

# Demography in Mali

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*Situation and implications*

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## Introduction

This study is mainly in the context of the next Session of the Board of PPD to be held in South Africa (Pretoria)

The focus will be to examine the evolution of the Malian population in recent years.

And see especially what are the different policies and programs implemented to achieve a certain stabilization of the population

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### 1. Mali: economic and social

Mali, a country in West Africa with an area of 1,241,238 sq. km, extending from the Sahara to the forest edge of Guinea and Côte d'Ivoire. It also shares borders with Algeria, Burkina Faso, Mauritania, Niger and Senegal.

**Figure 1: Map of Mali**



The country has eight administrative regions (District and houses the capital, Bamako), 49 circles and 703 communes.

The density varies from 90 inhabitants per square kilometer in the central delta of Niger to less than 5 inhabitants per square kilometer in the Saharan region of the North. The population is concentrated in the southern part of the country and along the Niger River. The Ségou, Sikasso and Koulikoro alone absorb 51% of the population. The three northern regions of Gao, Kidal and Timbuktu two thirds of the land area for only 10% of its population. To the south, the country is divided between the regions of Kayes, Koulikoro, Mopti, Segou, Sikasso and the District of Bamako.

Mali is one of the countries in the developing and poor countries (HIPC) and occupies the 160th out of 169 in HDI 2010. The following table provides an overview of the evolution of certain demographic variables and social-economic of the country.

**Table 1: Evolution of several variables, Mali**

Year	1976	1987	1998	<sup>1</sup> 2009
<b>Population (in thousands)</b>	6394	7696	9811	14 517
<b>GDP per capita <sup>2</sup></b>	206.33	237	217.66	304.24
<b>Growth rate of GDP <sup>3</sup></b>	13.62	-0.52	6.03	4.50
<b>Health expenditure (% of GDP)</b>			6.20	5.58

**Sources:** (i) World Bank Indicators, (ii) Preliminary RGPH 2009, Review of implementation of CSCR 2007 to 2011 Preliminary Results 2009 RGPH

US constant dollar (base year = 2000)

at constant prices (base year = 2000)

The data in this paragraph are taken from the 2010 balance CSCR 2007 to 2011

In Mali, although per capita GDP believes that growth is at a rate slightly decreasing. It should be noted that economic performance in Mali depends on several endogenous and exogenous factors including the public and private investment, the international environment (trade and official development assistance) and transfers of migrants. This decrease in GDP per capita may be due largely to demographic (population growth of 3.6% per year between 1998 and 2009), in determining the distribution of national wealth.

Strategies for poverty reduction implemented since 2002 have failed to achieve the objectives. The poverty rate increased from 68.3% in 2001 to 59.2% in 2005 whereas it was expected 47.5%. In 2009, 43.6% of Mali's population lives below the poverty line.

In terms of recent changes in social conditions <sup>4</sup> (i) the gross enrollment ratio (GER) in the first cycle of basic education increased from 79.5% in 2009-2010 to 80.4% in 2010-2011 but with marked regional disparities often, (ii) the rate of adult literacy (15

years and over) is at 29.4% (ELIM 2009), (iii) only 58% of the population lives within 5 km of a health center, 464 maternal deaths are recorded per 100 000 live births with a rate Infant mortality is 96 per thousand (56% of births are attended by trained personnel), (iv) the rate of prevalence of HIV / AIDS fell from 1.7% to 1.3% between 2001 and 2006, (v) between 2007 and 2010, the proportion of population with access to safe drinking water rose from 68.1 to 82% (in rural areas, this rate is 69% in 2010).

In the implementation of actions to achieve the MDGs by 2015, Mali is lagging behind. The greatest advances are in the areas of education, access to clean water and access to treatment for HIV / AIDS.

