rates over the last three decades, huge challenges remain. The family planning needs of some 137 million married women in developing countries are still unmet. About a third of the approximately 205 million pregnancies each year are unintended, and half of induced abortions performed globally are unsafe. Some 28 countries, mainly in Sub-Saharan Africa, have a total fertility rate greater than 5, and the decline in fertility rates has been very slow or has stalled. In most countries, national averages mask substantial differences in fertility levels between the well-off and the poor, highlighting equity concerns.

Over the past decade, the focus has shifted from core population and fertility issues in response to several factors. Chief among them have been a broader human rights perspective following the 1994 International Conference on Population and Development; competing demands for resources and attention for HIV/

AIDS, tuberculosis, and malaria programs; and the complacency that set in as fertility rates dropped in several developing countries. Not until October 2007 was reproductive health added to the Millennium Development Goal targets.

This shift in focus prompted the Population and Reproductive Health Team in the Health unit of the Human Development Network (HDNHE) to undertake a study to better understand how some high-fertility countries managed to dramatically reduce fertility and to draw lessons from their experience. Broad reviews of the literature on fertility decline and lessons learned already exist, such as the World Bank (2007) report “*The Global Family Planning Revolution: Three Decades of Population Policies and Programs*” documenting lessons from family planning in 23 countries. The objective of this study is not to repeat those discussions and findings but rather to provide evidence-based, relevant, and practical information on population/family planning issues to stimulate policy dialogue with client countries and influence World Bank lending in countries that still have high fertility rates.

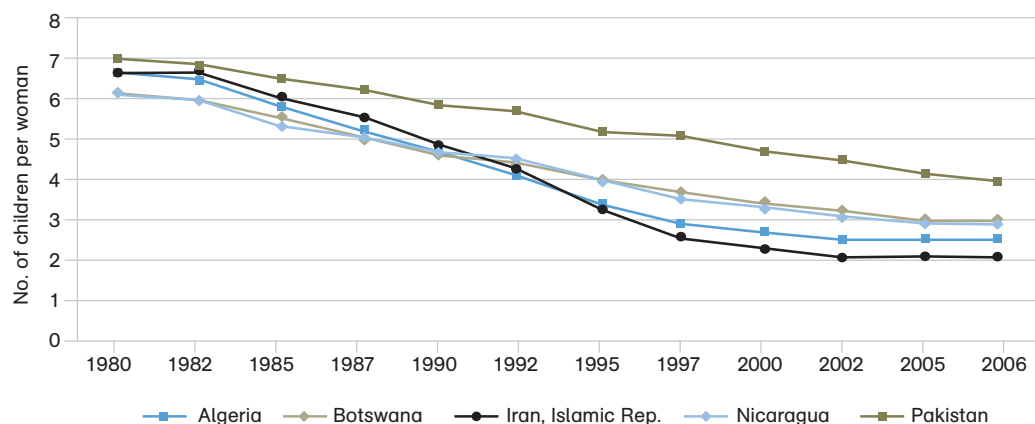
Large Fertility Declines in Five Countries

Five countries (Algeria, Botswana, Iran, Nicaragua, and Pakistan) that succeeded in reducing high fertility rates, during 1980–2006, were chosen for detailed case studies documenting their varied histories in fertility reduction (Annex 1). These countries have all had impressive declines in fertility (see figure 1), if mixed performance on the Millennium Development Goals overall.

Algeria is the most populous country in the Maghreb, with some 33.8 million inhabitants. The crude birth rate accelerated from 35 per 1,000 population per year in 1911–15 to 48.5 by 1961–65. Between 1966 and 1987, the population grew more than 3 percent a year. In 1980, the total fertility rate was 6.76.