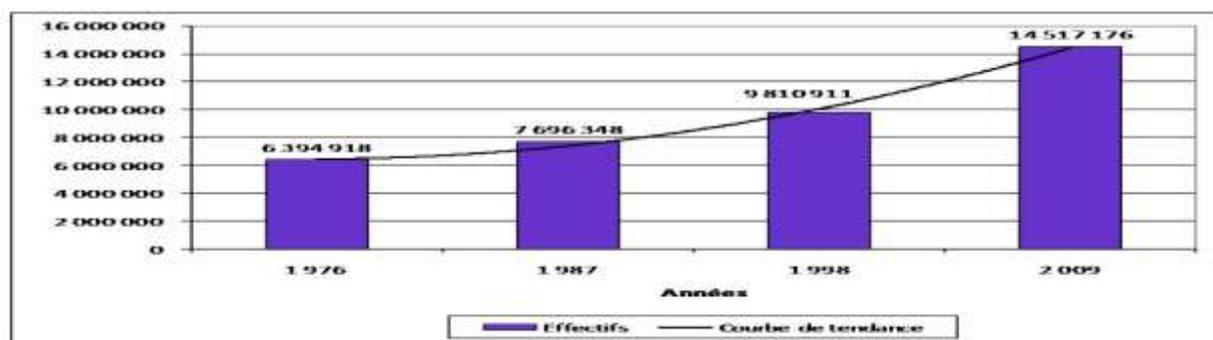
## 2. Demographic trends in Mali

### 2.1 Population dynamics

Mali has experienced since independence four population censuses (1976, 1987, 1998 and 2009). With regard to the last census, only preliminary data are available.

Between 1987 and 1998 the annual growth rate of the population stood at 2.2% and between 1998 and 2009, it rose to 3.6%. At current growth rates, the Malian population will reach about 30 million people in 20 years (5 times the population of 1976) with a density of 24<sup>5</sup> inhabitants per km<sup>2</sup> with its implications (pressure on natural resources, urbanization / migration rapid growth of social spending especially ...). The graph below shows the evolution of the Malian population since 1976.

**Figure 1: Evolution of the Malian population**



Source: INSTAT, Preliminary Results RGPH 2009

5 This density is relativized with respect to the land area (1,241,238 square kilometers) and the fact that nearly two thirds of the country are often in the Saharan zone with a density of less than one per km<sup>2</sup>.

Given the change in the number of its population, Mali is ranked in the group of countries, says traditional model, where for 20 years, mortality declined but birth rates remain at very high levels.

Several factors contribute to this rapid population growth in Mali. Indeed, it is found that:

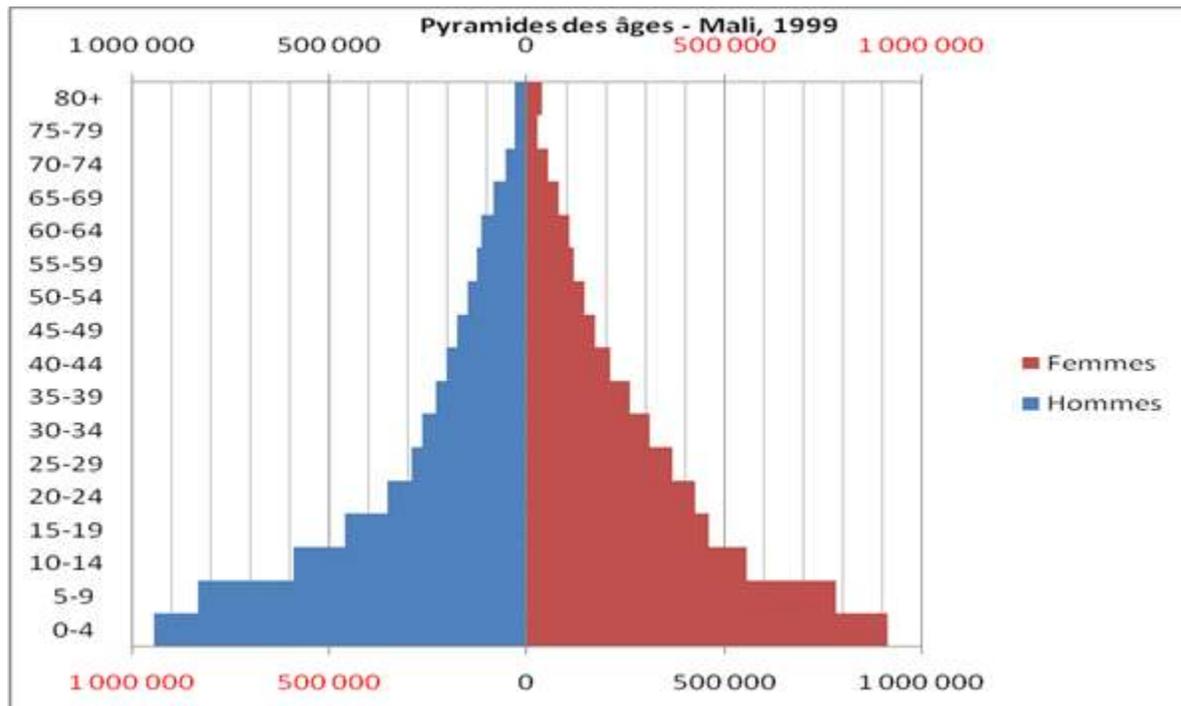
- the crude death rate was almost divided by 2 between 1950 and 2005 (over 30 per thousand to almost 15 miles) while the birth rate has remained almost constant over the same period to more than 50 miles;
- Mortality, especially mothers and children, fell sharply. The maternal mortality rate rose from 582 to 464 deaths per 100,000 live births between 2001 and 2006 and the infant mortality rate fell from 123 to 96 per thousand live births between 1990 and 2006. These trends continued downward have been encouraged by the strengthening of health coverage, improving the health system and strengthening the supply of health.
- Fertility is early, intensive and late (6.6 children per women) and very low contraceptive prevalence (6.9% in 2006). The Total Fertility Rate has remained virtually unchanged since 1987.
- Mali seems to be a land of transit and destination for thousands of people fleeing insecurity and conflict in the countries of the region. Net migration is beginning to reverse the benefit of immigration, it becomes positive.

## **2.2Population structure**

Mali's population lives mostly in rural areas (68.3% in 2006 against 73.2% in 1998) and is very educated (29.4% of persons aged 15 and over are literate in 2009 against 15.5% in 1998). The more women (50.4% according to the RGPH 2009) than men. Population projections of the National Population provide an overview of the age structure of the population in 1999 and 2035.

The structure of the Malian population is typical of that of countries with high rates of population growth and expansion. An analysis of age structure can realize how high fertility (6.6 children per woman on average) and the young population (60% are under 25 years).

**Figure 2: pyramid âges\_Mali 1998**



*Source: Based on data from the National Population*

Concentrated in the southeast quarter of the country, this population is predominantly rural (70%). However, urbanization is increasing rapidly and we see in particular the capital (Bamako) growing and expanding day by day.

The effects of the phenomenon of migration (internal and external) is little known in Mali but a statement reported a decline in the proportion of rural population is greatly reduced due to rural exodus and urbanization is today ' Today because of the magnitude of this internal migration but also return migration, because of political instability and economic cross many jurisdictions Home in Africa.

### **3. A view of the implications of rapid population growth on economic and social situation of Mali**

Mali is one of the few countries where the demographic transition has not yet begun when the economy is mainly based on the primary sector and the social demand growing at a rate much higher than economic growth. Indeed, rapid population growth leads to increased demand in social areas such as health, education, land management and urban housing, drinking water supply, energy etc. but also a constraint on economic performance.

### **3.1 Population growth and economic**

Economic growth is often low, fluctuating and largely dependent on exogenous factors, is a large phase shift with increasing population size and growth rate of the needs of young people. This results in absorption of capital gains and a slowdown in investment (source of growth) in the construction of quality infrastructure. Thus, over the period 2007-2011 capital expenditures were only 37% of total spending by the state while the CSCR provided 45.5%.

Rapid population growth may prevent the achievement of results of economic policies in a country like Mali, an area heavily dependent on primary and a more traditional third sector provider of relatively little labor. This could also lead to an increase in the share of public resources allocated to social spending without managing to increase the level of human capital despite the increase (though less than proportional) capital expenditure and operation: *whether more schools, more hospitals, it is also more teachers and health personnel*. In addition, if the population grows very quickly, the additional production (economic growth) is to be distributed among a growing number of people (and dependents), reducing the growth of per capita income.