By 2006, Algeria's annual population growth rate had fallen by half, to just 1.47 percent, and its total fertility rate had fallen 40 percent, to 2.4. The contraceptive prevalence rate was 61.4 percent, with a majority of women using the pill and half of them indicating that they wanted no more children. The transition began in 1965–70, coinciding with the greater availability of modern contraceptive methods and the transformation of key reproductive behaviors, including higher age at first marriage. Rising rates of female education also contributed; nearly all Algerian girls are enrolled in primary school, and more than 80 percent complete their primary education.

Figure 1 | Total Fertility Rates, in Five Countries, 1980–2006



Source: Online World Development Indicators

Botswana is one of the few upper middle-income countries in Sub-Saharan Africa. While population rose more than 2.5-fold after 1971, the rate of population growth has slowed considerably since the 1980s, following critical actions by the government in reorganizing the health system and providing effective family planning services.

The impacts of the government's efforts have been substantial: the total fertility rate fell more than half between 1971 and 2001, knowledge of contraceptive methods increased dramatically to 97 percent in 1996, and use of modern contraceptive methods rose to about 51 percent in 2007.

Iran, with a population of just over 70 million in 2006, is one of the most populous countries in the Middle East. After the revolution in 1979, the government focused on three priority areas: reduction of disparities in food, health, and education. The Constitution entitles Iranians to basic health care, and the country has an extensive primary health care system. Considerable progress has been made in reducing infant and child mortality. Comprehensive family planning services were incorporated into the health care delivery system in 1989. Young couples are required by law to take family planning counseling classes before they can obtain a marriage license.

The fertility decline in Iran began in the late 1980s and continued throughout the 1990s. Following the war with Iraq, the government of Iran reintroduced family planning programs, largely in response to resource limitations and the impending youth bulge. According to the most recent census of 2006, the total fertility rate now stands at below re-

placement levels. The contraceptive prevalence rate rose steadily to an estimated 74 percent in 2000 (77 percent in urban areas and 67 percent in rural areas).

Nicaragua, a largely urban country (56 percent of the population lives in urban areas), is one of the least populous (5.53 million) and poorest countries in Central America. Following reforms in the 1980s, Nicaragua made remarkable progress in gender equity in education and the labor force, while the wide availability of primary health care, including family planning services, led to improvements in infant and child mortality rates.

The total fertility rate fell dramatically between 1980 and 2007, dropping 22 percent during the 1980s, 31 percent in the 1990s, and 17 percent during 2000–07, for a total decline of 55 percent. The fertility rate is lower for urban women than for rural women, though the reduction has been greater since 1998 in rural areas (30 percent) than in urban areas (24 percent). Fertility rates have dropped for all age groups, but especially for young women ages 20–24. Nicaragua's contraceptive prevalence rate rose dramatically as well, from 27 percent in 1981 to 72 percent in 2007 among women ages 15–49.

Pakistan is the world's sixth most populous country and has the second largest Muslim population after Indonesia. Since independence in 1947, Pakistan's turbulent political situation has frequently disrupted government development policies. Health status has improved since 1990, but the pace of improvement has been slow and perfor-

mance lags behind other South Asian countries. Large gender disparities persist in education and health status, as well as in access to education, health, employment, assets, and justice.

The total fertility rate in Pakistan stood at an estimated 6.8 from the 1960s to the late 1980s. Then, in the late 1980s to early

1990s, the fertility rate started to decline rapidly until 2000, when the decline seems to have slowed. Estimates of the current total fertility rate vary from 3.8 to 4.1, roughly a 40 percent decline since the 1980s. Contraceptive prevalence also rose, from 12 percent in 1990 to 30 percent in 2006.

Strategies that Have Worked

So how did these countries succeed in reducing fertility so dramatically? The case studies reveal some common themes:

1. Ensure Access to Quality Family Planning Services

Make family planning and maternal and child health services readily available. Botswana, Iran and Algeria, countries that substantially reduced fertility, had a widespread network of service outlets that integrated family planning services with an existing government-funded primary health care network. The integrated approach ensures that primary care doctors and other professionals provide family planning counseling and services as part of their core services, even to people who come to the health care system for unrelated health needs.