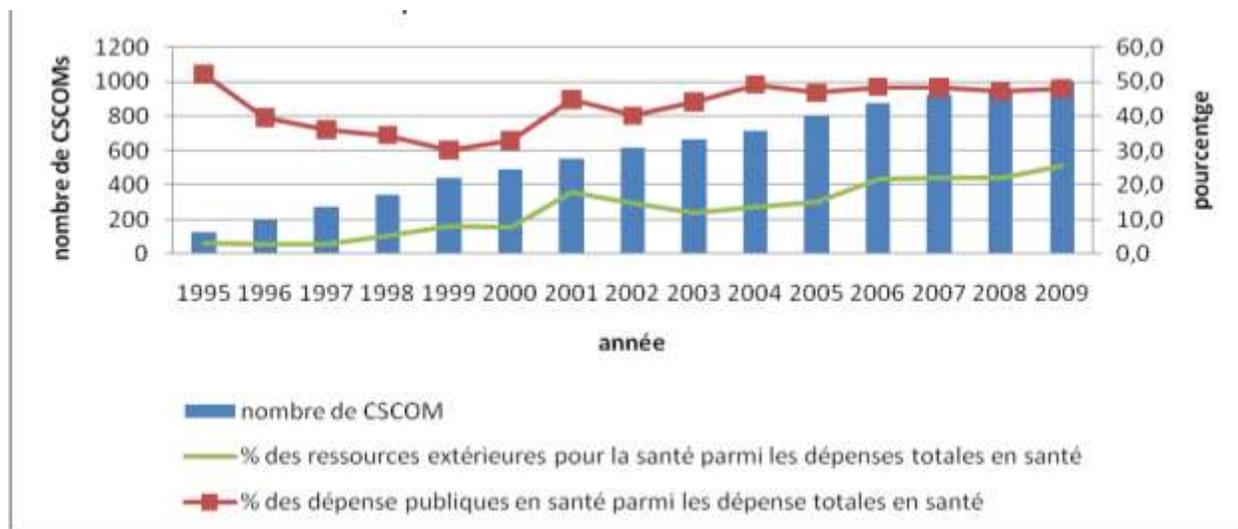
### **3.2 Population growth and supply of health services**

The problems associated with population growth are very noticeable in the field of health particularly through the increased needs at all levels of the health pyramid. High population growth due to the needs (ever increasing) health services, a real challenge for the structures in charge of this area.

The need for new infrastructure, equipment and hospital nursing staff is increasing year by year at an increasing rate. The gap financing the health sector is also growing, despite a greater external assistance.

At the end, achieving the MDGs and PRODESS is affected because of the consequences of rapid population growth on the supply of services and quality services. The following chart provides an overview of the development of indicators of the health system.

**Figure 2: Infrastructure (CHC), foreign aid and public expenditure on health from 1995 to 2009**



*Source: Note from a contribution of UNFPA to the formulation of Mali CSCR 2012 - 2017, July 2011*

### 3.3 Population growth and education

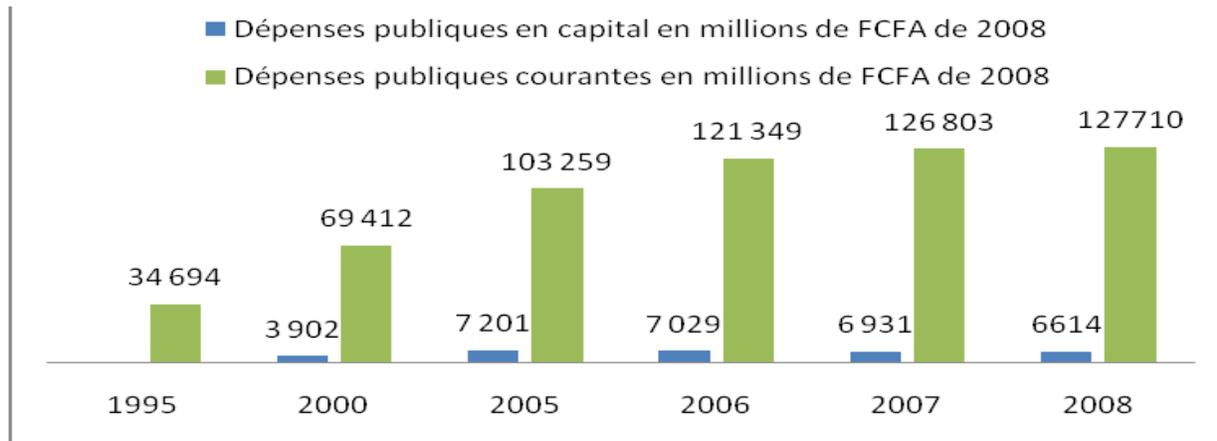
Public expenditure on education has quadrupled between 1995 and 2008. Despite the increasing efforts of the Government for education and partly because of the high population growth, indicators of education fall short of targets and thus constrain achievement of MDG 3. For example, the following table provides an evolution of public spending on education in Mali since 1995.