→ In *Botswana*, the government integrated services for family planning and maternal and child health and sexually transmitted infections from the outset in 1973. When women visit health facilities for maternal and child health services (antenatal care, postnatal care, immunizations) and sexually transmitted infections, they are also offered family planning services. With the advent of the HIV epidemic in the 1990s, HIV/AIDS services were also integrated. These integrated services, offered daily through a vast network of primary health care facilities in both rural and urban

areas, have made family planning services widely available.

→ In *Iran*, the government set up an extensive primary health care network, with “health houses” serving a central village and several surrounding villages in rural areas and health centers in urban areas. In 1991, Iran had nearly 12,000 health houses and 4,000 health centers, and 75 percent of the rural population had coverage. By 2002, 95 percent of the rural population had coverage. When the government decided to offer family planning services, this public health network was pressed into service.

→ In *Algeria*, where family planning was controversial and government commitment was weak, the government increased access by establishing “birth spacing” centers, which were more politically and culturally acceptable than family planning centers.

Provide outreach services to complement static services. In many regions, geographic and sociocultural barriers, such as difficult terrain and cultural taboos against women traveling alone, reduce access to family planning services. In such cases, trained outreach workers can increase women’s access to family planning services.

→ In *Pakistan*, when services provided in fixed facilities were found to be under-

Box 1 | A winning strategy in Nepal

Following an expansion of the family planning program in Nepal, the wide availability of a range of contraceptive methods, free of cost, led to an increase in contraceptive use among ever-married women—from 29 percent in 1996 to 48 percent in 2006. More than 90 percent of these women and their husbands used modern methods, including sterilization, injectables, oral contraceptives, condoms, and IUDs. The proportion of contraceptive users practicing child spacing methods rose from 30 percent in 1996 to 41 percent in 2006.

utilized because of geographic and socio-cultural constraints (women had to be accompanied by a male family member when going outside the home), the government introduced the Lady Health Worker Program. The program delivered family planning services to women in their homes, boosting use of family planning services.

- In *Botswana*, services at fixed facilities are complemented by outreach services using mobile units and home visits to reach people who do not use the fixed services.

Make a wide range of contraceptive methods available. An extensive and efficient contraceptive logistics and distribution system that coordinates activities of the government, international donors, the private sector, and nongovernmental organizations (NGOs) can bridge gaps in the delivery system. Some countries have used innovative programs such as social marketing of condoms to increase access to contraceptives and services by drawing in private sector providers.

- In *Nicaragua*, contraceptives are available from multiple sources. The Ministry

of Health, which distributes family planning supplies through departmental and regional health offices and facilities, is the main source of free modern family planning methods. The private sector and NGOs supply condoms procured internationally and repackaged for sale at low cost locally. They operate their own clinics and network of agents for distributing contraceptives.

- In *Pakistan*, private sector involvement started in the 1980s, with a U.S. Agency for International Development–supported condom social marketing campaign. Greenstar provides 30 percent of modern contraceptives used in Pakistan, the second largest family planning service provider after the government.