**Table 2: Evolution of current public expenditure and education in relation to population pressure on the sector, 2000**

Current expenditure	1995	2000	2005	2006	2007	2008
Millions of current CFA	22 603	49 240	89 203	110 189	118 088	127 710
in FCFA 2008 per child 7-15 years	14 729	25 541	32 727	37 330	37 860	37 010

Figure 3 shows how the constraints to population growth are enormous, particularly manifested by a large gap between current operating expenditures in the field of education and capital expenditures, that is, that investment in new infrastructure and equipment. The state, which is facing the rapid growth of the workforce each year, is finally forced to spend most of the resources allocated to the management of effects related to the increased demand in the various cycles of education.

**Chart 3: Composition of public expenditure on education**



*Source: CSR 2010*

### **3.4 Population growth and spatial imbalance**

The spatial distribution in Mali is characterized by a large disparity between the North and the South with an average density ranging from 1.3 per km<sup>2</sup> in the Timbuktu region to 37 in the region of Sikasso. There is also a high concentration of populations around the sources of subsistence (bed of the River Niger, wetlands) and in cities with economic functions. Thus, over 91% of the population occupies less than 25% of the country. The pace of this imbalance is steadily increasing since the first RGPH of 1976 which provided for the northern 14% of the total population as against less than 9% in 2009.

This spatial imbalance is not without impact on the environment and natural resources. For example, the economic consequences of environmental damage and inefficient use of natural resources and energy are evaluated from 2008 to 20% of GDP, more than 680 billion CFA francs. Population pressure on resources could rise in the coming years and threaten the survival of plant and animal areas and beyond the well-being of people in Mali and the poor especially in the current context of climate change.

Another consequence of rampant population growth, cities are becoming large without this development is the fact of greater industrialization. The rate of urbanization is increasing rapidly, mainly due to high migration from rural to urban areas. This poses the challenge of land use, infrastructure, crime, public health and sanitation / hygiene. The urban population rose from 22% in 1987 to 26.8% in 1998 and is located in 2006 to 31.7% of the total population.

#### 4. Family planning as a response to high population growth

The control of population growth undoubtedly going through the promotion and use of family planning services and birth spacing with respect to the high fertility rate in Mali. The implementation of an effective family planning is needed when you realize that since 1987 the fertility rate did not change significantly, remaining around 6.6 children per woman. In Mali, since 1991, a National Population Policy (NPP) exists and its implementation through the Priority Program of Action and Investments failed to achieve the objectives in population and development.

##### 4.1 Overview of the National Population Policy

The interest of national authorities to take account of population materialized in 1983 with the creation of a "population unit" to coordinate the work of a multi-sectorial group responsible for developing a population policy. A Statement of National Population Policy was adopted in 1991 and has been revised in 2003.

The architecture of government has increased the management of population policy in several departments (Ministry of Health, Prime Minister's Office, Planning and Land Management, Economics). The National Population Council (PSC) erected in 2004 for the management of the PNP is now attached to the Ministry of Economy and Finance.

The reading of the document on population policy in 2003, achievements included to quantify <sup>6</sup> (somewhat!) Targets and take into account the recommendations of the International Conference on Population and Development (ICPD, Cairo - 1994). The overall objective assigned to this policy is "improving the level and quality of living" through 10 objectives and 25 specific objectives.

In the area of reproductive health, for example, the policy should help:

6 Numerical targets have been identified in three goals on 10. These objectives related to education, health and fertility

- reduce maternal and infant, child and improve the health status of populations, especially in reproductive health (Objective 2) by, among others:
- the 50% reduction in prevalence of STIs (1.7% in 2001 to 0.5% by 2025);
- reducing maternal mortality from 582 deaths per 100,000 live births in 2001 to 291 by 2025;
- reducing the infant mortality rate from 113 ‰ in 2001 to 50 ‰ in 2025, and the child mortality rate from 128 ‰ in 2001 to 65 ‰ by 2025;
- Increasing the rate of uptake of reproductive health.