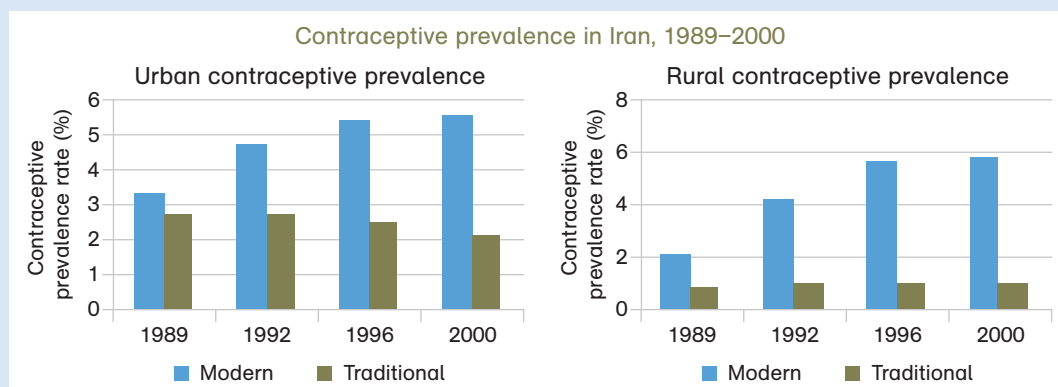
2. Strengthen Health Systems

Focus on improved quality of care. Integrating family planning with all other health programs boosts commitment to family planning—it becomes the responsibility of the entire health ministry, rather than a separate (vertical) program. Strengthening the management and quality of care of the health ministry, through training and stringent monitoring, positively affects such factors related to family planning as infant mortality and child survival, reducing the desire for additional children.

- *Botswana* has taken the most systematic approach to strengthening health system capacity and quality of care. The Ministry of Health embarked on an intensive training program for health personnel, nursing students, and tutors. Additionally, several family welfare educators were

Box 2 | Contraceptive use in Iran: a mix of methods

Modern methods were introduced in Iran in the 1960s, when the government allowed imports of oral contraceptives. Early efforts focused mainly on providing oral contraceptives, which may have slowed the program's growth. Traditional contraceptive methods had been used in Iran for centuries and may also have contributed to fertility decline in the 1970s, especially in urban areas. However, as early as 1989, data show a growing preference for modern contraceptive methods, which have steadily replaced traditional methods (see figures).



While oral contraceptives remain the most popular contraceptive method, female sterilization has gained steady acceptance and popularity, especially among women ages 33–34 from more religiously conservative provinces and with an average of five children. These women appear to use sterilization as a last resort when they have achieved their desired family size. Still unclear is whether these women had used any other form of contraceptive before sterilization.

Source: Abbasi-Shavazi 1998; Mehryar 2001; World Bank 2007.

trained for home visits and community outreach activities at mobile stops. These measures contributed to improved child survival: infant mortality rates fell dramatically, from 97.1 deaths per 1,000 live births in 1971 to 37.4 in 1998, contributing to the transition from high to low fertility.

Collect and use health sector data regularly.

Effective use of information can have an enormous impact. Information has been used to:

- Raise awareness of the need for family planning and focus political and technical attention on the issue.

- Guide service delivery approaches and design programs with a greater likelihood of success.
- Motivate program managers to higher levels of performance by sharing information with them on strategies and interventions that have worked elsewhere.
- Introduce mid-course corrections in program implementation.

3. Promote Demand for Family Planning Services

Bring about behavior change. Effective and extensive information campaigns, both through interpersonal communication and mass media, can greatly increase awareness of contraceptive

Box 3 | Thailand's winning strategies

Thailand reduced fertility dramatically, from 5.5 births per woman in 1970 to 1.8 births per woman in 2007. How?

By building a strong national program. The Thai program was established early and, along with other health programs, performed strongly. Capacity building of the health system was a priority. Improvements in a range of health indicators showed that the health system was capable of delivering services effectively.

By giving people a choice. The Thai family planning program is noted for providing a wide array of contraceptive methods, either free of cost or highly subsidized.

By rapidly building up services in rural areas. Family planning services tend to take off well in urban areas, but usually falter in rural settings. Thailand addressed this problem by using an established grassroots network to distribute modern contraceptives. Paramedical personnel were used to distribute oral contraceptives in rural areas.

By building on cultural values to reinforce change. Paramedics not only supplied the contraceptives, but also disseminated information on the need for family planning and the availability of different family planning methods. This legitimized people's concerns about having a large number of children and reinforced their desire for small families.

methods. Information campaigns for health and family planning programs can be integrated, to make the most of limited budgets.

- In **Botswana**, the Condom Social Marketing program generated demand for condoms for dual protection against HIV and pregnancy.
- In **Iran**, family planning counseling classes are a prerequisite for obtaining a marriage license. The classes inform couples of their family planning choices, encourage birth spacing, and provide samples of accepted contraceptives. In addition, compulsory population education is included in school and university curricula.
- In **Nicaragua**, a literacy brigade of 100,000 young people went into rural areas to teach elementary health principles. Along with health education—on sanitation, vaccination, and nutrition—

they disseminated information on contraception.

Promote prolonged breastfeeding. Prolonged breastfeeding can help to reduce the number of children and increase child spacing.

- In **Botswana**, cultural norms supporting prolonged breastfeeding and postpartum abstinence might have contributed to the fertility decline. The 2000 Multiple Indicator Survey reported that more than half of children ages 12–15 months were still being breastfed. In addition, the 1988 Botswana Family Health Survey found that half of women abstained from sex in the first year after delivery, and nearly half had not resumed menstruation one year postpartum. The prolonged breastfeeding coupled with postpartum abstinence has contributed to longer birth intervals.

4. Create an enabling environment

Support governments and other stakeholders in providing consistent support for family planning. Government backing for family planning needs to be maintained over a long period to affect fertility rates strongly and lastingly. This requires steady, strategic government and donor support to sustain family planning services. Almost all the programs studied had 20 or more years of consistent support; where support was not consistent and long standing (as in Pakistan), the impact on outcomes has been weakened. It is possible to provide steady support to family planning even where there is religious opposition.

- In *Algeria*, the government was able to win the broad support of religious leaders through a process of consultation. Algeria's experience challenges the widely held belief that Islam inhibits fertility reduction. Fertility declined in Algeria and women's age at marriage rose during the 1990s, at the height of the Islamist movement.

Support government efforts to enact laws increasing age at marriage and empowering women. All the case studies demonstrate the impact of women's empowerment on increased demand for family planning ser-

vices. Educated women are more able to make independent choices about delaying marriage and childbirth, limiting family size, and adopting contraception. Educated women are also better able to negotiate with their spouses, even in highly patriarchal societies.

- In *Iran*, the government reintroduced adult literacy programs as part of its efforts to educate people about family planning. The main beneficiaries were rural women. Although the relationship between female education and fertility is complex, it is clear that empowerment increases women's sense of control over their bodies and their lives.
- In *Algeria*, fertility declined despite the government's ambivalence toward the family planning program, largely because of broad gains in female education. The median age at first marriage and first childbirth also rises with women's education, another important contributor to reducing fertility. And by enabling more Algerian women to enter the labor force, gains in women's education further contributed to lower fertility: the 1970 national fertility survey (ENSP) found that employed urban women had fewer children.

How Can We Use this Information?

Some common strategies, applicable in varied sociopolitical settings, underlie the large fertility reductions in the case study countries. Some of the strategies relate to macroeconomic policies and programs (overall economic development, increased opportunities for employment). Others call for intersectoral coordination (women's empowerment through education and labor force participation).

- **Dialogue with governments.** There is strong evidence that sustained government commitment to family planning programming is positively related to significant declines in fertility. This evidence could be used to prompt commitment from senior levels of government.
- **Advocacy.** Even conservative countries have been able to gain support for contraception and family planning among religious leaders and other opponents by using economic and other data (for example, on high levels of youth unemployment and poor prospects for employment growth). Governments can often persuade religious leaders to support birth spacing efforts, if not a full family planning program.
- **Promoting intersectoral coordination.** Evidence shows that supporting investment in women's empowerment through female education and greater labor force participation can contribute directly to fertility reduction. The World Bank, in its programs in high-fertility countries, can encourage a multisectoral approach that promotes synergies across programs influencing fertility decisions, including education and poverty reduction. Mainstreaming the population and reproductive health agenda into the core strategies of both the Bank's Human Development and Poverty Reduction and Economic Management Networks could promote such a holistic approach.
- **Encouraging health systems reforms.** These case studies provide a good basis for promoting health systems reform in several areas: integrating and mainstreaming family planning services into the primary health care network rather than treating them as a separate program; promoting synergies within the health sector, for example, by encouraging condom use as a priority for both family planning and HIV/AIDS and other sexually transmitted illness control programs; improving the quality of care and service delivery for all services, which can improve maternal and child health outcomes overall; and focusing on monitoring and supervision to maintain close oversight and strengthen management of health programs.
- **Promoting opportunities for public-private partnerships.** Using as wide a network as possible to distribute and promote modern contraceptive products in-