- contribute to the progressive control of fertility (Objective 3) by:
- the increase in modern contraceptive prevalence rate from 8.2% in 2001 to 30% in 2025;
- The promotion of age at first marriage of the girl 18.

The lack of means on the one hand and the low commitment of the players on the other (lack of understanding of the unifying role of the policy document and the role of coordinator DNP) had a binding impact on the achievement of priority actions identified in the documents of Priority Programs of Actions and Investments in Population (PPAIP) at national and regional levels, and the effective integration of population issues into policies and strategies in Mali <sup>7</sup>.

## **4.2 State Family Planning in Mali**

Following numerous interventions in outreach and advocacy, a law (No. 02-044) on the reproductive health and an Action Plan to ensure Secure Contraception were adopted respectively in 2002 by the National Assembly and the Government Mali. This national commitment was to contribute to the promotion of strong family planning in Mali on the one hand and also to national funding of contraceptive commodities. However, it is from 2009 that the government has committed since 2009 to support 10 to 15% of the annual cost of contraceptives.

Several other programs of reproductive health have been implemented with the support of technical and financial partners to meet in emergency care (EmOC and EmOC) in support of STI / HIV / AIDS. Given the somewhat marginal place of family planning in the financing of these programs and plans, Mali has undertaken since 2005 in favor of "repositioning family planning" with a national campaign for one month each year.

Today, some with the assistance of UNFPA, a Strategic Plan for Securing Products Reproductive Health (RHCS) was developed and is implemented with four components: obstetric and neonatal care, family planning, STI / HIV-AIDS and blood products.

The evolution of the appeal and use of family planning services is as follows.

**Table 3: Contraceptive prevalence in Mali**

DHS	EDS	EDS	EDS	EDS
	1987	1995 to 1996	2001	2006
<b>Contraceptive prevalence rate (without breastfeeding without LAM) in% of women</b>	<b>4.7</b>	<b>6.7</b>	<b>6.9</b>	<b>7.7</b>
• modern methods	1.3	4.5	5.7	6.4
• traditional methods	3.3	2.2	1.1	1.4

*Source:* inspired Guengant Diallo JP and H. (2009)

The level of use of contraceptive prevalence remains one of the lowest in the sub-region (e.g., when Benin, Burkina Faso and Togo to 17%). The non-use of contraceptive practice is reinforced by the persistence of certain customs. For women from 25 to 49 years, the median age at first birth remained constant (18.9 years) and one of the lowest in Africa. The proportion of adolescents (15-19 years) already mothers increased from 40% in 2001 to 36% in 2006 (EDS IV), already at that time in their lives, adolescents in this age group account for 14% to Total fertility.

Table 6 shows how the demand and use of family planning services is low in Mali, especially in women less educated and poorer. As noted above, the customs but the low level of education and poor decision-making ability may explain this situation. However, whatever the level of education and poverty status of women, the average number of children expected and desired by women is between 5 and 7 children.

**Table 4: Use, need and demand for contraceptive education and wealth quintile, DHS 2006**

	Use of contraceptives	Unmet	Demand for family planning			% Of demand met
			spacing	stop	total	
<b>By educational attainment</b>						
uneducated women	5.6	30.5	23.8	12.3	36.1	16
women in primary	14.1	31.6	33.2	12.5	45.8	31
female high school or more	29.0	38.1	52.4	14.7	67.1	43
<b>By wealth quintile</b>						
poorest women	3.7	31.7	23.6	11.8	35.4	11
very poor women	5.0	30.6	22.6	12.9	35.5	14
Poor	4.6	30.8	22.3	13.1	35.3	13
Foyennes	8.0	29.3	26.1	11.3	37.4	22
wealthy women	19.1	33.6	39.3	13.4	52.7	36
<b>TOGETHER</b>	<b>8.2</b>	<b>31.2</b>	<b>26.9</b>	<b>12.5</b>	<b>39.5</b>	<b>21</b>

*Source:* inspired Guengant Diallo JP and H. (2009)

### **4.3 Recommendations for effective promotion of family planning**

The suggestions are neither exhaustive nor exclusive.

- provide more opportunities for girls to reach a level of education equal to at least the key to allow them greater access to information on fertility;
- develop and implement a communication plan on reproductive health of women;
- implement a real plan of action for FP involving all stakeholders at central and local levels;
- Take into account effectively the issues of population throughout the planning process in order to achieve a harmonious and respectful of social, cultural and gender.

### **4.4 The strategy against HIV and AIDS**

In Mali, the context of the fight against AIDS is marked as much by assets as of the challenges:

- Mali is a signatory to major international commitments and sub-regional in the fight against HIV / AIDS: MDGs, UNGASS, Abuja;
- The march towards democracy and the general framework of shared governance are major assets;
- As part of fight against poverty and sustainable development are defined;

- The country's geographical location presents significant challenges and constraints to development and adequate supply of services to people;
- The economy is vulnerable;
- The level of access to education and communication is below the threshold required;
- The challenges of human development are many;
- The national policy statement of the fight against HIV and AIDS recommends that provide free care and medications (ARVs) to all PLWHA;
- The National Strategic Framework to Fight against AIDS (CSN) and the AIDS Sector Plan of the Ministry of Health (2005-2009) who put special emphasis on the decentralization of the prevention, care and treatment
- Policies, Standards and Protocols.

### **The prevalence of HIV / AIDS**

According to the results of DHS III (2001) and IV (2006), the prevalence rate increased by 1.7% in 2001 to 1.3% in 2006. Although small, the research and monitoring indicate risk seeking strong action

#### Sentinel surveillance

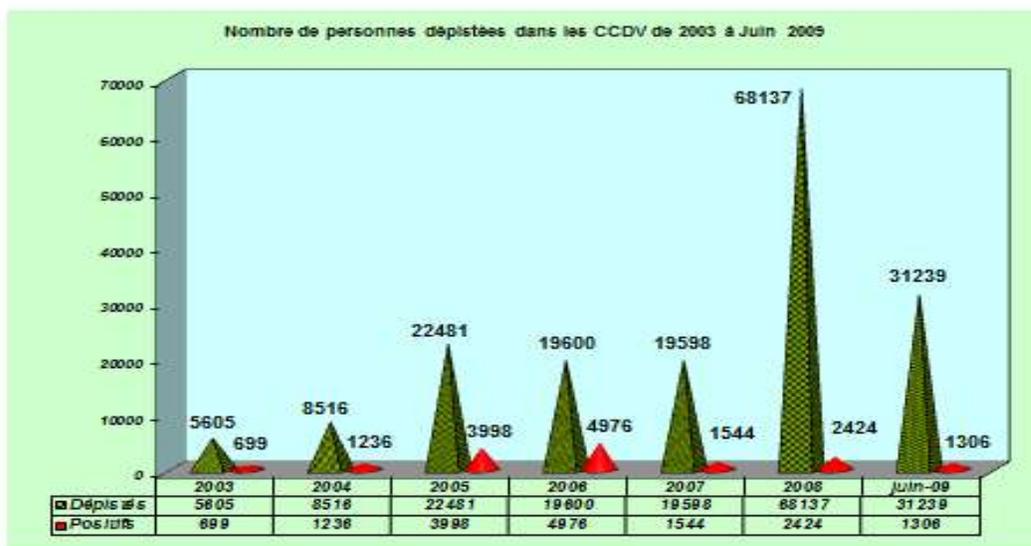
The integrated survey on the prevalence of HIV, STIs and behaviors among the groups most at risk (ISBS) carried out in 2006 gives the following results:

- Sex workers: 35.3%;
- Street vendors: 5.9%;
- Road: 2.5%;
- Touts: 2.2%;
- Caregivers: 2.2%.

## Blood safety

- Development of a national blood transfusion
- 8 antennas transfusion were created in areas in addition to the National Blood Transfusion Centre (CNTS) in Bamako;
- 140,743 units of blood were collected and tested at the eight antennas and the District of Bamako since 2006 including 28 762 of January to June 2009
- In addition to HIV, testing for hepatitis B (HBS), hepatitis C (HCV) and syphilis (BW) are performed on blood bags
- Security Care
- A national policy document on injection safety was developed;
- Training of staff at central and operational;
- Implementation of care packages of accidental exposure to blood (AEB)
- Supervision of activities to implement the policy of prevention in health care

**Figure 4: number of people screened in the CDS sites**



The main determinants of the epidemic in Mali are the sexual risk behavior, the important migration flows increasing internal and external vulnerability, widespread poverty makes people more vulnerable to the ravages of the epidemic, unequal gender relations exacerbate the risks, vulnerabilities and impacts of HIV / AIDS, discrimination, marginalization and stigmatization of PLHIV and families and communities affected by HIV / AIDS persist and finally, the impact of socio-cultural practices at risk affects efforts to create conditions that ensure a culture of inclusive care.