creases access and thus the likelihood of their adoption. Partnering with the private sector in primary health care and

family planning services can increase access in underserved rural areas.

Some Limitations of the Approach

The study has identified policies, interventions, and environments that may have been associated with substantial fertility reduction in the selected case study countries. No attempt was made to attribute causality between interventions and fertility reduction. Second, the study is a desk review of the literature; no new research was conducted. Thus, it is possible that some determinants of fertility reduction were missed because they were

not covered in the literature. Finally, this study relied primarily on English-language sources and likely missed important work available only in national languages.

Full case studies and references are available at the HNP website: <http://www.worldbank.org/hnppublications>.

Annex 1. Criteria for the Selection of Countries for Case Studies

The cases studies covered 5 countries that have demonstrated significant total fertility reduction during 1980–2006 compared with other countries in the respective region. The following criteria were established to select 5 countries globally:

- **High total fertility rate as of 1980.** Total fertility rate trend data from 1980 to 2006 (the latest year with available data for most countries) in the World Development Indicators database was used to initially select high fertility countries as of 1980 (defined in this instance as total fertility rate more than 6.0). As a result, 61 countries were initially selected. The reference point of year 1980 seems appropriate, as many countries adopted population/family planning policies and started implementation of these policies through the 1980s and beyond after the World Population Conference in Bucharest in 1974.
- **Significant fertility reduction during 1980–2006.** Of the 61 countries with high total fertility rate in 1980, 22 countries which have experienced “significant” fertility reduction (defined as 40% or more during 1980–2006) were further chosen.
- i. **Medium to large scale countries.** Considering the applicability of good examples to other countries with continuing high fertility, countries with population size with less than 1 million were excluded. Accordingly, five countries—Bhutan, Maldives, Cape Verde, Comoros, and Solomon Islands—were excluded from the list of 22 countries.
- **Preliminary review of the literature.** Of the remaining 17 countries, preliminary review of the literature was conducted to obtain a general idea of (a) what factors/interventions have been discussed in the literature and (b) whether the amount and quality of information for the country is sufficient to conduct an in-depth country case study. This brought the number down to the 5 countries finally selected: Algeria, Botswana, Iran, Nicaragua and Pakistan

Table 1 | Countries with total fertility rate of 6.0 and above in 1980

Country Name	Region ¹	1980	2006	Difference between '80 and '06	Absolute reduction in TFR (%) between '80 and '06	Population size (2006)
Iran, Islamic Republic	MENA	6.58	2.06	4.52	69%	70,097,913
Algeria	MENA	6.76	2.41	4.35	64%	33,351,137
Bhutan	EAP	6.52	2.34	4.19	64%	648,766
Libya	MENA	7.26	2.79	4.47	62%	6,038,643
Maldives	SAR	6.88	2.67	4.21	61%	300,292
Syrian Arab Republic	MENA	7.30	3.16	4.14	57%	19,407,558
Oman	MENA	7.20	3.14	4.06	56%	2,546,325
Jordan	MENA	7.01	3.21	3.80	54%	5,537,600
Nicaragua	LAC	6.05	2.80	3.25	54%	5,532,364
Saudi Arabia	MENA	7.14	3.44	3.70	52%	23,678,849
Botswana	AFR	6.13	2.95	3.17	52%	1,858,163
Namibia	AFR	6.51	3.27	3.24	50%	2,046,555
Lao PDR	EAP	6.41	3.29	3.12	49%	5,759,402
Cape Verde	AFR	6.57	3.45	3.12	48%	518,562
Honduras	LAC	6.24	3.39	2.85	46%	6,968,687
Zimbabwe	AFR	6.96	3.80	3.16	45%	13,228,191
Comoros	AFR	7.20	4.03	3.17	44%	613,606
Pakistan	SAR	7.00	3.92	3.08	44%	159,002,039
Swaziland	AFR	6.22	3.54	2.68	43%	1,137,915
Solomon Islands	EAP	6.68	3.96	2.71	41%	484,022
Haiti	LAC	6.05	3.64	2.41	40%	9,445,947
Ghana	AFR	6.56	3.95	2.61	40%	23,008,443
Djibouti	MENA	6.68	4.06	2.62	39%	
Micronesia, Fed. Sts.	EAP	6.16	3.81	2.35	38%	
Cote d'Ivoire	AFR	7.41	4.58	2.83	38%	
Sao Tome and Principe	AFR	6.34	3.95	2.39	38%	
Yemen, Republic	MENA	8.70	5.61	3.09	36%	
Kenya	AFR	7.36	4.97	2.39	33%	
Sudan	AFR	6.41	4.35	2.06	32%	
Guatemala	LAC	6.14	4.24	1.90	31%	
Cameroon	AFR	6.40	4.43	1.97	31%	
Rwanda	AFR	8.50	5.94	2.56	30%	
Togo	AFR	6.98	4.91	2.07	30%	
Mauritania	AFR	6.28	4.46	1.81	29%	

(continued on next page)

Table 1 | Countries with total fertility rate of 6.0 and above in 1980 *(continued)*

Country Name	Region ¹	1980	2006	Difference between '80 and '06	Absolute reduction in TFR (%) between '80 and '06	Population size (2006)
Gambia, The	AFR	6.52	4.79	1.73	27%	
Zambia	AFR	7.12	5.27	1.85	26%	
Congo, Republic	AFR	6.11	4.55	1.56	26%	
Madagascar	AFR	6.48	4.88	1.60	25%	
Malawi	AFR	7.53	5.68	1.85	25%	
Senegal	AFR	7.00	5.30	1.70	24%	
Benin	AFR	7.12	5.51	1.62	23%	
Ethiopia	AFR	6.82	5.33	1.50	22%	
Nigeria	AFR	6.90	5.43	1.47	21%	
Burkina Faso	AFR	7.71	6.08	1.63	21%	
Guinea	AFR	7.00	5.52	1.48	21%	
Eritrea	AFR	6.50	5.14	1.36	21%	
Tanzania	AFR	6.62	5.26	1.36	21%	
Mozambique	AFR	6.48	5.19	1.28	20%	
Somalia	AFR	7.22	6.12	1.10	15%	
Niger	AFR	8.11	7.00	1.11	14%	
Mali	AFR	7.56	6.55	1.00	13%	
Angola	AFR	7.20	6.50	0.70	10%	
Chad	AFR	6.75	6.26	0.48	7%	
Uganda	AFR	7.10	6.70	0.40	6%	
Congo, Dem. Rep.	AFR	6.66	6.30	0.36	5%	
Liberia	AFR	6.90	6.78	0.12	2%	
Sierra Leone	AFR	6.50	6.48	0.02	0%	
Guinea-Bissau	AFR	7.10	7.08	0.02	0%	
Burundi	AFR	6.80	6.80	0.00	0%	
Afghanistan*	SAR	7.76	–	–	–	
Iraq*	MENA	6.53	–	–	–	

Source: World Development Indicators

¹ AFR= Africa; EAP= East Asia and Pacific; LAC= Latin America and Caribbean; MENA = Middle East and North Africa; SAR= South Asia.

Note*: The recent TFR data for Afghanistan and Iraq is not available in the World Development Indicators; the latest data for Afghanistan is 1987 (7.9 per woman) and 1997 for Iraq (5.37 per woman).