The impact of the epidemic affects all sectors of the economy by reducing the labor and working time, increased direct and indirect costs

The national response against the scourge is marked by both strengths and weaknesses. Among the strengths include a strong will and political commitment, an initiative of civil society.

The technical and financial partners help create the conditions appropriate strategic control.

The national policy statement of the fight against HIV / AIDS was adopted April 7, 2004 The High Council of National AIDS Control (HCNLS) has been reorganized. It has equal representation between the public sector, private sector and civil society that counts among its member representatives of associations of people living with HIV. The structure, as its implementing body, the Executive Secretariat, was placed under the direct responsibility of the Head of State. Representatives of development partners are also involved in HCNLS.

The fight against HIV / AIDS is based on the vision and mission includes:

The vision - Mali reverse the trends of HIV / AIDS in the population, raises the barriers to ownership, sustainability and good governance in the fight, reduce risks and vulnerabilities of individuals, families, communities and mitigates the impact of the epidemic on the economic, social and cultural development.

Mission - Through a multi-sectorial framework of response, coordinated by the HCNLS, anchored in the organs of local governance, rooted in communities and actively supported by a successful partnership of all stakeholders, Mali provides increased and the massive expansion of programs and interventions to promote:

- prevention of HIV / AIDS;
- care, treatment and support for individuals, families and communities infected and / or affected by HIV / AIDS;
- Mitigating the social, economic and cultural HIV / AIDS <sup>8</sup>.

<sup>8</sup> The vision and mission take into account the decisions taken at international level, including UNGASS, the Lomé Declaration on HIV / AIDS in Africa, the Consensus Action Plan Africa, the guidelines adopted at the International Conference on HIV / AIDS (ICASA), The Three Guiding Principles (Three Ones)

## **5. Conclusion and Recommendations**

High population growth (3.6%) can be regarded as a constraint to growth and economic development if we look at the structure of the Malian population. The very large proportion of young people under 25 can constitute a threat to social stability because of the constraints it faces unemployment, schooling, welfare.

The Government of Mali seems to have realized the urgency to act, embodied in the work of beginning the process of formulating the next CSCR: taking into account the demographic and population issues in general. But it remains to be succeeding in the integration of these questions in this CSCR under weak technical capacity of national structures in charge of the formulation and implementation.

## ANNEXES

### Key development indicators in Mali

Indicators	Year	Value
Current GDP at market prices (billions of CFA francs)	2009	8 996,4
Growth rate of real GDP (%)	2010	5.8
Nominal GDP per capita (in thousands of CFA francs) per year	2010	295.6
Population (million)	2010	14.2
Rate of population growth (in %)	2009	3.6
Life expectancy at birth (years)	2009	49
Incidence of poverty (in %)	2010	43.6
Prevalence of HIV / AIDS in adults (in %)	2010	A
Households with access to drinking water (in %)	2010	75.5
In urban areas (in %)	2010	79.3
In rural areas (in %)	2010	73.90
Proportion of malnutrition among children under 5 years (%)	2010	18.9
Infant mortality rate (per 1,000 live births)	2010	95.8
Child mortality rate (per 1,000 live births)	2009	101
Infant mortality rate - mortality (per 1,000 live births)	2008	178.9
Maternal mortality rate (per 100,000 live births)	2009	460
Gross enrollment ratio (GER) in primary education (in %)	2010	83.4
Girls (in %)	2010	74.9
Boys (in %)	2010	92.2
Parity index (Girls / Boys) in primary school (in %)	2010	79.7
Adult literacy rate (in %)	2010	78.4
Women (in %)	2010	72.1
Men (in %)	2010	84.8
<b>Source:</b> Document draft CSCR 2012 - 2017		

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